



Occupation: Retired
Status: Married with adult children
Financials: Owns own home, Fixed income
Tech: Tablet User, Needs Some Help

Care Needs: Complex
Conditions: COPD, Diabetes
Wants: Choices, Control, Straight Answers, Value for Money, Best Care

“ I’m not sure what I need, but I want the best care for the money I put into the system. ”

Gord’s Scenario:
Gord is facing a health crisis and has just been admitted to hospital. He is not yet aware of the changing health care system and doesn’t know what his options are. If his condition worsens, he does not want the same outcome as his parents (retirement home). He wants to remain independent and not be a burden to his family.

Gord’s Journey	Health Crisis - In Hospital (2 days)	At Hospital Discharge (24 hrs)	Arrive Home - In Community	Maintenance Period (3 mo)	Visit Emergency - Readmission	3 Month Reassessment	Service Discharge
Gord’s Goal	<ul style="list-style-type: none"> To understand his condition To heal quickly 	<ul style="list-style-type: none"> To get released quickly Not be a burden to his family To stay out of the hospital 	<ul style="list-style-type: none"> To feel safe at home To get back to “normal” To recover his independence 	<ul style="list-style-type: none"> To find a “new normal” To be independent To not be a burden on family 	<ul style="list-style-type: none"> To get better and return home 	<ul style="list-style-type: none"> To set & meet new daily living and recreational goals To heal and stay out of hospital 	<ul style="list-style-type: none"> To learn how to manage without CCAC and CSS Find other community resources
CCAC’s Goal	<ul style="list-style-type: none"> To catch him as soon as we can To engage with his care team asap Assert ourselves as the central source 	<ul style="list-style-type: none"> Create Care Plan based on his goals Give him the confidence to leave 	<ul style="list-style-type: none"> Service providers & equipment arrive on time Coordinator books appointment 	<ul style="list-style-type: none"> Having patient recover as per their treatment plan 	<ul style="list-style-type: none"> Learn about this visit & reason Identify changes needed to care plan 	<ul style="list-style-type: none"> Establish new goals for patient Improve adherence to care plan Lifestyle adjustment recommendations 	<ul style="list-style-type: none"> Ensure patient stays safe in home Ensure patient can now manage their own care
Gord’s Activities	<ul style="list-style-type: none"> Asking questions Receiving treatment, switching rooms Speaking to care team Calling family & friends 	<ul style="list-style-type: none"> Learning about care requirements Understanding impact on his life Getting lots of paperwork Increasing mobility/activity 	<ul style="list-style-type: none"> Getting comfortable Learning his limitations Trying to process instructions Adjusting to life - catch up with tablet 	<ul style="list-style-type: none"> Following his treatment plan Interacting with service providers 	<ul style="list-style-type: none"> Waiting, asking questions Getting tested & treated Speaking to care team Calling family & friends 	<ul style="list-style-type: none"> Tries to match goals with new reality and physical limitations Ongoing treatment (nurse, PSW, nutrition/smoking cessation counseling) 	<ul style="list-style-type: none"> Maintain new learned behaviours Manage care needs Address mental health care needs (if necessary)
CCAC’s Activities	<ul style="list-style-type: none"> Assessment Learn about his family and home situation to better support his needs Get referrals 	<ul style="list-style-type: none"> Assigning Gord a care coordinator Sharing information Presenting a plan Providing contact information 	<ul style="list-style-type: none"> Have his coordinator contact him and book a meeting Convey My Story and Set Goals 	<ul style="list-style-type: none"> Providing alternate resources Adjusting treatment services 	<ul style="list-style-type: none"> Consult with care team Reassess patient Update care plan 	<ul style="list-style-type: none"> Complete patient reassessment Create new plan/align with new goals Discuss continuation of CSS services with patient & discharge plans 	<ul style="list-style-type: none"> Convey the reason for discharge Provide patient with tools to manage the system post-discharge
