Toronto Central LHIN

## REDEFINING ACCESS BY CONNECTING THE DOTS

# BUILDING AN INTEGRATED ACCESS TO CARE MODEL

**Toronto Central LHIN Discussion Paper**

**July 2014**

Ontario
Local Health Integration Network

**Intent of the Discussion Paper**

**This discussion paper has been drafted to articulate a conceptual model for integrating access to care within the Toronto Central LHIN (TC LHIN) with an initial focus on primary and community-based care. The intent is to promote further discussion to advance models to support integrated access to care and services.**

This paper builds on the great discussions and work from the TC LHIN Primary Care Strategy Development, Health Link Community Transformation work, and the many sector specific efforts to enhance access to care.

Specifically, this paper:

- Confirms the TC LHIN's desire to improve access, flow and transitions across the continuum (*see Setting Context: Transforming Care Through Improved Access*);
- Identifies the common challenges and need for enhancing access (*see Addressing the Challenges Clients and Providers Face Every Day*);
- Articulates a clear picture for access in the TC LHIN that supports Ontario's goal to deliver Better Access, Better Quality and Better Value (*see Developing a Practical Picture for Integrated Access to Care*);
- Describes the benefits and expected outcomes of integrated access to care for clients, families and providers (*see Declaring Expected Outcomes for Clients, Families and Providers*);
- Articulates a conceptual integrated access model (*see Building a Conceptual Model to Guide Future Planning*); and
- Declares a request of providers to be part of this transformation (*see Ensuring Support to Move Forward*).

**This paper does not have all the answers for how access will be improved. Rather, the paper is intended to start a dialogue for what integrated access may look like, and is intended to be a catalyst for future planning and discussions.**

# Executive Summary

The Toronto Central LHIN providers understand the need and urgency for enhancing access to care, and appreciate that no single organization or group of organizations can achieve it alone. Transforming access to care can only be achieved when sectors and provider organizations work together across historic boundaries to ensure appropriate care and services are delivered by the right provider, at the right time. This discussion paper sets out to confirm the need for a more coordinated approach for accessing community-based care; define the expected outcomes and benefits; and draft a conceptual model framework to ignite further discussion and creativity.

There is little doubt amongst the public and providers that access to care can be improved. While there are well coordinated approaches for accessing care for specific services that have been developed by providers, there is no system-wide approach to accessing care in the community. The result: many uncoordinated points of entry created by a complex maze of phone books, help lines, and directories; varying levels of understanding and knowledge of the many services and how to best access them; a lack of standardization of common processes across organizations; and limited information to support decisions and evaluation of the system.

An integrated approach to accessing care is required.

- The model must be grounded with an "open door" to anyone who may require care or services by a community provider. The requester can be an individual, family member, or a provider seeking support on behalf of their client, and providers can be health or non-health organizations. The requester will contact an Integrated Access Point using a number of means including phone, fax, email, portal or walk-in (for select Access Points). The requester of services should not need to know who they should speak to nor have memorized specific people's names and numbers, but simply know that they need care and services;
- Integrated Access Points will receive the request for services and will transition the request to the most appropriate provider(s). The important feature is that the Access Point is not associated with any single provider organization or even sector, but serves as a gateway to cross-sectoral services (e.g., community support services and community mental health & addiction sectors). And, there will not be a single Access Point, but a number of Integrated Access Points to ensure effective coverage of both geography and service needs. To meet the needs, Access Points will support a number of functions (e.g., 24/7 live response, common intake and information, client navigation, warm transfers, outreach tools) and have supporting infrastructure (e.g., IT, standards, policies and procedures, governance, optimized processes) to ensure timely and appropriate transitions to care. Over time, Access Points will be expanded to include additional services including non-health funded services; and
- Clients and relevant information will be transitioned seamlessly by the Access Point to the most appropriate provider (e.g., primary care, community providers, CCAC, long term care homes, hospitals, or non-health agencies) using warm handoffs. From a client perspective, the Access Point will devote time to understand the client's need in order to ensure the referral, or warm handoff, is as appropriate as possible. Throughout the transition, a clearly defined lead/most responsible person will be established and known to the client. The lead/most responsible person will be the primary contact for gathering client information. The aim is to reduce the burden on the client to repeat information multiple times. It is important to note that clients and providers who have prior relationships are entitled to continue to work directly. However, the Integrated Access Points will be available at any point, for a client or a provider, to use should they require any support in accessing services in general.

It is clear that the solutions will not happen overnight, however it is imperative that current and future planning includes strategies aimed towards phased implementation of the overarching vision for integrated access. The TC LHIN fully recognizes that solutions are not starting from scratch, and that there are many efforts to build on. The intent is to not to dissolve past work, but to refine and link solutions to build a more integrated approach to access to help address the changing and emerging needs of clients.

The TC LHIN is looking for leaders to bring expertise, knowledge and the will to help take the conceptual model and apply it to their sectors/areas of work to help further set the stage for required change. While there is always risk to change, we believe there is a greater risk with maintaining the status quo.

## Setting Context: Transforming Care Through Improved Access

**The Belief: Transforming care can only be achieved through a focus on a population health mandate, where sectors work together across historic boundaries to ensure appropriate care the client needs, by the right provider, at the right time.**

Key enablers to support this change include:

- Better coordination and integration of services and information that make it easier for clients to receive the care they need, and ensure providers have access to information they require to deliver superior services must be the norm;
- Enhanced expectations regarding client and family involvement in decision-making processes to reflect their needs, with systems/processes for care delivery grounded in the client and family voice; and
- A system centred on the patient, and not on institutions and practitioners. Deliberate shifts away from the hospital-centric illness care models of the past to systems grounded in a stronger community-based sector, and robust, primary care solutions are critical.

