



Review of Coordinated/Centralized Access Mechanisms: Evidence, Current State, and Implications

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KEY MESSAGES

- For some time, there has been a lot of interest in making it easier to access mental health and addiction services in Ontario. In the past 10 years, approaches to coordinated or centralized access have grown rapidly across the province. Many have appeared recently and more are being developed.
- Together, these approaches represent a major evolution in the way mental health and addiction service are being delivered. But there is no published description of the different coordinated or centralized access approaches across Ontario. There also is no summary of the research that can help improve and evaluate current approaches.
- We undertook a project to review the ways that coordinated and centralized access for mental health and addiction services is being done across Ontario. This unique project not only describes these approaches but also includes a review of scholarly articles, books, and other sources on the subject.
- This project did not evaluate the various approaches. Instead, it describes the coordinated and centralized access landscape in Ontario to start a discussion on lessons learned and to facilitate planning, performance measurement, and evaluation.
- Coordinated access aims to simplify access to services by using consistent processes and tools to assess and refer clients needing mental health and addiction services.
- We need more research on different approaches and their use in different settings to be able to identify which ones are most effective. One of the challenges is that the approaches that have been evaluated are specific to the region where they are being used, so it is difficult to draw firm conclusions about how effective they would be in a different context.
- Strong leadership, stakeholder buy-in and adequate resources were reported to be the most important factors for successful implementation. The flexibility to adapt to local circumstances and ongoing collaboration of key stakeholders were found to be crucial for the viability of the coordinated access approach.
- Suggested next steps:
 - There should be thoughtful discussion of the main findings and their implications at the provincial and regional level.
 - These discussions should put a strong focus on evaluation.

- At the provincial level, evaluation questions should consider the efficiency and capacity of the larger mental health and addictions system to handle a major increase in demand for treatment.
- There is a need to engage a broader range of stakeholders in the next phase.
- A planning guide or resource toolkit based on the findings of this report might be helpful to support future development of regional and local access models.

EXECUTIVE SUMMARY

For some time there has been a strong interest in improving access to mental health and addiction services in Ontario and, over the past 10 years, many coordinated or centralized models have proliferated across the province. Many are quite recent and more are under development. ConnexOntario, a provincial program aimed at facilitating access to treatment and support services, has been in existence for almost 25 years and there are varying levels of collaboration between the relatively new regional access services and this long-standing provincial program. Together these various models of coordinated and centralized access constitute a major evolution in the landscape of Ontario's mental health and addiction service delivery system. There is currently no provincial description of these services, and no published synthesis of relevant research literature that may guide continued evolution and evaluation.

It was in this context that Addictions and Mental Health Ontario (AMHO) and the Centre for Addiction and Mental Health (CAMH) Provincial System Support Program (PSSP), undertook a project to review the current status of coordinated and centralized access for mental health and addiction services across Ontario. This is a "first-of-its-kind" project that describes the coordinated access models for mental health and addiction services across Ontario, and placed in the context of a comprehensive research synthesis. This project was led by Dr. Brian Rush, Scientist Emeritus at CAMH and supported by Birpreet Saini, Research Policy Analyst at AMHO. It was funded by the Ministry of Health and Long-Term Care. It is important to note at the outset that the project was not an *evaluation* of the province's coordinated or centralized access models but rather a descriptive *environmental scan* intended to prompt reflections on lessons learned, and facilitate future planning, performance measurement and evaluation.

The authors drew on multiple data sources, including : (a) an exhaustive literature review of research on the topic, which included the examination of similar models in other health and social service sectors, (b) interviews with Mental Health & Addiction leads from each of the 14 LHINs focusing on approaches to coordinated and centralized access being implemented and those being planned or considered, (c) follow-up interviews with individuals who are more directly involved in delivering many of Ontario's access services, including ConnexOntario, CritiCall Ontario (for the Inpatient Mental Health Bed Registry Project) and (d) program documents including utilization statistics, wherever available. The report begins with a background on models and frameworks to improve access, followed by findings from the literature review, and a description of the different coordinated access approaches for mental health and addictions across Ontario. They then discuss implications for more evaluation work and current and imminent provincial initiatives.

Coordinated access offers the promise of simplifying access to services through the consistent use of standardized processes and tools for assessment and referral. It can be understood using

a “traffic system” analogy, as a system that has an efficient flow of traffic because of clear “rules of the road”. In general, there are two models of coordinated access: centralized (single point of access for services) and decentralized (every door is the right door – multiple locations to access services).

The research reveals mixed findings about the effectiveness of coordinated access models. Further research is needed on different approaches and in different contexts before this approach should be considered as a “best practice” in system design and development. While the concept remains very attractive, the research does not point to any optimal approach or the “critical ingredients” of a good model. One of the challenges is the context-specific nature of the programs that have been evaluated and which makes it difficult to draw firm conclusions across the body of evidence.

The findings of our review clearly indicate strong support for coordinated access mechanisms in the mental health and addiction sector across Ontario. In order to facilitate description, critical reflection and consideration of future implications we categorized the Ontario models based on their “complexity”. “Complex” models included: Waterloo Wellington LHIN, Mississauga Halton LHIN, Champlain LHIN, South West LHIN, Central and Toronto Central LHIN, and less complex models included Hamilton Niagara Haldimand Brant LHIN, Central West LHIN, South East LHIN, North East LHIN, North West LHIN and Erie St. Clair LHIN. The models developed in these regions differ in terms of number of access points, services offered at each access point, referral process, and authority/scope of intake. Strong leadership, stakeholder buy-in and adequate resources were reported to be the most important factors for successful implementation. Flexibility of the model, for example, to adapt according to local circumstances, and ongoing collaboration of key stakeholders were found to be crucial for the viability of the coordinated access approach.

We suggest that next steps include a thoughtful discussion of the main findings and implications of the results among the key players provincially and regionally. One important limitation of the current project is that resources did not allow for a wider process of data collection, for example, gathering the perspective of the many program managers and staff who are, or will be serving the clients who access their services through a central access model. Their perspective is critical to a more complete assessment of the impact of these central access models, including potential unintended consequences.

Direct input from clients and family members is also very important going forward. Furthermore, our focus here was on “specialized” mental health and addiction access models and related services while a large percentage of people seeking help do so through, for example, community health centres, family health teams, school counselling, to name just a few critical sectors and services also affected by and affecting movement toward more

coordinated access models. In short, feedback is needed on our report not only from the key stakeholders contributing to it, but also a much wider range of stakeholders.

We suggest that critical reflections on our report should include a strong focus on evaluation needs going forward. This can occur, for example, by posing critical questions about particular models and the contexts in which they exist. However, questions can also be posed at a higher level, for example, what are the critical success factors for this overall provincial move towards more coordinated access, how does it fit with other major provincial initiatives to improve evidence-based practice (e.g., new staged screening and assessment tools) and performance measurement and quality improvement (e.g., provincial performance indicators and/or the emerging, common approach to assessing client perception of care with the OPOC-MHA tool). Perhaps most importantly, a provincial lens to evaluation could address important questions related to the efficiency and capacity of the larger mental health and addictions system response to handle a major increase in treatment demand. A developmental approach to future work could be used to examine critical questions at a provincial level but with a view to contributing workable solutions to critical questions about the overall “health” of Ontario’s treatment and support system for mental health and addiction concerns.

Lastly, our review identified a host of lessons learned and potential challenges in the planning and implementation of a more coordinated approach to accessing mental health and addiction services. We see the potential for a planning guide or resource toolkit to support future development of regional/local access models. And put this forward for consideration within next steps and among relevant stakeholders.

If you have any questions regarding this project or the report and would like further information, please contact info@addictionsandmentalhealthontario.ca.

1. INTRODUCTION

For some time there has been high interest in improving access to mental health and addiction services in Ontario. Over the past 10 years, coordinated or centralized models have proliferated across the province. Many are quite recent and more are under development. ConnexOntario, a provincial program aimed at facilitating access to treatment and support services, has been in existence for almost 25 years¹ and there are varying levels of collaboration between the relatively new regional access services and this long-standing provincial program. Together, these models of coordinated and centralized access constitute a major evolution in the landscape of Ontario's mental health and addiction service delivery system. There is currently no provincial description of these services, and no published synthesis of relevant research literature that may guide continued evolution and evaluation.

It was in this context that Addictions and Mental Health Ontario (AMHO) and the Centre for Addiction and Mental Health (CAMH) Provincial System Support Program (PSSP), undertook a project to review the current status of coordinated and centralized access for mental health and addiction services across Ontario. This is a "first-of-its-kind" project that describes the coordinated access models for mental health and addiction services across Ontario and placed in the context of a comprehensive research synthesis. This project was led by Dr. Brian Rush, Scientist Emeritus at CAMH and supported by Birpreet Saini, Research Policy Analyst at AMHO. It was funded by the Ministry of Health and Long-Term Care. It is important to note at the outset that the project was not an *evaluation* of the province's coordinated or centralized access models but rather a descriptive *environmental scan* intended to prompt reflections on lessons learned, and facilitate future planning, performance measurement and evaluation.

2. OBJECTIVES

- 2.1. To review the literature on coordinated and centralized access models and strategies.
- 2.2. To assess and describe current status of coordinated and centralized access for mental health and addictions in Ontario. This includes an assessment of what is being implemented, as well as what is being, or has been, planned and considered.
- 2.3. To identify lessons learned and implications for current and imminent provincial initiatives

¹ Drug and Alcohol Registry of Treatment (DART) started in October 1991, Ontario Problem Gambling came in 1997 and mental health was added in 2005.

3. PURPOSE

The findings of this review will help to describe the elements of an integrated approach that can facilitate centralized/coordinated access to mental health and addiction services. This review will be the first of its kind to identify variations across that continuum. The findings will then inform decision making, development of new strategies, and/or modifications of existing models/approaches. It will also set the stage for evaluation of existing coordinated/centralized mechanisms.

4. METHODS

4.1. LITERATURE REVIEW OF COORDINATED ACCESS MODELS AND STRATEGIES

Relevant peer reviewed journal articles, reports and government documents published in English were searched from 1990 to September, 2015 using the search terms: “centralized access”, “centralized services”, “integrated care”, “coordinated care”, “coordinated access”, “collaborative care”, “continuity of care” and “seamless care”. Reports, best practice guidelines, toolkits and presentations prepared for the Ontario Ministry of Health and Long Term Care (MOHLTC) have also been included. The websites of LHINs were also searched for reports, conference proceedings, planning documents and meeting notes. Reference lists of relevant journal articles and reports were searched to find all pertinent literature not retrieved by the electronic search. Table 1 below lists the main databases and websites sourced for the literature review.

Table 1 Databases and websites sourced for the literature review

Library Databases	Websites	Government websites
Google Scholar	Canadian Mental health Association	Health Canada
PubMed	Center for Substance Abuse Treatment	Ministry of Health and Long-Term Care
PsychINFO	Ontario Centre of Excellence for Child and Youth Mental Health	
MEDLINE	All 14 LHINs in Ontario	
EMBASE	Coordinated access program websites (for e.g. Here 24/7, One Link, OOARS, Access Point, Streamlined Access, Central Access, Coordinated Access to Addictions Services, Access CAMH)	
	ConnexOntario	
	CritiCall Ontario	

4.2. REVIEW OF THE LOCAL SERVICES SYSTEM

Semi-structured interviews were conducted with Mental Health and Addiction Leads at all fourteen LHINs in Ontario using an interview guide (See Appendix A). Contact was initiated with a personalized email request for an interview with a short description of the research purpose and interview guide attached. Interviews were then conducted individually over the phone or in person. Anonymity was guaranteed in order to give participants the opportunity to freely express their views (See Appendix D for verbal consent form). A second round of interviews was done with managers/leads of the central access programs in Waterloo Wellington, Champlain, South West, Toronto Central and Central LHINs. The purpose was to check the reliability of data collected in the first round and supplement the first interview. For a list of key informants interviewed for the project, see appendix E.

Interviews were also held with key informants at ConnexOntario and CriteCall Ontario (For interview guide see appendix B and C). Connex Ontario is the key provincial organization collecting, validating, and distributing mental health and addiction information across Ontario. CriteCall Ontario operates the Provincial Inpatient Mental Health Bed Registry which contains information about the specific services provided by each hospital in Ontario, as well as the availability of all critical and acute care beds within those hospitals.

5. LIMITATIONS

Following are limitations related to methodology of the review:

- The work of Community Health Centers (CHCs), Nurse Practitioner-Led Clinics (NPLCs), and Aboriginal Health Access Centers (AHACs) has not been captured as they were not included in the interviews.
- The findings do not reflect experiences of service providers potentially impacted by coordinated/centralized access in their region.
- The findings do not reflect experiences of clients and their family members.

6. FINDINGS FROM LITERATURE REVIEW

6.1. ACCESS: DEFINITIONS, DIMENSIONS, BARRIERS, INDICATORS

Access is a fundamental feature of healthcare systems and an important concept in planning the delivery healthcare services. The World Health Organization has defined access to healthcare as, “the continuing and organized supply of care that is geographically, financially, culturally, and functionally within easy reach of the whole community. The care has to be appropriate and adequate in content and in amount to satisfy the needs of people and it has to be provided by methods acceptable to them” (p. 58).¹ Access is a complex notion and has been

interpreted in different ways: ² while some see it as the, “degree of fit between the clients and the system” (p.128),³ others have conceptualized it at the interface of clients and healthcare resources.⁴ It has also been viewed as the degree of utilization of healthcare services by the population.⁵

The College of Family Physicians of Canada defines access as the “extent to which an individual who needs care and services is able to receive them; more than having insurance coverage or the ability to pay for services; determined by the availability and acceptability of services, cultural appropriateness, location, hours of operation, transportation needs, costs and other factors.”⁶ Most frequently, in Ontario and elsewhere it has been related to the ability or willingness of clients to enter the healthcare system.^{7, 8}

There are five dimensions of access: 1) Approachability; 2) Acceptability; 3) Availability and accommodation; 4) Affordability; 5) Appropriateness, and from a patient-centered perspective, the corresponding dimensions of accessibility are: 1) Ability to perceive; 2) Ability to seek; 3) Ability to reach; 4) Ability to pay; 5) and Ability to engage.⁹ These are described below:

- Approachability is related to the availability of information about services and treatments and the ability to perceive need for care.
- Acceptability includes the factors that influence the likelihood for people to accept the services and the ability to seek care includes the autonomy and capacity to seek care.
- Availability and accommodation means that health services can be reached in a timely manner and ability to reach health care is related to the mobility of those seeking care. Affordability and the ability to pay is related to the economic capacity of people to spend resources on services.
- Appropriateness includes the provision of services that meet client’s needs and the ability to engage is related to the participation of client’s in making decisions related to their treatment.

The disparities in access to healthcare have been explained in terms of geographic barriers (spatial access to healthcare providers),¹⁰ socio-demographic factors (aspatial access), such as social class, income, ethnicity, age, sex, etc.,¹¹ structural factors (e.g. long wait lists, continuity of care),¹² financial barriers (e.g. low income, insured vs. uninsured)¹³ and cognitive factors (e.g. health literacy, patient-provider communication).¹⁴ In the health economics literature, the concept of access has been studied as the interaction between supply-side factors (healthcare staff, technology, quality of services) and demand-side factors (information about providers/services, education, cultural preferences, beliefs, attitudes and norms).¹⁵ Ensuring equitable access is about getting supply and demand in equilibrium. As a result, the determinants of supply and demand directly influence access to healthcare services by acting as barriers or facilitators. ^{16,17}

The indicators for access should be directly observable, objectively measurable, reliable, and have good predictive validity with regards to utilization.¹⁸ These elements are highlighted at different levels in Table 2 below:

Table 2 Determinants of Access

Access dimension	Individual characteristics	Community characteristics	Health system characteristics	Provider characteristics
Geographic	<ul style="list-style-type: none"> Residential location Employment location Available modes of transportation 	<ul style="list-style-type: none"> Physical Geography such as terrain, and weather Built environment such as road quality, traffic conditions and public transportation 	<ul style="list-style-type: none"> Service locations Outreach programs Telemedicine services Contracting with non-VA providers 	<ul style="list-style-type: none"> Willingness to practice in remote locations Circuit riding
Temporal	Opportunity cost of time (depends on responsibilities at work and home)	<ul style="list-style-type: none"> Work hour flexibility of local employees Availability of child care services 	<ul style="list-style-type: none"> Hours of operation Wait-times 	Stays on appointment schedule
Financial	<ul style="list-style-type: none"> Household annual income Service connection Private insurance status 	Health benefits offered by insurance companies and public programs	<ul style="list-style-type: none"> Eligibility policies Co-insurance rates Charges 	<ul style="list-style-type: none"> Orders unnecessary tests Conducts unnecessary procedures Prescribes generic medications
Cultural	<ul style="list-style-type: none"> Age Race and ethnicity Marital status Health literacy Coping style Religiosity and spirituality Social support Community embeddedness 	<ul style="list-style-type: none"> Social norms Public stigma 	<ul style="list-style-type: none"> Provision of services tailored to special populations (e.g. VA women's clinics) 	<ul style="list-style-type: none"> Cultural competency Multilingual capability Communication style Provider stigma
Digital	<ul style="list-style-type: none"> Availability and sophistication of personal communication 	<ul style="list-style-type: none"> Broadband availability Satellite coverage 	<ul style="list-style-type: none"> Synchronous patient-to provider communication systems 	<ul style="list-style-type: none"> Computer literacy Willingness to communicate

	<ul style="list-style-type: none"> technologies • Computer literacy 	<ul style="list-style-type: none"> • Public use computers 	<ul style="list-style-type: none"> • Asynchronous digital patient-to-provider communication systems • Digital peer-to-peer communications • Computer health applications 	<ul style="list-style-type: none"> digitally • Receives reimbursement or workload credit for encounter less digital communications
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Adapted from Fortney et al. (2011)

Although the Canada Health Act seeks “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers”,¹⁹ many Canadians are not receiving the required mental health services, including addictions.^{20,21} In 2012, an estimated 600,000 Canadians reported that in the previous 12 months they had unmet mental healthcare needs, and more than 1,000,000 had partially met mental healthcare needs.²² They reported barriers to access because of factors including, stigma,^{23,24} low income,²⁵ race/ethnicity,^{26,27} language differences,²⁸ lack of integration between mental health and health services,²⁹ shortage of mental health professionals,³⁰ regional disparities³¹ and cross cultural diversity.³² As a result, the evidence suggests that demand for mental health services appears to be exceeding its supply and a large proportion of the population is not receiving appropriate services to meet their mental healthcare needs.

6.2. HELP-SEEKING FOR MENTAL HEALTH PROBLEMS AND ADDICTIONS

Help-seeking behaviour of those in need has been described as, “the behaviour of actively seeking help from other people. It is about communicating with other people to obtain help in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience”(p.4).³³ It is a multi-stage process, which includes recognizing the need for care, making a decision to seek help and choosing a source of help.³⁴ In response to mental health problems, help can be sought from formal (mental health professionals) or informal sources (friends and family).

A systematic review on help-seeking for *mental health problems* found that the prominent barriers to help seeking were stigma and embarrassment about seeking help, concerns about confidentiality, lack of understanding about the symptoms of mental illness, lack of knowledge about mental health services, lack of accessibility (e.g., time, transport, cost) and negative attitude of the healthcare providers.³⁵ In contrast, people with positive past experiences,³⁶ higher level of education³⁷ and greater episode length³⁸ were more likely to seek help. Certain cultural beliefs have been found to be negatively associated with help-seeking attitudes due to

the stigma associated with mental illness.^{39,40} Several studies have reported age and gender-related differences in help seeking attitudes; older adults and women were found to be more likely to seek professional help for mental problems.^{41,42,43} Also, greater social support increased the likelihood of seeking help from informal sources.

