



Coordinating Access to Specialized Geriatric Services: A Review of Evidence and Current Practice

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Introduction

Many older adults living with complex health conditions experience the Canadian healthcare system as fragmented and uncoordinated. Challenges include multiple entry points, care delivery driven by available services rather than patient need, costly services with long waiting lists, limited information sharing, and non-standardized tools which lead to redundant assessments (Heckman et al., 2013). Lack of coordination in care delivery contributes to long waitlists, redundancies, increased costs, and repetition, as older adults must re-tell their story multiple times (Ploeg et al., 2017). Older adults living with multiple chronic conditions report challenges managing medications prescribed by different prescribers and the burden of seeing multiple health providers for physical, psychological, and social concerns. Some older adults report this experience as “being split into pieces” (Ploeg et al., 2017, p 5) as they receive health care from multiple professionals for different conditions.

PGLO believes that coordinating access to services is a key enabler of integrated care for older adults living with complex and chronic health conditions. Coordinated access mechanisms that enable access specifically to interprofessional specialized geriatric expertise are older person-centred and connect the right care to the right individual efficiently. Such coordination also enables cross sector partnership and shared responsibility for continuity of care, as ties between services are strengthened and linkages expedited.

Efforts to coordinate access to specialized geriatric services (SGS) are underway in various regions in Ontario. However, there is variation in the approaches used and currently no consensus on the optimal features of coordinated access models.

The purpose of this Coordinated Access Project was to review existing models of coordinated access in the literature and the current state of such models in SGS to identify features and approaches to design and delivery. The main question guiding this review was: what are the required elements needed in coordinated access mechanisms that will support integrated care for older adults?

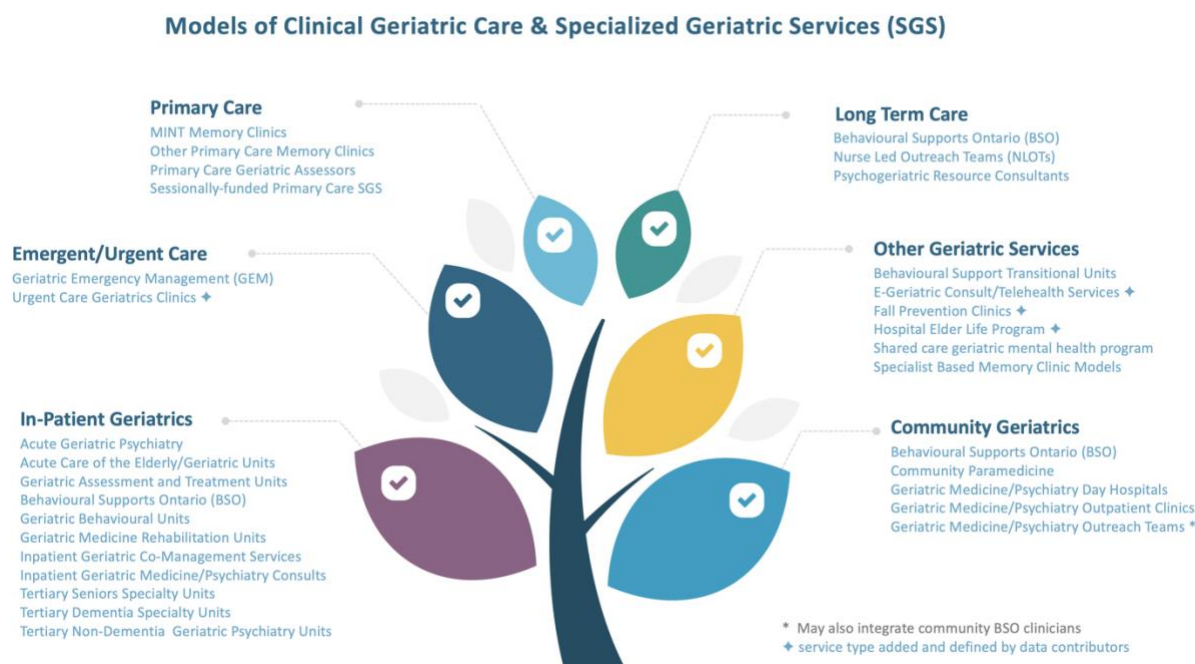
This report summarizes the results of a review of available literature, organizational processes and expert opinion and informs best practices in coordinated access mechanisms. The results can aid improved coordination between services and create scalable mechanisms for coordinating access to required services, optimizing care for older adults living with complexity in the community.

Defining Specialized Geriatric Services

Provincial Geriatrics Leadership Ontario (PGLO) defines Specialized Geriatric Services (SGS) as a comprehensive, coordinated system of health services that assess, diagnose, and treat older adults living with complex health conditions. These services are provided across the continuum of care by interdisciplinary teams with expertise in the care of older adults. SGS is inclusive of Geriatric Medicine, Geriatric Psychiatry, Seniors Mental Health, Care of the Elderly Primary Care and Interprofessional Geriatric Teams.

SGS programs in Ontario provide a diverse range of clinical supports to older adults living with complex health conditions. PGLO, working with the Ontario Ministry of Health, clinicians, researchers, and administrators, has defined several distinct service types of SGS (see Figure 1).

Figure 1: Types of SGS in Ontario



Each of these service types provides care tailored to older adults to diagnose, treat, and manage complex health conditions as a complement to primary care. Many of these services operate independently and are not integrated with other providers. This results in care that is often fragmented for older adults who require support to manage multiple chronic conditions. Access to SGS also varies by region, program, and provider.

Defining Coordinated Access

Our review identified a variety of terms and definitions used to describe features of coordinated access. These terms and definitions have been consolidated and are summarized in Table 1 below:

Table 1: Terms and Definitions Relevant to Coordinated Access

Term	Consolidated Definitions
Centralized intake model	A system that provides a single point of contact for screening, triaging, and managing patient referrals by urgency, using common waitlists. (Barber et al., 2015; Suter et al., 2015; Melathopolous & Cawthorpe, 2019)
Intake	A process of screening, assessment and referral that precedes and determines admission to a program or service. (OCECYMH, 2016)
Triage	A clinical process conducted by skilled clinicians to prioritize urgency and risk, and identify treatment and service needs. (OCECYMH, 2016)
Single entry model (SEM)	An approach to wait time management that provides a single queue for those seeking services, frequently designed for patients to see the next-available service provider. (Damani et al, 2017; Lopatina et al., 2017; Brown et al., 2018; Damani et al., 2018;

In our view, centralized intake, intake, triage, and single entry are component parts of a broader system, which we have called a coordinated access system.

In the SGS context, coordinated access includes referral and management of one or more interventions through a single access point. SGS coordinated access mechanisms typically harmonize the referral process to services that support older adults living with complexity, making links between programs and services and the older adult through their primary care provider. In Ontario, SGS coordinated access is organized regionally, bringing multiple service types together under one referral process staffed by a team, usually comprised of clinicians, who complete referrals on behalf of primary care providers and can support triage and follow-up between SGS programs and primary care.

What Problem Does Coordinated Access Solve?

Coordination of services and supports has been identified as a requirement for older adults living with complex health conditions. McGilton et al. (2018), in a scoping review examining the needs of older adults, care partners, and health care providers, found a convergence of needs among all three groups in five main areas:

1. Need for information;
2. Need for coordination of services and supports;
3. Need for preventive, maintenance, and restorative strategies;
4. Need for training older adults, care partners, and health care providers to help manage the older adults' complex conditions; and
5. Need for person-centred approaches.

The target population seeking health services from SGS includes older adults who are usually experiencing multiple, co-morbid and often interactive health conditions. These individuals experience specific challenges accessing health services as their requirements are often complex and interrelated. As a result, a single disease-specific clinical pathway is insufficient to address their requirements. Instead a unique plan must be organized for each older adult. To do this, patients and families, along with referring clinicians, require a seamless, easy-to-use process to reach appropriate services in a timely manner without having to repeat health information along the way.

At the same time, SGS programs and service types offered in Ontario vary by region. There are different ways to access SGS programs, various clinical information platforms, and multiple referral and intake processes that often do not share referral information and health records. As there are currently many defined service types of SGS programs (see Figure 1), and several different foci (e.g. geriatric medicine, geriatric psychiatry, seniors mental health, care of the elderly, interprofessional geriatric teams), primary care providers are often uncertain which SGS service types are most appropriate for older adult patients and their care partners. Thus, they may send referrals to multiple programs, resulting in duplicate assessments and inflated appointment queues¹. This creates frustration for patients and the potential for delay of diagnosis, treatment and interventions.

