Central Point of Intake (CPI) Model

Report, Recommendations and Implementation Plan

June 2nd, 2022

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Contents

Purpose of this Document

The purpose of this ***Report, Recommendations and Implementation Plan*** document is to:

- Summarize the case for change and guiding principles that informed the design of a Central Point of Intake (CPI) for infant, children and youth mental health services.
- Describe the recommended entry point service pathway and key model parameters for infant, children and youth mental health services.
- Describe the recommended governance and operational model for the centralized point of intake (CPI) for infant, children and youth mental health services.
- Outline the implementation activities and high-level key performance indicators to support the adoption of the recommended central point of intake (CPI) model.

Important Note

This ***Report, Recommendations and Implementation Plan*** document outlines Optimus SBR's recommendation for the Central Point of Intake (CPI) for infant, children and youth mental health services in Toronto.

Optimus SBR is an independent consulting firm that was brought in to lead and support this initiative due to its neutral, third-party perspective, as well as its understanding of broad sector trends and intake models.

The recommendations outlined in this document were drafted based on a holistic, big-picture analysis that took into consideration the following inputs:

- The collective voice of the sector through various facilitated working sessions and discussions with those who deliver child and youth mental health services;
- The voice of system partners, such as the education sector and Ministry-level stakeholders;
- Findings and best practices from the environmental scan and literature review; and
- Optimus SBR's experience with access models and system transformation.

Acknowledgements

This work would not have been possible without the dedication and experience of the Central Point of Intake Task Force:

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- Janet McCrimmon, Strides Toronto

Project support provided by:

- Lead Agency: David Willis, Catharine de Leeuw, Anubha Williams Phillip
- Optimus SBR Team: Andrea Spencer, Gary Sandor, Beatriz Graetzer, Clare McNeil

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Executive Summary

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Case for Change for the Model

Designing and implementing a central point of intake for infant*, children and youth requiring mental health services will result in numerous benefits in the short- and longer-term.

Problem Situation

Children, youth, and families currently experience confusion, frustration, and delay when seeking child and youth mental health services, across the spectrum of needs.

Referral to, eligibility for, matching to suitable options, service planning, and pathways to treatment are not integrated, consistent, universally applied, or transparent.

Benefits of Proposed Central Point of Intake Model

Short-Term:

- Client is informed about services
- Client feels heard and understood
- Client feels hope
- Client's choices and preferences are addressed in a plan
- Client obtains needed services and treatment
- Client feels connected and supported
- Client feels less stress/anxiety
- Clients are matched to right service at the right time
- Client reaches out to Navigator for guidance as needed
- Client understands their service pathway
- Client is ready and motivated for services

Longer-Term:

- Efficient resource allocation (i.e., more efficient and sustainable use of financial and clinical resources)
- Enhanced system sustainability
- Better understanding of system strengths, constraints, capacity and gaps
- Improved connection between clients and providers
- Better coordination across services
- Better waitlist management
- Transparent and consistent system for children, youth and families

* Please note that throughout the report, we refer to child and youth mental health, but that infants are included as well

Guiding Principles

The central point of intake model for infant, children and youth mental health services in Toronto follows seven core guiding principles that show how clients/families will experience the entry point. Note: the CPI TF reviewed and accepted Guiding Principles 2-7 developed through the Intensive Services Redesign consultation process in late 2021.

1. The Voice of the Client During the Process Must be Heard and Integrated into the Service Pathway

There are clients and families who have had an active and meaningful part in planning this model. My views and preferences are accounted for throughout the process.

2. Simple, accessible, streamlined and efficient processes

My experience accessing the entry point is easy and simple. I only need to make a single call/email and/or my provider can also send a referral form on my behalf.

3. Timely, accurate information sharing and clear understanding of client's needs

My provider completes a referral form based on my needs and my context. I know the information is shared with the appropriate providers, so I don't have to repeat my story. I understand what to expect throughout the process.

4. Ease of accessibility of data and client information

I understand that as a client/family, I get to see and control my information whenever reasonable and possible.

5. Mutually accountable, respectful and collaborative partnerships

I know the providers serving me are working together collaboratively, in partnership with me and have my best interest in mind.

6. Equity, Diversity, Identity Affirming and Inclusion, and Anti-Racist, and Anti-Oppressive lens

I recognize that providers are treating me with dignity and respect, taking an interest in me and understanding of my history, background and other factors. My language preferences (including French) and other unique needs are accounted for.