The Toronto Central (TC) LHIN understands the need for transformational change and is working tirelessly to meet its goal of *transforming the system to achieve better outcomes for people now and in the future*. However, the TC LHIN understands that it must not drive these changes alone and has adopted a collaborative model for working with its partners, spreading work across the continuum to support Ontario's vision *to make Ontario the healthiest place in North America to grow up and grow old*.

The TC LHIN recognizes that a fundamental enabler for building integrated care is improving access, flow and transitions across the care continuum. However access is not simply about opening a door or offering more services. Access to care is about helping people to receive appropriate health care resources at the right time in order to improve their health and the health of the population. To enhance access, we must *establish a seamless care system from the eyes of the client* by changing how we collaborate as partners, and how we hold one another accountable to ensure we collectively deliver the care we would want for our loved ones.

## Addressing the Challenges Clients and Providers Face Everyday

**Simply put – Access is not what it needs to be.**

| Client's and Family Perspective | Provider's Perspective |
|---|---|
| Clients and their families/caregivers find accessing services complex, confusing, fragmented, and frustrating. They do not know who or where to call, they are handed off by organizations, they experience unnecessary delays, go to the wrong doors and are often redirected. There are also clients who never seek the services they need. | Providers have a similar perspective. Providers, acting on behalf of their clients struggle to know where to send their clients. Even when they know, they struggle with timely access to services. Providers also have difficulty keeping up with all of the changes and the many different ways the system functions. |

To meet clients' and providers' expectations of simple and streamlined access to care and services, a number of challenges must be addressed to help clients and providers work together.

- **Many Uncoordinated Points of Entry.** There are hundreds of health care agencies in the GTA, creating a complex maze of phone books, help lines, directories, and voicemails. People don't know who to turn to, and may go without services because they don't know where to look. The Globe and Mail wrote that "one of the fundamental structural problems in Canada's health system is the lack of a clearly identified front door. Regardless of what door patients use to enter the health system, there is little continuity in their care." *Picard, A. (2011, November 7), Health-care system needs a front door. The Globe and Mail.* It was also highlighted that the de facto entry point into the system becomes the ED or walk-in clinics – both of which are inefficient, expensive, and don't provide the type of care and/or follow up that is often required to achieve optimal health outcomes. *An integrated point of access will make finding and connecting to the right services easier and quicker.*
- **Transition to Care Challenges.** There are varying levels and degrees of understanding of the health care system resources amongst both clients and health service providers. This results in a lack of warm hand-offs or inappropriate hand-offs that transition a client to a service they either do not need or where it is not the best option for care. *An integrated access model will help ensure that referrals are "well-informed", and that warm handoffs are made to the most appropriate place of care for the individual client.*
- **Lack of Standardization.** Some providers have insights and practices for how they ensure access to care for their clients but these are neither standardized nor well known, creating potential issues related to equity and allocation of resources. An effective access model will not only build a level of standardization of practices to best meet the needs of the populations, but also ensure a clearer understanding and consistency for how the system of care works and creates a level of flexibility to address needs that may not typically align with standardized criteria. *An integrated access model will reduce inappropriate use of system resources (e.g., right resource is providing the most appropriate service); duplication of effort (e.g., providers are not repeating unnecessary services or assessments); and will reduce the risk of clients falling through the cracks.*
- **Challenges in Accessing Information.** Currently, there are gaps in information and information sharing that reduce effective care planning and decisions, and may contribute to suboptimal care. *An integrated access model provides improved capacity to understand a client's needs, identification of the most appropriate provider, and supports seamless transition of the client.*

## Developing a Practical Picture of Integrated Access to Care

**Access to care is a highly discussed and debated topic internationally. There is no doubt we all want greater access – but what does this truly mean and how do we achieve this?**

The plain and simple truth is that clients and providers have the same goals with respect to health care:

- To access/provide the right level of service, at the right time;
- To access/provide the most culturally appropriate care;
- To enable client choice and input into their care;
- To ensure clients have warm handoffs so that someone is always accountable for making sure that they are connected to the right services and care;
- To reduce duplication and redundancies in processes;
- To ensure the right information is available when it is needed; and
- To ensure consistent access to services that support health equity.

### A Practical Picture for Integrated Access to Care

The following diagram depicts key attributes of an integrated access to care model

However, if this was easy to do – providers and the broader system would have done it already. While there is a real need for enhancing access, fortunately, the time is also right to develop solutions that will connect providers as a system of care. Governments, provider agencies, advocacy groups, monitoring and evaluative agencies, and most importantly, the public, are all calling for enhancements in access to care and services.