SGS administrators in Ontario have identified:

- Inconsistencies with triage approaches across SGS programs and teams;
- Inefficiencies with managing wait times;
- Lack of coordination and inability to share background information across multiple sources to inform referrals;
- Duplication of assessments across services;
- Difficulties experienced by patients and families in accessing and navigating services; and

¹ Central East Coordinated Access Document, 2017

- Lack of uptake of modern technology, as there is still significant reliance on faxed referrals.

Coordinated access can help providers and patients determine the most appropriate SGS program to address particular needs, can support timely access and prevent duplicate assessments. Coordinated access is facilitated by standardized referral, screening, intake, and clinical triage processes, as well as waitlist management strategies, permitting limited SGS resources to be optimized. For example, the Waterloo-Wellington SGS Coordinated Access Model has demonstrated the following outcomes:

- Enhanced access to client information;
- Increased client focus and direct service due to reduced time for clinicians to gather clinical information;
- Enhanced ability to build a timely positive rapport with clients;
- Increased number of referrals processed and improved referral flow;
- Improved understanding of client's situation through virtual clinical assessment completed by clinical intake; and
- More older adults living with frailty accessing SGS services in a timely manner.

Methods

This review sought to identify the required elements needed in coordinated access mechanisms that can support integrated care for older adults. The approach used included: a review of published literature; a scan of relevant reports; a review of program documents; and collection of expert opinions through interviews and a focus group with SGS administrators.

Literature Search

In October and November of 2020, a search was conducted of EBSCOhost research databases including OVID, AgeLine, Scopus, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and ProQuest. Syntax used in the formal search was based on the following search terms: central* intake, coordinated access, central* clinical intake, geriatric, older adult, senior, and elder. The electronic database search was also supplemented with a manual search of articles using a targeted website (Google Scholar) with the search term 'coordinated access AND geriatric' to ensure literature relevant to the research question was not missed. We focused on papers published in the past three years. SGS organizations in Ontario were also asked to share any literature they used to inform their approach to coordinated access, and these were included in the articles imported for screening. Some of these recommended articles were older than our search range but were included as they had informed current processes.

Our search identified 172 references which were imported for screening with 7 duplicates removed. We screened the abstract and title of 165 studies and excluded 127 studies based on relevance. Thirty-eight (38) studies were assessed for full-text eligibility, with 18 studies excluded as they were not specific to the process of coordinated access (15), described only a specific role (e.g. care coordinator) (2), or proved to be a duplicate (1). Twenty (20) studies were included in our analysis.

Reports

In addition to published academic literature, we review several key reports relevant to coordinated access. Most of these reports were commissioned by groups considering or planning to implement coordinated access or integrated models of care in their local region or for specific clinical conditions (e.g. joint replacement, mental health and addictions). Included in this aspect of our review were:

- Waddel, J., & Frank, C. (2011). Hip & Knee Replacement Toolkit. Bone & Joint Canada.
- Deloitte. (2011). Evaluation of Central Intake and Assessment Centres for Hip and Knee Replacement
- Rush, B. & Saini, B. (2016). Review of Coordinated/Centralized Access Mechanisms: Evidence, Current State, and Implications. (Report submitted to the Ontario Ministry of Health and Long-Term Care).
- Deloitte. (2017). Central East LHIN Mental Health and Addictions System Review.
- KPMG. (2018). Central East Local Health Integration Network Regional Mental Health and Addictions Coordinated Access Model.

- North West Territories Health and Social Services. (2020). Making the Case for Change Advancing the NWT Chronic Disease Management Strategy
- Provincial Geriatrics Leadership Ontario. (2020). Designing Integrated Care for Older Adults Living with Complex and Chronic Health Needs: A Scoping Review.
- Harris, J. (2021). Single-Entry Models in Surgical Services. (Prepared for CADTH).

Document Review

Documents relevant to coordinated access services (process maps, policies etc.) were requested from SGS administrators and analyzed. In particular, we sought to understand general features of these services, staffing and the nature of services being coordinated.

Interviews and Focus Group

Interviews were conducted with regional SGS administrators in Spring and Summer 2021. The purpose was to update information gathered initially in 2018 and obtain additional details about regional coordinated access processes. Throughout these meetings, SGS administrators discussed their thoughts on coordinated access more broadly including the challenges of creating and implementing coordinated access

In July 2021, a focus group was held with 12 SGS administrators from across Ontario to discuss coordinated access. The discussion was guided by the following questions:

- What have you learned through the process of creating and implementing your own coordinated access mechanisms?
- What is your biggest challenge with coordinated access?
- How do you see coordinated access fitting into integrated care for older adults in your regions?
- What are your goals for coordinated access in the future?

Key themes from the discussions and organizational information provided by SGS administrators were identified and are presented in this report.

Results

Literature Review

Our review identified 20 articles. Of these, 13 were Canadian, three were conducted in the United States, and another three (review articles) were not country specific as they examined international literature. One study was specific to Australia.

The articles described approaches to coordinated access for different patient populations, and included patients seeking:

- Rheumatology services (2)
- Surgical treatment for osteoarthritis or rheumatoid arthritis (joint replacement) (6)
- Gastroenterology services (1)
- Children and youth mental health services (2)
- Specialist consultation for Parkinsons' Disease (1)
- Services for older adults (3)

The remaining (5) studies examined approaches to coordinated that were less speciality specific (e.g. any internal medicine subspecialty, patients seen in the emergency department) or the population served was not specified.

Across all 20 articles, 33 possible features of coordinated access systems were identified. Table 2 identifies the occurrence of these features in the literature reviewed.

Table 2: Occurrence of Coordinated Access Features Across Studies

Most common (≥10 articles)	Somewhat common (<10 and >2 articles)	Less common (≤2 articles)
• Standardized clinical triage process (e.g. screening tools) (16) • Standard prioritization tools/mechanism (e.g. determination of urgency, flags for concerns) (14) • Quality assurance process/common metrics (Validating appropriateness of referral, service impact etc.) (13) • Single portal of entry (phone/fax/electronic) (10) • Common database (10)	• Standardized referral/application form (e.g. common information requirements) (9) • Pooled/common waiting lists/referrals (waitlist management) (8) • Skilled clinical triage practitioners (7) • Defined pool of participating specialists (Buy-in, champions) (5) • Standardized assessment (e.g. surgical readiness, mental health) (5) • Case management (e.g. assessment, monitoring, reassessment, chronic disease management) (4) • Patient/family self care education and information (4) • Public information/information management (e.g. access portal, knowledge and information about local services) (4) • Service referrals/navigation support (4)	• Dedicated (on-call) specialist support for Coordinated Access team (e.g. review of complex cases) (2) • Direct treatment offerings for defined problems (e.g. non surgical interventions) (2) • Embedded advanced practice/unique roles (2) • Formal handover process (e.g. three way calling to help patients connect with intended service, formalized links with community services) (2) • Proactive case finding (2) • Access to team for virtual support while waiting (e.g. patient access) (1)

Most common (≥10 articles)	Somewhat common (<10 and >2 articles)	Less common (≤2 articles)
	• Administrative support (e.g. clerical review of incoming referrals) (3) • Communication/service policy/linkage to primary care (e.g. confirmation of referral, acceptance, appointment scheduling etc.) (3) • Data entry/collection process (3) • Pre-consultation patient questionnaire (e.g. preCGA, pre-surgical questionnaire) (3) • Referral allocation process (e.g. fair distribution of referrals to specialists, next-available specialist processes) (3)	• Care planning (1) • Interim care management (until placement) (1) • Measurement of system capacity (1) • Multiservice/multiagency team (1) • Ongoing staff education (1) • Regular communication with clinical team (1) • Scheduled post visit follow-up (e.g. proactive appointment offers at 3, 6 months) (1)

The need for certain elements may have been taken for granted by several authors, and not overtly named in their respective studies. For example, only seven articles referenced skilled triage practitioners, yet most studies (16/20) discussed the need for a standardized clinical triage process. Further, only three articles discussed a specific data entry and data collection process, although 10 referenced a common database. Thus, there may be many more important elements and processes included in the coordinated access systems discussed than are referenced in the related studies.

With this caution in mind, Table 2 provides a relatively comprehensive list of core necessary elements and potential add-ons or innovations, to suit local requirements. Appendix 1 provides additional details of elements of coordinated access by author.