7. Relevant reporting on system needs, gaps, capacity and constraints

I appreciate that data is being collected and reported to help providers better work as a system and meet the needs of families.

Overview of Entry Point Service Pathway

Below is a high-level summary of the recommended central point of intake for infant, child and youth mental health services. Anyone who contacts the Entry Point (especially family members or youth) should learn what to expect of the entry process, whichever platform is used. It should be noted that the access point will be bilingual and that services will be adapted to meet the needs of Francophones.

WHO CAN CONTACT

- Children/Youth
- Family Members

HOW TO CONTACT

- Phone
- Website
- Email
- Text/Chat

CONTACT MADE

Initial Contact

Use any of the four methods to make the initial inquiry

WHO CAN CONTACT

- Child and Youth Mental Health Core Service Providers
- Intersectoral Partners e.g., Education, Child Welfare
- Broader Healthcare System

HOW TO CONTACT

- E-Referral Platform
- Email Referral

CONTACT MADE

Complete Referral

Complete a standard e-referral form either through e-referral portal or online secure form submitted through email

ENTRY POINT SERVICE PATHWAY

Conduct Triage *(screening)*

Assess level of risk and validate eligibility for services; using a flexible yet standard screening tool*.

Assess Service Needs

Use a standard assessment tool agreed upon by CSPs for the purpose of understanding initial clinical needs and matching child/youth to the right service with the right provider. Expectations for the process are discussed with child/ youth/family.

Complete Resource Matching & Referral

Match client to appropriate resources based on client need, choice and multiple other factors. (e.g. using a tool such as interRAI, CA/LOCUS standardized tool)

Service Navigation/Feedback Loops (including Physicians)

*There are multiple ways to assess risk, existing work has gone into a risk register, see appendix

Experiences with Entry Point Service Pathway

Below is a summary of the **client's experience** with the recommended central point of intake for infant, child and youth mental health services.

Initial Contact	Conduct Triage *(screening)*	Assess Service Needs	Complete Resource Matching and Referral	Ongoing Service Navigation and Feedback Loop
• I know about the Entry Point. • I can contact them directly at any point in my journey. • I know I'm in the right place.	• I understand the process and know someone is working on finding the right help. • I am kept informed about what happens with myself or my family member.	• I have a full understanding of what I need from services. • I know myself or my child/youth/family are being assessed through an equitable process that is culturally responsive. • I know that I will not be required to tell my story multiple times.	• I know what is happening next and where my service(s) will come from. • I am confident that the Central Intake team is matching myself or my family member to the appropriate CSP based on my clinical needs, service offering and capacity. • I am continuously informed on my progress and transitions throughout my care journey. • I contribute to decision making and can exercise choice.	• I always have someone to check in with when I want to know the status of myself or my family member's referral.

Experiences with Entry Point Service Pathway

Below is a summary of the experience of **Core Service Providers, Intersectoral Partners, Broader Healthcare System and others** with the recommended central point of intake for infant, child and youth mental health services.

Complete Referral	Conduct Triage *(screening)*	Assess Service Needs	Complete Resource Matching and Referral	Ongoing Service Navigation and Feedback Loop
• I understand what the Entry Point is and how to access it to submit my referral. • I have made initial contact because I have a client with a need and I know I'm in the right place based on their needs.	• I don't do the triage but understand how it is done and trust that the Intake Worker knows what to do. • I am kept informed about what happens with my client.	• I don't do the assessment of service needs, but may contribute to it, and trust that the Clinical Assessor knows what to do and what support my client needs. • I am kept informed about what happens with client. • I know my client is being assessed through an equitable process that is culturally responsive.	• I am confident that the CPI team is matching my client to the appropriate CSP based on my client's clinical needs, CSP on level of care required, service offering and capacity. • I am kept in the loop on my client's transition to service.	• I always have someone to check in with when I want to know the status of my client's referral.

High-Level Model Parameters

The recommended model for centralized access to infant, child and youth mental health services in Toronto has four key parameters: **Entry Point**, **Triage and Assessment**, **Resource Matching and Referral**, and **Service Navigation**. Note that Service Delivery is not in scope for this initiative.