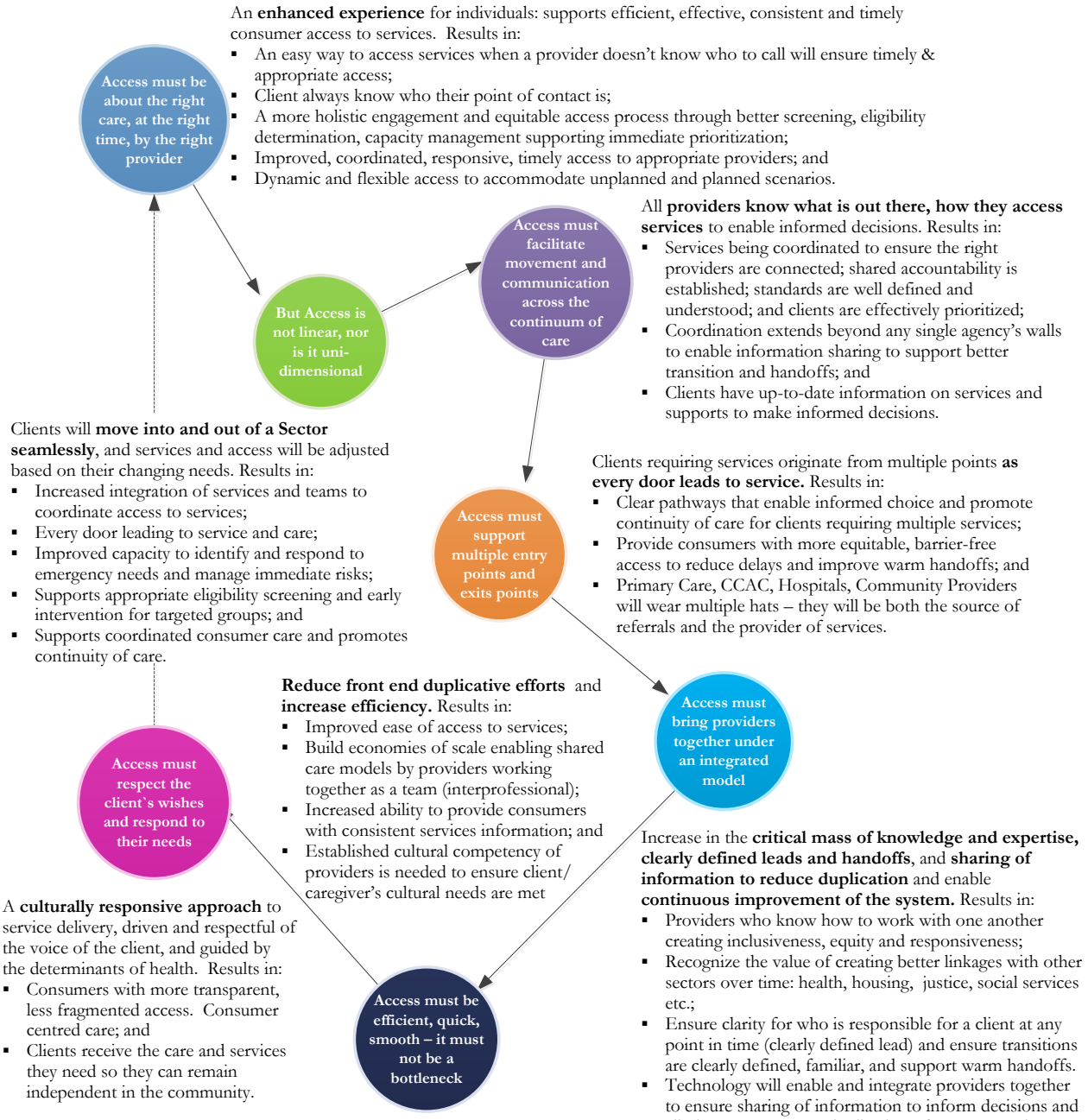
This is enabling a shift in historical position and views – that is making room for new ways to ensuring timely, appropriate access. For example:

- Challenges of operational silos have been replaced by a new level of collaboration that is being led at both the system level and directly by providers who want to work together to better meet the needs of their clients;
- Gone are the days where system design was solely the role of providers. A new, more powerful voice of the consumer and families is driving change and raising expectations of services. More and more, services are reflecting the needs of clients, are culturally competent, and are including clients in the design and evaluation of service models;
- Traditional boundaries of care are being challenged as services shift from institutional care to primary care and the community. Funding has also followed this trend with new dollars going to community-based services and the expansion of primary care;
- Patients and caregivers have articulated their dissatisfaction of having to complete multiple forms and repeat their story to multiple providers, multiple times. This, coupled with a rise in caregiver burden, will further contribute to a demand for "one stop shopping" where one call/visit can serve as a gateway to referrals to all needed services for the client; and
- Technology has advanced to provide more innovative tools to share and communicate information enabling better care decisions. Patients and caregivers of the future want to navigate the health care system on their own and require the tools (information technology, social media) to do so.

## Declaring Expected Outcomes for Clients, Families and Providers

An integrated approach to access care will improve the client/patient experience by meeting people's needs as defined by the client; enhance access to services when and where they are needed; ensure equity of access regardless of where a person lives or population subgroups they represent; support providers to deliver services that are effective and reflective of best practices; build an efficient system that we can afford now and in the future; and promote inter-professional teamwork and collaboration to enable integration of care as required.

The following diagram depicts the **Expected Outcomes of Integrated Access for Clients and Providers** *(see Appendix A)***.** The goal is to connect the dots.




An **enhanced experience** for individuals: supports efficient, effective, consistent and timely consumer access to services. Results in:

- An easy way to access services when a provider doesn't know who to call will ensure timely & appropriate access;
- Client always know who their point of contact is;
- A more holistic engagement and equitable access process through better screening, eligibility determination, capacity management supporting immediate prioritization;
- Improved, coordinated, responsive, timely access to appropriate providers; and
- Dynamic and flexible access to accommodate unplanned and planned scenarios.

All **providers know what is out there, how they access services** to enable informed decisions. Results in:

- Services being coordinated to ensure the right providers are connected; shared accountability is established; standards are well defined and understood; and clients are effectively prioritized;
- Coordination extends beyond any single agency's walls to enable information sharing to support better transition and handoffs; and
- Clients have up-to-date information on services and supports to make informed decisions.