Thirteen (13) articles referenced quality assurance frameworks or outcome measurement (Aronoff-Spencer et al, 2020; Barber et al., 2015; Damani at al. 2017; Damani at al. 2018; Fullerton et al. 2020; Gooch et al. 2012; Hazelwood et al. 2016; Lopatine et al. 2017; Melathopolous & Cawthorpe, 2019; Mion et al. 2001; Mohr & Bourne, 2004; Novak et al. 2013; Suter et al. 2015). Table 3 below synthesizes the indicators and outcomes identified by the various authors.

Table 3: Synthesis of Indicators and Outcomes Demonstrated in Coordinated Access Models

Indicators	Outcomes demonstrated
• Wait time (in weeks) • Time to initiation of treatment (e.g. Time from receipt of complete referral to appointment) • Pre-assessment completion prior to specialist consult • Patient experience (access, information, quality)	• Reduced wait times, reduced variability in wait times • Decreased time to initiation of treatment (early) • Increased number of patients with preparatory assessments, laboratory or diagnostic tests completed prior to specialist appointment

Indicators	Outcomes demonstrated
• Waitlist length and distribution (Distribution of referrals in each urgency category (using standardized tool) • Number of patients • Appropriateness • Provider satisfaction (primary care, specialist, interprofessional team) • Duplication • Length of stay • Accuracy of triage/assignment of urgency (e.g. Agreement of centralized intake assessment with confirmed assessment/diagnosis clinically) • Data quality (e.g.% of referrals received with complete information) • Communication with PCP and patients • System capacity • Effectiveness • Service integration and planning (ratio of patient flow to estimated clinical capacity of teams participating in centralized intake)	• Patient receipt of self-care education prior to specialist consult • Improved health related quality of life • Decreased waitlist length • Increased patient volume • Increased appropriateness of referrals • Increased provider satisfaction • Reduced duplication • Reduced length of stay (e.g. due to prepared, proactive patients, shorter wait for treatments) • Increased accuracy (those needing service the most receive it first) • Improved availability and quality of data • Improved communication with patients and PCP • Increased referrals to community agency • Return visits to the ED within 30 days • Subsequent unplanned hospitalizations after discharge home from the ED • Nursing home placement within 3 months of the index ED visit • Increased service integration (dental) and capacity to inform planning

One study specifically examined coordinated access for people living with multiple chronic conditions. The authors noted correlation between multiple chronic conditions and age, providing a helpful context for understanding and explaining the kind of care that is required to support older adults living with complex health and social care needs (Ploeg et al., 2017). The literature was broadly in agreement that as the number of health and social care needs increases, care becomes more complex and the need for coordinated care increases. When care is coordinated, it results in better health outcomes for older adults (Powell Davies et al., 2006; Powell Davies et al., 2008).

Reports

This section describes information included in key reports reflecting components of coordinated access models, the benefits and key success factors, and challenges for implementation. We have also summarized the recommendations from these sources and proposed an approach to implementation planning, to support future development in this area.

Components of Coordinated Access Models

Rush and Saini (2016) identified four guiding principles for coordinated access, including:

- 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

In work to identifying an ideal vision for coordinated access for mental health and addictions services, KPMG (2018)² concluded the following were important features:

- | | |
|---|---|
| • 1st appointment scheduling | • Peer/Family Support Services |
| • 24/7 Crisis supports | • Screening |
| • Appointment reminder calls | • Selfcare (e.g. iCBT, Big White Wall) |
| • Consent (release health information, for screening and/or assessment) | • Service delivery (mobile response, virtual consult) |
| • Education and Information resources | • Service matching and admission |
| • Intake and triage | • Suitability assessment |
| • Intervention | • Trained, specialized staff |
| • Linking with service providers | • Virtual infrastructure (web and telephone/virtual access) |
| • Monitoring response | • Waitlist management |
| • Navigation and information support | |

Consistent with the scholarly literature, Waddell et al. (2011) recommended: a single centralized access point and pooled waitlist; wait time management processes; triage (including criteria for urgency), screening and standardized comprehensive assessment (including functional assessment); standard referral forms/data, accompanied by relevant history (social, medical), laboratory and diagnostic imaging reports; and standardized communication processes including documentation and primary and patient notification. These authors also noted the importance of engaging support persons in care planning and providing patients and families with relevant education to support self-care and to prepare them for specialist consultation (Waddell et al., 2011).

Benefits and Key Success Factors

Coordinated access is a foundational component of integrated care. Deloitte (2017), described the benefits and efficiencies for both patients and providers that could be realized with the development of integrated system of care for mental health services, which includes coordinated access.

² One note the ideal state described in this report has not yet been implemented.

Table 4: Benefits for Patients and Providers from an Integrated System of Care

Benefits	Patients	Providers
Entry Points	• Support can be readily accessed, when needed • ‘No wrong door’ to access care	• Increased capability in engaging clients and how to direct them to the right resources • Access to navigation tools to point clients in the right direction
Access	• Individuals from all ethnic/cultural groups feel supported to access the system • Shorter wait times to services	• Understand distribution and range of available services
Assessment	• Individuals recount their story only once, yet providers understand where they are with their condition • Feel hopeful about recovery	• Apply evidence-based protocols to assess clients • Understand importance of seeing the client as a person as opposed to a set of symptoms
Intervention	• End to end needs are met • Feel respected and cared for; opinion is valued and considered	• Use standardized clinical pathways to manage client’s care • Practice in collaboration with the right multi-disciplinary teams • Aware of innovative service delivery models • Track standardized outcomes from the services they deliver to ensure supports need the client’s needs
Wellness	• Feel hope in managing one’s day-to-day life independently • Feel empowered to connect with others to feel supported	• Aware of standardized screening and preventive care principles to support clients to feel empowered in their lives in the community • Forge partnerships to better meet client needs

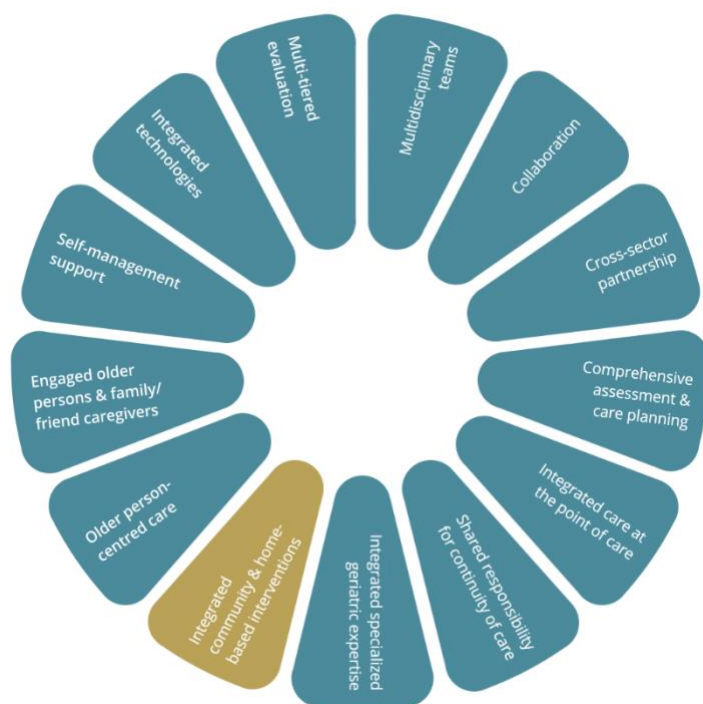


Figure 2: Design Elements of Integrated Care for Older Adults, Aligned with Coordinated Access Models (PGLO, 2020)

Coordinated access models, when designed and implemented according to best evidence, are also consistent with nearly all design elements of integrated care for older adults (PGLO, 2020). Figure 2 highlights in teal which of the design elements of effective coordinated access models have been directly identified in this review. Integrated community and home-based interventions, while not clearly identified, are an essential component of an integrated system of care and their inclusion in coordinated access models is critical.

Success Factors

Factors influencing the success of coordinated access models include: leadership and system governance, with support and buy-in from providers and health policy leadership; concurrent investments in health system resources to address clinical demand, including health human resources dedicated to staffing the coordinated access model; the development of standardized clinical pathways and tools that reduce variation and facilitate streamlining; key performance and quality metrics, standardized data collection, and public reporting; and a focus on communication, change management, quality improvement and patient-centred care (Rush & Saini, 2016; KPMG, 2018; Harris, 2021).