The barriers to treatment for those with *substance use problems* have been discussed as internal factors, i.e. beliefs or perceptions within the person and external barriers, related to the health care system, and socio-cultural–environmental factors.⁴⁴ Internal barriers include: lack of incentives to go for treatment,⁴⁵ fear of disclosure of their addiction to spouse/family member,⁴⁶ stigma,⁴⁷ privacy concerns,⁴⁸ time demands,⁴⁹ inconvenience,⁵⁰ and the belief that treatment will not be beneficial.⁵¹ External barriers include: wait times,⁵² lack of health insurance coverage/cost,⁵³ eligibility criteria (e.g. the need for ID)⁵⁴ and lack of inter-agency coordination.⁵⁵ Social pressure has been identified as both a facilitator and barrier to help seeking.⁵⁶

6.3. IMPROVING ACCESS

There is a growing body of evidence about the models of health systems that support accessible and effective delivery of health and mental health services. Table 3 below summarizes some of these models.²

Table 3 Models for improving access to healthcare services

	Models for improving access to healthcare services	Author/Year
Potential vs. Realized Access	The proposed model recognizes that <i>potential</i> access to healthcare is related to the availability of health care resources relative to their needs, and <i>realized</i> access is related to the actual use of resources; the use being influenced by availability of services and inherent characteristics (barriers and facilitators) of the system.	Khan and Bhardwaj (1994) ⁵⁷
Central intake units (Central Diagnostic and Referral Service)	Single point of entry for intake, assessment and referral for consistency in the screening and referral process.	Zold-Kilbourn, Tucker and Berry (1999) ⁵⁸
Continuity of care	The care team maintains contact with patients, monitors their progress, and facilitates access	Bachrach (1993) ⁵⁹

² This list is not exhaustive

	to needed services; Case managers facilitate both health and social services.	
Integrated services	Integrated services provide single point access to a range of services by offering generalized and specialized medical care and necessary allied health and community services (rehabilitation programs, employment, and housing support).	Fleury and Mercier (2002) ⁶⁰
Traditional Model: Meet Urgent Demand Now and Meet Non-urgent Demand Later	The appointment is based on urgency of clinical condition, as a result those with most pressing needs get care quickly. However, this system makes inefficient use of the time of healthcare providers because of the need for triage, decision making, filing future appointments.	Murray and Berwick (2003) ⁶¹
Carve-Out Model: Predict Urgent Demand and Reserve Time to Meet It	In this model, supply of urgent care is reserved by designating a “triage doctor of the day” or “jeopardy doc., and setting aside appointments in order to reserve some time. However, this system is prone to making incorrect triage decisions. It also makes the referral process difficult to navigate.	
Advanced access model	The appointment is based on the availability of clinician, not urgency of the condition. Patients calling to request for an appointment with a physician not present that day are given the choice of seeing another physician the same day or waiting to schedule an appointment with their physician later that week. It is the patient’s choice to seek immediate access from another physician or continuity of care from their physician. While the other 2 models push appointments into the future, the advanced access model tries to meet both urgent and routine demands of care.	
Models of quality improvement in primary care mental health	It includes four components: 1) Training primary care staff regarding mental healthcare, 2) Consultation-liaison (an ongoing consultation relationship with primary care clinicians, 3) Collaborative care (aspects of both	Bower and Gilbody (2005) ⁶²

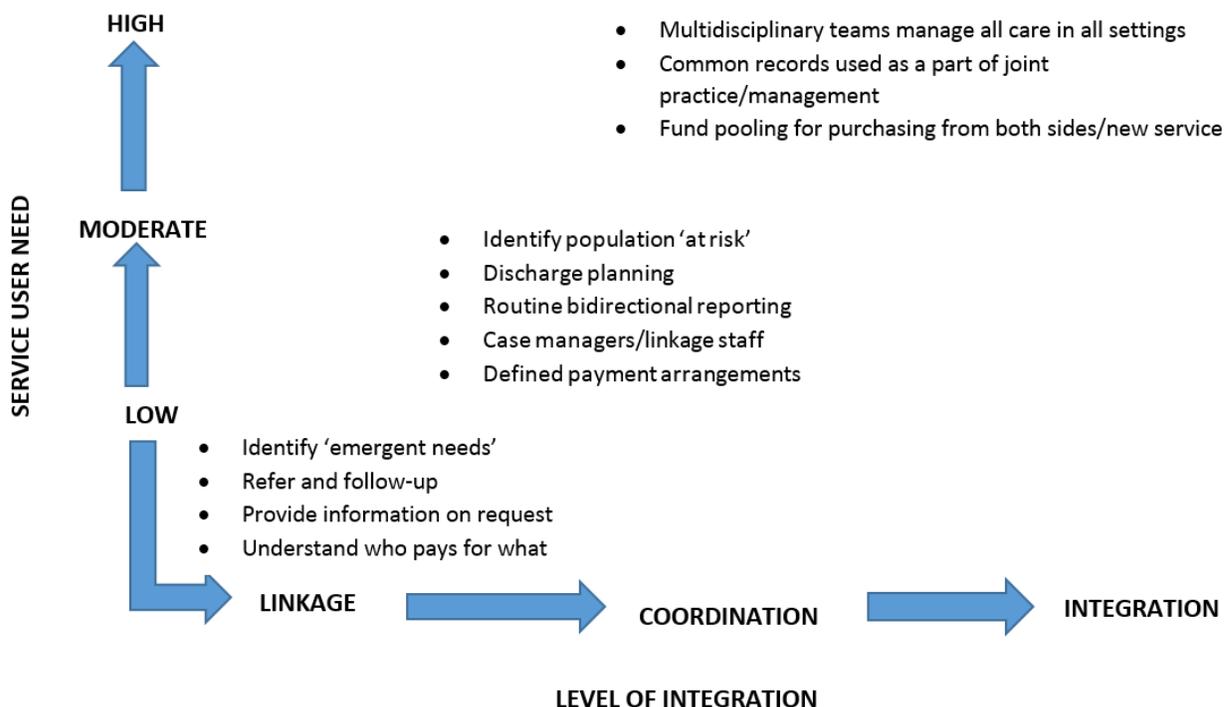
	training and consultation-liaison but also includes the addition case managers who work with patients and liaise with primary care clinicians and specialists in order to improve quality of care, 4) Replacement/referral (to the specialist).	
Collaborative mental health care	<p>It is defined as “care that is delivered by providers from different specialties, disciplines, or sectors working together to offer complementary services and mutual support.”</p> <p>It includes activities that strengthen links between primary care and mental health services, for instance regular visits by a mental health care worker to a primary care setting, regular consultations between primary care and mental health care team, incorporation of mental health interventions into the management of general medical conditions etc.</p>	Kates et al. (2011) ⁶³ ; Haggarty (2007) ⁶⁴
The Quadrant Model: Collaborative Connections across Primary Care, Mental Health and Addiction Services and Systems	Clients with mild to moderately severe substance use and mental disorders are seen in primary and community healthcare settings and those with moderate to severe problems are eligible for specialized systems. Where both addiction and mental illness are severe, the client is eligible for treatment with an integrated multidisciplinary care team.	Center for Substance Abuse Treatment (2005) ⁶⁵
Chronic care models	Focus is on self-management support to help patients take a more active role in their care; clinical information systems, such as provider feedback and electronic registries; delivery system redesign to support prevention-oriented clinical care; and decision support, such as the use of treatment guidelines or expert consultants; healthcare organization support by local leadership and linkages to community resources	Wagner, Austin, and Von Korff (1996), ⁶⁶ Bodenheimer, Wagner and Grumbach (2002) ⁶⁷

6.4. FRAMEWORKS TO SUPPORT ACCESS TO MENTAL HEALTH AND ADDICTIONS TREATMENT SERVICES

The shift from institutional to community mental health services and supports, and many other factors such as the high level of co-occurring disorders and the need for increased efficiencies in the overall treatment and support systems, have increased the need for better collaboration between mental health and addictions services within the health care system, including the need for functional and/or structural integration as appropriate.^{68,69} It has also made it necessary to offer a comprehensive continuum of services that can be accessed when needed at a location convenient for clients.⁷⁰ Evidence indicates that collaboration and integration improves the ability of service providers to meet the needs of their clients in a coordinated, cost-effective, evidence-based and accessible manner.⁷¹ It involves “actively managing all elements of the continuum of health and care services required by individuals and communities in order to achieve a seamless care pathway for the individual or client group”.⁷²

Leutz (1999), proposed an *integration framework* that describes three levels of integration based on three groups of service user’s need: those with mild-to-moderate but stable conditions, those with moderate levels of need; and those with long term, severe, unstable conditions (Figure 1).⁷³ The needs of the first group can be served through ‘linkage’ of different systems, while the second group requires coordination of care and services across different sectors. Those with severe needs would benefit most from a high level of integration. An integrated mental health and addictions system would lead to: continuity of care, coordination of services and efficiency, which in turn will result in better client experience and clinical outcomes. This is similar to the concept of *graduated integration* proposed by Rush and colleagues later in 2011.⁷⁴

Figure 1: Levels of integration and user need



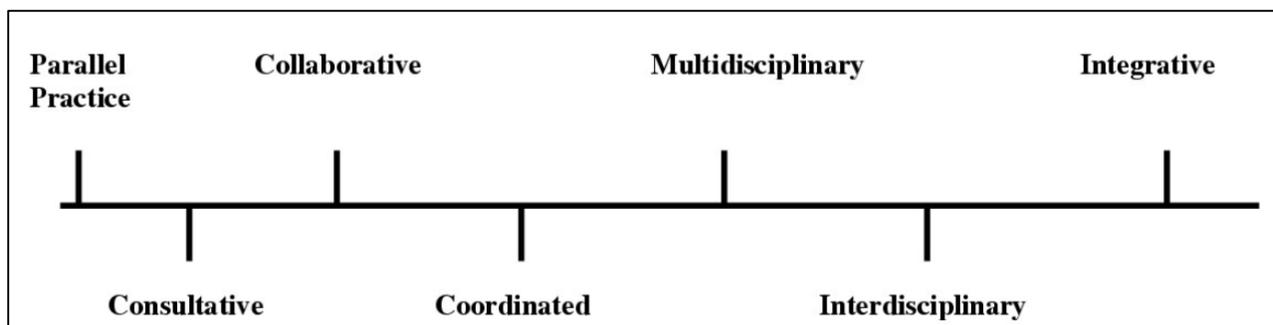
Adapted from Leutz (1999)

An 'organized' service delivery system provides a coordinated continuum of services and is accountable for health outcomes of the population served.⁷⁵ Boon et al. (2004) proposed a continuum from the non-integrative to fully integrative approach to patient care (Figure 3).⁷⁶ *Seven models across the continuum are:*⁷⁷

- parallel (healthcare practitioners work independently in a common setting),
- consultative (healthcare professionals are available for consultation/ professionals advice),
- collaborative (practitioners share information regarding patients on a case-by-case basis),
- coordinated (information about an illness or treatment is transferred to and from relevant practitioners and the patient),
- multidisciplinary (patient care is planned by teams and integrated later), interdisciplinary (practitioners that make up the team make group decisions about patient care), and
- integrative (seamless continuum of decision-making and interdisciplinary patient-centred care and support).

Movement along the continuum from left to right coincides with an increase in the complexity of the structure, number of people who are actively involved in the process of care and diversity of outcomes. Understanding this continuum can help to identify the model that best meets the health needs of different populations and compare the health outcomes and costs associated with different models.⁷⁸

Figure 2: Continuum of healthcare practice models



Adapted from Boon et al. (2004)

Another framework based on continuum-of-care principles is the *stepped care* approach in which clients are assigned on the basis of assessment to the least intensive and intrusive level of care and then “step-up” if outcomes are not positive and, when appropriate, “step-down” for the maintenance of gains and ongoing support.⁷⁹

Rush (2010)⁸⁰ conceptualized the *Tiered Model* for planning and implementation of mental health and addiction care, in order to address the need for broader multi-sectoral collaboration. It uses several core principles of collaborative mental health and addictions care and support, including client-centred care, self-management and the role of families.

Tier 1: Population-based health promotion and prevention functions targeted at the general population - emphasis on the social determinants of health.

Tier 2: Early intervention & self-management functions targeted to people at risk - includes screening/identification, information & referral, brief interventions, brief psychotherapy, psychopharmacy, self-management, motivational and peer support functions.

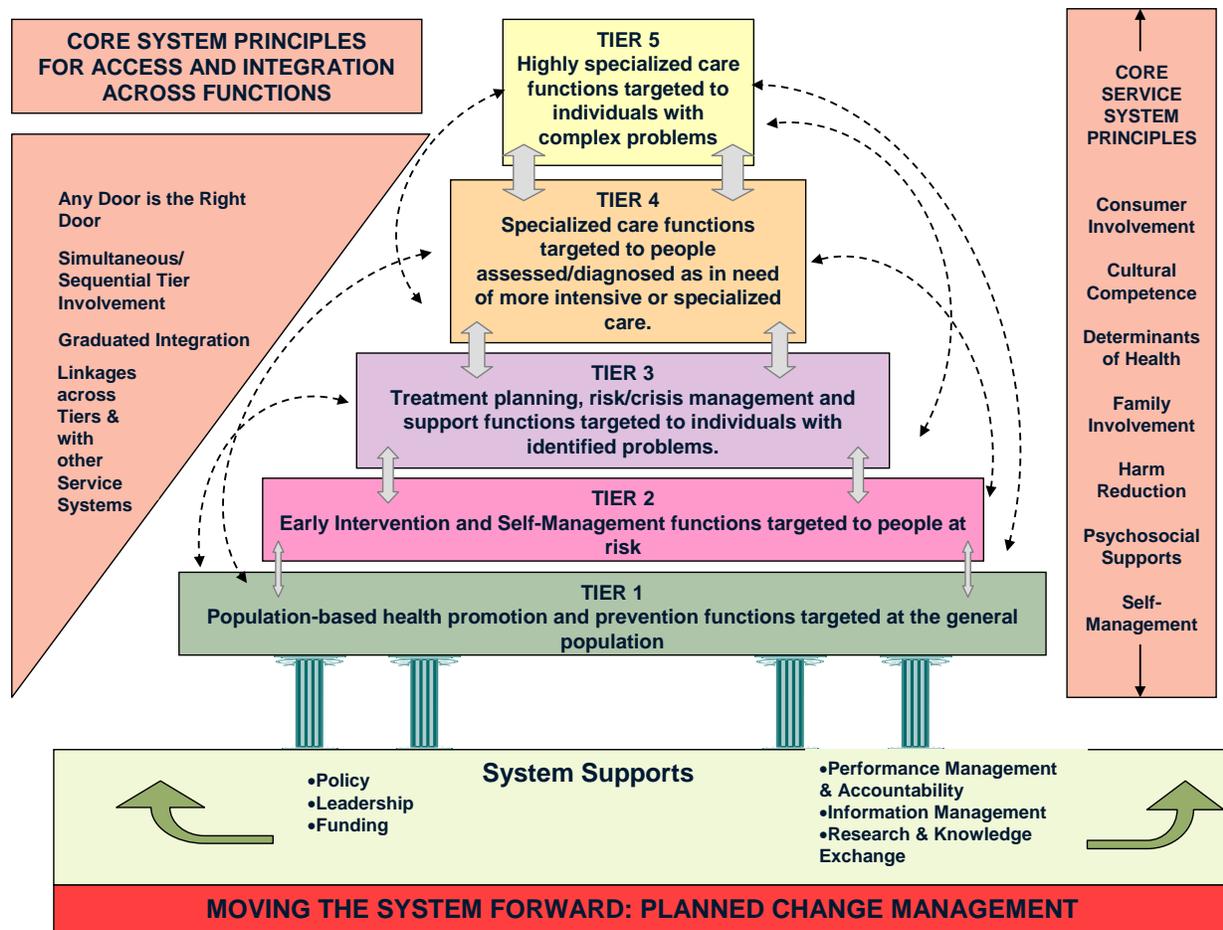
Tier 3: Treatment planning, risk/crisis management and support functions targeted to individuals with identified problems - includes comprehensive assessment/diagnosis, outreach/engagement, and case management.

Tier 4: Specialized-care functions targeted to people assessed/diagnosed as in need of more intensive or specialized care - include ambulatory and structured residential interventions,

including pharmacotherapy, psychotherapy, and may involve multidisciplinary teams (e.g., ACT).

Tier 5: Highly specialized-care functions targeted to individuals with complex problems – includes inpatient medical withdrawal management; comprehensive inpatient/residential concurrent disorder services; inpatient forensic services; long-term inpatient psychiatric care.

Figure 3: Tiered Model for mental health and addiction service delivery



Adapted from Rush (2010)

To sum up, effective service delivery systems are: **integrated** (common intake; 'seamless' service delivery), **coordinated** (common intake; co-location of services), **holistic** (care is not delivered in isolation; the focus is on identification of strengths, needs and issues in order to address the problems through referrals and partnerships), **accessible** (services are designed and delivered in a way that those in need can use them in a timely manner), and **consistently evaluated** for performance and outcomes.⁸¹

Although there is no single model or framework for achieving coordinated care, several strategies have been recommended to improve the healthcare service delivery system in Canada:⁸²

- focus on the needs of individuals and their families
- emphasis on primary healthcare services (health promotion and disease prevention, diagnosis and treatment, supportive and rehabilitative services, comprehensive health assessments and being the referral agency to other parts of the system)
- integrated information systems
- virtual networks that facilitate coordination
- needs-based funding
- systematic mechanisms to monitor and evaluate

Other mechanisms to support health service collaboration and integration include: single assessment processes to reduce the number of assessments between mental health, addiction and various health and social service providers; shared electronic medical record; centralized access point to care; and system navigators to support the transitions across services and sectors.⁸³

A systematic review analyzed studies from six countries (United States, Australia, United Kingdom, Netherlands, New Zealand and Canada) to identify the strategies used to coordinate care.⁸⁴ They found that these operate at three levels: patient/provider, organization or health system level.

Patient and provider-level strategies included:

- improved communication between service providers,
- using care plans, shared decision support, or shared records, shared information or communication systems,
- arrangements for coordinating service provision between providers, including coordinated or joint consultations, shared assessments, and arrangements for priority access to another service,
- support for service providers,
- structuring the relationships between service providers and with patients, including co-location, case management, multidisciplinary teams or assigning patients to a particular primary health care (PHC) provider, and
- providing support for patients, including education, reminders, and assistance in accessing PHC.

The *organizational level strategies* included: joint planning, funding and/or management of a program or service and formal agreements between organizations to coordinate services. The system level strategies included changes to funding arrangements.

In an effort to determine the essential components of a successful system redesign of mental health and addictions treatment, Gustafson (2011) collected data from experts in the field.⁸⁵ The findings indicated *11 crucial elements for an effective mental health and addictions treatment system*:

- Anytime/anywhere direct-to-consumer assessment, treatment, and continuing care: Immediate and timely help (HERE and NOW)
- Minimal variation in the quality of assessment, treatment, and continuing care: consistent, predictable service
- Emerging and existing technologies: initiatives such as mobile health
- Global assessment, treatment, and continuing care of patient (and family) needs and assets: integration of mental health and addictions treatment with primary care; recognition of other needs such as: employment, housing, other acute and chronic illnesses
- Soft and minimal handoffs: smooth transition
- Evidence based practices
- Connect, support and engage patients, families, peers, and providers before, during, and after treatment: emotional and instrumental support to patients and their families
- Continuing care, on-going monitoring (with outreach, skill development, preventive intervention, social support, and emergency response to derail crises)
- Mechanisms to help the patient and family recover in a hostile environment: job support, housing programs etc.
- Valid, timely, and practical progress measures
- Pay for performance

6.5. IMPLICATIONS FOR ONTARIO

The concept of a coordinated/ centralized approach is consistent with the overall direction of the provincial and federal government. Several policy documents have highlighted the need for a centralized/coordinated approach in Ontario. Some of the recent ones³ are discussed below.

Patients First: Action Plan for Health Care (2015)⁸⁶

³ This is not an exhaustive list.

The report emphasized on “improving access – providing faster access to the right care” (p.6). For improving access, the focus is on quality primary care, faster access to specialists, expanded mental health and addiction services and more coordinated care for patients with complex medical conditions (p.9).

Open Minds, Healthy Mind, Ontario’s Comprehensive Mental Health and Addictions Strategy (2011)⁸⁷

The report indicated that it is difficult for people to navigate the health system and access services because of the “silo” approach of health system (p.18). It recommended the need for a “system that easily gets us the services we need when we need them and that enables us to move easily from one service to another” (p.18).