Service Navigation: the process of helping clients and families understand and navigate the complex system of MH supports and services. It links clients and families to the required, mental health and community services based on need, and coordinates care/services, leading to a more holistic, person-centred approach to service delivery. It is also the process of being an independent advocate, acting on behalf of children, youth and families.

Service Navigation

Entry Point → Triage and Assessment of Service Needs → Resource Matching and Referral → Service Delivery *(not in scope for this initiative)*

Entry Point: the first point of contact for families and professional providers to get access to information about available services. It includes the various channels by which people would first interact with the system. Key functions included are receiving the first inquiry, sharing information, and sending client in the right direction.

Triage and Assessment: parts of a staged process to identify, confirm, categorize and prioritize a clients' needs. **Triage** tends to be quicker, more cursory, and with the expectation that initial needs are identified, while **Assessment of Service Needs** tends to be more extensive, requires intake skills and possible in-person interaction.

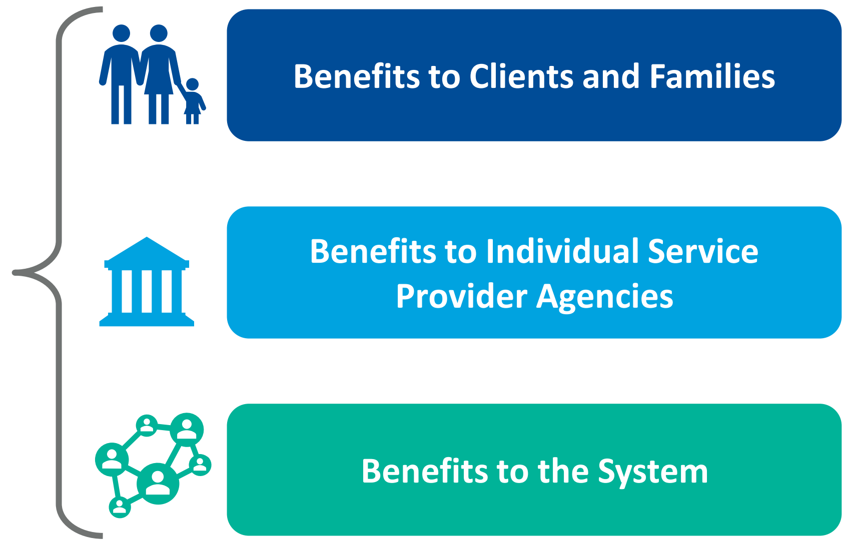
Resource Matching: the process of matching specific resources/services to the person's needs once they are known. Typically requires clear eligibility criteria and accurate information on resources available. The client can contribute to decision making and can exercise choice.
Referral: a referral to another provider, which typically does not involve resource matching.

Centralized Governance Model

Optimus SBR recommends a **centralized governance and operational model** for access to infant, child and youth mental health services, as it brings several benefits to clients, families, and the system, and is strongly aligned to the model's key guiding principles.

A **Centralized Governance Model** is a governance/ operational model where only one of the provider agency oversees and administers all aspects of the centralized point of intake model for services.

This includes operational responsibilities on the staffing, technology, tools, reporting, evaluation, communication and promotion of the model, plus central coordination to support the partnership.



Informed by best practices and the desired objectives/outcomes of the model, Optimus SBR recommends that governance, administration and delivery of the model be housed with **the Lead Agency for infant, children and youth mental health in Toronto**. This is in alignment with the Lead Agency's mandate for developing and operationalizing system-wide changes to improve access, experience and mental health outcomes for Toronto's diverse communities.

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System Alignment

In addition to the benefits listed in the previous slide, a centralized governance and operational model led by the Lead Agency is strongly aligned to broader transformation initiatives in Ontario's mental health sector, such as 811 Health Connect Ontario.

Client and Families
Core Service Providers
Education
Child Welfare
Justice
Broader Healthcare
Other Stakeholders

Help Ahead

'Help Ahead' Central Point of Intake for Child and Youth Mental Health Services → Service Delivery of Child and Youth Mental Health Services

Entry Point and Navigation for **Intensive** Child and Youth Mental Health Services → Service Delivery of **Intensive** Child and Youth Mental Health Services

Entry/Access Point for Other Related Services → Service Delivery of Other Related Services

A centralized governance and operational model also aligns to other existing successful models with similar intake functions, such as triage/screening, assessment, and resource matching. Please refer to the Appendix for a brief description of similar select comparable intake models.