Challenges for Implementation

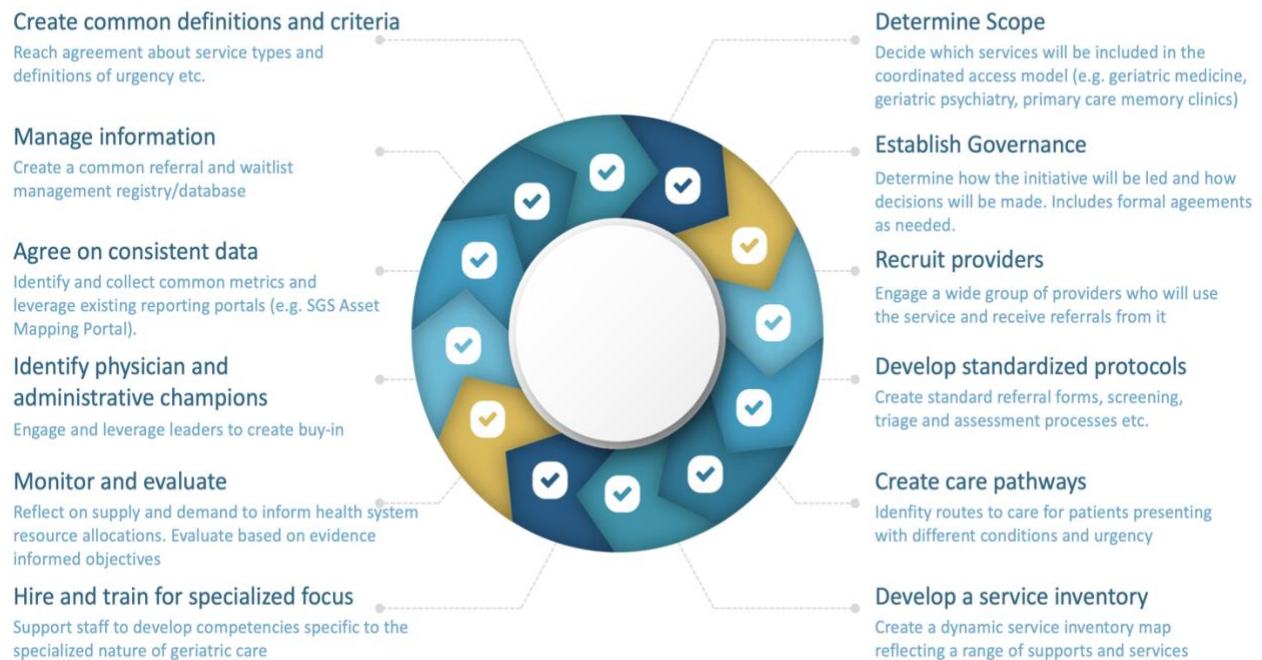
Several authors noted that system pressures in other parts of the health care system could influence the effectiveness of coordinated access models (Rush & Saini, 2016; Harris, 2021). Other challenges included sustaining funding, maintaining strategic focus and managing system change (Harris, 2021).

Implementation Planning

Figure 3 summarizes the implementation recommendations appearing across the reports reviewed, highlighting key steps in designing and implementing coordinated access models.

Figure 3: Implementation Recommendations for Coordinated Access Models

Implementation Planning: Coordinated Access



Deloitte, 2011; Rush & Saini, 2016; Deloitte, 2017; KPMG, 2018; Government of NWT, 2020; PGLO, 2020; Harris, 2021.

Current State of Coordinated Access in Specialized Geriatric Services

Document Review

In Summer 2021, PGLO requested information from Regional Geriatric Programs and Regional Specialized Geriatric Services regarding their current approach (if any) to coordinated access. We received responses describing 16 SGS coordinated access services, which are summarized in Table 5.

In general, most (13/16) responding services identified that they utilized a standardized clinical triage process and had dedicated staffing performing this function. Staffing ranged from 1.0 Full Time Equivalents (FTEs) to 8.8 FTE. Among these services, all but two identified they employed clinical staff, and nine (9) services reported additional administrative/clerical roles. There was no established benchmark for staffing levels, although one recommendation of 1.0 FTE registered nurse to 1000 referrals as a minimum was suggested.

Many services indicated that they utilized a single portal of entry (13/16) and standard prioritization tools/mechanisms (10/16). We note that it is likely that most services may carry out these functions and did simply not highlight them in their response.

Table 5: Features of Coordinated Access	Waterloo Wellington SGS	HNHB BSO/SGS Central Clinical Intake	HNHB Seniors Mental Health	North East Behavioural Supports (Ontario)	Regional Geriatric Program of Toronto	Mississauga Halton SGS	South East Regional Geriatric Program	South East Seniors Mental Health	North West SGS	North Simcoe Muskoka SGS	Central East Behavioural Supports/SGS	GeriMedRisk	North East Specialized Geriatric Centre	Regional Geriatric Program of Eastern Ontario	Ottawa/Champlain Geriatric Psychiatry	South West Regional Geriatric Program
General																
Standardized clinical triage process (e.g. screening tools)	Y	Y		Y	Y		Y	Y	Y	Y	Y	Y	Y	Y		Y
Standard prioritization tools/mechanism (e.g. determination of urgency, flags for concerns)	Y	Y		Y	Y		Y		Y	Y		Y	Y	Y		Y
Quality assurance process/common metrics (Validating appropriateness of referral, service impact etc.)	Y	Y		Y	Y		Y		Y		Y	Y	Y	Y		Y
Common database	Y	Y			Y							Y	Y	Y		Y
Single portal of entry (phone/fax/website)	Y	Y		Y	Y	Y	Y	Y	Y	Y		Y	Y	Y		Y
Standardized referral/application form (e.g. common information requirements)	Y	Y		Y	Y		Y	Y	Y	Y	Y	Y	Y	Y		Y
Pooled waiting lists/referrals (waitlist management)						Y			Y			Y				Y
24/7 access (e.g. call centre)																
Data Access (e.g. discharge summaries, DPV, hospital clinical notes, OLIS, CHRIS, Connecting Ontario)	Y	Y		Y	Y		Y	Y	Y	Y	Y	Y	Y	Y		Y
Service Standards (e.g. turnaround)	Y	Y		Y	Y		Y				Y	Y		Y		Y (for BSO)
System Navigation	Y			Y				Y	Y	Y				Y		Y
Coordinated Access Team Staffing																
Skilled clinical triage practitioners	6	7		2	2	1	1	3	1	2	2	*	0.5	2		5
Clerical/Admin Support		1.8		0.8		6.4			1	2		1	0.5	1		1.5
Services Coordinated																
Geriatric Medicine	Y	Y			Y	Y	Y		Y	Y	Y	Y	Y	Y		Y
Geriatric Mental Health	Y	Y		Y	Y		Y	Y	Y	Y	Y	Y	Y	Y		Y
Behavioural Supports	Y	Y		Y				Y	Y	Y	Y		Y			Y
Primary Care Memory Clinics	Y										Y			Y		
E-Geriatric Consults				Y					Y	Y				Y		
Virtual Services (e.g. GeriMedRisk, telemedicine)		Y		Y					Y	Y				Y		Y

Clinical Behaviour Response Specialist				Y									◆			
Nurse Practitioner	Y			Y					Y							
BSO Consulting Service (Primary and Speciality Care)	Y			Y						Y						
Consulting Pharmacist				Y					Y	Y		Y				
Dedicated LTCH BSO Staff				Y				Y	Y	Y						
Home and Community Care Liaison Support				Y							Y					
Geriatric Outpatient Clinics	Y	Y			Y		Y		Y	Y				Y		Y
Geriatric Outreach Team	Y	Y		Y	Y	Y			Y	Y				Y		Y
Geriatric Day Hospitals					Y		Y		Y					Y		Y
Geriatric Emergency Nurse									Y					Y		
Nurse Led Outreach Team																
Specialized inpatient units				Y	Y		Y		Y							
Inpatient consultation teams					Y				Y							
Psychogeriatric services				Y				Y	Y	Y						
Falls Prevention					Y	Y			Y	Y				Y		
Continence Program						Y			Y							
Adult Day Program									Y							
Outpatient Rehab									Y	Y			Y			Y
Mental Health Outreach	Y	Y		Y	Y		Y	Y	Y	Y			Y			Y
Geriatric Resource Nurses										Y						Y
Cognitive Neurology Clinics									Y							Y

*numerous consulting specialists and pharmacists. ◆included as part of BSO program

Nine services identified specific service standards such as 72-hour turn-around for first point of clinical contact (4 to 24 hours for urgent referrals), 24 to 72 hours (business day) to get information out to clinical teams. GeriMedRisk, a unique service among the respondents, indicated a standard of the provision of a single integrated consult and educational materials to consulting clinicians within 5 business days.