Clients will **move into and out of a Sector seamlessly**, and services and access will be adjusted based on their changing needs. Results in:

- Increased integration of services and teams to coordinate access to services;
- Every door leading to service and care;
- Improved capacity to identify and respond to emergency needs and manage immediate risks;
- Supports appropriate eligibility screening and early intervention for targeted groups; and
- Supports coordinated consumer care and promotes continuity of care.

Clients requiring services originate from multiple points **as every door leads to service.** Results in:

- Clear pathways that enable informed choice and promote continuity of care for clients requiring multiple services;
- Provide consumers with more equitable, barrier-free access to reduce delays and improve warm handoffs; and
- Primary Care, CCAC, Hospitals, Community Providers will wear multiple hats – they will be both the source of referrals and the provider of services.

**Reduce front end duplicative efforts** and **increase efficiency.** Results in:

- Improved ease of access to services;
- Build economies of scale enabling shared care models by providers working together as a team (interprofessional);
- Increased ability to provide consumers with consistent services information; and
- Established cultural competency of providers is needed to ensure client/ caregiver's cultural needs are met

A **culturally responsive approach** to service delivery, driven and respectful of the voice of the client, and guided by the determinants of health. Results in:

- Consumers with more transparent, less fragmented access. Consumer centred care; and
- Clients receive the care and services they need so they can remain independent in the community.

Increase in the **critical mass of knowledge and expertise, clearly defined leads and handoffs**, and **sharing of information to reduce duplication** and enable **continuous improvement of the system.** Results in:

- Providers who know how to work with one another creating inclusiveness, equity and responsiveness;
- Recognize the value of creating better linkages with other sectors over time: health, housing, justice, social services etc.;
- Ensure clarity for who is responsible for a client at any point in time (clearly defined lead) and ensure transitions are clearly defined, familiar, and support warm handoffs.
- Technology will enable and integrate providers together to ensure sharing of information to inform decisions and eliminate unnecessary duplication of requests; and
- Comprehensive data and information will be collected, shared, and used to continually adjust and improve the system where it is needed.

## Building a Conceptual Model to Guide Future Planning

**To meet the needs for care and services of the TC LHIN's population, it is widely recognised that redefining access will be a critical step to ensure clients receive the right care, by the right provider, at the right time. This section articulates a conceptual model for integrated access to care.**

An Integrated Access Model will establish hubs that support access to health and non-health organizations, across sectors. From a client's view, any community support services and community mental health and addiction service needs can be accessed through the hub, with clear accountabilities and standards for the coordination of care. The hub will not be specific to any single or selected group of organizations. Over time, the hub may be expanded to support access to additional services. The Integrated Access Model will:

- Establish **clear points of access** for information and referral for all providers including health and non-health providers, family and client that supports an "every door leads to care philosophy" and ensures multiple entry points will be leveraged. For primary care providers, a mental health or community support service access point can be one of the ways to access services. Consideration will be given to the role for provincial and city run information and referral lines. Linguistic diversity will need to be accommodated.
- Identify a **clearly defined lead/most responsible person** for the individual seeking access to service(s).
- Use **clear eligibility criteria** and **screening processes** to prioritize and identify the most appropriate care and services to best meet the needs of a client. An Integrated Access Point will be responsible for the client who comes into contact with the system during the referral phase, and will ensure clients are **transitioned using warm handoffs** to the appropriate provider who will then assume responsibility for the client's care coordination. An Integrated Access Point will be staffed by **highly skilled** and **trained** individuals to provide information, assess urgency, support matching functions, and able to deal with complex situations.
- Determine **priority** and **urgent access to services**. For complex clients with urgent needs, the access point will provide a warm handoff of the client directly to an organization that will be accountable for ensuring access to the appropriate care. Some access points may also be equipped to respond to urgent/crisis needs. Capacity management tools will ensure effective matching of needs with services ensuring equitable and transparent allocation of resources, with capacity to address urgent cases.
- Be supported by an **electronic referral systems** and other technologies that will assist with matching and capacity management, and **support information collection, storage and sharing** to reduce unnecessary duplication of requests from the client.
- Provide **leadership** and be responsible for **reporting/monitoring data** for the referral and access system.
- Designed to **adapt to the changing population, provider landscape, and service needs**. The model will be scalable to support provincial solutions for access.