Ontario’s Action Plan for Health Care (2012)⁸⁸

The report highlighted difficulty in navigating the health system and need for integration of health providers (p.5). It emphasized that, “patient-centred integration is the right thing to do for patients, and for our health care system” (p.7).

Changing Directions, Changing Lives: The Mental Health Strategy for Canada (2012)⁸⁹

The report outlined need for providing better access to supports and services for those living with mental health illnesses by promoting transition from intensive services to community mental health services (p.50).

Respect, Recovery, Resilience: Recommendations for Ontario’s Mental Health and Addictions Strategy (2010)⁹⁰

The Minister’s Advisory Group submitted their recommendations for a 10-Year Mental Health and Addictions Strategy for Ontario. The report emphasized on the need for integration of services as, “better coordination across the health system would help reduce avoidable emergency room visits as well as the current long waits for some mental health and addiction services” (p.31). It also highlighted the importance of continuity of care across health sectors and transition between health services (p.35). The strategies to provide integrated care clearly indicated the need for common assessment and intake, referral and resource matching tools (p.42).

Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians (2010)⁹¹

In this report the committee recommended that clients should be connected to system navigators who in turn will direct them to appropriate treatment and community support service providers (p.7).

6.6. CURRENT INITIATIVES

Besides the proliferation of regional models in Ontario to facilitate coordinated access to mental health and addictions, there are multiple provincial initiatives that connect closely to the issue of access to and evaluation of mental health and addiction services directly or indirectly. These include the Basket of Core Mental Health and Addiction Services; the development of a provincial Performance Measurement Framework for mental health and addiction services (e.g., defining wait times and access to service) and a range of DTFP-funded projects such as the provincial implementation of the new staged screening and assessment protocol for addiction services, the implementation of standardized cost-based performance indicators; and the implementation of the Ontario Mental Health and Addictions Perception of Care tool. There are also issues of how these regional models will coordinate/collaborate with the work of ConnexOntario.

6.7. COORDINATED ACCESS MODEL

Various sectors including housing/homelessness,⁹² child and family services,⁹³ mental health and addictions^{94, 95} have implemented coordinated or centralized access mechanisms in response to challenges such as poor service continuity, concerns around appropriate coordination of services and client's difficulty in navigating the system. While some literature is drawn from mental health and addictions sectors, findings from other areas of health care (e.g. orthopedics) and sectors, including housing are also included.

The coordinated access model uses the same set of assessment tools to determine eligibility and a consistent criteria to make decisions about referrals. There are **four guiding principles** of coordinated access (4 A's):⁹⁶

- Access: clear path to services, transparent eligibility criteria and screening process
- Assess: common assessment forms
- Assign: clear priorities, transparent referral process
- Accountability: monitor system and program outcomes

6.8. INTENDED BENEFITS/OUTCOMES OF COORDINATED ACCESS MODEL

The coordinated access model has been implemented in order to facilitate more effective screening,⁹⁷ reduce wait times, triage referrals, improve referral quality, facilitate continuity of care and ensure that the right patient arrives at the right place at the right time.⁹⁸ Such an approach is expected to increase the coordination and integration of services particularly for

clients presenting with greater problem severity and chronicity.⁹⁹ Table 4 below summarizes the intended outcomes of coordinated/centralized access model on service delivery:¹⁰⁰

Table 4 Intended outcomes of coordinated/centralized access model on service delivery

Before coordinated/centralized access	After coordinated/centralized access
Should we accept this client into our program?	What is the best available program/service strategy for this client?
Client has the responsibility to find services	Ease of access, multi-provider coordination
Inconsistent communication and understanding about what services are available	Consistent, clear communication to partner organizations and clients about what's available (Real-time knowledge about program capacity)
Unique forms and assessments for each agency/program	Standard forms and assessment for every client at each entry point

Adapted from Vermont Coalition to End Homelessness (2014)

6.9. KEY DIMENSIONS OF A COORDINATED ASSESSMENT PROCESS

There are several steps or dimensions to the coordinated access process that relate to the client flow as well as documentation. Table 5 below describes the key dimensions.

Table 5 Key dimensions of a coordinated assessment process¹⁰¹

Dimension	Key Points	Description
Access (making contact)	Do clients know how to reach the assessment centers? Are they easy to reach?	Ability of a client to reach the assessment points in their community. It includes transportation links, hours of available services (days/evenings v/s 24/7) and single v/s multiple assessment points.
Intake	What happens when clients enter the system?	Eliminate duplication at the intake stage by ensuring that the clients are not asked the same questions that they were during assessment.

Assessment	Is there a consistent, standardized process for determining client's need?	Assessment determines which services the clients need.
Referral	Is there a process in place for guiding clients that need a program/service based on their needs?	For the clients that need referrals, a standard criteria to make decisions about the "fit" with available programs.
Data entry and sharing	Is there a reliable data system that is being used properly?	A consistent process for gathering data, entering it, protecting sensitive information, and sharing information across programs so that it is not gathered more than once.
System change	How will programs and resources change to become more efficient, effective, and better accommodate needs?	Evidence-informed system-wide decisions towards coordination and collaboration between programs.

Adapted from National Alliance to end homelessness (2012)

6.10. MODELS OF COORDINATED ACCESS

There are two general models for coordinated entry systems – centralized and decentralized:¹⁰²

- In a centralized model ("single point of access"), clients go through a central intake and assessment process through which they are referred to the level of care that fits their needs.¹⁰³ Such a model offers a single, coordinated entry point which improves accessibility for clients, particularly for hard to reach populations,¹⁰⁴ by offering a central location to access services.¹⁰⁵ *Centralized intake is the most organized form of coordinated entry.*¹⁰⁶ It can be a geographically centralized intake system (one physical location where clients can go to access intake and assessment) or a virtual, telephone-based centralized intake model (one number that clients can call to access intake and get referrals).

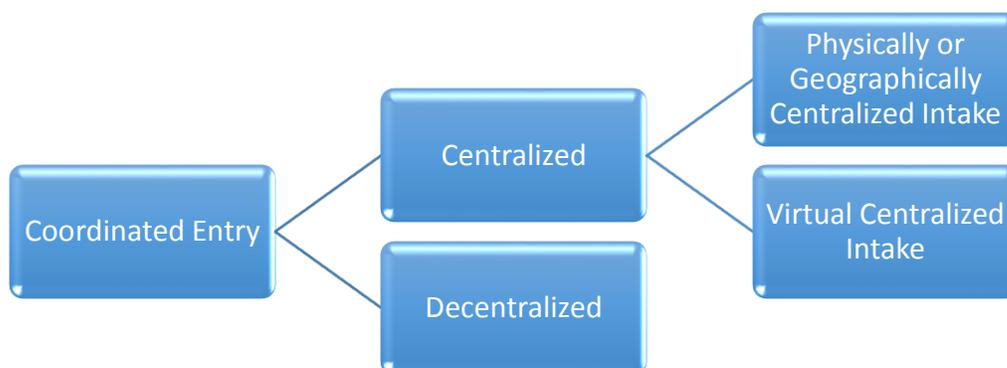
Some programs provide only centralized information and referral, while others have full authority to admit clients to receiving programs, while still others combine roles in different ways. Depending on the role and "authority" of centralized intake programs they can have:¹⁰⁷

- *Centralized Information and Referral Only* - the centralized intake program provides a central point for information and referral, but has no authority to commit services
- *First-Level Screening* – the centralized intake program conducts initial screening and service matching, while the receiving program conducts further screening, assessment, verification, and makes final admissions decisions
- *Admissions Authority* – the centralized intake program conducts full screening, assessment, verification, and makes admissions decisions that are binding on the receiving program
- *Mixed Authority* - the centralized intake program provides centralized information and referral, and has admissions authority over some service types.

The streamlined access to multiple services in a centralized model not only makes it easier for clients to navigate through the system but also improves the quality of client screening and assessment.¹⁰⁸ Moreover, the overall capacity of system to provide timely and effective services increases.¹⁰⁹ Other potential benefits include: improved communications among patients and health care professionals and increased consistency in the format and type of language used in referrals,¹¹⁰ decreased length of time to admission,¹¹¹ decreased repetitive assessments,¹¹² improved retention¹¹³ and improved client satisfaction.¹¹⁴

- The decentralized intake model (“Every door is the right door”) offers the clients multiple locations from which they can access services. The coordinated aspect of this model comes from the fact that each agency doing intake uses the same set of assessment and tools and makes referrals using the same criteria.

Figure 4: Different types of coordinated entry models



A comparison of the key features of centralized and decentralized intake model are shown in Table 6 below.¹¹⁵

Table 6 Key features of centralized and decentralized intake model

Centralized Coordinated Entry	Decentralized Coordinated Entry
Distinct physical location(s), and/or one phone number to access intake and get referrals	Multiple coordinated locations
<i>Disadvantages:</i> A single location may not be equally accessible to everyone	<i>Disadvantages:</i> Less control over consistency of services and data management- an increase in the number of organizations participating in coordinated entry system may increase the likelihood of variation in terms of how assessments and referrals are handled.
<i>Advantages:</i> Fewer sites necessary; no time/training needed to work on coordinating multiple providers	<i>Advantages:</i> More locations available to clients

6.11. MODELS OF CENTRALIZED INTAKE

Several variations and combinations of central intake and coordinated entry models exist in health and social services sector. The choice depends on factors such as geography of the area (rural vs. urban), the level of existing service integration, and resources available for centralized intake.¹¹⁶

1. A literature review on central intake models for orthopedic surgery identified three types of models: *central triage*, *pooled referrals*, and *'choose and book'*.¹¹⁷ In *central triage* programs, the referral request is reviewed and the patient's level of urgency is assessed based on predetermined triage criteria before a patient appointment is scheduled. In *pooled referral* systems, referrals are directed to the next available specialist in the pool without triage, and in *'choose and book'* system patients have a choice of place, date and time for their first specialist appointment and the specialist can review the referral information electronically and modify the priority or redirect the patient if necessary.
2. The U.S. Department of Housing and Urban Development discussed centralized client intake for prevention and rapid re-housing programs and outlined three models: *single location central intake*, *multiple location uniform intake* and *phone centralized intake*.¹¹⁸ While clients in a single location central intake may call or go to a central intake site at specific geographic location, clients in a multiple location uniform intake may call or go to any one of multiple participating programs at different geographic locations. The

comparison of key features of the three models in context of housing programs is described in Table 7 below:

Table 7 Types of centralized intake models

Program Characteristics	Single location centralized intake	Multiple location centralized intake	211 Phone
Service approach	Single point of service access, single process	'Any door' service access, single process	'Anywhere' service access, single process
Authority/role	Good for centralizing all aspects intake and referral, including program admissions	Intake and admissions usually remain with the receiving programs, which use a standardized process and tools	Typically conducts first level of screening, while further assessment and admissions remain with the receiving programs
Geography	Good for urban areas with reliable transportation where the service system is well integrated	Facilitates client contact in a larger geographic area, or where transportation is poor	Makes client contact possible irrespective of geography and the level of service coordination
Program Collaboration	Need willingness to share authority and good communication between participating programs	Need provider willingness to change intake process and adopt uniform procedures and tools	Need provider support for integrating client intake procedures with 211 or other hotline provider
Method of client contact	Initial contact can be by phone or walk-in; some programs begin with phone contact followed by in-person appointment		Contact by phone followed by referral to an in-person meeting or an in-person meeting or appointment with the receiving program
Depth of client contact	Face-to face meeting allows for more in-depth client contact/assessment		Phone meeting is usually brief, with more in-depth client contact/assessment by the receiving program
On-site services	On-site services	On-site services	On-site services are

	(vouchers, food, etc.) are possible	(vouchers, food, etc.) are possible, and often co-located with other service programs	typically not possible
Facilities	Need a single office, disability accessible, close to public transportation, with space for confidential meetings	Intake is integrated into existing programs, should be disability accessible, close to public transportation, with space for confidential meetings	Need a call center with space for one or more workers; should have interpretation for language accessibility
Hours of operation	Depends upon resources for staffing; evening and weekend hours improve client access		
Staffing/caseload	May need to hire and train new intake staff with housing assessment skills	Likely can implement with existing program staff who may need training on uniform procedures	May be implemented with existing 211 or other hotline staff, but need to train for or hire a housing specialist
Cost	Staff, facility, and other costs may be offset by efficiencies at receiving programs	Staff, facility, and other costs may be absorbed in existing programs, some efficiencies may be lost	May need to pay a share of existing 211 or pay additional costs for a housing specialist.

Adapted from U.S. Department of Housing and Urban Development (2009)

3. The Rural Community Health Intake Study based in Australia¹¹⁹ outlined five different types of intake: *direct*, *rostered*, *dedicated*, *walk-in* and *centralized*. *Direct intake* is conducted by the practitioner themselves in response to walk-in and telephone inquiries. This approach is more appropriate in smaller communities, with smaller caseloads. In a *rostered intake*, roster of counseling staff conducts intake and assessment services. The *dedicated intake* approach involves a 'dedicated' intake worker to conduct intake and assessment. *Walk-in sessions* offer intake and counseling on a set day or time. In the *centralized intake* model, calls go to a single location and assessment tools are uniformly applied across callers for assessment and triage.

6.12. EVIDENCE ABOUT THE EFFECTIVENESS OF CENTRALIZED/COORDINATED ACCESS APPROACH

There has been limited research on the evaluation of central access models, particularly on which models are more effective with different client groups.¹²⁰ Moreover, the literature reflects mixed results in terms of effectiveness of central access models. A study conducted to assess the centralized intake and assessment process in a drug abuse treatment system found that the Central Intake Unit (CIU) and non-CIU participants did not differ on most measures of treatment access and satisfaction.¹²¹ However, the CIU may have improved access for a more 'difficult-to-treat' disabled population.¹²² Another study found that CIU participants were less likely to complete treatment than those who entered treatment in settings without CIUs.¹²³ Similarly, noting the failure of CIUs in Philadelphia, United States, Bencivengo (2001) suggested that CIUs negatively affect the treatment outcomes.¹²⁴ A survey to assess the responsiveness of a centralized mental health intake service for children and youth found that although central intake mechanism minimized response time for its initial service, it did not reduce wait times for delivery of mental health services.¹²⁵

In contrast, Scott et al. (2002) found that the individuals who participated in case management services provided through centralized intake were more likely to show for treatment and receive referrals to non-substance abuse treatment services.¹²⁶ Another study found that referral to treatment from CIUs was associated with higher treatment completion rates. However, the authors believed that centralized intake improved patient treatment matching, which in turn resulted in greater treatment completion.¹²⁷ Findings from the Target Cities Project in Chicago indicated that participants in the CIU cohort demonstrated lower drug use and improved employment outcomes than participants in the pre-CIU cohort.¹²⁸

Central intake has also been found to improve scores on the Addiction Severity Index with regard to legal problems when compared with patients who entered the treatment program directly.¹²⁹ Aldridge and Kanowski (1998) found that in the context of rural mental health services centralized intake approach improved access and reduced variations in service quality.¹³⁰ Within the home healthcare delivery system, centralization of intake and case management was found to reduce costs and increase customer satisfaction.¹³¹ It has also been found to be effective in providing more appropriate referrals, within and beyond the community programs.¹³² In United Kingdom, use of centralized systems reduced wait times for patients from sixteen to four weeks and decreased non-attendance rates from 18% to 2%.¹³³

Fraser Health, one of the six health authorities in British Columbia, analyzed the pros and cons of having a centralized system to access acute healthcare services.¹³⁴ Their findings are summarized in Table 8 below:

Table 8 Summary of Pros and Cons of having a centralized access model

PROS	CONS
Resources are allocated to those who need them the most; reduced bed days lost to delays	Not strategic in nature: Access Coordinators have to spend time dealing with daily bed capacity issues
Improved connectedness between the 12 hospitals sites under Fraser Health region	Lacking control at the local level: repatriation of patients to their local communities is considered low priority by the local administration
Improved repatriation of patients to their local communities	System change: moving to a centralized access model needs resources and efforts
Faster mobilization of resources	
Sharing of best practices between the sites because of constant communication between employees across the health region	

Adapted from Brown (2005)

McClennan et al. (2003) pointed out that although having multiple entry points into care is inefficient, these might reduce barriers to accessing healthcare services by offering multiple avenues for intake. They highlighted the need for rigorous evaluation of centralized intake services to ensure that new barriers are not created.¹³⁵ Another study found that substance abusers in a centralized intake unit experienced difficulty in admission, poor treatment availability, and time conflict.¹³⁶ Further, individuals with a shorter wait after centralized assessment were found to be more likely to attend an initial treatment appointment.¹³⁷

In order to make centralized services more efficient, the need for collaboration between organizations, setting of realistic goals and expectations, and adaptability to the changing socio-political environment has been suggested.¹³⁸ Another study emphasized the importance of continuous communication and provider commitment for successful implementation and management of a centralized model.¹³⁹ In order to increase physician's satisfaction with the centralized intake referral service, clearly defined criteria for referrals and timely update of the placement decisions has been recommended.¹⁴⁰

KEY LESSONS REGARDING THE EFFECTIVENESS OF CENTRALIZED/COORDINATED ACCESS APPROACH

- Centralized/coordinated access approach offers the potential to improve treatment outcomes at the client and system-levels by matching clients with the services(s) most appropriate to their needs and also making efficient use of available resources such as through a stepped care model.

- There are mixed findings about the effectiveness of coordinated/centralized access models in large part because effectiveness appears to depend on a variety of factors, including quality of clinical decision making,¹⁴¹ standardization of referral pathways, resources, infrastructure capacity, collaboration among providers and other aspects of community context.

6.13. APPROACHES/STRATEGIES USED TO IMPLEMENT A COORDINATED/CENTRALIZED ACCESS MODEL

The centralized/coordinated intake and assessment process is complex and requires the incorporation of evidence-informed practices in planning and implementation.¹⁴² The National Alliance to End Homelessness developed a coordinated assessment checklist for planning the process.¹⁴³ Its key components are discussed below:

Phase I: Planning and Preparation

- Establish planning committee
- Identify target population
- Decide on the structure of coordinated assessment (assess which model is best suited)
- Identify the resources that should be available at the coordinated assessment center(s)
- Map out the existing assessment and intake process (evaluate the existing system for strengths and weaknesses, and identify the ways in which it can be improved with a coordinated approach)
- Sketch out a preliminary needs assessment/screening tool

Phase II: Implementation

- Identify the organization(s) that have resources and capacity to host coordinated assessment
- Identify additional staffing and resource needs based on the anticipated intake volume
- Obtain resources by sharing staff or hiring new staff
- Identify data needs
- Train the staff
- Ensure that providers have incentives for participating in the coordinated assessment process
- Create a plan for how the coordinated assessment will be implemented (dates, times, and contingency plans)
- Finalize the screening/assessment tool that will be used when the coordinated intake goes into effect

- Create a referral process
- Identify a process for evaluating and making adjustments to the coordinated assessment process
- Create a communications plan

Phase 3: Evaluation (ongoing)

The best practice guideline for introducing coordinated entry for homeless families discussed the following planning and implementation strategies:¹⁴⁴

- ‘System mapping’ to assess what services they have available, what services are lacking, what unique services can be provided and what opportunities exist for collaboration and consolidation
- Having a database of services available in the community and updating it regularly
- Getting buy-in of providers
- Training of intake staff
- Assessment of how program resources can be used efficiently by doing community-wide needs assessment, staff observations etc.
- Eliminate “side doors,” access points to services that exist outside of the centralized system; refuse to accept new clients unless they have been referred from the intake center
- On-going evaluation

Another report on centralized intake for homelessness prevention and rapid re-housing programs that discussed planning and operational considerations focused on getting input from all the key stakeholder groups and assessing the needs of population. It also highlighted the need for considering the following operational issues:¹⁴⁵

- Defining specific project goals or objectives
- Identification of the target population
- Clarifying the role of intake process (limited to referral or has control over admission to programs)
- Determining which type of intake model is most appropriate
- Identifying the lead agency (if there are multiple organizations involved)
- Deciding which services will be offered on-site or off-site
- Deciding outreach strategies
- Deciding how screening and assessment will be conducted
- Determining how data will be managed
- Deciding about the policies and procedures that will help manage the program

- Identifying what resources are needed
- Determining how to support ongoing collaboration with stakeholders

The best practices for developing central intake systems for human services system focused on the following:¹⁴⁶

- Importance of buy in of all of the key stakeholders
- Clear understanding about the eligibility criteria
- Consistent documentation
- Centralized data system (with access to all providers)
- High quality, consistent training
- Continuous monitoring and evaluation.