Eleven services specifically identified that they retrieved patient information directly from hospital discharge summaries, the provincial drug profile viewer (DPV), hospital clinical notes, Ontario Lab Information System (OLIS), Connecting Ontario, and/or the Client Health and Related Information System (CHRIS), which facilitated the creation of clinical synopses that accompanied a referral on to a clinical service.

There was wide variation regarding the types of programs included in the various coordinated access services. Most commonly, services coordinated access to: geriatric medicine (12/16) including a range of specific service types, geriatric mental health (13/16), and/or behavioural supports (i.e. Behavioural Supports Ontario [BSO] teams) (9/16). Less frequently (3/16), access

was coordinated to primary care memory services (e.g. memory clinics), e-consults, virtual services (e.g. other services facilitating access to GeriMedRisk), and specific specialized geriatric programs (e.g. geriatric day hospitals, geriatric outreach teams, falls prevention programs).

Indicators and Outcome Data

SGS coordinated access services currently collect different outcome data. Many (if not all) collect the number of new referrals and report this information publicly via annual reports and/or to their funders. Other process measures include referral source (e.g. primary care, geriatric emergency management [GEM] nurse, acute care inpatient unit, etc.), referral location (e.g. Local Health Integration Network region or county) triage disposition, disposition summary, mean triage wait time, referral acceptance rate, and inappropriate referrals received. Still others collect measures related to reduction of transfer to hospital, usually determined by asking the referrer to indicate if the service was not available, would they have sent the patient to hospital. The BSO/SGS Central Clinical Intake Program identified a comprehensive list of indicators, including:

1. Type of enhancements to existing service models
2. New central intake staffing resources
3. Number of new patients triaged through central intake to BSO Teams
4. Number of patients triaged through central intake to SGS
5. Number of community BSO patients who were connected through central intake to a consulting physician/specialist
6. Number of specialty consultations and assessments facilitated by central intake
7. Number of patients/caregivers connected to alternate community services
8. Alternate referral destinations
9. Wait time for access to BSO services
10. Wait time for access to SGS
11. Patient/Caregiver Experience
12. Provider Experience
13. Number of individuals served
14. Number of visits provided

Themes from Interviews and Focus Group

During Spring and Summer of 2021, PGLO interviewed SGS administrators across Ontario who operate a range of coordinated access services. Several challenges and six common themes were reflected in current approaches and suggest several opportunities for improving SGS coordinated access. These expert opinions are summarized and compared to findings from the literature.

Challenges

Respondents described several challenges with implementing coordinated access models, including: the difference in service availability in different communities, particularly rural communities; transportation challenges facing older adults; and variation in wait times. One respondent in a geographically-large region noted that ensuring the availability of

appointments across the region “has been problematic because the resources are different in each community within our region.”

Others noted the lack of transparency about wait times at the program level can impair coordinated access efforts. Several noted the need to engage specialists and primary care early in the development process, making them partners in the development of a coordinated access service, and enlisting them to test the processes and participate in routine troubleshooting and problem-solving communication.

Several programs noted that intake staff needed to search multiple electronic databases to gather patient information to inform the development of a clinical synopsis, a time-consuming task. Multiple and varying access to electronic medical records, and other digital platforms, impeded information gathering by coordinated access staff. Distinct privacy policies from one collaborating organization to another were difficult to navigate. Standardized memoranda of understanding were seen to be a possible solution to streamline approaches to privacy across organizations.

Many referrals are found to be incomplete by coordinated access staff, delaying the referral to the receiving program. At the same time, primary care has expressed frustration about the details required on referral forms, which can be burdensome. In addition, unclear or inconsistent inclusion or exclusion criteria at the program level may mean referrals are rejected or questioned, despite appearing acceptable to the referring clinician and/or the coordinated access staff.

Some noted a lack of consistency regarding the definition and measurement of wait times, and difficulties measuring the impact on older adult/family experience. Risk screening was also noted to be inconsistent, and some respondents were aware that there were different approaches to coordinated access across different types of clinical services or regions. These differences in process also added to a lack of clarity for time to referral.

There are still several paper-based processes, including the use of fax between providers, which were seen to contribute to inefficiencies. The fluctuation of referral volumes was also identified as a concern, both for fee-for-service specialists who had concerns about certainty of income, and for coordinated access services that might experience lower productivity at times throughout the year.

Several respondents noted that having both clinical and administrative resources would best support the functions of coordinated access. In some cases, a lack of understanding about specialized geriatric services created a perception of competition with other services and inhibited referral through SGS coordinated access.

Respondents noted the need for balancing between comprehensive case review and expedient triage to support timely access to care. They also noted difficulties when patients required complex care and service (i.e. multiple services), as it was unclear which program should

receive the patient first. Numerous respondents identified a need for a universal triage urgency rating scale relevant for the older adult patient that could be used in all services.

Suggested improvements identified by SGS Administrators were reflected by six themes, including: leveraging technology; definition; access to electronic medical records and data sharing; wait times and older adult experience; resources and appropriate staffing; and collaboration and education.

1. Leveraging technology

Many of the SGS administrators shared similar sentiments regarding the issues they face with maintaining and incorporating coordinated access mechanisms. They noted gaps in technology between different access points of the coordination process. One administrator shared the challenge with using an electronic fax machine that partners in remote regions of the province do not have. This administrator stated that if any advance or change is made in the technology used, other access points where information is being sent or received must be interoperable. These challenges impede the uptake of technology which cannot be introduced suddenly or consistently. An administrator stated their reliance on the fax machine was outdated and that communicating with service providers through fax was inefficient. Many administrators stated leveraging technology in the future is important to them with the ultimate goal of a fully electronic end-to-end referral process.

2. Definition

The SGS administrators also agreed on the need for a clear definition of coordinated access. The administrators stated there is confusion on the concept of 'coordinated' since it is often confused with and used interchangeably with concepts such as coordinated care and clinical intake. The administrators agreed a definition and accompanying framework of coordinated access would benefit all providers. Suggestions made included developing principles and goals of coordinated access and determining whether coordinated access is provider- or patient-driven. An administrator also suggested a clear definition of coordinated access may change the way providers approach the process, which would create an opportunity for growth and improvement for coordinated access mechanisms within organizations.

3. Access to Electronic Medical Records and Data Sharing

Having access to electronic medical records (EMRs) and obtaining data sharing agreements was another challenge identified by administrators. Administrators agreed that having robust data sharing and privacy agreements would make the coordination process more efficient across services.

The need for coordinated access staff to log into several EMR platforms to compile all the information required for a referral was identified as tedious and time consuming. However, an administrator stated when clinicians have access to several EMRs, a better review of information results in a well-rounded clinical synopsis. This was perceived to allow for a greater understanding of the older adult's service needs.

4. Wait Times and the Older Adult Experience

Administrators reinforced that the older adult's experience throughout the coordination process should be given more consideration. One administrator noted that one of their goals was for the older adult and/or their care partner not to have to repeat their story to several individuals on multiple occasions. Having the older adult on various waitlists with little to no coordination was described as a stressful experience, and sometimes so much so that the older adult would disengage from receiving a required service. Building access models that take waitlist management into account was identified as an important goal. Transparency in wait times for services between providers, coordinated access staff and older adults was also identified as important. Administrators reinforced the importance of this transparency as the older adult may have to undergo reassessments before receiving a service due to long wait times.

5. Resources and Appropriate Staffing

Access to resources including funding to support coordinated access mechanisms was a challenge for several SGS organizations. A lack of resources impacted administrators in their efforts to deliver coordinated access in several ways. For example, one administrator faced challenges with purchasing and implementing new software when budgets for IT are limited and unsustainable. Several administrators also noted their efforts to pull from other budgets to support coordinated access, specifically in the staffing of coordinating clinicians. One administrator stated their funding allows for one registered nurse to manage referrals, but to better support the program, three other nurses are on the coordination team and funding unrelated to coordinated access is leveraged to manage this support. Other administrators stated they can only accommodate part-time positions or must divide coordinated access positions between programs.

Several administrators noted they have administrative staff but no clinicians to support coordination of referrals. This is in contrast to most administrators who confirmed the importance of having a clinician involved in the coordinated access process to manage triage. A clinician such as a nurse or other allied health professional was seen as better equipped to create a clear clinical synopsis, identify needs and refer to appropriate programs, and better manage waitlists. Clinicians in these positions were also found to have the knowledge, skills, and judgement in conjunction with the appropriate tools to intervene and mitigate risk when managing referrals.