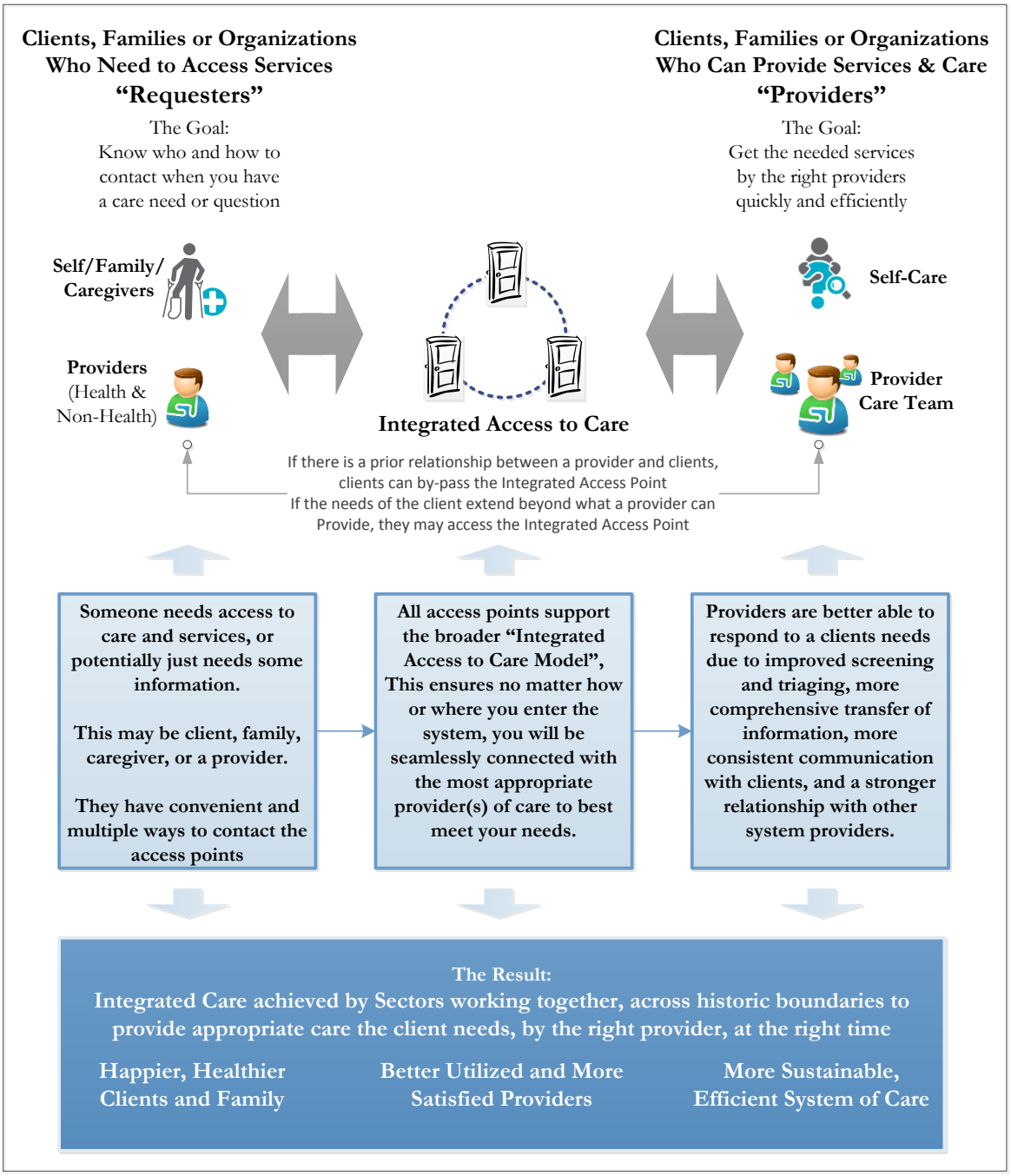
Under an Integrated Access Model, while clients can enter through any door, the access model ensures clients are supported by skilled experts who understand sector resources and can support a number of key functions: information and referral; screening and triage; eligibility determination; service matching and waitlist management; and data collection and reporting for all populations requiring and who are eligible for community services.

The model will not start from scratch but will build on existing sector or institutional access hubs *(see Appendix B)*. There will also be other specialty hubs that will need to be utilized and linked into the integrated access model. Over time, the various Access Points will be integrated to enhance care coordination across sectors. To help build a clear picture of a conceptual Integrated Access Model, two conceptual diagrams will be used.

The first diagram depicts the *Benefits of an Integrated Access* where a requester of services, who may be a client/family member, caregiver or a provider seeking care for their client, will be able to call, email, access via the internet, fax, or walk-in (for selected sites) to an access point that will ultimately take on all responsibilities

for connecting the client to the right provider quickly and efficiently. The requester for care does not need to know the provider agencies, know any special numbers to call; or know who they should call. They only need to know that they need services or care – the Integrated Access Point will take care of the rest.

The following diagram depicts the **Benefits of Integrated Access** – what they will see and experience.