Other critical factors for implementation of a central intake mechanism are: staff recruitment and selection; training; coaching, mentoring, and ongoing supervision; internal management support; systems-level partnerships; and evaluation.¹⁴⁷ The studies that evaluated the operational aspects of a centralized mechanism have highlighted the role of factors such as financial incentives on implementation by increasing the number of family physicians' patient enrolments.¹⁴⁸ In response to inflation of centralized wait lists, the need for regular audits has been recognized.¹⁴⁹

Wiktorowicz et al.¹⁵⁰ compared the governance models and organizational mechanisms that mental health networks used to coordinate services across ten Canadian local mental health networks from 2003 to 2006 by exploring the organizational processes adopted among them. They conducted focus groups and interviews with executives and frontline managers in ten mental health networks across four provinces. Their findings indicated that *coordination efforts were not well supported* when:

- budget and planning decisions were made at different jurisdictional levels (provincial vs. local level). Because of the divided authority, organizations that reported to the Ministry were not held accountable when their services were not aligned with the organizations in their network.
- hospitals did not have an incentive to align their care with community services. As a result, patients experienced delays in achieving continuity of care and were more likely to "fall through the cracks" and re-enter hospital.
- there were insufficient resources to develop information systems.
- Metropolitan areas seek to establish coordinated care because of challenges in developing trust and cooperation among the large number of organizations involved.

6.14. CENTRALIZED/COORDINATED ACCESS INITIATIVES OUTSIDE CANADA

Target Cities Project

Target Cities Project is one of the biggest research projects in addition to enhance local treatment system performance and improve clinical outcomes. Through this project, nineteen US cities were funded in two five-year waves by the federal government's Center for Substance Abuse Treatment. The first wave of cities included: Albuquerque, Atlanta, Baltimore, Boston, Los Angeles, Milwaukee, New York and San Juan and the second wave included: Chicago, Cleveland, Dallas, Detroit, Miami, Newark, New Orleans, Portland, St. Louis and San Francisco. Philadelphia was funded between the first and second wave. The projects were funded in response to poor infrastructure, service provider capacity, accessibility and quality; budget deficits and lack of service integration/coordination.¹⁵¹

The goals were to increase the coordination and integration of addiction treatment services, enhance the quality of clinical assessment, increase treatment access via the creation or enhancement of central intake units and reduce barriers to access.¹⁵² Stakeholders in each of the nineteen cities developed and implemented a plan to improve the services. Common features included standardized assessment, physical health screening, use of a management information system to facilitate data collection and reporting functions, matching and referral of clients to appropriate treatment programs, and a centralized waiting list.¹⁵³ However, their plans differed in terms of implementation of centralized intake. The key lessons from these projects are summarized below.

*Lessons learned (implementation):*¹⁵⁴

- Projects aimed at changing the local service structures require sufficient time for pre-implementation planning.
- Pre-implementation planning must include local stakeholders.
- Implementation of a standardized model in the country might be difficult and vary in the degree of success because of the differences in pre-existing models.
- A common operational definition of central intake is necessary to ensure that the goals to achieve/enhance central intake are common. For example, in the first wave cities, local treatment programs could contract with central intake units to provide assessment. In contrast, second wave cities were required to provide assessment to all patients. Also many activities that were 'optional' for cities in the first wave were 'required' in the second wave cities. At the same time, central intake models in multi-site projects should reflect the needs of the local populations.
- The process of data collection needs to be standardized from the beginning of the project.

- Efforts to match clients to particular programs and services are affected by factors, such as distrust of the matching process, client preferences, poorly defined matching paradigms, lack of staff training and direct admission of desirable clients.
- Disparities across agencies in terms of available staff resources and case management models must be addressed.

*Lessons learned (evaluation issues):*¹⁵⁵

- Evaluations must include system outcomes as well as individual client outcomes.
- Evaluations across sites should make use of common methodology and instruments. For instance, while Detroit focused on case management for evaluation, Portland focused on increasing access to treatment.
- Sufficient resources need to be allocated for evaluation.

ACCESS program (Access to Community Care and Effective Services and Supports)

The ACCESS program was a five year program sponsored by the Center for Mental Health Services of the U.S. Department of Health and Human Services to assess the effect on client outcomes of efforts to improve systems integration.¹⁵⁶ The purpose was to, “evaluate the impact of implementing system change strategies that would foster collaboration and cooperation among agencies and reduce the fragmentation of service systems in communities that also provided intensive outreach and assertive community treatment services” (p. 946).¹⁵⁷ Nine states (Connecticut, Illinois, Kansas, Missouri, North Carolina, Pennsylvania, Texas, Virginia and Washington) received about \$17 million a year to participate in the study. These funds supported implementation of strategies for systems integration in nine community sites (one experimental and one comparison site in each state). Following were the key findings:

- Providing earmarked funds and technical assistance to implement systems integration strategies did not result in higher levels of system integration in the nine experimental sites when compared with the nine comparison sites. However, it resulted in higher levels of project-centered integration than at the nine comparison sites.
- Regardless of study conditions, sites that more fully implemented the integration strategies experienced higher levels of systems integration and project-centered integration.
- Providing earmarked funds and technical assistance to the nine experimental sites did not result in greater improvement in client outcomes across the four cohorts than at the nine comparison sites.
- More complete implementation of a greater number of strategies designed to improve systems integration were not associated with superior outcomes.

- Regardless of study condition or the implementation of systems integration strategies, change in the level of system integration across cohorts were not associated with parallel improvement in client outcomes.

The evaluation of ACCESS program demonstrated that “the implementation of systems integration strategies will not necessarily improve integration on a system wide level but is likely to improve integration between a designated mental health agency and other agencies in the same community” (p. 968).¹⁵⁸ In other words, the ACCESS program was successful in project-centered integration but not overall system integration.

Georgia Crisis and Access Line⁴

The Georgia Crisis & Access Line (GCAL) was launched on July 1, 2006 to improve access to mental health and addictions services with the mandate of providing, “one visible door that is always open”. It is a state-wide crisis service (single point of entry to North Georgia Crisis Services, including mobile crisis, crisis stabilization units, etc.) and a hotline where professional staff connect callers to appropriate services. “GCAL's services go beyond those of a "hotline" because it offers callers standardized, statewide access to a comprehensive and coordinated system of care. It links people to mental health, addiction treatment, and other services while providing emergency intervention when needed. Thus, it functions as an integral component of Georgia's comprehensive mental health system, ensuring access to and continuity of care (p. 26).”¹⁵⁹ Overall, GCAL has reduced wait times, improved access, prevented the inappropriate use of emergency services by diversion of callers to community based services and cut operational costs, as it replaced 25 existing central intake lines.¹⁶⁰ Some of the key features of GCAL are:

- Sophisticated software applications and databases that supports call triage, live scheduling and the ability to follow up with patients.¹⁶¹
- Electronic scheduling with partners:¹⁶²
 - Providers contracted to provide appointment times – real time information available to all providers regarding appointments booked, etc. through secure website
 - Providers can designate between routine and urgent slots, can go in and change times, see who’s scheduled, etc.
- Real-time monthly updates on key indicators, such as average speed of answer, abandonment rate, hospital diversions.¹⁶³

⁴ ‘Here 24/7’ in Waterloo Wellington LHIN is based on the model of Georgia Crisis and Access Line.

KEY FINDINGS FROM INTERNATIONAL MODELS

- Implementation of systems integration strategies is resource and time-intensive.
- Client-level treatment outcomes do not necessarily improve with system-level changes.
- It is critical to consider the community and policy context and understand how it affects different outcomes among different population groups.

6.15. COORDINATED/CENTRALIZED ACCESS INITIATIVES IN CANADA

In the recent years, several centralized intake programs have been introduced in Canada to enhance service delivery. For example, the “811 program” is a centralized information phone service available in a number of different provinces to provide non-emergency health information and services.^{164, 165} In Calgary, “Access Mental Health”, a non-urgent service directs/refers clients to the addiction and mental health programs most appropriate for their needs.¹⁶⁶ Other initiatives include the Cardiac Care Network (CCN) in Ontario to coordinate and manage patients waiting for cardiac surgery, catheterization, and angioplasty in twelve surgical and catheterization centers across the province, using a standard prioritization scheme and central registry.¹⁶⁷ Table 9 below summarizes some of the Canadian projects⁵ based on centralized/coordinated access approach.¹⁶⁸

⁵ This is not an exhaustive list

Table 9 Summary of selected Canadian projects based on centralized/coordinated access approach

Project Name & location	Aim	Implementation strategies/activities	Challenges	Success	Lessons learned
<i>OsteoArthritis Service Integration System (OASIS), Vancouver Coastal Health Authority, Vancouver, BC</i>	To provide a coordinated access system for patients waiting to be assessed and treated for osteoarthritis	<ul style="list-style-type: none"> • “First Available Surgeon” and “coordination of care” options; Individualized action plan based on client goals • Feedback loop to Primary Care Physicians and referring provider • Program evaluation focusing on: access to information and services, client health outcomes and quality of life, and use of system resources and expertise • Multiple partnerships 	<ul style="list-style-type: none"> • Buy-in for change • Concerns of Primary Care Physicians about losing patients • Resources 	<ul style="list-style-type: none"> • Increased access • Reduced workload • Knowledge transfer • Partnerships 	<ul style="list-style-type: none"> • Need for senior leadership, champion Primary Care Physicians • Early and ongoing stakeholder engagement • Enough time for creating a program • Focus on program goals and vision
<i>Rheumatology Central Access and Triage, Calgary, AB</i>	To triage the referrals for getting the right patient to the right place at the right time	<ul style="list-style-type: none"> • Single point of access • Right patient - right provider - right time - right diagnosis • Regular updates to referring and family physician re status of referral • Sub-specialty 	<ul style="list-style-type: none"> • Referral Quality • Number of referrals for number of appointments available • Patients with urgent needs are a priority-routine wait times become longer 	<ul style="list-style-type: none"> • Streamlined referral process • Prioritization of referrals • Improved communication to Referring Physicians 	<ul style="list-style-type: none"> • Need for buy-in from specialists • Importance of communication and planning

		interdisciplinary clinics			
RAAPID (Referral, Access, Advice, Placement, Information, and Destination), Calgary and Edmonton, AB	<ul style="list-style-type: none"> To connect referring physicians, to the consultant physician (for advice or higher level of care) To ensure that the right patient arrives at the right place at the right time 	<ul style="list-style-type: none"> Find the site with the most available capacity, and direct the patient to that spot Moving a patient closer to his or her community when they no longer need an acute care facility 	Lack of resources	<ul style="list-style-type: none"> Equalize access to acute care across the province Improved communication in the care and transfer of patients 	Importance of communication and data
Hip & Knee Arthroplasty Wait Times, Edmonton, AB	To achieve the recommended wait times for joint arthroplasty	Central intake clinics using the next available surgeon	<ul style="list-style-type: none"> Incenting physicians to take part in the central intake model Coordination of resources 	<ul style="list-style-type: none"> Standardized continuum of care for total hip and total knee arthroplasty Decreased length of stay Decreased readmission rates 	<ul style="list-style-type: none"> Importance of communication with primary care team Need for incentives for physicians to participate in central intake
Saskatchewan Surgical Initiative: Pooled Referral Project, Regina, SK	To pool referrals in order to eliminate wait time for the first consult appointment	Assign new patient referrals to the next available qualified specialist within a group instead of the traditional approach of referring a patient to a specific specialist	<ul style="list-style-type: none"> Scarce literature Developing a central fax intake line for surgeons who are not co-located Buy-in from surgeons who wish to work in a preferred area of practice 	<ul style="list-style-type: none"> One standardized referral form Standardized wait times 	<ul style="list-style-type: none"> Transparency in the implementation process Giving resources to surgeons for developing their own pooled referral system - surgeon buy in
The Ontario College of Family Physicians' (OCFP)	Rapid access to mental health and additions team for	Family physicians (mentees) can contact the mental health and	Concerns over medico legal liability	<ul style="list-style-type: none"> Decreased referral to specialists Fewer Emergency 	

Collaborative Mental Healthcare Network, Toronto, ON	family physicians	additions experts (mentors) to access appropriate professional assistance - continuity of care		visits	
Academy of Medicine Ottawa - Psychiatric Referral Service, Ottawa, ON	To facilitate the psychiatric referrals process between Family Physicians offices and Psychiatrists	<ul style="list-style-type: none"> Family physician contacts the referral service with a request and the service matches it to appropriate psychiatrists. They have a choice of picking one of the psychiatrists to work out the details for consultation/referral 	<ul style="list-style-type: none"> Resources Recruitment and participation of psychiatrists 	<ul style="list-style-type: none"> Increased access to Psychiatrists Reduced wait times 	
Orthopedic Central Intake Project: Surgical Services Eastern Health, St. John's, NL	To develop and implement a standardized orthopedic referral tool	<ul style="list-style-type: none"> New patient referrals to be booked with the next available surgeon Opportunity to refer to a specific surgeon, however the wait may be longer 	<ul style="list-style-type: none"> Lack of IT support Difficult to establish baseline measures for clinic volumes/wait times 	<ul style="list-style-type: none"> Standardized wait time definitions across the patient continuum Standardized screening/triage criteria Improved access Increased transparency 	<ul style="list-style-type: none"> Electronic database system for managing data recording and reporting Early engagement of people Constant communication
Total Joint Assessment Clinic, Ottawa, ON	To decrease the wait time for assessment and treatment of hip and knee arthritis	<ul style="list-style-type: none"> Patients are assessed by a physiotherapist or advanced practice nurse within 2 weeks of referral being received Patients receive an assessment 	Surgeon buy-in	<ul style="list-style-type: none"> High patient satisfaction High referring physician satisfaction 	<ul style="list-style-type: none"> Need for surgeon buy-in All sites should use the same type of assessor and provide the same service

		<ul style="list-style-type: none"> • They can choose to consult with a specific surgeon or the first available surgeon 			
Central Intake and Assessment Center, Regional Hip and Knee Replacement Program, Ottawa, ON	To receive all referrals for potential hip and knee replacement patients within the Champlain LHIN	The referrals are sent to one of the three assessment sites ⁶ based on patient choice: language, hospital, surgeon	Surgeon buy-in	<ul style="list-style-type: none"> • High patient satisfaction • High referring physician satisfaction 	<ul style="list-style-type: none"> • Surgeon champion • All sites should use the same type of assessor and provide the same service
Centralized access for community healthcare programs, Central Okanagan, British Columbia¹⁶⁹	A single access point to community and residential Care for information, referral and services		<ul style="list-style-type: none"> • Tight timelines • Conflicting priorities • Staffing issues (difficulty in 'classification' of skills and experience required for the position of central intake nurse) 	<ul style="list-style-type: none"> • Skills of the project manager • Clear timelines • Mutual respect among team members • Involvement of relevant stakeholders • Clear goals • Excellent team preparation and participation • Skills and knowledge of central intake nurse • communication to staff 	<ul style="list-style-type: none"> • Understanding of how the power base is important to facilitate change • Personal growth in new role • Need for strong leadership • Staff dynamics and working relationships • Gaps in the communication system • Need for a broad perspective • Need for clear timelines
ConnexOntario, London, Ontario	To provide a human voice 24-hours a day to all individuals seeking information on, for example,	In addition to telephone, email and webchat, mobile applications have been introduced to facilitate centralized	<ul style="list-style-type: none"> • Only some LHINs have coordinated their local coordinated access model with 	<ul style="list-style-type: none"> • The Helplines are available 24/7/365, and calls are live-answered at an average rate of 95 	

⁶ Queensway Carleton Clinic, Hôpital Montfort Clinic, and the Cornwall Community Hospital Clinic

	<p>mental health, drug, alcohol, and gambling problems.</p> <p>To provide data to service planners seeking access to quality health and human services information.</p>	<p>access to the mental health and addictions system and subsequent resource matching to appropriate services and support</p>	<p>ConnexOntario, which limits its provincial role</p> <ul style="list-style-type: none"> Challenges in updating the information when providers do not share data regularly 	<p>percent.</p> <ul style="list-style-type: none"> Stock and/or custom reports are provided upon request and, on average, external report requests are met in 28 minutes. 	
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6.16. GAPS IN LITERATURE

- There is a need for studies on operational aspects of coordinated/centralized intake mechanisms.
- Cost benefit and mixed method analysis (client surveys, stakeholder interviews, quality of care data, epidemiological surveys) of the centralized intake systems can help to determine if it is an evidence-informed way to conduct intake and assessment.
- Studies on coordinated/centralized access in different contexts can help to examine its relevance in different settings. For instance, different subpopulations (youth, immigrants, refugees etc.) access the system different ways. There is a need for research into ways that can help to capitalize on any existing structures in place for different subpopulations and create an assessment process that takes population needs into consideration.
- There is little known about the work processes and information flow in coordinated/centralized access based mental health and addiction services offered in Ontario.

KEY FINDINGS FROM LITERATURE REVIEW

- Various sectors have implemented coordinated or centralized access mechanisms in response to challenges such as fragmented services, client's difficulty in navigating the system, barriers in accessing timely services (wait times), variation in the quality of care (triage, intake, assessment, treatment and continuing care), inconsistent data reporting and service provider's lack of clear understanding about best available program/service options.
- Coordinated Access models can be centralized or decentralized.
 - A centralized access model is based on a single point of access approach where clients go through a central intake and assessment process through which they are referred to the level of care that fits their needs.
 - A decentralized intake model is based on clients accessing services from multiple locations as each intake agency uses the same set of assessment and referral tools and criteria.
- These models have a lot of variation around them. It's a helpful generalization but more like two ends of a continuum.
- There has been limited research on the evaluation of central access models, particularly on which models are more effective with different client groups or community context.

- Overall, the literature reflects mixed results in terms of effectiveness of central access models.

7. DESCRIPTION OF COORDINATED/CENTRALIZED ACCESS INITIATIVES WITHIN MENTAL HEALTH AND ADDICTION TREATMENT SYSTEMS IN ONTARIO

The section below briefly describes the key areas of coordinated access initiatives within the mental health and addictions treatment systems in Ontario. It is based on the information conveyed by key informants in the interviews and is described as reported. All participants were requested to read through the analyses and provide feedback on the interpretations of their responses in order to address any inaccuracies. The information has been presented with brevity, and additional information is included as appendices wherever available. The description is not intended to be a comparison of the different access models.

7.1. DESCRIPTION BY LHIN

Following data and information gathered through interviews and document reviews, has been divided into three groups, based on the complexity of coordinated access approaches used for improving access to mental health and addiction services. The 'complexity' of these models includes the components shown in Figure 5 below:

Figure 5: Features of complex and less complex models

Complex models



Centralized access point(s) - single/multiple

Decentralized

Combinations/Hybrid

Less complex models



Warm hand off to other services

Integration of services

Co-location of services

Common screening and assessment process, common referral forms

LHINs with ‘complex’ coordinated access models:

- Waterloo Wellington
- Mississauga Halton
- Champlain
- South West
- Central
- Toronto Central

LHINs with ‘less complex’ coordinated access models⁷:

- Hamilton Niagara Haldimand Brant
- Central West
- South East
- North East
- North West
- Erie St. Clair

LHINs with no coordinated access models:

- North Simcoe Muskoka
- Central East

COMPLEX MODELS

Key features of these ‘complex’ models are described below:

Waterloo Wellington

Expressed need - To understand what services are available, improving patient experience

Type of model – Blended approach: Centralized access model with an option for clients to access services from multiple locations (no door is the wrong door)

- **‘Here 24/7’** – launched in April, 2014 is a coordinated access service for the mental health, addictions and crisis sector from one single point of access.
 - It has 5 hub (physical) locations – 1) Fergus, rural North Wellington, 2) Guelph, East and South Wellington, 3) Waterloo and rural North Waterloo, 4) Kitchener and rural West Waterloo, 5) Cambridge and rural North Dumfries.