6. Collaboration and Education

Education and capacity building between organizations was identified as a challenge. Some administrators noted the challenges of organizations whose catchments overlap and opportunities for cross-coverage in areas with limited services or service pressures. For example, one administrator stated the coordinated access process becomes difficult in their region due to the lack of services and resources. This pushes the referral boundaries for the region as providers try to locate services for those who require them. Another administrator recalled the challenge of attempting to integrate systems and services and the push back they

received from organizations and programs trying to preserve their individuality, whether this benefits the patient or not.

Coordinating access was also identified as an opportunity to improve health equity which was considered a primary goal of coordinated access. Administrators also agreed that a one-size-fits-all approach to coordinated access would not be beneficial due to the context of the regions they currently serve.

Discussion

The literature and document reviews, interviews and focus group reinforce the need develop definitions, policies and procedures to guide consistent approaches to coordinated access for older adults living with complex health conditions. Successful coordinated care is based on codified relationships between providers and the coordinated access mechanism, which maintains primary care as the ‘medical home’ for the older adult receiving care (Breton et al., 2017). This central role of primary care was reinforced in the literature and subsequent discussions. Key informant interviews with SGS administrators in Ontario identified policy and program refinements needed for a model for coordinating access to appropriate SGS care within their respective regions. Such a model should leverage existing efforts and include:

- Policy that outlines the purpose and governance of the SGS coordinated access mechanism;
- Agreements that spell out the relationships, responsibilities, and accountabilities between SGS providers and the coordinated access mechanism;
- Program documents that outline the referral pathways and operations of the coordinated access mechanism;
- Funding for SGS coordinated access staff; and
- Tools to facilitate referrals, share medical information, and communicate with primary care, older adults, and their care partners.

An SGS coordinated access model can facilitate more effective screening, reduce wait times, triage referrals, improve referral quality, support continuity of care, and support patients to access the appropriate SGS program in a timely fashion. Building on a single point of access, an SGS coordinated access model also supports clinicians to access a central intake and assessment process to refer their patients to the service that best fits their older adult patient’s needs.

Core Principles for SGS Coordinated Access

Among the many themes identified through interviews and the focus group, we identified three core principles for SGS coordinated access:

1. **Co-design:** SGS programs work with willing partners to build relationships, connect services, and form coordinated access mechanisms that reflect available services and the needs of older adults. Regional delivery of SGS services across organizations necessitates co-design in both the creation and operation of coordinated access mechanisms. In order to provide coordinated access, collaboration between organizations is necessary where hierarchical connections do not exist (e.g. between a community service organization and a hospital; between home care and in-patient clinics; etc.). Older adults are part of the design and regular evaluation of coordinated access mechanisms to ensure they serve patients and their care partners effectively.

2. **Access:** SGS programs prioritize system navigation, triage, and wait times for older adult care. Coordinated access mechanisms leverage a single point of entry for a group of services that support older adults with diagnosing, managing, and responding to multiple chronic conditions. Barriers for primary care to refer to SGS are low, available services are clearly described, and coordinated access staff have a keen understanding of the wait times and triage requirements of each program. Older adults, their care partners, and primary care clinicians are part of the discussion on the purpose and desired outcomes of each SGS service they receive.
3. **Person-centred:** SGS programs consider the individual care requirements of each older adult referred to coordinated access in treatment planning and service delivery. Older adults and their care partners do not need to repeat their health information and medical history to each SGS provider. Coordinated access mechanisms use referral pathways to transmit information about the older adult that will support care in addition to the clinical reason for referral. Information is shared securely among providers supporting the older adult and treatment recommendations are communicated to primary care along with the rationale for a course of action.

These principles for coordinated access can be used to guide the creation, management, and enhancement of coordinated access mechanisms in the delivery of SGS programs. They speak to the approach or the ‘how’ of SGS coordinated access.

Action Plan for SGS Coordinated Access

The literature sheds light on the operational requirements, or the ‘what’, of SGS coordinated access. Multiple studies produced lists of commonly cited requirements for coordinated access mechanisms. PGLO’s design elements of integrated care serve as a useful tool to organize the operational requirements of SGS coordinated access mechanisms from the literature into one synthesized list (PGLO, 2020).

Using the three principles of SGS coordinated access and the 13 design elements of integrated care, an action plan for the development and delivery of SGS coordinated access mechanisms can be created. Table 6 identifies operational requirements for SGS coordinated access.

Table 6: An Action Plan for SGS Coordinated Access - Operational Requirements

Principle of SGS Coordinated Access	Design Element of Integrated Care	Operational Requirement
Co-design	Multidisciplinary teams	Geriatric medicine, seniors’ mental health, interprofessional geriatric teams, and community service providers form the pool of specialists receiving referrals and may participate directly in coordinated access mechanisms

Principle of SGS Coordinated Access	Design Element of Integrated Care	Operational Requirement
	Collaboration	Formal agreements between providers and coordinated access services that outline circle of care and how services share clinical information
	Cross-sector partnership	Governance structure that includes SGS providers
	Integrated specialized geriatric expertise	Clinical geriatric expertise is directly included in triage processes
	Integrated community & home-based interventions	Service referrals include home and community services
Access	Comprehensive assessment & care planning	Standardized approach to intake, clinical triage, assessment, and referral
	Integrated technologies	Single electronic platform for referrals, information sharing, and data collection
	Multi-tiered evaluation	Evaluation plan that includes indicators and metrics to measure efficacy of processes, older adult experience, and health outcomes
Person-centred	Self-management support	Recommendations are shared with older adults and their care partners, or shared with primary care providers for their patients, to support self-management of chronic conditions
	Integrated care at the point of care	Coordinated access staff include a variety of disciplines and service perspectives and can exercise clinical judgment when making referrals
	Shared responsibility for continuity of care	Follow-up and hand-off processes support primary care as the medical home, and communications are routine and clear between specialists, primary care and patients
	Older person-centred care	Approaches are responsive to diverse patient needs, with the older adult engaged in decision-making with SGS providers and primary care
	Engaged older persons & family/friend caregivers	SGS coordinated access provides information to care partners and involves them in information-gathering and referral decisions with older adults

Conclusion

This Coordinated Access Project reviewed existing models of coordinated access in the literature and the current state of such models in SGS across Ontario to identify features and approaches to design and delivery. We have identified foundational elements for coordinated access for older adults, including the need for standardized clinical triage process, standard prioritization tools/mechanisms, quality assurance process/common metrics, a single portal of entry, a common database – with data linkage to the SGS Asset Mapping Portal, standardized referral/application forms – integrated within primary care EMRs where feasible, pooled/common waiting lists/referrals (waitlist management) and skilled clinical triage practitioners.

We have also identified a preliminary action plan to guide further development of coordinated access models. Further, we have demonstrated the value of coordinated access to provide better integration and quality of care for older adults living with complex health conditions. Given the development of Ontario Health Teams, many of which have identified older adults living with complex health conditions (e.g. frailty) as a priority, the time is right to coordinate access to diverse yet limited SGS resources.

We also note that coordinated access services should optimally be organized at the regional level to avoid duplication, support access across specialized geriatric services (e.g. geriatric medicine, geriatric psychiatry, seniors' mental health, primary care memory services, behavioural support services, interprofessional geriatric teams, etc.), and have dedicated, sustainable funding to best support older adults and their primary care providers.