Overview of Implementation Activities

Optimus SBR has identified various activities required for the successful implementation of the entry-point model, per our recommended future state. Some activities will be the sole responsibility of the Lead Agency as the oversight and administrator for the model, while other activities will require an interdisciplinary, multi-agency working group to provide input and/or support.

Lead Agency Activities:

Branding, Promotion and Communications

Activities to raise awareness about the central point of intake, incl. ensuring stakeholders are informed about any changes to processes.

Staffing

Activities to define the staffing requirements and capabilities, and to source, recruit, retain and train the staff delivering the entry model functions, including bilingual capabilities.

Technology

Activities to identify the ideal technology solutions that meet that meets the model requirements/ functions and allows for proper, safe information sharing.

Change Management

Activities to ensure Change Management principles and strategies are applied in order to continue building support for the model and enable its transformation.

Building Knowledge of CSP Services

Activities to ensure that appropriate staff at the Entry Point gain a deep understanding and familiarity of the full range of programs and services that are offered by each CSP.

Working Group Activities:

Strategy and Governance

Activities to develop formal contractual relations between those funding, delivering, and supporting the model, and define how partners will work together.

Tools and Eligibility

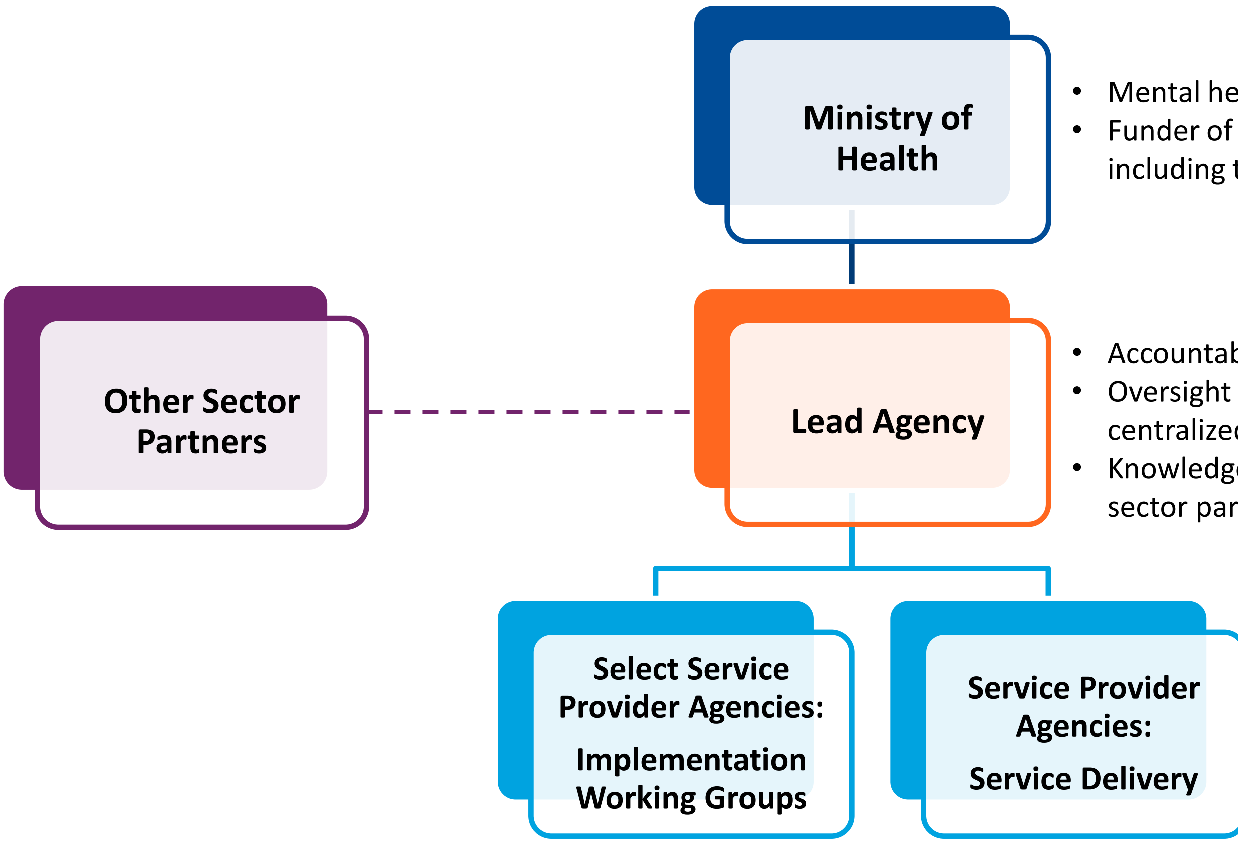
Activities to identify standardized tools that will be used to operationalize the identified model functions.