⁷ It is important to note that LHINs categorized under ‘less complex models’ are developing their existing approach to a more ‘complex’ model.

- a 24 hour, 7-day a week live answer phone line– 1 844 437 3247
 - Other methods of client contact – Fax, Emails, Walk- ins
- *Staffing* - Designated 40 F/T staff and a relief pool of 15 staff, trained in both MH & A and crisis
- *Implementation strategies* - The service is provided by Canadian Mental Health Association Waterloo Wellington Dufferin (CMHA WWD) and it is delivered in partnership with 11 other addictions and mental health service providers.
- *Core functions* - Community Service Information, Screening/Intake, Standardized Assessments, Crisis Intervention, Service Navigation/Coordination, Immediate Referral to services provided by 12 partner agencies, Brief Support/Intervention
- *Scope of Services* - Information, assessment and referral, Crisis intervention, Short term crisis support beds, Support Coordination, Community counselling and treatment, Diversion and Court Support, Day and Evening Treatment, Assertive Community Treatment, Eating Disorders, Early Psychosis Intervention, Residential Treatment, Peer, Self Help, Support Within Housing
- *Authority for intake*- The intake program conducts full screening, assessment, verification, and makes admissions decisions that are binding on the receiving program
- *Demographics* – All age groups
- *Tools/Data Systems* - GAIN, LOCUS, Risk screening tool, priority assessment tool, Here 24/7 assessment tool, Caseworks

Reported outcomes⁸

- One number to call for a range of services
- Less response time for crisis
- Fewer ED visits
- Fewer people on wait list but wait times not reduced

<i>Outcome measures/indicators</i>	<ul style="list-style-type: none"> ▪ Average Admission Rate (based on answered calls) ▪ Wait 1 – 90th Percentile Wait – Referral to Assessment completed (in days) by referral method, incoming referrals by reason and source
<i>Process measures/indicators</i>	<ul style="list-style-type: none"> ▪ Total Contacts ▪ Total Calls Accepted ▪ Total Calls Answered Live ▪ Average Live Answer Rate

⁸ See Appendix F for data reported in 2015

	<ul style="list-style-type: none"> ▪ Total Unique Individuals
<i>Indicators for service utilization</i>	<ul style="list-style-type: none"> ▪ Number of calls/faxes/walk-ins, people served (# received information and referral for assessment, # assessed, # waiting for assessment, # referred to other services) ▪ Call wait times ▪ Dropped calls ▪ Average live answer rate
<i>Level of service utilization</i>	Overwhelming – received 4 times the expected volume of calls
<i>Service provider and client satisfaction</i>	Strongly positive responses

- *Cost-effectiveness*: Yes; nothing formal in place to measure it
- *Effectiveness in achieving intended goals*: Yes

Reported lessons learned

- Facilitators:
 - Collaboration of all partners in implementation and design
 - Regular communication
 - Understanding individual roles in planning
 - Use of principles from implementation science
- Barriers:
 - Under-estimation of needs (volume of calls)
 - Under-estimation of costs
 - Technological platform was neither strong nor cost-effective
- Best Practices:
 - Use of implementation science in planning and implementation
 - Having Mental Health, Addictions and crisis as a part of the coordinated access service for holistic client care

Mississauga Halton LHIN

Expressed need - Unmet client needs, inequitable access to services, difficulty navigating the system/accessing services and inconsistent services

Type of model - Blended approach: Centralized access model with an option for clients to access services from multiple locations (no door is the wrong door)

- **One Link** - single point of access for referrals to mental health and addiction service providers (including supportive housing and employment supports) are funded by the Mississauga Halton LHIN.
- Current state of implementation - One-thirds to half way into implementation
- *Staffing* – representatives on staff with expertise in all services that one-link referring is to
- *Implementation strategies* –
 - Series of consultations to highlight key priority areas: access, navigation, integration. The process started with scan of existing central intake initiatives to improve access, followed by community consultations/engagement to get feedback on their proposed model.
 - Worked with e Health ON and KPMG to work on the Clinical and Business Process Mapping focused on the current state and future vision for clinical and business processes related to Mental Health and Addictions System Access Model, Palliative Care Central Registry, and Diabetes Education Program Central Intake.
 - The use of Plan Do Study Act (PDSA) cycles, quality improvement and formal change management processes.
 - Developed a draft dashboard for activity metrics that will evolve as it is developed and implemented
- *Core functions* – central intake, information and referral, screening, triaging and eligibility review, peer facilitation and support, service matching and wait list management, choice facilitation and navigation as well as data collection and reporting.
- *Scope of Services* – Full spectrum of mental health and addictions services except crisis services. It includes housing and employment support services as well.
- *Authority for intake*– The intake program conducts initial screening and service matching, while the receiving program conducts further screening, assessment, verification, and makes final admissions decisions
- *Demographics* – 16 & up
- *Tools/Data Systems* – GAIN, LOCUS, Novari data systems

Reported outcomes

- Improved client experience
- Improved Access
- Improved Navigation
- Improved Consistency of services
- Improved Continuity of services
- Improve patient transitions

<i>Outcome measures/indicators</i>	<ul style="list-style-type: none"> ▪ % of clients going to the right programs ▪ Client and provider experience
<i>Process measures/indicators</i>	% of correct referrals
<i>Indicators for service utilization</i>	#calls, #transitions
<i>Level of service utilization</i>	N/A
<i>Service provider and client satisfaction</i>	N/A

- Cost-effectiveness: N/A
- Effectiveness in achieving intended goals: N/A

Reported lessons learned -

- Facilitators:
 - Formal change management processes
 - Quality improvement initiatives and processes
 - Commitment
- Barriers:
 - Time necessary to implement significant system transformation that impacts most health care practitioner's practices
 - New players in the public system: difficulty in setting up projects aiming at multi-year system transformation
- Best Practices:
 - Learning from others (other LHINs, Connex)
 - Dedicated project management and quality improvement resources

Champlain LHIN

Expressed need - To match the clients to best available services in a timely fashion, address duplication of services, reduction of wait times, difficulty in navigating the system, lack of information about available services

Type of model

- Blended approach: Centralized access model with an option for clients to access services from multiple locations
- **Ottawa Addictions and Access Referral Services (OAARS)** – Single point of access for addiction services in Ottawa. It provides bilingual services. There is a single phone number to speak with system navigators and get an appointment to be screened and

assessed. System Navigators will support clients and coordinate services until they are engaged in an appropriate service. Screening and assessments can be conducted face to face in the central office, or the hubs/clinics at community partner agencies or on the phone

- Other regions within the LHIN - Integration of community mental health and addiction agencies in Prescott-Russell, Renfrew County, and Stormont, Dundas and Glengarry to facilitate access.
- *Staffing* – Designated staff, 4 F/T navigators (Mon-Friday, 8 am to 8pm)
- *Implementation strategies for OAARS*–
 - In 2010, the Champlain LHIN asked the Champlain Addictions Coordinating Body (CACB) to implement an integrated model for coordination of addiction services in Ottawa.
 - All Ottawa addictions agencies funded by the Champlain LHIN signed an Interagency Agreement that identified how agencies will work as partners as this project is implemented. Montfort Renaissance was the lead of the project.
 - As part of the planning process, the CACB also identified the referral processes and tools to be used by the navigators.
- *Core functions* – Information, screening, triage, assessment, referral and navigation to addiction services and other sectors including housing, mental health and primary care services as appropriate.
- *Scope of Services* – Full range of addictions services
- *Authority for intake*– The intake program conducts initial screening and service matching, while the receiving program conducts further screening, assessment, verification, and makes final admissions decisions
- *Demographics* – Adults, 16 and up
- *Tools/Data Systems* – GAIN, ADAT, EMH-Ware (data system); Unique wait time list for all addiction agencies in Ottawa showing all client wait time information for treatment (EMH-Ware)

Reported outcomes –

- Reduced wait times
- Reduced duplicate references in the wait list
- Efficient matching to services

<i>Outcome measures/indicators</i>	<ul style="list-style-type: none"> ▪ Client satisfaction ▪ Partner satisfaction with services
<i>Process measures/indicators</i>	<ul style="list-style-type: none"> ▪ # client contacts ▪ # clients assessed
<i>Indicators for service utilization</i>	<ul style="list-style-type: none"> ▪ Record of all client contact ▪ Time waiting during transition ▪ No shows ▪ Time waiting for treatment
<i>Level of service utilization</i>	Overwhelming use
<i>Service provider and client satisfaction</i>	Positive

- *Cost-effectiveness*: Yes; nothing formal in place to measure it
- *Effectiveness in achieving intended goals*: performing well

Reported lessons learned -

- Facilitators:
 - Having all the partners involved in steering the project
 - Ongoing communication and respect for differences
 - Ongoing mapping of Addictions services to better address the differences in organizational priorities
 - Clear agreed upon criteria for referrals
 - Marketing and communication to stakeholders
- Barriers:
 - Initial fear of losing clients and partisan referrals among providers⁹
 - Occasional mistrust of navigators by some providers
- Best Practices:
 - Balancing a client centered approach vs agencies pressures
 - LHIN enforces in MSAAs that providers have their processes in place and do not revert back to old practices
 - LHINs take a leadership role to bring change in the system

⁹ The initial reaction to the shift in the client intake process for addictions treatment agencies was addressed through close collaboration between OAARS and the agencies, the formation of a clinical advisory committee and visit of each agency.

- Expansion
 - Connecting more closely with the mental health services network
 - Implementing a more in-depth mental health screening as a part of the assessment process

South West LHIN

Expressed need – Long wait times in some areas, reducing emergency department visits and 30 day readmission rates, service gaps, lack of collaboration between mental health and addictions sector, coordination of care, difficulty in navigating the system and improving the quality of services

Type of model – Variations exist throughout the LHIN, however the two ‘formal’ coordinated access mechanisms in place are:

- Thames Valley - Multiple and varied access points to services using an electronic shared referral calendar system (multi-site, no wrong door coordinated access model): with a single region-wide integrated crisis and access phone line, the use of common screening and assessment tools, and work towards a coordinated waitlist strategy. The program is getting started on implementation.
- Huron Perth – A single central intake phone line (virtual, single point of centralized access). Coordinated access functionality has been in place for 3 years.
- *Implementation Strategies-*
 - Thames Valley - Working closely in partnership with all LHIN funded community mental health and addiction programs, other community partners (such as CHC’s, FHT’s, etc.) and ConnexOntario on a shared calendar system to seamlessly connect individuals to appropriate services regardless of point of entry. Implementing a 1-800 24/7, live answer helpline with access to crisis services, information, listening and support, and referral to treatment through a shared calendar for three counties (Elgin, Oxford and Middlesex)
 - Huron Perth - Legal partnership with mental health and addiction agencies in Huron Perth region to form *Huron Perth Mental Health & Addictions Alliance*. The Partners include: Alexandra Marine and General Hospital, Canadian Mental Health Association Huron Perth, Choices for Change: Alcohol, Drug & Gambling Counselling Centre, Huron Perth Healthcare Alliance, Phoenix Survivors Perth County, CMHA Middlesex Exeter and Goderich sites. The Huron Perth Addiction and Mental Health Alliance allows the organizations to develop consistent practices, processes and policies in support of an integrated service system.

- Transformation of the Huron Perth Crisis Line to the *Huron Perth Helpline and Crisis Response Team*: While individuals may still access supports by calling individual providers, the transformation of the crisis line resulted in a *single access helpline* coupled with crisis-response supports and referrals to area mental health and addiction services and a commitment from members to contact individuals within forty-eight hours following a referral.
 - Oxford and Elgin – Shared calendar using the ConnexOntario platform
 - Grey Bruce - Mental Health Grey Bruce (MHGB) has been providing coordinated local access to some but not all mental health and addiction services through its model of five multi-disciplinary, geographic teams.
- *Core functions* – Screening, assessment, intake, referral, information
 - *Scope of Services* – Mental health, addictions and housing services
 - *Authority for intake*– The intake program conducts full screening, assessment, verification, and makes admissions decisions that are binding on the receiving program
 - *Demographics* – Primarily, adults
 - *Tools/Data Systems* – OPOC, GAIN, Meditech or Datis
 - *Staffing* - No new funding/positions, but realignment and consideration of new positions if required

Expected Outcomes – Reduce avoidable ED visits, decrease wait times for intake and referral, streamline access by offering one phone number to call, a more integrated system, reduce 30 day readmissions

Outcome/process measurement plans currently under development

Lessons Learned -

- Facilitators:
 - Buy-in from providers
 - Collaboration among providers and shared commitment
 - Joint accountability of member organizations
 - Media attention (highlighting service gaps)
 - Strong leadership
- Barriers:

- Disconnect among providers
- Best Practices:
 - Enough time for planning (paced approach)
 - Customize the coordinated access model according to geography and demographics of clients

Central LHIN

Expressed need - Multiple access points, long wait lists, repeat ED visits and lack of clarity in how to access mental health and addiction services

Type of model - Blended approach: Centralized access model (with a single centralized intake phone line and a single physical location/access point), with an option for clients to access services from multiple locations

Streamlined Access - Centralized access model for case management, Assertive Community Treatment (ACT), Psychogeriatric Community Treatment (PACT) and supports within housing. It has a single physical location in Aurora, but clients can also make contact through the phone line and online application through York Support services website.

- The Krasman Centre is the central access point for Wellness Recovery Action Plan (WRAP) and FWRAP (Family WRAP) groups delivered by various organizations in the Central LHIN and surrounding areas. Through a peer-led and peer-engaged group process, participants learn how to create a personalized recovery system of wellness tools and action plans to achieve a self-directed wellness vision.
- *Implementation strategies* – It was developed in 2004 out of Whitby Mental Health implementation task force recommendations –to form a collaborative partnership with York Support Services as the Lead for Streamlined Access. Recommendations from the report¹⁰ on mental health and addictions multi-service access model lead to coordinated access system linkages between Toronto Central and Central LHIN with the access point serving North York, Humber River hospital region and Streamlined Access serving a sub-LHIN region of York Region and South Simcoe.
- *Core functions* – information about supports and services available in York Region and South Simcoe, assessment, referrals to crisis supports, primary care services and peer support
- *Scope of Services* – Mental Health only

¹⁰ This report outlines recommendations of the Service Access System Steering Committee to the Central and Toronto Central LHIN.

- *Authority for intake*– For ACTT, PACTT and Supports within Housing: The intake program conducts initial screening and service matching, while the receiving program conducts further screening, assessment, verification, and makes final admissions decisions. For Case Management and Specialty Case Management services: it makes final admission decisions.
- *Demographics* – Adults, 16 and up
- *Tools/Data Systems* – Locus, Crisis triage rating scale, Service Prioritization Decision Assistance Tool (SPDAT), uses a self-developed data system
- *Staffing* – Designated staff (4.2), mostly with a background in mental health

Reported outcomes

- Decreased duplication
- Increased system capacity
- Shared clinical consultation
- More transparent and equitable access across the system, consistent criteria across programs offered by multiple agencies

<i>Outcome measures/indicators</i>	<ul style="list-style-type: none"> ▪ Stakeholder satisfaction-Percentage of stakeholders who report overall satisfaction
<i>Process measures/indicators</i>	<ul style="list-style-type: none"> ▪ Time for processing applications (Time from receipt of referral to initial contact with consumer) ▪ Time for service matching
<i>Indicators for service utilization</i>	New service requests, total number of service requests awaiting processing, total number of service requests in wait list (awaiting service initiation), total service requests deemed eligible, total service requests deemed ineligible, total service request deemed ineligible by reason, number of service inquiries received within the date range, average days of the new referral to first contact (average days waited from new service request until staff make first contact to client), average wait time from new referral to the waitlist, average wait time on the wait list (days), average wait time from referral to assignment, number of service requests assigned and closed from the program, clients awaiting for response from Service Provider,
<i>Level of service utilization</i>	Overwhelming use
<i>Service provider and client satisfaction</i>	Positive responses

- Cost-effectiveness: Not sure
- Effectiveness in achieving intended goals: efforts in place to meet the goals

Reported lessons learned -

- Facilitators:
 - Engagement of providers (hospitals critical)
 - Engaging referral partners and primary care sector
 - Involving people with lived experience and caregivers
- Barriers:
 - Historical criteria for funding programs
- Best Practices:
 - Standardizing eligibility criteria from the outset of the program
 - Involving all key players in decision making

Toronto Central LHIN

There are a number of different mental health and addiction coordinated access initiatives operating within the Toronto Central LHIN. These include:

1. Central Access (to withdrawal management services)
2. Coordinated Access to Addiction Services
3. Access CAMH
4. The MHA Access Point

Access CAMH and Central Access to withdrawal management services are initiatives to improve access to a single organization or a sub-set of services. Coordinated Access to Addictions services is a referral point to any addictions services in the LHIN, or beyond. The MHA Access Point is a coordinated access point for individuals to apply for a range of individual mental health support services (like case management and Assertive Community Treatment) and Supportive Housing.

1. Central Access

Expressed need - Lack of coordination (in general), Repeat ED visits, exclusionary criteria of organizations which added barriers to accessing services

Type of model – Virtual, single point, centralized access

Central Access is a toll free number (1-866-366-9513) for those who need to connect to the Toronto Withdrawal Management Services System. It is run through the 211 infrastructure and therefore has 24/7, multi-linguistic staffing. It manages the bed capacity for all withdrawal management services sites in the Toronto Central LHIN.

People looking for a bed call the line and if there is a bed available, they are referred through a facilitated call between the person and the Withdrawal Management Services location. The bed is held for a period of time pending the arrival of the person, after which it will be released to the next caller. There are no wait lists. This is a direct placement, not merely a referral. It has been in place for 10 years.

- *Implementation strategies* – Minimal planning was done for Central access – “In the beginning there were 2 phones with 4 lines, gradually IT support helped build the model.” Well-trained clinicians answered phone calls during the day and 211 Findhelp answered the calls at night.
- *Core functions* – Information and referral only
- *Scope of Services* – Addictions only - Community and day withdrawal programs, Residential withdrawal management centers
- *Authority for intake* – No authority over admissions
- *Demographics* –16 and up
- *Tools/Data Systems* – Self-developed triage form; Catalyst
- *Staffing* – 2 full-time staff

Reported outcomes¹¹

Ease in service navigation

<i>Outcome measures/indicators</i>	<ul style="list-style-type: none"> ▪ Client satisfaction ▪ Partner satisfaction with services
<i>Process measures/indicators</i>	<ul style="list-style-type: none"> ▪ Referral volumes
<i>Indicators for service utilization</i>	<ul style="list-style-type: none"> ▪ Call volumes ▪ Response time ▪ Wait times on calls ▪ Talk-time ▪ Answer rates ▪ Dropped calls ▪ Queue time
<i>Level of service utilization</i>	<i>Service utilization</i> - overwhelming use – difficult to get access to beds

¹¹ See Appendix F for data reported in 2015

<i>Service provider and client satisfaction</i>	Positive
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- Cost-effectiveness: Yes
- Effectiveness in achieving intended goals: Performing well

Reported lessons learned -

- Facilitators:
 - Having a consultation table of all providers
 - Engaging the providers
 - Strong leadership
 - Clear vision
 - Collaboration of services to enhance intake policies and procedures
- Barriers:
 - Lack of an electronic bed reporting system
 - Not enough resources to have clinicians answer the phone
- Best Practices:
 - Collaborative system that works together to manage intake policies and practices

2. Coordinated Access to Addiction Services

Expressed need - Lack of coordination (in general), Repeat ED visits, exclusionary criteria of organizations which added barriers to accessing services

Type of model – Virtual, single point, centralized access

Coordinated Access to Addictions Services is a central number (1-855-505-5045) that individuals, family members and community agencies can call for addiction support within the City of Toronto. It has been in place for almost 3 years.