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Appendix 1: Coordinated Access Elements by Reference Article

Elements of Coordinated Access/Article	Aronoff-Spencer et al, 2020	Barber et al., 2015	Bichel et al. 2009	Brown & Menec, 2018	Chow et al. 2015	Damani at al. 2017	Damani at al. 2018	Fullerton et al. 2020	Gooch et al. 2012	Hazelwood et al. 2016	Lopatine et al. 2017	Martin Walsh et al. 2019	Melathopolous & Cawthorpe, 2019	Mestre et al. 2018	Mion et al. 2001	Mohr & Bourne, 2004	Novak et al. 2013	Ontario COE for Child and Youth Mental Health, 2016	Robinson et al. 2010	Suter et al. 2015
Access to team for virtual support while waiting (e.g. patient access)														x						
Administrative support (e.g. clerical review of incoming referrals)		x						x												x
Care planning																			x	
Case management (e.g. assessment, monitoring, reassessment, chronic disease management)	x								x				x						x	
Common database	x				x		x			x	x	x	x	x			x			x
Communication/service policy/linkage to primary care (e.g. confirmation of referral, acceptance, appointment scheduling etc.)			x		x		x													
Data entry/collection process	x						x													x
Dedicated (on-call) specialist support for Coordinated Access team (e.g. review of complex cases)										x							x			
Defined pool of participating specialists (Buy-in, champions)		x				x	x	x		x										
Direct treatment offerings for defined problems (e.g. non surgical interventions)																	x ^c			x
Embedded advanced practice/unique roles								x ^a								x ^b				
Formal handover process (e.g. three way calling to help patients connect															x			x		

Elements of Coordinated Access/Article	Aronoff-Spencer et al, 2020	Barber et al., 2015	Bichel et al. 2009	Brown & Menec, 2018	Chow et al. 2015	Damani at al. 2017	Damani at al. 2018	Fullerton et al. 2020	Gooch et al. 2012	Hazelwood et al. 2016	Lopatine et al. 2017	Martin Walsh et al. 2019	Melathopolous & Cawthorpe, 2019	Mestre et al. 2018	Mion et al. 2001	Mohr & Bourne, 2004	Novak et al. 2013	Ontario COE for Child and Youth Mental Health, 2016	Robinson et al. 2010	Suter et al. 2015
with intended service, formalized links with community services)																				
Interim care management (until placement)													x							
Measurement of system capacity													x							
Multiservice/multiagency team											x									
Ongoing staff education																x				
Patient/family self care education and information							x		x				x						x	
Pooled/common waiting lists/referrals (waitlist management)			x	x	x	x	x				x		x				x			
Pre-consultation patient questionnaire (e.g. preCGA, pre-surgical questionnaire)	x						x							x						
Proactive case finding															x				x	
Public information/information management (e.g. access portal, knowledge and information about local services)					x		x					x						x		
Quality assurance process/common metrics (Validating appropriateness of referral, service impact etc.)	x	x				x	x	x	x	x	x		x		x	x	x			x
Referral allocation process (e.g. fair distribution of referrals to specialists, next-							x				x						x			

Elements of Coordinated Access/Article	Aronoff-Spencer et al, 2020	Barber et al., 2015	Bichel et al. 2009	Brown & Menec, 2018	Chow et al. 2015	Damani at al. 2017	Damani at al. 2018	Fullerton et al. 2020	Gooch et al. 2012	Hazelwood et al. 2016	Lopatine et al. 2017	Martin Walsh et al. 2019	Melathopolous & Cawthorpe, 2019	Mestre et al. 2018	Mion et al. 2001	Mohr & Bourne, 2004	Novak et al. 2013	Ontario COE for Child and Youth Mental Health, 2016	Robinson et al. 2010	Suter et al. 2015
available specialist processes)																				
Regular communication with clinical team								x												
Scheduled post visit follow-up (e.g. proactive appointment offers at 3, 6 months)														x						
Service referrals/navigation support				x	x								x	x						
Single portal of entry (phone/fax/electronic)				x	x	x	x				x	x	x			x		x		x
Skilled clinical triage practitioners	x							x		x			x		x	x	x			
Standard prioritization tools/mechanism (e.g. determinization of urgency, flags for concerns)	x	x	x		x		x		x	x	x		x			x	x	x	x	x
Standardized assessment (e.g. surgical readiness, mental health)													x			x		x	x	x
Standardized clinical triage process (e.g. screening tools)	x	x		x	x	x	x	x		x	x		x		x	x	x	x	x	x
Standardized referral/application form (e.g. common information requirements)	x		x		x		x		x	x	x						x	x		

(a) Advanced Clinician Practitioners in Arthritis Care OT/PT)

(b) Central Intake Nurse

(c) future plan

Appendix 2: Selected Annotated Bibliography of Included and Additional Gray Literature

Canadian Alliance to End Homelessness

The CAEH defines coordinated access as a “community-wide system that streamlines the process for people experiencing homelessness to access housing and supports...” (para 1). CAEH describes the following three key steps to coordinated access:

a. Access to the system:

- Process and structure for intake
- Access points
- Outreach to support full coverage of the community
- Supports at all levels of need

b. Common assessment and prioritization:

- Standardized intake
- Common assessment tool that provides insight into the strengths and vulnerabilities of each person
- Goal of aiding in prioritization and accommodation of those with highest levels of need first

c. Referral process

- Asset mapping of services
- Policies to aid matching individuals with services and supports
- Status of services and new resources
- Performance monitoring

Enablers for coordinated access

- A system leader providing oversight, guidance, community engagement, development, monitoring, evaluation
- Data management and real-time data, including inputting, storing, monitoring and effectively utilizing data

Source: <https://caeh.ca/cas/>

Ottawa Children’s Coordinated Access

OCCA’s system of coordinated access and referral is described as a “case resolution mechanism designed to provide recommendations and referrals for families, children and youth who have complex needs and are experiencing difficulties gaining access to support and services in the community. The mechanism is a collaborative and cross-sectoral community effort intended to provide recommendations and referrals to resolve difficult situations.” (Coordinated Access, para 1)

OCCA facilitates the Case Resolution Committee. The collaborative Coordinated Access and Referral mechanism is activated by professionals who bring forward applications for consideration that meet the following criteria: a) support and service options, in the community have been exhausted and the service system is unable to respond to the needs of the individual (i.e. child/youth); and b) the individual (i.e. child/youth) has multiple complex mental health and/or developmental needs, many more than one challenge such as mental health problems, psychiatric disorders, behavioral issues, dual diagnosis, family conflict, concurrent disorders.

Case Resolution Committee responsibilities include:

- Intake and triage
- Fostering open communication and collaboration between agencies involved in Case Resolution
- Outreaching to organizations working with children and youth facing complex situations to provide them with orientation to using Coordinated Access
- Developing and recommending improvements to policy, procedure and protocol
- Maintaining records
- Ensuring follow through and monitoring of all cases
- Providing quarterly and annual reports to Steering committee
- Resolving and trouble-shooting situations that impede agencies from working together in the interests of children and youth with complex needs
- Be the communication link between all committees and across sectors
- Identify gaps in services and highlight those to the Steering Committee
- To promote flexibility and the exchange of services

Source: <https://coordinatedaccess.ca/about/>

Evaluation of Mental Health Coordinated Access Mechanisms in Ontario (Rush, B., Turner, R., & McCon, K., 2017).

Key Findings:

Features of coordinated access that do or could contribute to success:

- Having a range of options for accessing coordinated access (e.g., online, satellite services)
- Providing live answer rather than call-back to enable responding to immediate needs and decrease the risk of people falling through the cracks
- Having skilled staff with a range of expertise and knowledge of the mental health and addictions system
- Providing the right type and intensity of service from first point of contact
- Effectively and actively managing waitlists
- Building strong partnerships with a broad range of service providers
- Enhancing relationships with service providers to build trust and buy-in
- Improving knowledge/information management

- Using more integrated client relationship management databases
- Better promotion of coordinated access services

Source: <https://amho.ca/wp-content/uploads/Coordinated-Access-Evaluation-Report.pdf>

Rapid Access Models for Substance Use Services: A Rapid Review

(Rush, B. & Furlong, A., 2020)

In the context of rapid access models for substance use services, “centralized and coordinated access models offer an efficient approach to service matching if implemented with standardized processes and tools and monitored with appropriate performance measurement indicators” (Rush & Furlong, 2020, p. 5).

Common features of centralized and coordinated access models in substance use services described in this report include the following dimensions:

Access: Mechanisms to support service navigation, such as clear and strategic messaging to both the general public and service providers about how to access the service, including the specific means of contact, which increasingly includes both web-based technology and direct walk-in services.

Intake: Eligibility criteria and screening tools and processes that are clear, well-documented, low-threshold and transparent and that both “screen-in” based on the eligibility criteria and offer clear pathways to information and support for those who do not meet the eligibility criteria.

Assessment: The use of common, validated assessment tools and procedures that complement the screening processes at intake and that match individual strengths and needs to available resources.

Assignment or referral: Clear priorities, and transparent and consistent criteria and processes for referrals or authority for direct admission into required services. These processes may include informal or formalized approaches to stepped care.

System navigation: Support in making transitions, including from the point of assessment to the next direct service, as well as facilitated opportunities to return for additional assessment, and treatment and support planning, if needed. System navigation may include the use of peer support workers.

Data entry and sharing: Infrastructure for the transfer of health information, including screening and assessment results and service outcomes, that facilitate transitions and minimize the need for the client and family members to repeat critical information for treatment and support planning and monitoring.

System change: Ongoing communication and planning among the key community partners and the use of routinely collected process and outcome indicators to measure performance and make continuous improvements (Rush & Furlong, 2020, pp 38-39).