Data, Reporting and Evaluation

Activities to identify and/or create mechanisms that enable accountability, transparency, understanding of system strengths and areas for improvement.

Implementation Governance Structure

The following illustration represents the proposed governance structure for the Central Point of Intake to infant, child and youth mental health services.



Ministry of Health

- Mental health system oversight
- Funder of child and youth mental health services, including the central point of intake and navigation

Lead Agency

- Accountable for overall system planning
- Oversight and administration of all aspects of centralized point of intake model for services
- Knowledge exchange and coordination with other sector partners, as required

Select Service Provider Agencies: Implementation Working Groups

Participation in some implementation working groups related to the centralized point of intake model for child and youth mental health services (i.e., Strategy and Governance, Staffing, Tools, and Data, Reporting and Evaluation)

Service Provider Agencies: Service Delivery

Service delivery for child and youth mental health services

Executive Summary

Implementation Timelines

The following is the high-level timelines for conducting the implementation activities. We also advise that the working groups for the intensive and broader CPI initiatives be combined. Tentative launch would be Fall 2023.

Lead Agency Activities

1. Change Management
E.g., develop and apply Change Management Framework, and develop communications and key messages based on CM principles

2. Branding, Promotion and Communications
E.g., define branding, develop Marketing and Promotion Strategy, launch communications, and develop Client Engagement Framework

3. Staffing
E.g., define competency framework, develop job descriptions, assign/hire and train staff, etc.

4. Technology
E.g., conduct environmental scan of technology solutions, and select/contract preferred solution

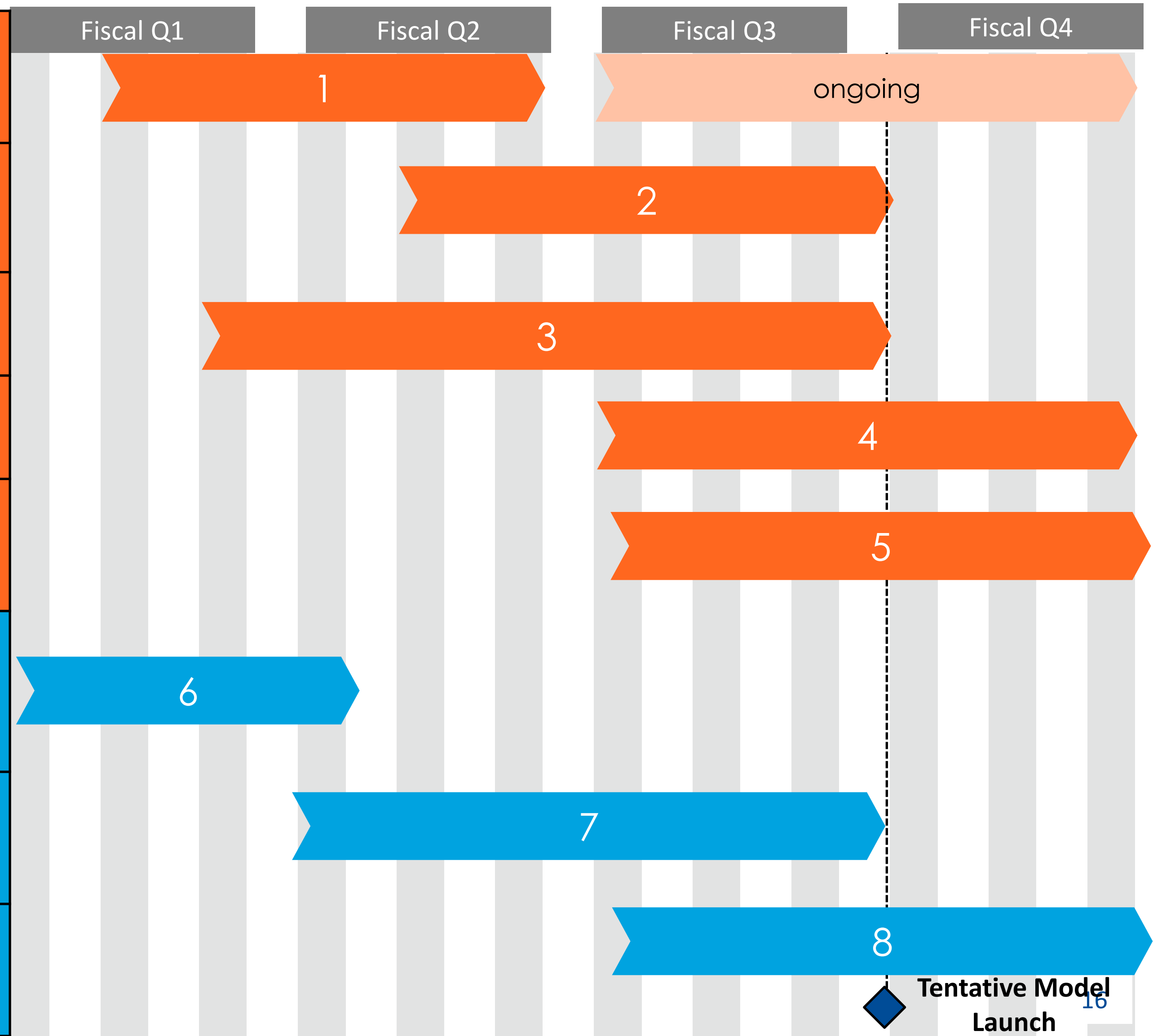
5. Building Knowledge of CSP Services
E.g., Activities to ensure that staff at the Entry Point gain an understanding the full range of programs and services offered by each CSP.