- *Implementation strategies* – Well-trained information and referral specialists were hired to direct people appropriately.
- *Core functions* – offers triage, screening and referral, as well as follow-up.
- *Scope of Services* – Addictions only – It has links to 35 addiction support providers as well as a number of community based networks, including: residential, day and community withdrawal services, residential and community treatment, services for people with concurrent mental health and substance use problems, services to minimize

the harm caused by an addiction (e.g. needle exchange programs), rapid access to medical clinics, community case workers and family programs

- *Authority for intake* – No authority over admissions
- *Demographics* –16 and up
- *Tools/Data Systems* – Self-developed triage form; Catalyst
- *Staffing* – 2 full-time staff

Reported outcomes¹²

Ease in service navigation

<i>Outcome measures/indicators</i>	<ul style="list-style-type: none"> ▪ Client satisfaction ▪ Partner satisfaction with services
<i>Process measures/indicators</i>	<ul style="list-style-type: none"> ▪ Referral volumes
<i>Indicators for service utilization</i>	<ul style="list-style-type: none"> ▪ Call volumes ▪ Response time ▪ Wait times on calls ▪ Talk-time ▪ Answer rates ▪ Dropped calls ▪ Queue time
<i>Level of service utilization</i>	Underwhelming use
<i>Service provider and client satisfaction</i>	Positive

- Cost-effectiveness: Yes
- Effectiveness in achieving intended goals: Performing well

Reported lessons learned -

- Facilitators:
 - Having a consultation table of all providers
 - Engaging the providers
 - Strong leadership

¹² See Appendix F for data reported in 2015

- Clear vision
- Barriers:
 - Implementation around the same time as other models, including Access CAMH¹³
 - Unwillingness to compete with other access models in terms of marketing – Limited budget for marketing
 - Providers ‘hanging on to old practices’ - not thinking about improving client experience in the system
 - Providers not mandated report the bed availability
- Best Practices: Focus on client experience

3. Access CAMH

Expressed need – Difficulty navigating CAMH - approximately 45 referral forms, very few of the more than 80 phone lines were managing intake and responding to calls live, and around 130 clinics in CAMH alone.

Type of model - Virtual, single point, centralized access (416-535-8501, press 2)

- Access CAMH is designed to provide a single access point for all referrals and requests for information about accessing clinical services at CAMH as well as resources in the community.
- *Implementation strategies* – Fully implemented since December 2014, after completion of a series of partial implementations. Existing staff were reassigned to Access CAMH, and full implementation required hiring of additional staff. Model was developed following workflow mapping and lean analysis.
- *Core functions* – information, referral, screening and assessment
- *Scope of Services* – All Mental Health and Addictions services that CAMH offers as an outpatient service, with the exception of a small number of services with clear referral pathways.
- *Authority for intake*– The intake program conducts full screening, assessment, verification, and makes disposition decisions that are binding on the receiving program (only applies to CAMH)
- *Demographics* –5 and up

¹³ Recent collaboration between Access CAMH and Coordinated Access to Addiction Services has resulted in an increase in the number of calls being transferred from Access CAMH to Coordinated Access to Addiction Services. For instance, in the number of calls received in April, 2016 were equivalent to the previous quarter.

- *Tools/Data Systems* – Inclusion and exclusion criteria developed by CAMH Clinical Programs for screening and triage
- *Staffing* - Up to 25 FTEs approximately 16 administrative and 10 allied health (social service workers, nurses) – rotating shifts. Staff is trained in both mental health and addictions.

Reported outcomes –

- Ease of navigation
- Improved access

<i>Outcome measures/indicators</i>	<ul style="list-style-type: none"> ▪ Client satisfaction ▪ Referral source satisfaction
<i>Process measures/indicators</i>	<ul style="list-style-type: none"> ▪ Referral volumes ▪ Referrals processed ▪ Referral processing times
<i>Indicators for service utilization</i>	<ul style="list-style-type: none"> ▪ Call volumes ▪ Response time ▪ Answer-time ▪ Types of calls ▪ Calls in/out
<i>Level of service utilization</i>	Overwhelming use
<i>Service provider and client satisfaction</i>	Positive

- Cost-effectiveness: Don't know
- Effectiveness in achieving intended goals: Performing well

Reported lessons learned -

- Facilitators:
 - Common understanding regarding need for the program
 - Buy-in from senior leadership
 - Collaborative approach
 - Efficient change management
 - Learning from others
- Barriers: Difficulty connecting with services outside CAMH/Toronto
- Best Practices:
 - Clear vision and scope
 - Efficient use of resources, including staff

4. The MHA Access Point

Expressed need - Client experience, equitable client services, improved efficiency, better resource management, streamline services, ability to prioritize, desire to improve access – reduce the number of application forms, provide choice, reduce duplication on wait lists, and a less fragmented and confusing system for service users and their family members

Type of model – Blended approach: Centralized access model (with a single centralized intake phone line and a single physical location/access point), with an option for clients to access services from multiple locations.

Implementation strategies –

- The MHA Access Point was formed in 2013, as a result of the integration of two access points formerly known as Access 1 and Coordinated Access to Supportive Housing (C.A.S.H.).
 - It is funded through partnership between Toronto Central LHIN and Central LHIN.
 - It serves areas beyond the TC LHIN boundaries, i.e. the City of Toronto, including North York and Scarborough.
 - Access to individual support services and supportive housing was coordinated / centralized.
 - One of the highlights of this process was creation of a single common application form that would provide referring agencies and service user's access to up to 50 supportive housing and support service agencies.
 - Online application process was implemented last fiscal and it improved access and productivity.
 - Moving to live answer in fiscal 2016-2017.
- *Core functions* – Information and referral only for addictions; information, referral, screening, service matching for mental health
 - *Scope of Services* – Mental Health, Addictions and supportive housing services, including intensive case management, assertive community treatment teams (ACTT), early psychosis intervention, subsidized housing, permanent and transitional housing options
 - *Authority for intake* – The intake program conducts initial screening and service matching, while the receiving program conducts further screening, assessment, verification, and makes final admissions decisions
 - *Demographics* – 16 and up
 - *Tools/Data Systems* – Self-developed tools to determine eligibility and differentiate the various levels of priority for services

- *Staffing* – one director, two team leaders, ten service navigators, one peer support worker, one support staff, one database programmer

Reported outcomes

- Greater transparency of intake processes
- Fewer declines by scarce resources such as ACT
- High rate of referral acceptance by support services providers
- Data that provides a better understanding of the level of need for mental health services in the community
- Two years of sector wide data on all referrals, and information about who is getting service quickly and who is not
- An on-line application process and an electronic matching tool
- 53 provider organizations that use one application form

<i>Outcome and process measures/indicators</i>	Benchmarks related to services initiation and intake experience
<i>Indicators for service utilization</i>	<ul style="list-style-type: none"> ▪ # applications ▪ # service requests ▪ time to process applications ▪ # admits to service of each type ▪ # client contacts ▪ # declines by provider ▪ # declines by clients
<i>Level of service utilization</i>	Growing over time, number of applicants has doubled in the last couple of years
<i>Service provider and client satisfaction</i>	Positive

- **Cost-effectiveness:** No formal evaluation yet, however, Access Point is currently undergoing a transformation through which the “live answer” rate will be dramatically increased, which should yield efficiencies throughout the process, and in combination with a system redesign effort at the LHIN level, will result in quicker connection of applicants to the providers who will serve them (i.e., quicker accountability transfer of the client to the service provider, rather than having the applicants wait on a list at the middle point).
- **Effectiveness in achieving intended goals:** The Access Point has usually met its targets, and particularly within individual support services, there’s a sense that equity of access has been improved in part because of the comprehensive review of reserved access partnerships that was undertaken at the beginning of the process. The increases in

demand over time has resulted in increasing waitlists, although some providers have shifted their practices to increase flow through their services.

Lessons Learned -

- Facilitators:
 - LHIN's support is critical – as the LHINs' support for the projects increased, so did engagement and participation in the process
 - Building participation into organizations' M-SAAs and H-SAAs is helpful.
 - Leadership of providers
- Barriers:
 - Insufficient resources cause some partner agencies to get discouraged about what coordinated access can and can't do to improve the system for clients.
 - Lack of a mandate to enforce partner agencies to move away from service delivery practices that are agency-focused to client-centered and system-minded practices.
- Best Practices:
 - "Push out" referrals for certain core services as they come in and are assessed. This will allow local providers to solve the capacity problems in their own sub-LHIN area
 - Coordinating access along with changing service delivery practices (e.g., service targets, limits to service duration, service resolution tables/processes) would yield the most benefit, because coordinating access increases demand/access, and actions must be then taken to increase flow throughout the system.
 - There is a need for common data and service definitions across sectors/ system.

LESS COMPLEX MODELS

These are described below in Table 10.

Table 10 LHINs with ‘less complex’ coordinated access models

LHIN	Expressed need	Model/Approach	Implementation	Services	Reported/expected outcomes	Reported lessons learned
Hamilton Niagara Haldimand Brant	Need for one number that people can call to access services	MH & A access line - essentially a warm hand off; toll free number answered 24/7 by trained volunteers to facilitate referrals to appropriate MH & A services ¹⁴	In place for a year; Lacked implementation strategy, no formal work plan	<ul style="list-style-type: none"> • <i>Scope</i> – MH & A • <i>Demographics</i> – Adults 	<ul style="list-style-type: none"> • Easy navigation of the system • Connect clients with the right services 	<ul style="list-style-type: none"> • <i>Facilitators</i>- LHIN and community partners were supportive • <i>Barriers</i>- Lack of understanding of needs and evidence to inform the appropriate model to address needs, challenges in performance monitoring • <i>Best practices</i>- knowledge of implementation planning by providers, Importance of accurate needs assessment
Central West	<ul style="list-style-type: none"> • Need for streamlined transitions • improved access reduction of wait 	A network of mental health and addiction (MH&A) services providing “any door” access following standardized business	Getting started on implementation - phase one implementation to start in April 2016	<ul style="list-style-type: none"> • <i>Scope</i> – MH & A • <i>Demographics</i> – Adults 	<ul style="list-style-type: none"> • Needs-based Access and Transitions • Supports while waiting 	<ul style="list-style-type: none"> • <i>Facilitators</i> - Provider leadership and involvement, managing change, collaboration with

¹⁴ See appendix F for data reported in 2014-2015 fiscal year

	<p>times</p> <ul style="list-style-type: none"> • repeat emergency visits • integration of services 	<p>processes, using standardized clinical tools, and deploying a single data management system. MH&A services designated as SAM Partners support clients who chose their service door to warm transfer for SAM's full range of services to centralized virtual services (phone, text, chat, video conference, web) or one of five walk-in locations of a SAM Provider. The intention is also to have a centralized wait list.</p>			<ul style="list-style-type: none"> • Supported Discharge Planning and Client Flow • Proactive Service Resolution • Shared Client Records • Cross-LHIN and Cross-sector Protocols • Quality and Timely Data for Service/System Planning • Centralized Records and Waitlist • Transparent, less fragmented access to services • Up-to-date information on services across sectors • Equitable, access to all LHIN-funded MH & A services 	<p>LHIN, funding (base and <i>one-time</i>), principle of “don't do anything that may need to be undone”.</p> <ul style="list-style-type: none"> • <i>Barriers</i>- No dedicated project management resources, waiting for the work of other LHINs to avoid duplication (pushing deadlines) • <i>Best practices</i>- Build on what comes before you: use the research from other LHINs to organize and drive work
South East	<ul style="list-style-type: none"> • Improve 	Blended approach: come in	Planning completes	<ul style="list-style-type: none"> • <i>Scope</i> – MH & A 	<ul style="list-style-type: none"> • Confidence that 	<ul style="list-style-type: none"> • <i>Facilitators</i>-

	<p>coordination between MH & A sector</p> <ul style="list-style-type: none"> • Seamless transition between MH & A • Improve access • Help clients navigate the system better • Inconsistent services • Primary care experienced difficulty in making referrals 	<p>through any door but get directed to one of the three centralized intake doors – functionally one doorway</p>	<p>by March 31st, 2016</p>	<ul style="list-style-type: none"> • <i>Demographics</i> – Adults (18 and up) and youth (16 and up) 	<p>referrals will go to a place where they know that services are</p> <ul style="list-style-type: none"> • Clients will be appropriately assessed, equity of access 	<p>Continuous engagement of clients</p> <ul style="list-style-type: none"> • <i>Barriers</i>- Not involving clients • <i>Best practices</i>- Learning from Connex and other LHINs about coordinated access
<p>North East</p>	<ul style="list-style-type: none"> • Improve Access • Reduce wait times • Address fragmentation of services • Lack of coordination among mental health providers (to a lesser degree addictions) • Repeat visits 	<ul style="list-style-type: none"> • Two Centralized intake models – one in Sudbury (Espanola site), one in Algoma • LHIN is introducing a common referral form to refer for any community MH & A service (pilot starting Jan 1) 	<p>In place for a year</p>	<ul style="list-style-type: none"> • <i>Scope</i>- Algoma – MH & A Espanola – MH only • <i>Demographics</i> – Algoma – Youth and adults Espanola – Adults only 	<ul style="list-style-type: none"> • Integration of services • Improve access to the system – make it easier for people • Reduction in wait time • Ensuring the clients get right services in a timely fashion • Shared capacity, 'positive 	<ul style="list-style-type: none"> • <i>Facilitators</i>- Resources, Buy-in from all community providers, Engagement of Primary care providers • <i>Barriers</i>- inconsistencies between models across regions in LHIN, Business practices of individual organizations, HSN

	<p>(Sudbury has been consistently having high repeat visits)</p> <ul style="list-style-type: none"> • Multiple agencies doing multiple assessments for same individual • Match clients to right service 				<p>collaboration that cuts through silos', streamlined access to services</p> <ul style="list-style-type: none"> • Faster access to services 	<p>and CMHA are not well coordinated</p> <ul style="list-style-type: none"> • <i>Best practice</i>- Buy-in from community partners, mandating Coordinated Access might be helpful, Hospital and community sector must work in a more collaborative way
North West	<ul style="list-style-type: none"> • Need for one access point • Difficulty accessing services • Silos between organizations around continuity of care 	<p><i>Thunder Bay</i>: centralized access with Alpha Court, Thunder Bay Regional Health Sciences Centre (TBRHSC), St. Joseph's Care Group (SJCG) and CMHA Thunder Bay</p> <p><i>Kenora</i>: using a decentralized intake process</p>	<p><i>Thunder Bay</i>: roll out by spring</p> <p><i>Kenora</i>: logic model to be completed by March 2016</p>	<ul style="list-style-type: none"> • <i>Scope</i> - Thunder Bay- MH; Kenora – MH • <i>Demographics</i> - Thunder Bay- Adults; Kenora - child and adult clients 	<ul style="list-style-type: none"> • Reduced wait times • Greater accountability • Quality improvement 	<ul style="list-style-type: none"> • <i>Facilitators</i>- common vision • <i>Barriers</i>- being dependent on 2nd party to do assessments for you
Erie St. Clair	<ul style="list-style-type: none"> • Repeat emergency visits • Integration of services • Seamless transitions 	<ul style="list-style-type: none"> • Decentralized intake model • Partnership with Connex ON to facilitate electronic bookings • Integration of services in Chatham Kent region, including Schedule 1 hospital with Canadian Mental Health 	<p>In place since 4 years</p>	<ul style="list-style-type: none"> • <i>Scope</i> – MH & A • <i>Demographics</i> – Adults (16 and up) 	<ul style="list-style-type: none"> • Reduction in ED visits and hospital visits • Ensuring people receive right services at the right time • Easy navigation of the system 	<ul style="list-style-type: none"> • <i>Facilitators</i>- LHIN's leadership role, use of Connex's existing platform • <i>Barriers</i>- Poor promotion • <i>Best practice</i> – Regular Communication, buy-in from

		Association, Lambton Kent				providers, provincial oversight to standardize the processes
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LHINS WITH NO COORDINATED ACCESS MODELS

It is important to note that both North Simcoe Muskoka and Central East LHIN have several initiatives underway to improve access, including the integration of services. However, there is no coordinated access model in place, partly because of how the services are organized.

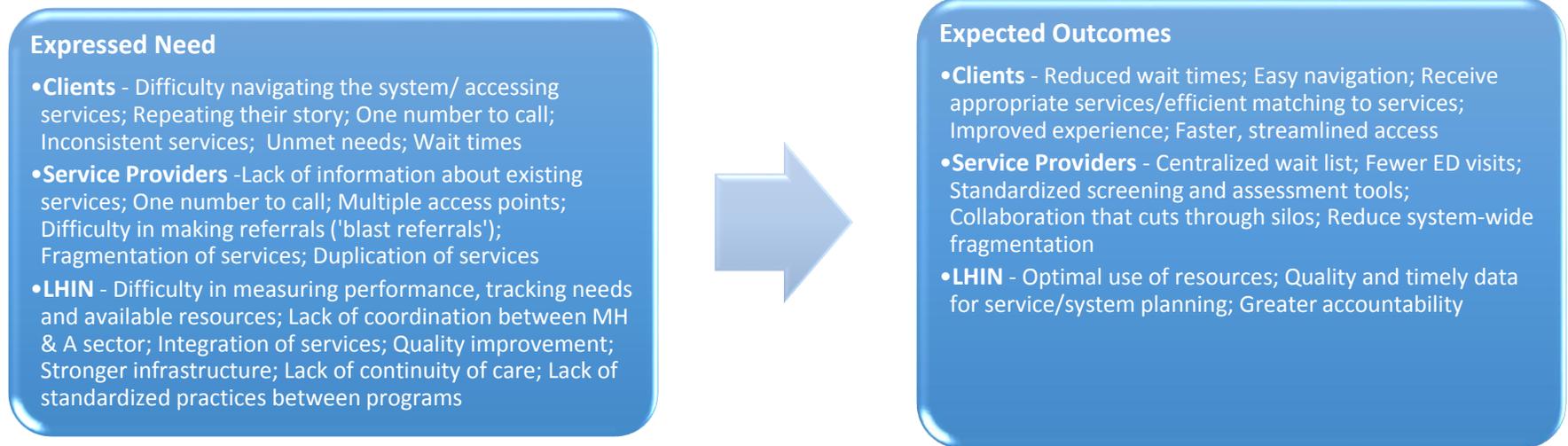
- North Simcoe Muskoka -
 - There has been voluntary integration of agencies, as a result there are no “stand alone” community addiction agencies, which simplifies navigation of the system.
 - Greater need to address significant gaps in services rather than direct resources to coordination.
 - Challenge is not the “coordinated” part, it’s the “access” part since there are significant gaps in the continuum of services, and there basically is no access to some things.

- Central East –
 - Not considering coordinated access as a stand-alone approach. The objective is to look at the system’s effective and cohesive functioning, attempts are made to ensure that no matter where clients go they get the services that they need.
 - Most of the work done so far is to improve integration of services and integration of smaller organizations so that they become stronger and larger with better infrastructure.

7.2. KEY THEMES

Although there is a high degree of variation in the coordinated access models across the fourteen LHINs in Ontario there were commonalities with respect to needs for improving access and expected outcomes (Figure 6).

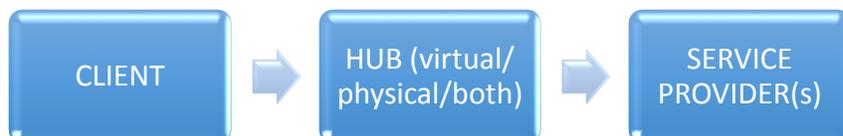
Figure 6: Commonalities with respect to expressed needs and expected outcomes



Consistent with the existing literature we found *3 broad categories of coordinated access models* –

1. Centralized access model

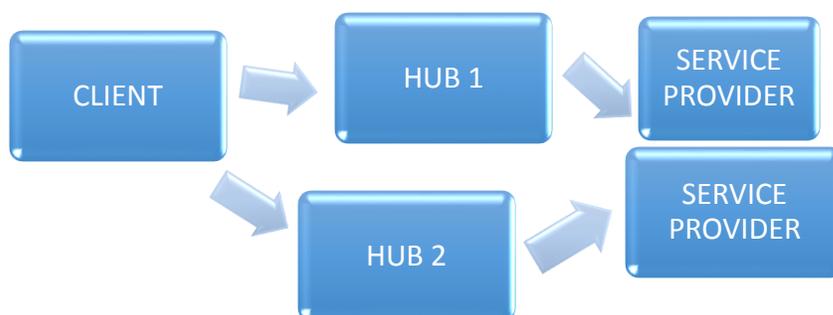
1 (a) Centralized model with *single point of access*



The functions of centralized access hub can range from information and referral only to information, referral, assessment and triage, and in some cases, even service matching, navigation and waitlist management. The client is connected to the service provider through a centralized access point/hub which can have a physical location, and/or a single phone line to serve clients.