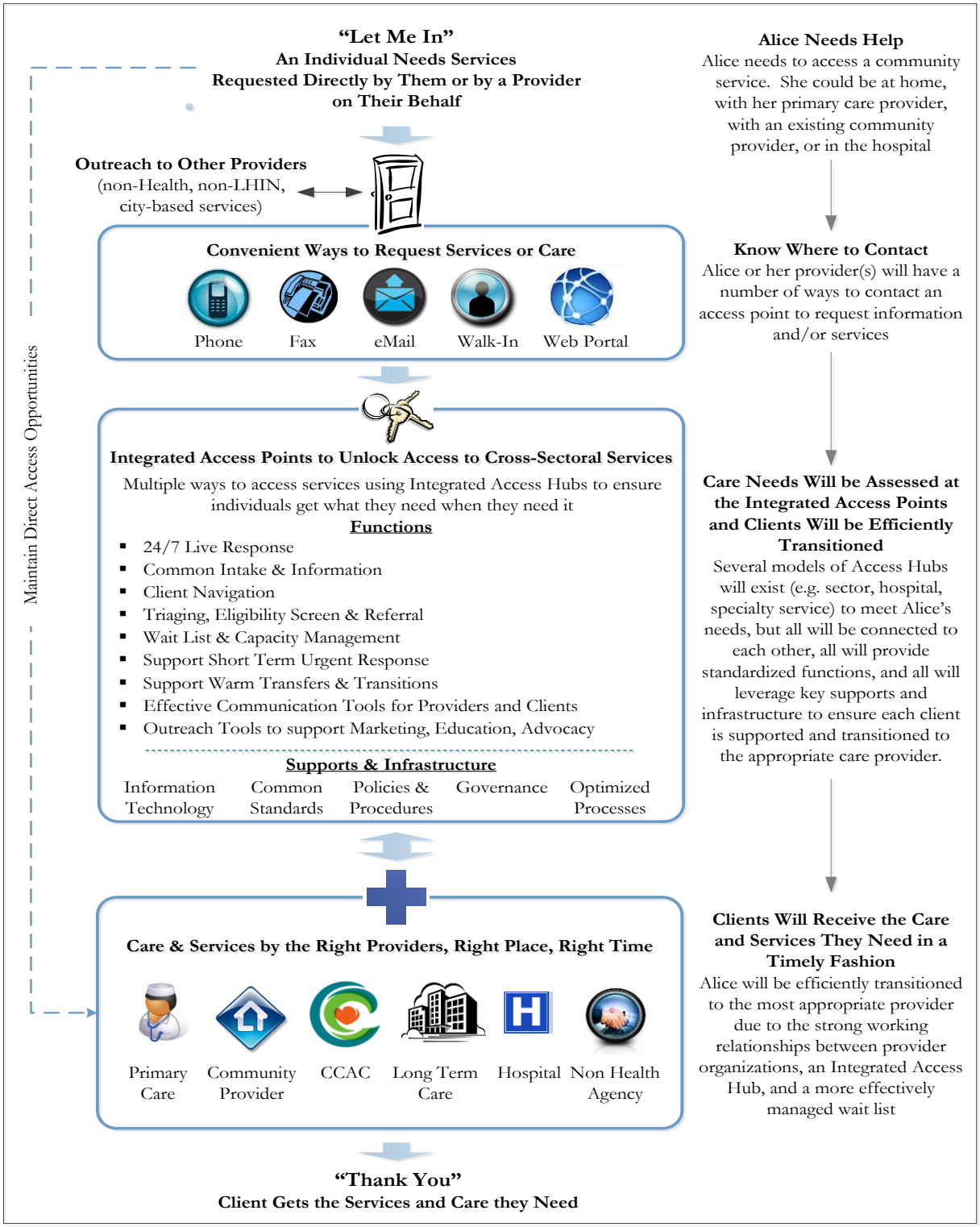

The second diagram depicts the *Functional View of Integrated Access*. Under this diagram, providers are equipped with the fundamental building blocks (functions and infrastructure) of the conceptual system. These include:

- A **New Front Door** defined by various ways to request services (phone, fax, email, walk-in, web portal).
- **Integrated Access Points to Unlock Access to Cross-Sectoral and Specialized Services** supported by a structure of integrated access points and speciality access points (reflecting smaller organizational entities responsible for access to smaller niche services e.g., SCAL). Both of these points are required, and

the model must support bringing them together in an integrated, seamless fashion. In addition, key functions are described and supporting infrastructure identified.

- An **Array of Care Providers** reflecting the continuum of care, working together to ensure the right care, by the right providers, at the right place and time.

The following diagram depicts the **Functional View of Integrated Access** – how will access be managed.



## Ensuring Support to Move Forward

**The Toronto Central LHIN believes that integrated access to care can only be achieved when Sectors work together to ensure residents receive the care they need at the right time in order to improve their health and the health of the population.**

To deliver on this goal, an integrated approach to accessing care has been described within this discussion paper. The model has been designed to address acknowledged access challenges which include the:

- Many uncoordinated points of entry that create a complex maze of phone books, help lines, directories, and voicemails. *The Integrated Access Points will ensure clients move into and out of a Sector seamlessly; services and access will be adjusted based on changing client needs; and result in an overall enhanced experience for individuals and providers.*
- Transition to care challenges created by the varying levels and degrees of understanding of health care system resources by both clients and service providers. *The Integrated Access Points will ensure all providers know what is out there; how they access services to enable informed decisions; and ensure a culturally responsive approach to service delivery, driven and respectful of the voice of the client, and guided by the determinants of health.*
- Lack of standardization that results in a high degree of variability, equity gaps, and resource allocation issues. *The Integrated Access Points will reduce front end duplicative efforts and increase efficiency; and ensure clients requiring services get the most appropriate services by the most appropriate provider as every door leads to service.*
- Challenges in accessing information in a timely fashion that impacts care planning decisions and may result in suboptimal care. *The Integrated Access Points will increase the critical mass of knowledge and expertise, establish clearly defined leads and handoffs, and support sharing of information to reduce duplication and enable continuous improvement of the system.*

This approach builds on the many creative and successful efforts currently being deployed (e.g., Health Links), but goes one step further by trying to take these successes for focused populations of clients and raise them to a system standard. However, the TC LHIN recognizes that this cannot and should not be done in isolation.

The TC LHIN hopes this paper:

- Creates greater dialogue and discussion amongst providers and the public to build support for a collective vision of integrated access to care within the TC LHIN;
- Supports further development of the conceptual model and ultimately uses the model to inform provider's current planning and development processes to facilitate a system-wide integrated approach to access; and
- Supports the ongoing engagement of clients and providers in this discussion to ensure we build an approach to access that we would want for our loved ones.

It is clear that the solutions will not happen overnight, however it is imperative that current and future planning includes strategies aimed towards phased implementation of the overarching vision for integrated access. The TC LHIN fully recognizes that solutions are not starting from scratch, and that there are many efforts to build on. The intent is to not to dissolve past work, but to refine and link solutions to build a more integrated approach to access to help address the changing and emerging needs of clients.