Gord’s Thoughts	<ul style="list-style-type: none"> Has a high expectation of service Thinking about their own mortality “I don’t know what questions to ask.” “Why do I have to repeat myself?” “Who are you now?” 	<ul style="list-style-type: none"> “How will this affect my lifestyle?” “I’m afraid to talk to the doctor about these private matters.” “How will I remember all this?” “I don’t want my wife to be my nurse.” 	<ul style="list-style-type: none"> “I need to process all of this info.” “I want some private time.” 	<ul style="list-style-type: none"> “Why isn’t this covered?” “I thought I paid for this.” “How can I manage these gaps in care?” 	<ul style="list-style-type: none"> “Here we go again.” “I thought I would be fine.” 	<ul style="list-style-type: none"> “I think I’m better, but afraid to be alone now.” “I still need more care/services.” “My family can’t do it all.” 	<ul style="list-style-type: none"> “I hope I can stay healthy and manage on my own.” “Life is changed forever now.”
Gord’s Feelings	<ul style="list-style-type: none"> Afraid / Overwhelmed / Confused Angry / Stressed / Out of control Dehumanized / Vulnerable 	<ul style="list-style-type: none"> Worried / Depressed / In Denial Conflicted 	<ul style="list-style-type: none"> Relief More In Control Depressed (limitations) 	<ul style="list-style-type: none"> More Relaxed Concerned / Fear Possible Denial (mental health) 	<ul style="list-style-type: none"> Afraid / Frustrated Irritated / Stressed / Out of control Unconfident 	<ul style="list-style-type: none"> Relieved yet afraid Guilt (family re: readiness for discharge) 	<ul style="list-style-type: none"> Some Fear & Anxiety Increasing in Confidence
Gord’s Pain Points	<ul style="list-style-type: none"> Inconsistent messages, fear of the unknown, lack of “human” quality 	<ul style="list-style-type: none"> Information overload, learning self-care, conflict with family 	<ul style="list-style-type: none"> Understanding medical terms, dealing with limitations of self and caregiver 	<ul style="list-style-type: none"> Family availability, financial surprises, finding more resources 	<ul style="list-style-type: none"> Inconsistent messages, repetition of information, lifestyle adjustments 	<ul style="list-style-type: none"> Comparing level of care to others Quality & Level of care available 	<ul style="list-style-type: none"> Stress at home re: care requirements Financial concern re: no subsidies
Opportunities	<ul style="list-style-type: none"> Ideally, HCC visits BEFORE discharge Tell family about CCAC May be best to stick with in-person communication only at this point so as not to overwhelm the patient/caregivers with documentation 	<ul style="list-style-type: none"> Give Gord time to settle in Talk to BOTH Gord AND his caregiver Let him know what will happen next Inform him who to call for what 	<ul style="list-style-type: none"> Find out what’s important to Gord Set expectations for 3 months Re-Introduce Bill of Rights in more detail now that he’s able to process the information, but don’t overwhelm with forms 	<ul style="list-style-type: none"> This is a good time to convey (on an on-going basis) the portions of the BoR that address what to do when things go wrong Convey through after hours calls and CCC visits Get feedback on the BoR 	<ul style="list-style-type: none"> Talk to Gord and caregiver about changes to plan, who to call, and what to expect next 	<ul style="list-style-type: none"> Work with Gord and family to review goals, household etiquette, long term maintenance plan 	<ul style="list-style-type: none"> Can call 60-90 days after to request feedback
Touchpoints	<p>Pre-crisis: Consider offering brochures in doctor’s offices, pharmacies, etc. to educate about existence of CCAC and the changing healthcare system, BEFORE the service is needed.</p>	<p>HCC could provide link to video/slideshow OR a well-designed booklet with relatable stories/analogs to convey BoR components (vs. current text-only format which would likely be lost in a mountain of paperwork).</p>	<p>Assigned coordinator meets in home and discusses BoR in detail (provides folder and plan), but could also leave behind BoR “story” booklet which directs them to the site for more info.</p>	<p>Consider sending a weekly email with one friendly BoR “story” per week. PSW’s could also leave behind “story” postcards that would allow the patient or caregiver to provide feedback via snail mail, email or online.</p>	<p>HCC could review BoR again, however patient should have a full understanding of the bill by this point. Ideally, the assigned coordinator would make contact to follow-up on care (phone).</p>	<p>BoR is most relevant to patient only when things go wrong. If that is during this phase of the journey, then coordinator should review BoR again. Continue emails/social media campaign/story post cards.</p>	<p>Upon follow-up, encourage patients and caregivers to share their positive stories for use in future educational/marketing materials.</p>
BoR Relevance	<p>1.1 1.2 1.3 2.1</p>	<p>1.1 2.1 3.1</p>	<p>1.1 2.1 2.2 2.3</p> <p>3.1 3.2</p>	<p>2.1 2.2</p>	<p>1.1 1.2 2.1 2.2</p> <p>2.3 3.1 3.2</p>	<p>2.1 2.2 2.3 2.2</p> <p>3.1 3.2 3.3</p>	<p>3.2</p>