E.g. Huron Perth (South West LHIN), Central Access (Toronto Central LHIN), Coordinated Access to Addictions Services (Toronto Central LHIN), Access CAMH (Toronto Central LHIN)

1 (b) Centralized model with *multiple points of access*



The client is connected to the service provider through a centralized access point/hub which has multiple physical locations. So, the clients can go to either of the hubs to get connected to the providers.

E.g. Thames Valley (South West LHIN)

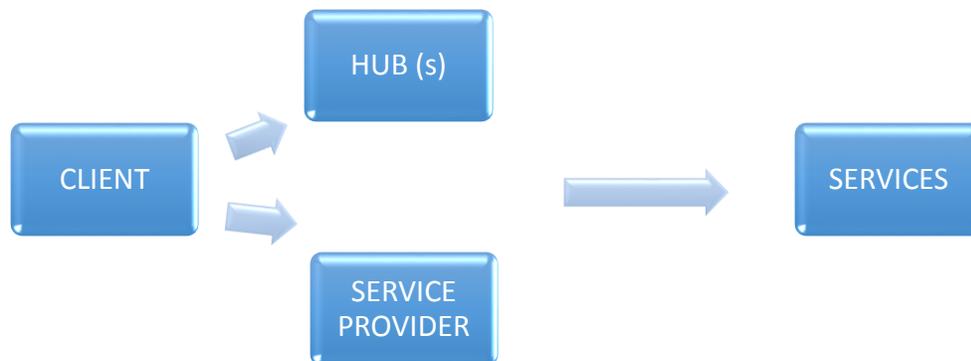
2. Decentralized access model



This model is based on the ‘every door is the right door’ approach where clients can access services from multiple locations as each intake agency uses the same set of assessment and referral tools and criteria.

E.g. Erie St. Clair LHIN

3. Hybrid

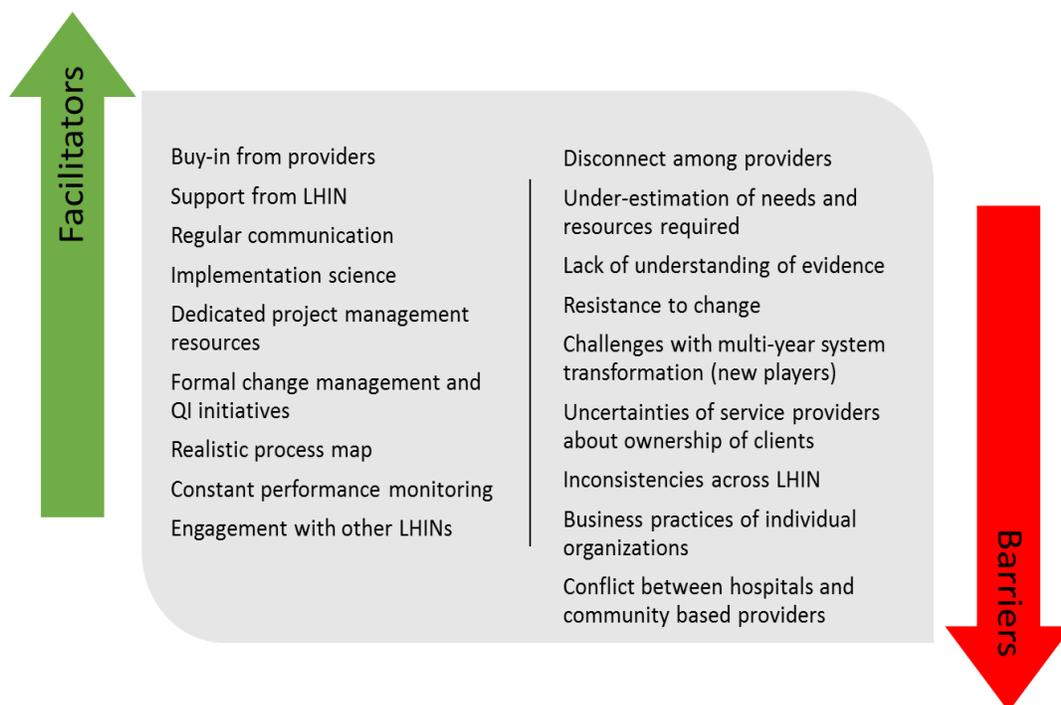


The hybrid model is a combination of the models described above, i.e. there is a centralized point of access (with single or multiple locations) with alternative access points.

E.g. ‘Here 24/7’ (Waterloo Wellington LHIN), ‘One Link’ (Mississauga Halton LHIN), OAARS (Champlain LHIN), Streamlined Access (Central LHIN), Access Point (Toronto Central LHIN)

Based on the input from key informant interviews, we were able to identify facilitators and barriers for adopting a coordinated access approach (Figure 7)

Figure 7: Reported facilitators and barriers for adopting a coordinated access approach



SYNTHESIS OF KEY FINDINGS

- The majority of LHINs in Ontario have implemented or are in the process of implementing some type of coordinated access system for mental health and addiction services.
- The choice of models depended on several factors, includes the desired role of coordinated access model in the system, the existing level of collaboration among partners (provider buy-in, type and level of system integration and partnerships), and available resources. The different models vary by number of access points, services offered at each access point, referral process, and authority/scope of intake. **No single model fits all contexts.** These models have been developed to meet the unique needs and priorities of each LHIN (or sometimes sub-regions within the LHIN).
- Since a coordinated access approach is typically a major systems change, it is important to get consensus for the overall project vision from key stakeholders. LHIN leadership and commitment is crucial for both planning and implementation. Planning should include ongoing collaboration with all the key community stakeholders.

- Implementation planning based on implementation science has the potential to improve outcomes. Phased implementation and use of consistent tools (for screening, intake, assessment) and referral procedures is the key to successful implementation of a coordinated access model. The program needs to be modified and improved continuously to increase the likelihood of achieving the desired outcomes and making the most efficient use of resources.
- Different outcome/process indicators are being used for program evaluation. These inconsistencies make it difficult to compare the performance of programs across the province.
- Coordinated access mechanism does not necessarily address the issue of capacity in the system to handle a major increase in help-seeking but offers an efficient approach to service matching if implemented with standardized processes and tools.

7.3. PROVINCIAL LEVEL

CONNEXONTARIO

ConnexOntario Health Services Information, funded by the Ministry of Health and Long-Term Care (MOHLTC), operates The Mental Health Helpline, The Drug and Alcohol Helpline, and the Ontario Problem Gambling Helpline. These helplines offer a provincial, centralized point of access to mental health and addiction service system. It provides free information and referral to all MOHLTC-funded mental health and addictions programs. The calls are live-answered at an average rate of 95 percent. It also provides data upon request- data related to services provided by the provincially-funded mental health and addiction services and access-related information. In fiscal 2014/2015, the organization responded to over 1700 data requests.¹⁵

Strengths

- Provincial scope – callers can get information regarding services outside their LHINs
- Callers are provided information regarding location of programs that offer services through Ontario Telemedicine Network (OTN) – this helps those who cannot directly access services due to resource gaps and transportation issues
- 24/7/365, live answered
- In addition to helplines, contact can be made through webchat (a very popular method) and email
- Partnerships with LHINs regarding data sharing (e.g. Toronto Central, Central, North East) and using 'DirectConnex', the new appointment booking and calendar tool (e.g.

¹⁵ See Appendix F for data reported between April 2015 and February 2016

Erie St. Clair, Oxford County). It allows the information and referral specialists at ConnexOntario and participating organizations to directly book callers/clients into appointments. This minimizes the wait time, makes the transition seamless for clients and allows the organizations to optimize their client-service efforts. Confirmation emails after the appointments also help to keep a track of show/no-show rates.

- ClientConnex is another web-based client management tool that has not been deployed yet but has the potential to function in a centralized or decentralized service environment, as well as assist with the management of client status, including whether a client is pending assessment, waiting for service, or is not on any waitlists; client issues; income and funding considerations; contact information of decision makers; intake details; and service requirements
- Database contains data regarding caller demographics, gender, presenting issue(s) etc. which can be used for planning services
- Data-collection staff are in regular communication with MOHLTC-funded participating organizations; data validations are annual, and program changes are processed immediately, with notifications sent directly to the MOHLTC and LHINs. In terms of availability and wait lists, data is updated daily, weekly, monthly, or annually depending on the service type.
- Regular performance monitoring is done. There is an optional feedback survey at the end of web chat which reflects positive responses regarding client satisfaction.

Challenges

- Only some LHINs have coordinated their local coordinated access models with ConnexOntario, which limits its contribution at the provincial level.
- Some local access providers and their respective LHIN's have become are reluctant to share data with Connex on service availability and providers have not been reporting data regularly.
- Referrals coming from models with a single point of access are slow.
- Variations in the models within sub-regions of LHINs also hinder the provincial role of ConnexOntario.
- Lack of mandate to report services funded by other ministries, including Ministry of Child and Youth Services (MCYS).
- Performance data from Connex is largely process oriented documenting the number of calls, and most recently service satisfaction. Due to the confidential nature of the Connex services linking the contribution of Connex to subsequent treatment, engagement and health outcomes is not feasible.

CRITICALL ONTARIO: PROVINCIAL INPATIENT MENTAL HEALTH BED REGISTRY

CritiCall Ontario is dedicated to supporting access to and delivery of urgent and emergent care within Ontario. CritiCall Ontario, through their Call Centre, provides 24/7 case facilitation to hospital-based physicians in Ontario who need support or resources beyond what is available in their hospital to care for urgent or emergent patients. The Ministry of Health & Long-Term Care has contracted CritiCall Ontario to operate the Provincial Inpatient Mental Health Bed Registry. It is housed in CritiCall Ontario's Provincial Hospital Resource System (PHRS) which contains information about the specific services provided by each hospital in Ontario, as well as the availability of all critical and acute care beds within those hospitals. This information is required to be updated daily to help ensure CritiCall Ontario has the information it needs to provide effective assistance with the day-to-day management of critically or emergently ill patients. This information also assists the province and CritiCall Ontario during times of local, regional and provincial disasters/crisis when resource management is challenged and a coordinated response is required.

The Bed Registry Project is comprised of two Mental Health & Addiction Resource Boards (one for Adult and one for Child & Adolescent) and a Provincial Mental Health & Addiction Dashboard, all housed within CritiCall Ontario's existing Provincial Hospital Resource System (PHRS). Adult resource board went 'live' in December 2015 and the Child and Adolescent resource board went 'live' in March 2016. All hospitals (with a Schedule 1 designation¹⁶) with MOHLTC funded inpatient mental health & addiction beds¹⁷ are required to input information into the Resource Board. They provide province-wide up-to-date information about the number of available mental health and addiction inpatient beds in Ontario hospitals, and mental health and addiction inpatient bed capacity information which is based on the number of individuals waiting for inpatient beds. Its goal is to use this information to improve access to and optimize the use of inpatient mental health beds across the province.

Strengths

- Provincial approach to Schedule 1 psychiatric services- real-time data around the availability of the approximately 3,200 adult mental health and addiction beds across

¹⁶ The designation of a schedule 1 facility is determined by the Ministry of Health and Long Term Care and refers to public hospitals and other health facilities that provide observation, care and treatment for patients experiencing mental health disorders. In addition to meeting the regulations outlined in the Mental Health Act, a schedule 1 facility must provide the following essential mental health services: inpatient services, outpatient services, day care services, emergency services, consultative and educational services to local agencies.

¹⁷ Forensic Beds are out of scope

over 60 sites and more than 300 child and adolescent mental health and addiction beds across 26 sites.

- Enhanced inter-hospital communication and collaboration through the establishment of a shared communication tool with standard definitions of bed types and common indicators.
- Detailed monthly and quarterly reports on occupancy rates, occupancy trending, surge and compliance monitoring made available in the PHRS Library that can be accessed by the MOHLTC, LHINs and hospitals to evaluate how the system is operating at a local, LHIN and provincial level, and to identify opportunities for continuous quality improvement at the system level.
- CritiCall Ontario has pursued partnerships with provincial Mental Health committees, associations and hospital and physician leaders to help champion and promote the uptake and usage of the two PHRS Mental Health Resource Boards and supporting resources.
- CritiCall Ontario is collaborating with LHINs at a local level on the implementation and performance management, including compliance rates, of the PHRS mental health and addictions Resource Boards and supporting resources to help patients receive care in the most appropriate setting. Some LHINs have set up Working Groups to assist with this local level implementation.
- CritiCall Ontario is exploring with the MOHLTC future opportunities to maximize the availability of information in the Mental Health and Addictions Resource Boards such as including information on the availability of community crisis beds, withdrawal management beds and beds funded by the Ministry of Child and Youth Services.
- CritiCall Ontario is having ongoing conversations with MOHLTC, ConnexOntario, provincial working groups and the LHINs about how the Inpatient MH&A Bed Registry can collaborate with and support local or centralized coordinated access models as they evolve, including supporting capacity planning for mental health and addictions programs and services across Ontario.

Challenges

- Hospitals are responsible for the data entered, including its accuracy and completeness. Hospitals are continuing to work on their internal processes to ensure the data is robust and accurately reflects what is happening in their organization.
- Given that the Resource Boards have only been operational since December 2015 (Adult) and March 2016 (Child & Adolescent), CritiCall Ontario is working with the LHINs to increase compliance rates (currently compliance rates are not yet at 100%).

Evaluation

CritiCall Ontario's Provincial Mental Health and Addiction Bed Registry Advisory Committee has been monitoring the implementation of the Provincial Inpatient Mental Health Bed Registry Project in the short term. They have been making recommendations to support hospitals in updating the Boards and to support the appropriate usage of the Resource Boards at local, LHIN and provincial levels. Ministry will evaluate this initiative after two years to ensure its overall effectiveness and ongoing success. It will be based on the evaluation plan developed by the CritiCall Ontario's Provincial Mental Health and Addiction Bed Registry Advisory Committee. The evaluation process will include the following:

- Review of performance indicators, including monthly compliance, occupancy, trending and surge reports, which will provide insight into patient outcomes and impact on ED visits
- Development of a provincial and/or LHIN dashboards
- Qualitative and quantitative survey to measure satisfaction with and use of the MH&A Resource Boards and supporting tools, as well as to demonstrate improvements at the local and provincial levels.

8. CONCLUSION

For some time there has been strong interest in models of coordinated and centralized access to mental health and addiction services in Ontario and over the past 10 years models have proliferated across the province. Many are quite recent and more are under development. ConnexOntario, a provincial program aimed at facilitating access to treatment and support services, has been in existence for almost 25 years and there are varying levels of collaboration between the relatively new regional access services and this long-standing provincial program. The Inpatient Mental Health Bed Registry Project, a fairly recent initiative also offers a coordinated provincial system for utilization of available inpatient mental health beds to help ensure that patients receive timely access to the bed and resources that best meet their needs. While together these various models of coordinated and centralized access constitute a major change in the landscape of Ontario's mental health and addiction service delivery system, there is no provincial description of these services and no published synthesis of the research literature that may have guided their development and their future evolution.

These factors prompted this review of the current status of coordinated and centralized access for mental health and addiction services across Ontario. As noted earlier, the project was not an *evaluation* of the province's coordinated or centralized access models rather a descriptive *environmental scan* intended to prompt reflections on lessons learned, and facilitate future planning, performance measurement and evaluation.

Coordinated access offers the promise of simplifying access to services through the consistent use of standardized processes and tools for assessment and referral. It streamlines the entry of clients into a system of care that helps to identify the needs and most appropriate treatment options for individuals through the consistent use of standardized tools. In other words, it does not create new resources, or address the potential problem of inadequate capacity but improves referral appropriateness and coordination by increasing the evidence-based decision-making and understanding among partners of what resources are available

The research reveals mixed findings about the effectiveness of coordinated access models and further research is needed on different approaches and in different contexts before this approach should be considered definitively as a “best practice” in system design and development. While the concept remains very attractive, the research does not point to the optimal approach or the “critical ingredients” of an optimal model. One of the challenges is the context-specific nature of the programs that have been evaluated and which makes it difficult to draw firm conclusions across the body of evidence.

An analysis of coordinated access models for mental health and addictions in Ontario shows that a majority of the LHINs have implemented, or are in the process of implementing a coordinated access model. This indicates that coordinated access is perceived to be a viable alternative to traditional forms of coordination. Although these models are based on similar core principles of integration-standardization of practice (through consistent information, standard forms and assessment processes) and the intention of a well-coordinated referral process, they differ in design to best meet the unique needs of local system. The models differed in terms of scope, number of access points, services offered at each access point, referral process, and authority/scope of intake. The most important factors for successful implementation were said to be: strong leadership, stakeholder buy-in and adequate resources. Flexibility of the model, for example, to adapt according to local circumstances, and ongoing collaboration of key stakeholders was reported as crucial for the viability of the local coordinated access approach.

9. IMPLICATIONS

9.1. STRATEGIC DIRECTION

While there have been significant developments at the regional LHIN level and sometimes close communication across the LHINs, overall there is no standard access model embraced by all LHINs, nor there has been strategic oversight in the development of the provinces coordinated access models. The process of implementing coordinated access has been described by one of the interviewees as, *“Somebody brought in a thousand piece puzzle, and took the picture on the box away. So you don’t know what the picture for the puzzle looks like. There are some pieces*

that we can put together but we are lacking an overall picture of how we are going to work on it.” There is limited clarity regarding what a coordinated access model should look like, and the degree to which they are meeting their stated objectives. Moving forward, a program logic model or guiding framework needs to be created at the provincial level to better guide the development of these models at the regional and community level. One key consideration provincially as well as regionally is whether the current capacity of the province’s mental health and addiction system is large and robust enough to effectively and efficiently manage the likely increase in people seeking access to services. Just as regional and local service delivery systems need to adapt to new models of access so does the provincial system writ large, for example the relative balance of investment in outreach services, residential versus community treatment options, and the use of Internet/mobile technology. These are but examples of the considerations that require more provincial-level strategic direction.

9.2. PERFORMANCE MEASUREMENT

There is a need to identify performance measurement indicators that can be used to measure and monitor access indicators and outcomes at the system, program and client level. There is a huge variation in the data being routinely kept by the various models across the province, which makes it important to have consistent indicators across the LHINs. An important and historically quite challenging example is the actual definition of “wait time to treatment or support”.

Related to this point is the fact that the existing coordinated/centralized mechanisms are at different stages of evolution making the comparison of access, outcome and/or process measures/indicators challenging. It is pertinent that evidence-based performance indicators for coordinated access models be aligned with performance indicators for the mental health and addictions sector. This, also, would be facilitated by provincial direction and leadership.

9.3. EVALUATION

Clearly evaluation is needed to understand the effectiveness of coordinated access models in the Ontario context, for example, their optimal design and viability within the constraints of existing service capacity as well as performance measurement challenges. Due partly to the recency of the province’s coordinated access mechanisms for the mental health and addictions sector in Ontario. Limited attention has been paid to evaluation. Key stakeholders in the current review identified the need for more information on “*what is working in the Ontario context*”. This prompts consideration of the key questions for evaluation including:

- What are the key outcomes, and from whose perspective?
- Are there capacity concerns in the system as a whole as access to treatment and support is enhanced?

- Should we be comparing different models to identify best or better practices?
- Who would choose these for evaluation and with what criteria?
- Are there particular models in the province where an independent evaluation would be helpful from a quality improvement perspective?
- What are the optimum strategies for coordinating local/regional access models with a provincial access model such as ConnexOntario and inpatient mental health bed registry?
- How does local context impact the success of different types of models?
- What is the feasible and appropriate alignment of regional and provincial performance measures related to access?