The TC LHIN is looking for leaders to bring expertise, knowledge and the will to help take the conceptual model and apply it to their sectors/areas of work to help further set the stage for required change. While there is always risk to change, we believe there is a greater risk with maintaining the status quo.

**Appendix A: Expected Outcomes of Integrated Access for Clients and Providers**

| Access Criteria | Expected Outcomes |
|---|---|
| **Access must be about the right care, at the right time, by the right provider** | An **enhanced experience** for individuals: supports efficient, effective, consistent and timely consumer access to services. Results in:<br>▪ An easy way to access services when a provider doesn't know who to call will ensure timely & appropriate access;<br>▪ Client always know what their point of contact is;<br>▪ A more holistic engagement and equitable access process through better screening, eligibility determination, capacity management supporting immediate prioritization;<br>▪ Improved, coordinated, responsive, timely access to appropriate providers; and<br>▪ Dynamic and flexible access to accommodate unplanned and planned scenarios. |
| **But Access is not linear, nor is it uni-dimensional** | Clients will **move into and out of a Sector seamlessly**, and services and access will be adjusted based on their changing needs. Results in:<br>▪ Increased integration of services and teams to coordinate access to services within and across sectors;<br>▪ Every door leading to required service and care;<br>▪ Improved capacity to identify and respond to emergency needs and manage immediate risks;<br>▪ Supports appropriate eligibility screening and early intervention for targeted groups; and<br>▪ Supports coordinated consumer care and promotes continuity of care. |
| **Access must facilitate movement and communication across the continuum of care** | All **providers know what is out there, how they access services** to enable informed decisions. Results in:<br>▪ Services being coordinated to ensure the right providers are connected; shared accountability is established; standards are well defined and understood; and clients are effectively prioritized;<br>▪ Coordination extends beyond any single agency's walls to enable information sharing to support better transition and handoffs; and<br>▪ Clients have up-to-date information on services and supports to make informed decisions to meet their needs. |
| **Access must support multiple entry points and exits points** | Clients requiring services originate from multiple points **as every door leads to service.** Results in:<br>▪ Clear pathways that enable informed choice and promote continuity of care for clients requiring multiple services;<br>▪ Provide consumers with more equitable, barrier-free access to reduce delays and improve warm handoffs; and<br>▪ Primary Care, CCAC, Hospitals, Community Providers will wear multiple hats – they will be both the source of referrals and the provider of services. |

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| **Access must bring providers together under an integrated model** | Increase in the **critical mass of knowledge and expertise, clearly defined leads and handoffs**, and **sharing of information to reduce duplication** and enable **continuous improvement of the system.** Results in:<br>▪ Providers whose collaboration results in inclusiveness, equity and responsiveness;<br>▪ Recognize the value of creating better linkages with other sectors over time: health, housing, justice, social services etc.;<br>▪ Ensure clarity for who is responsible for a client at any point in time (clearly defined lead) and ensure transitions are clearly defined, familiar, and support warm handoffs.<br>▪ Technology will enable and integrate providers together to ensure sharing of information to inform decisions and eliminate unnecessary duplication of requests; and<br>▪ Comprehensive data and information will be collected, shared, and used to continually adjust and improve the system where it is needed. |
| **Access must be efficient, quick, smooth – it must not be a bottleneck** | **Reduce front end duplicative efforts** and **increase efficiency.** Results in:<br>▪ Improved ease of access to services;<br>▪ Build economies of scale enabling shared care models by providers working together as a team (interprofessional);<br>▪ Increased ability to provide consumers with consistent services information; and<br>▪ Established cultural competency of providers is needed to ensure client/caregiver's cultural needs are met |
| **Access must respect the client`s wishes and respond to their needs** | A **culturally responsive approach** to service delivery, driven and respectful of the voice of the client, and guided by the determinants of health. Results in:<br>▪ Consumers with more transparent, less fragmented access. Consumer centred care; and<br>▪ Clients receive the care and services they need so they can remain independent in the community. |

**Appendix B – Overview of Current Coordinated Access Initiatives in the Toronto Central LHIN**

The following provides a sample of current coordinated access initiatives underway within the TC LHIN.

| Access Point | Description | Contact Information |
|---|---|---|
| **CNAP Hub** | CNAP is a network of over 30 community support service(CSS) agencies in the Toronto area that have collaborated to improve access to and coordination of CSS services for older adults.<br>▪ CNAP Network Agencies aim to ensure that "every door leads to service" so that older adults can reach the care they need<br>▪ CNAP provides seniors living in the community and stakeholders in the health care system with a simplified approach to accessing services for seniors, providing improved access to community support services; smooth transfers to other agencies and improved coordination and access between community support services agencies, hospitals, primary care and other parts of the health care system.<br>▪ CNAP is operated by a lead agency- WoodGreen Community Services and has recently co-located with the CCAC Information and Referral Line team<br>▪ CNAP's phone line is open 9:00am to 5:00pm, Monday to Friday<br>▪ It is staffed by professional, French and English speaking Social Workers | Telephone: 1-877-540-6565<br><br>Health Professionals are encouraged to send referrals to CNAP via the electronic system: Resource Management and Referral (RM&R). |
| **MHA Access Point** | The Toronto Mental Health and Addictions Access Point (informally known as The Access Point) is a coordinated access point for individuals to apply for individual mental health support services (like case management and Assertive Community Treatment) and Supportive Housing.<br>▪ The Access Point is an integration of two access points formerly known as Access 1 and Coordinated Access to Supportive Housing (C.A.S.H.) and has recently rebranded to the new name. There are 47 service provider partners within The Access Point's network that can be accessed through one application form and process. Many of our service provider partners can also provide services to individuals with problematic substance use and involvement in the criminal justice system. The Access Point maintains the waitlist for these services and will match applicants with vacancies that are declared through the network. | Telephone: 416-640-1934<br>Fax: 416-499-9716<br><br>Website is currently in development.<br><br>Contact information is:<br>The Toronto Mental Health and Addictions Access Point; 661 Yonge Street, 4th floor; Toronto, ON M4Y 1Z9; |