One key concept described is that of stepped care which enables a matching of interventions to assessment findings, and the progression of clients through steps of interventions, depending on need. Features may include:

- 24/7 web portal access to community service directories
- Navigation strategies
- Information about mental health in general
- Access to self-help tools
- Phone or text access to peer support or, if urgent, professional crisis counsellors
- The provision of same-day, single-session walk-in clinics that offer solutions immediately with minimal assessment and a fail-forward strategy to engage more in-depth assessment, if needed
- The use of a range of technologies including web- and mobile-based apps
- Ongoing outcome monitoring to signal the need for transitions to more or less intense interventions (Rush & Furlong, 2020, p. 44)

Source: <https://www.ccsa.ca/sites/default/files/2020-10/CCSA-Rapid-Access-Models-Substance-Use-Services-Rapid-Review-Report-2020-en.pdf>

Hip & Knee Replacement Toolkit: A Living Document

(Bone & Joint Canada, Waddell, J., & Frank, C. Eds, 2011)

Central Intake is identified as a waitlist management strategy, best facilitated “through a single centralized (electronic waitlist) that prevents duplication and multiple referrals within the system” (p. 16). This report identifies central intake can enable access to a “next available surgeon” with some allowance for access to specific surgeons when patients have pre-existing relationships. Process efficiencies can be realized through standardized care pathways that engage other health professionals in assessment and treatment processes (e.g. advanced practice physiotherapists) which can contribute to surgeon productivity and patient satisfaction.

Source: http://boneandjointcanada.com/wp-content/uploads/2014/05/11-2821-RR_HipKnee_Replacement_Toolkit_V3.pdf

CADTH Health Technology Review – Single Entry Models (SEMs) in Surgical Services

(Harris, J., 2021, Canadian Journal of Health Technologies, 1(5), p 1-12)

Relevant key success factors:

1. Development and implementation of a standardized clinical pathway or triage criteria to reduce variation and clarify the need for specialist referral
2. Concurrent investments in health system resources to clear backlogs (e.g. expanded clinical health human resources capacity)
3. Leadership that guides the setting of clear, actionable, and measurable targets for wait times and champions change management
4. Concurrent focus on quality improvement and system integration, including a focus on team-based care and enhancing quality and safety of clinical care
5. Data collection and transparency, including standardized data collection and reporting, and KPIs

Source: <https://canjhealthtechnol.ca/index.php/cjht/article/view/cy0009>

Appendix 3: Process Flow Map Examples

Figure 3: Regional Geriatric Program Central - Central Intake Process

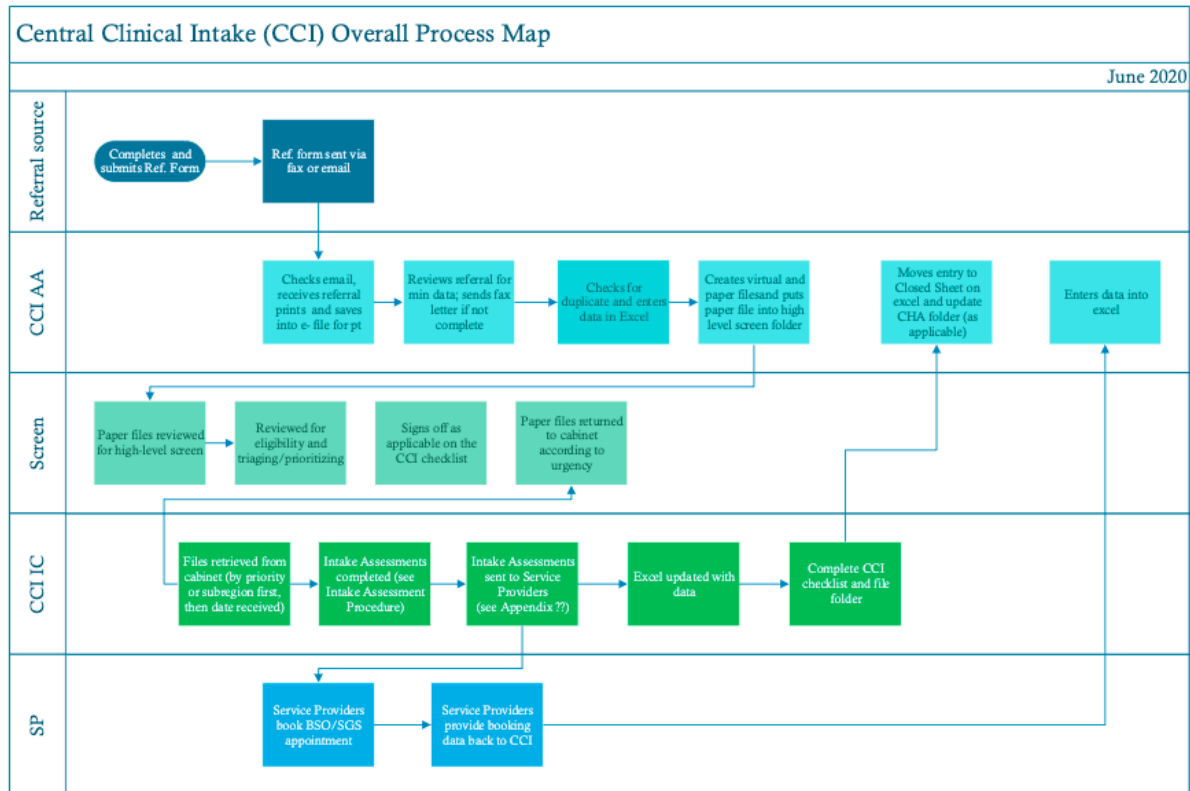


Figure 4: North Simcoe Muskoka: SGS Intake

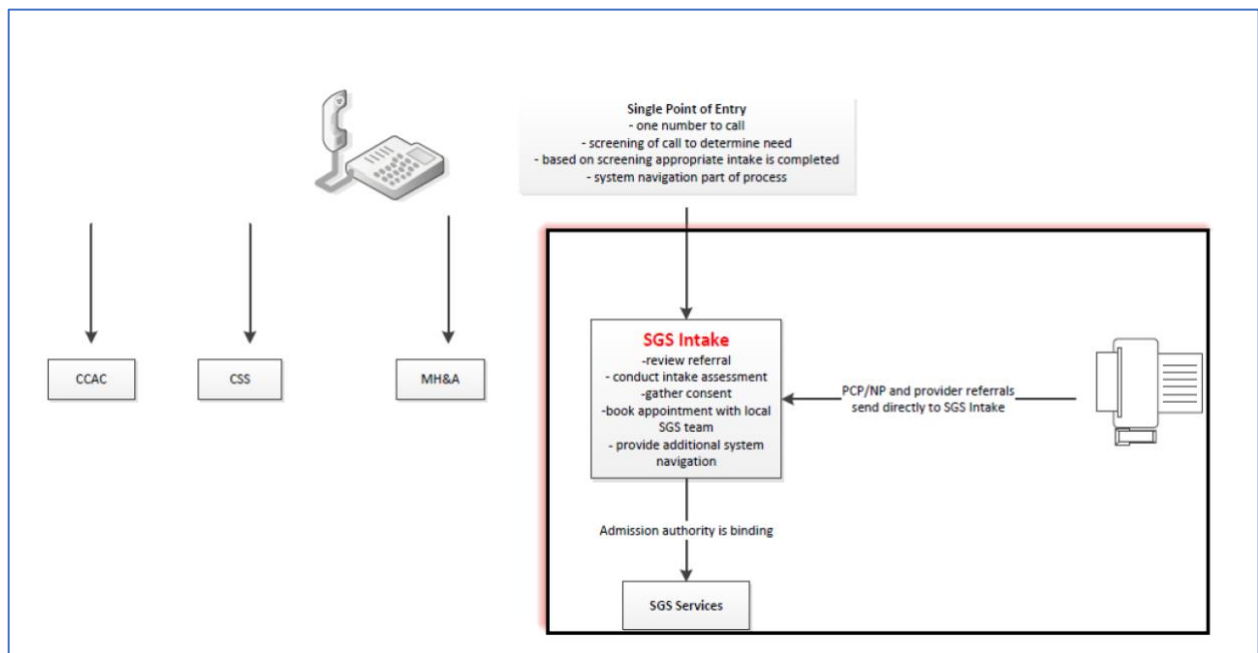


Figure 5: GeriMedRisk Referral Process



Figure 6: Sudbury SGS Coordinated Access Process