9.4. ALIGNMENT OF CONNEXONTARIO WITH OTHER MODELS

Although a majority of the LHINs have started implementing coordinated access models, only some have developed formalized partnerships with ConnexOntario (e.g. Erie St. Clair LHIN, South West LHIN and some parts of North East LHIN). Given the role of ConnexOntario in maintaining a comprehensive database for mental health and addiction services in Ontario, and providing significant direct services through its helplines and other innovative services, there is clearly potential for its services to be better aligned with the local coordinated access models, and vice versa. This can include, for example, providing real time information about clients and bed/service availability as well as data sharing in order to enhance access to information across the province. There is also a potential for more information to be gathered from clients wishing to enter the system, for example, screening information for mental health and addiction, including problem gambling. These and other potential points of collaboration need to be developed through cooperative agreements between the regional/local access models and ConnexOntario. Since the many regional and local access models have developed largely independent of ConnexOntario it is difficult, to turn the clock back and construct a uniform “*provincial access model*”. While this opportunity remains at least at a conceptual level, it will take considerable discussion and collaboration to find the optimal working relationships between the ConnexOntario provincial mandate and the rapidly evolving regional models. It is likely, this will now be best negotiated on a region-by-region basis. One critical element of this collaboration, however, must include renewed LHIN and provider commitment to regularly reporting accurate service availability data to ConnexOntario. LHIN engagement and Ministry leadership will be critical in facilitating these partnerships.

As these collaborative agreements get worked out regionally it is also critically important that the services offered by ConnexOntario and any further initiatives to contribute to provincial-level strategy and client flow be implemented in close concert with relevant provincial initiatives. This includes alignment, for example, with the projects on Data and Performance

Measurement in Ontario’s Mental Health and Addictions Sector, the System Alignment and Capacity Working Group and the Mental Health and Addictions Leadership Advisory Council in order to ensure that there is no duplication of work and a common understanding around data collection, analysis and reporting. Lastly, very close alignment is needed with the provincial DTFP-supported implementation of the new staged screening and assessment protocol given considerations underway at ConnexOntario for gathering first-stage screening information during initial contact with potential clients for mental health and addiction services. This must be thought through very carefully with provincial partners given the significant client process (e.g. confidentiality concerns) as well as information technology considerations that would have to be worked out to ensure all client screening and assessment data rests seamlessly within Catalyst according to the provincial implementation plan.

9.5 ALIGNMENT OF PROVINCIAL INPATIENT MENTAL HEALTH BED REGISTRY WITH CONNEXONTARIO AND LOCAL ACCESS MODELS

The inpatient mental health bed registry supports a coordinated, provide-wide approach to inpatient mental health beds in hospitals (with a Schedule 1 designation). Its alignment with ConnexOntario and local access models will optimize the utilization of available inpatient mental health resources. It can be used by local access models to locate beds for clients and coordinate their transfer to hospitals for potential admission and appropriate care settings for treatment. Further, protocols and policies to facilitate equitable and timely access, transfer, repatriation and discharge of clients can be used to not only support client/patient care and transitions but also to monitor how the system is operating at a local, LHIN and provincial level, and to identify opportunities for continuous quality improvement at the system level.

10. NEXT STEPS

We suggest that next steps include a thoughtful discussion of the main findings and implications of results of our review among the key players provincially and regionally. One important limitation of the current project is that resources did not allow for a wider process of data collection, for example, gathering the perspective of the many program managers and staff who are, or will be, the recipients of clients who access their services through a central access model. Their perspective is critical to a more complete assessment of the impact of these central access models including potential unintended consequences. Direct input from clients and family members is also very important going forward. Furthermore, our focus here was on “specialized” mental health and addiction access models and subsequent services while a large percentage of people seeking help do so through, for example, community health centres, family health teams, school counselling, to name just a few critical sectors/services also affected by and affecting movement toward more coordinated access models. In short,

feedback is needed on our report not only from the key stakeholders contributing to it, but also a much wider range of stakeholders.

We suggest that critical reflections on our report include a strong focus on evaluation needs going forward. This can occur, for example, by posing critical questions about particular models and the contexts in which they exist. However, questions can also be posed at a somewhat higher level, for example, what are the critical success factors for this overall provincial “movement” towards more coordinated access, how does it fit with other major provincial initiatives to improve evidence-based practice (e.g., new staged screening and assessment tools) and performance measurement and quality improvement (e.g., provincial performance indicators and/or the emerging, common approach to assessing client perception of care with the OPOC-MHA tool). Perhaps most importantly a provincial lens to evaluation could address important questions related to the efficiency and capacity of the mental health and addictions system writ large to handle a major increase in treatment demand. A developmental approach to future work could be used to examine critical questions at a provincial level but with a view to contributing workable solutions to critical questions about the overall “health” of Ontario’s treatment and support system for mental health and addiction concerns.

Lastly, our review identified a host of lessons learned and potential challenges in the planning and implementation of a more coordinated approach to accessing mental health and addiction services. We see the potential for a planning guide or resource toolkit to support future development of regional/local access models. And put this forward for consideration within next steps and among relevant stakeholders.

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12. APPENDICES

A – INTERVIEW GUIDE FOR LHINS

NEED

1. Has the LHIN/region considered and responded to the need for improved access to addictions and/or mental health services in the last three years?

If yes,

- 1.1. What was the initial catalyst/need of this approach (reduction of wait times, repeat emergency visits; an integration of services; general desire to improve access; increase the use of community supports)?
- 1.2. What need was expressed?
- 1.3. What was the response?
- 1.4. How was this need addressed?
- 1.5. Does this apply to the whole LHIN or sub-regions in the LHIN (if sub-regions consider doing separate templates)?

If no,

- 1.5. Why has there been no need expressed?
- 1.6. Is it being considered for implementation in the near future (next two years)?

TYPE OF MODEL/APPROACH

2. Has this response been articulated as a "coordinated access" approach?

If yes, which of the following best describes their approach/model:

- 2.1. Centralized Access/Single Point of Access - where clients go through a central intake and assessment process through which they are referred to the level of care that fits their needs.
- 2.2. Decentralized intake model/Every door is the right door - where clients can access services from multiple locations as each intake agency uses the same set of assessment and referral tools and criteria.
- 2.3. Both
- 2.4. Other approaches (e.g., community mobilization hubs, multi-service centers, etc.)

If no, which of the following best describes their approach/model:

- 2.5. Complex care committees- where the needs of complex clients are discussed on a case-by-case basis by a group of agencies on a regular basis.

- 2.6. Working closely in partnership with other organizations such as, ConnexOntario, distress centers to facilitate the referral of individuals to the addictions and mental health services.
- 2.7. “Warm hand” off to other services in the community.
- 2.8. Alignment with other system transformation initiatives such as Health Links.
- 2.9. Others, please describe.

IMPLEMENTATION

- 3. What is the current state of implementation of the coordinated access approach?
 - 3.1. Still planning
 - 3.2. Getting started on implementation
 - 3.3. Already in place
- 4. What are/will be their implementation strategies?
 - 4.1. What does the work plan look like?
 - 4.2. Which promotional strategies are being/will be used?
- 5. Who are the partners and lead agencies?
 - 5.1. Is there a partnership with community partners?
 - 5.2. Are the members from aboriginal groups, Francophones etc. included?
 - 5.3. What is the structure of advisory group/consultation table?
 - 5.4. What is the role of LHIN and other provincial players?

DESCRIPTION OF SERVICES

- 6. What is/will be the scope of services?
 - 6.1. Mental Health services only
 - 6.2. Addictions services only
 - 6.3. Mental Health and Addictions services
 - 6.4. Mental Health, Addictions and other (housing etc.) services
 - 6.5. Other variations, please describe
- 7. What are/ the demographics of population being served (youth, children, adults)?
- 8. Which category best describes the authority of coordinated intake model in place/under implementation?
 - 8.1. Information and referral only, no authority over admissions
 - 8.2. The intake program conducts initial screening and service matching, while the receiving program conducts further screening, assessment, verification, and makes final admissions decisions

- 8.3. The intake program conducts full screening, assessment, verification, and makes admissions decisions that are binding on the receiving program
 - 8.4. The intake program provides information and referral, and has admissions authority over some service types.
 - 8.5. Others, please describe.
9. Describe the range of services being offered/that will be offered (ACT, residential community treatment, crisis services, supportive housing, individual support services etc.)? What is the implementation scale of these services?
 10. What is the method of initial client contact (walk-ins, phone, in-person appointments, online/chat etc.)?
 11. What process of client referral is being/will be used by the program? How are the clients engaged in services? What supports are provided?
 12. Describe the tools being used/will be used for screening, triage, consent etc. (GAIN, LOCUS etc.)?
 13. Describe the data systems that is being used/will be used for gathering data, entering it, protecting sensitive information, and sharing information across programs (including, assessment information).
 14. Describe the staffing (plan, if not in place yet) of coordinated access project? What is/will be the training requirement/qualifications of staff (mental health, or addictions, or co-occurring disorders etc.)?
 15. Is the use of telemedicine for assessment, treatment and/or follow up being done/considered?

OUTCOMES/IMPACT

16. What are the (expected) outcomes from participating in coordinated access model (in terms of wait-times, referral services, response time etc.)? Reflect back on question 1
17. What process is/will be used for collecting and analyzing outcome and/or process measures/indicators to address quality improvement, effectiveness, future needs, or other issues?
18. If the coordinated access model is in place:
 - 18.1. Are the service providers satisfied with this approach?
 - 18.2. Are the clients satisfied with the procedure and services?

- 18.3. Which indicators are being/will be used to measure the utilization of services (calls, visits, emails, transitions)?
- 18.4. What is the level of service utilization? Is there a variation from expected use of services (underwhelming response/overwhelming use)?
19. Has the coordinated access approach been viable/cost-effective?
20. How effective is the program in achieving the intended goals (current efforts not meeting the plan, efforts in place to meet the goals, performing well)?

LESSONS LEARNED

21. Which factors have:
- 21.1. facilitated or are likely to facilitate the implementation of this approach (both the speed and scope of the project)?
- 21.2. impeded or are likely to impede the implementation of this approach to coordinated access (both the speed and scope of the project)?
22. Which key players have been identified as 'critical' in making the program effective and efficient?
23. Identify best practices/lessons learned for adopting a coordinated access approach that others may find helpful.
24. Are there plans in place for expansion/modification?
25. Are there any upcoming changes in the local policy and planning level that will affect the viability of this model?
26. Are there any other key planning, staffing, implementation, monitoring, and evaluation issues that have not already been identified in the preceding questions?

B – INTERVIEW GUIDE FOR CONNEXONTARIO

1. Briefly summarize the core services of Connex for supporting access to mental health and addictions services for the province as a whole.
- (a) What are the main strengths and challenges with respect to these core provincial services?
- (b) What information is available to highlight the Connex contribution at the provincial or regional level over the past few years?
2. (a) How has Connex partnered with and/or complemented the regional LHIN-level services that have recently been developed for central/coordinated access?

(b) What are the main strengths and challenges with respect to supporting these local access models?

(c) In general, have these local models helped or hindered Connex in meeting its core provincial mission? Which situations have been particularly challenging? How do you overcome these difficulties?

(d) Do you see potential for duplication of services? If yes, how is this potential for duplication being mitigated (or how might it be better mitigated)?

3. (a) What has been your most positive and your most challenging experience with specific coordinated access models? Please explain focusing on the features of the model (e.g., scope, nature of services provided) that made it particularly positive or challenging?

(b) Which features of central/coordinated access models can best be facilitated by Connex and vice versa?

4. Do you have current initiatives or future plans and directions to coordinate the provincial role of Connex with local models? If yes, please describe.

5. Overall, what are the current (or possibly future) facilitators and barriers to the provincial role of Connex regarding access to mental health and addictions treatment and support?

6. (a) What are your plans for periodic evaluation or ongoing performance monitoring of your provincial impact and regional coordinated access initiatives? Do you have suggestions for evaluation/performance measurement of your role, the role of the regional models and/or to demonstrate the benefits of working collaboratively in some way?

(b) What are the optimal indicators of success going forward with complementary provincial and regional access services?

C- INTERVIEW GUIDE FOR CRITICALLONTARIO

1. Briefly summarize the core services of CriteCall ON for supporting access to mental health and addictions services for the province as a whole. What are the main strengths and challenges with respect to these core provincial services?
2. Please describe the Provincial Inpatient Mental Health & Addiction Bed Registry Project.
 - a) What was the initial catalyst/need of this project?
 - b) What is the current state of implementation of the project?
 - c) Which factors have facilitated the implementation of the project?

- d) Which factors have impeded the implementation of the project?
 - e) Are there plans in place for expansion/modification?
 - f) What is the scope of the project?
 - g) What is the role of LHINs?
 - h) Describe the data systems and the process being used for gathering and entering the data.
 - i) What are the (expected) outcomes? How would you define success?
 - j) Which indicators are being used to measure the utilization of your services?
 - k) What is the level of utilization of your service? Is there a variation from expected use of your services (underwhelming response/overwhelming use)?
 - l) How effective is the program in achieving the intended goals (current efforts not meeting the plan, efforts in place to meet the goals, performing well)?
 - m) So far is there a sense the project has been viable/meeting its objectives/cost-effective?
 - n) Are there any other key planning, staffing, implementation, monitoring, and evaluation issues that have not already been identified in the preceding questions?
3. Do you have current initiatives or future plans and directions to coordinate with local access models? If yes, please describe.
4. Do you have current initiatives or future plans and directions to coordinate with Connex Ontario? If yes, please describe.

D- VERBAL CONSENT FOR PARTICIPATION

Before we begin the interview, I will like to highlight a few aspects of our process related to confidentiality of your answers.

The purpose of this project is to describe the coordinated and central access approaches for mental health and addictions across the province. We are interested in understanding your perspectives and experiences with access approaches. This interview will take about 60-90 minutes of your time. The information you provide will be held in confidence. We will not link your name to anything you say, either in the transcript of this interview or in the text of publications. However, we may use quotes to illustrate key themes but would do so in a way they cannot be identified.

You can, of course, decline to answer any question as well as to stop the interview at any time. I would like to record our discussion, so that I can have an accurate record of the information that you provide me. This will also make the interview more like a conversation so I don't have to take so many notes. I will transcribe that recording and will keep the transcripts confidential. I will erase the tape after I transcribe it. May I record your interview?

Do you have any questions about this project? Are you OK to continue?

E- KEY INFORMANTS INTERVIEWED

Contact	Date of interview (M/D/Y)	Method of contact
Mike O'Shea, North East LHIN	Mon 11/30/2015	Telephone
Jai Mills, Central East LHIN	Wed 12/2/2015	Telephone
Kevin Barclay, Champlain LHIN	Fri 12/4/2015	Telephone
Sherry Frizzell, North East LHIN	Mon 12/7/2015	Telephone
Chris Brens, North Simcoe Muskoka LHIN Susan Lalonde Rankin, Waypoint Centre for Mental Health Care	Tue 12/8/2015	Telephone
Rheanon M. Funnell CMHA Nipissing	Thu 12/10/2015	Telephone
Ashley Hogue, Central LHIN	Fri 12/11/2015	Telephone
Alison De Muy, Waterloo Wellington LHIN	Tue 12/15/2015	Telephone
Sandie Leith, CMHA Sault Ste. Marie	Tue 12/15/2015	Telephone
Ed Castro, Heather Kundapur, Zoe Gordon Mississauga Halton LHIN	Wed 12/16/2015	Face-to-face
Sue Kennedy, Hamilton Niagara Haldimand Brant LHIN	Mon 12/21/2015	Telephone
Siobhan Farrell, North West LHIN	Tue 12/22/2015	Telephone
Suzanne Robinson, Central West LHIN	Wed 12/23/2015	Face-to-face

Rebecca McKee, South West LHIN Kelly Simpson, South West LHIN	Tue 1/5/2016	Telephone
Jennifer Payton, South East LHIN	Thu 1/7/2016	Telephone
Lori Lucier, Toronto Central LHIN	Tue 1/12/2016	Telephone
Thomas Henderson, Coordinated Access to Addiction Services and Central Access	Tue 1/19/2016	Face-to-face
Karna Trentman, Addiction Services of Thames Valley	Fri 1/22/2016	Telephone
Jean West, Streamlined Access, York Support Services Network	Tue 1/26/2016	Telephone
Helen Fishburn, CMHA, Waterloo Wellington LHIN	Tue 1/26/2016	Telephone
Linda Mohri, Access CAMH	Fri 1/29/2016	Face-to-face
Penny Cardo, Huron Perth	Mon 2/1/2016	Telephone
Dawn Maziak, Erie St. Clair LHIN	Mon 2/8/2016	Telephone
Lise Girard, Montfort Renaissance Inc. Steve Vachon, Montfort Renaissance Inc.	Tue 2/9/2016	Telephone
Brad Davey, ConnexOntario Nicole Adkin, ConnexOntario Anne Counter, ConnexOntario	Tue 2/9/2016	Telephone
Susan Meikle, The MHA Access Point Jim Nason, The MHA Access Point and LOFT Community Services Adair Roberts, Independent Consultant	Thu 2/11/2016	Face-to-face
Patricia Syms Sutherland CritiCall Ontario	Wed 4/13/2016	Telephone

F – DATA ON PHONE BASED CENTRAL ACCESS MODELS IN ONTARIO (This list is not exhaustive)

HERE 24/7 (BASED ON DATA COLLECTED IN 2015)

- 67,445 Total Contacts
 - 62,048 Total Calls Accepted
 - 20,607 Total Calls Answered Live
 - 76 to 84 % Average Live Answer Rate
 - 11,996 Total Unique Individuals
 - 74.17% Average Admission Rate (based on answered calls)
-

CENTRAL ACCESS (BASED ON DATA COLLECTED IN 2015)

- 61,079 Call received
 - 56,493 Calls answered
 - 4,586 Calls abandoned
 - 92% Call Answer Rate
 - Average response time 0:42 Seconds
 - Average time of call 2:35mins
 - Average wait time in queue 0:56 seconds
 - Referral volumes - A total of 5,547 screenings were completed which represents 2,351 individuals. The total admissions were 2,351 which represents 1,734 individuals
 - Services available on phone - apart from admissions to detox, information provided on a wide range of community, social and government services including but not limited to: housing, shelter, financial, employment, counselling, health
-

COORDINATED ACCESS TO ADDICTION SERVICES (BASED ON DATA COLLECTED IN 2015)

- Call volumes about 1,000
- Average response time 0:40 Seconds
- Average time of call 8-10 minutes
- Average wait time in queue 0:35 seconds
- Referral volumes - A total of about 100 referrals that are entered on the triage form in Catalyst but many more are made informally on the phone as people do not want to provide a name or they just want the number of the service

- Services available on phone -Triage and information on a wide range of addiction services that are offered in the community, tele-counselling to family members on the phone

MENTAL HEALTH AND ADDICTIONS ACCESS LINE, NIAGARA

- Referral volumes (2014-2015 fiscal year)
 - 464 clients were warm transferred to local services via the access line
 - The average wait time for service initiation was 1.3 days
- Referral volumes (2015-2016 fiscal year)
 - 550 clients have been warm transferred
 - The average wait time for service initiation was 1.24 days
- Services include immediate support, crisis intervention, exploration of needs, and system navigation and referral based on client needs via a warm transfer model
- In the 14-15 fiscal year, 1026 follow up contacts to partner agencies team in regards to referrals completed to ensure connection to service and obtain wait time information completed
- In the 15-16 fiscal year, 904 follow up contacts were made

CONNEXONTARIO

- The Helpline services are available 24/7/365
- Staff - 32 Information and Referral staff (IRS); mix of full time, part time and relief staff.

Based on data - April 1, 2015 - February 29, 2016

• Referrals to services in Connex database	63,586
• Calls received	59452
• Chats received	14395
• Emails received	2504
• % abandoned calls	12%
• % abandoned chats	19%
• Average wait time before being answered - calls	:20
• Average wait time before being answered - chats	1:04
• Average length of call	3:53
• Average length of chat	5:43
• Average length of email	4:34