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|---|---|---|
| **Access CAMH** | Access CAMH is designed to provide a single access point for all referrals and requests for information on CAMH Ambulatory Clinical Services.<br>▪ The referral form for CAMH Ambulatory services can be found at www.camh.ca. Information on sending a referral can also be found on the website.<br>▪ Access CAMH can be reached through the CAMH main telephone line 416 535-8501, press 2, however, as Access CAMH is not yet fully implemented, there may be a delay in answering calls.<br>▪ As of June 2014, 75% of CAMH ambulatory services have been centralized through Access CAMH, and full implementation is expected in the Fall of 2014. | CAMH Main Telephone Line:<br>416-535-8501, Press 2 |
| **Withdrawal Management Toronto** | Central Access is a toll free number for those who need to connect to the Toronto Withdrawal Management Services System<br>▪ Central Access manages the bed capacity for all withdrawal management services sites in the Toronto Central LHIN. | Telephone: 1-866-366-9513 |
| **Seniors Crisis and Access Line** | SCAL provides one number to call in the TC LHIN serving as a single point of access for seniors in mental health crisis and supports triage/referral to community mobile crisis programs and crisis response service.<br>▪ SCAL's hours of operation are Monday to Friday from 10:00am to 9:30pm, and Saturday to Sunday from 10:00am to 6:00pm.<br>▪ SCAL is operated by a lead agency: Saint Elizabeth Health Care and is a partnership between 4 crisis providers delivering services to the TC LHIN community – Community Crisis Response Program (Saint Elizabeth Health Care); Crisis Outreach Service for Seniors – COSS (WoodGreen Community Services); Gerstein Crisis Centre; Mobile Crisis Program (The Scarborough Hospital).<br>▪ SCAL is a free service with translation support for 110 languages and it is available to those who are living in the TC LHIN community including seniors, caregivers, service providers, and others who are or know of someone who may be experiencing a mental health and/or addiction crisis situation or who may require consultation, education and/or information to prevent the situation from occurring. | Telephone: 416-619-5001 |

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| **Diabetes Education Program** | The Toronto Central Diabetes Referral Service will connect clients to a Diabetes Education Program that best meets their needs. The referral service is operated from South Riverdale CHC.<br>▪ Anyone can make a referral using the Toronto Central Diabetes Program Referral Service: including health care professionals, community organizations, or individuals with type 2 diabetes or pre-diabetes (self-referral).<br>▪ A Diabetes Education Program will be identified for the client, based on home or work address, and/or language, cultural, and program preferences. In TC LHIN 16 community-based diabetes programs receive referrals.<br>▪ If you need to find a diabetes program outside of the Toronto Central LHIN we can help you.<br>▪ The selected Diabetes Program will notify the referred person directly to book an appointment.<br>▪ If you are health care professional (and your client consents for the diabetes program to contact you) you will receive a complete report once he/she has been seen by the program, which will include the assessment, education and care plan.<br>▪ Additional chronic disease prevention and management resources and services will be linked to this website and referral service, over time. | Telephone: 416-778-0676<br>Fax: 416-778-1305<br>http://torontodiabetesreferral.com<br><br>Mail:<br>Toronto Central Diabetes Program Referral Service<br>955 Queen Street East, Toronto ON M4M 3P3<br><br>Fillable PDF available (can be uploaded to EMR)<br><br>Online referral completion/submission coming later in 2014 |
| **Center for Independent Living(CILT)** | Project Information Centre (PIC) is the centralized point of access for individuals with physical disabilities applying for the following Attendant Services in Toronto area - supportive housing, attendant outreach services and transitional and life skills program.<br>▪ PIC Application Package can be obtained by contacting PIC or can be downloaded directly from their website<br>▪ PIC receives and assesses applications for basic eligibility and forwards these applications to Attendant Service Providers.<br>▪ PIC is responsible for the maintenance of all eligible applications.<br>▪ PIC does not provide Attendant Services or housing.<br>▪ PIC is located at the Centre for Independent Living in Toronto (CILT), Inc. | Telephone: 416-599-2458<br>Fax: 416-599-3555<br>Email: pic@cilt.ca<br>http://www.cilt.ca/pic_application.aspx |

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| **Access to Specialists** | Project initiated as a result of LHIN primary care physician engagement process which identified access to specialists as one of the main barriers to providing integrated and seamless care<br>Project in second phase with Sunnybrook Health Sciences Centre as the Lead agency.<br><br>High priority enabler solution components are:<br>▪ The establishment of a Specialist Directory;<br>▪ The development and establishment of a Minimum Data Set for Referral Forms<br>▪ The investigation into the development of Secure, Closed-Loop Communication Tools to support consultations; and<br>▪ Investigate Patient Engagement Tools that also support the process. | Ashnoor Rahim<br>Primary Care Project Manager, TC LHIN<br>Telephone: 416 969-3895 |