Working Group Activities

6. Strategy and Governance
E.g., further define service parameters, organize funding allocations, develop service level agreements (or similar), define mechanisms for conflict resolution and decision-making, etc

7. Tools
E.g., define eligibility clinical checklist, develop standard referral form, define standard tool for triage and assessment of service needs, etc

8. Data, Reporting and Evaluation
E.g., establish a data reporting process, create and implement Evaluation Framework, define mechanism for continuous improvement, etc



Overview of Key Performance Indicators

Optimus SBR has developed a recommended listed of outcomes-based **Key Performance Indicators (KPI)** to track and measure progress towards the desired vision of the model. The following KPIs were developed in alignment with the model's guiding principles.

Client and Family Experience and Satisfaction

Metrics related to clients and families' overall experience with the central point of intake, including feeling that providers are treating them with dignity and respect, and are taking an interest in their history/background.

Response Time of Entry Point to the Right Service and Provider

Metrics related to the overall efficiency, effectiveness and timeliness of the entry point, including ensuring that clients are being matched and directed to the most appropriate service.

Partner and CSP Engagement and Satisfaction

Metrics related to the providers' overall experience accessing the entry points, including sharing of data and information, and feeling that providers are working collaboratively with their client's best interest in mind.

Knowledge, Understanding and Promotion of the Model

Metrics related to external partners, clients and families having a clear understanding on how to access the central point of intake for services should they need it.

Understanding of System Gaps, Capacity and Demand

Metrics related to data collection and reporting to help providers work better as a system and meet the needs of clients and families.

Note: Additional performance indicators may be tracked and reported on a regular basis as part of the implementation and ongoing operation of the central point of intake (CPI) model for child and youth mental health services.

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Project Overview

Project Background

Guided by extensive consultation with youth, families, and key stakeholders, the ***Re-imagining the Entry to Intensive Services Final Report*** outlined key recommendations for intensive community-based mental health services for children and youth. This information was foundational and applicable to the ***Central Point of Intake (CPI) for infant, children and youth mental health in Toronto***.

Participatory Co-Design and Planning

Participation from:

- Ontario Centre of Excellence for Child and Youth Mental Health
- Youth and Families
- Family Navigation Project, Family Advisory Council
- Intensive Services Informant Group
- Intensive Services Task Force
- Design Day Participants

Planning Approach:

- Applied a co-design approach
- Anchored by the voices of youth and families
- Focused on improving processes and outcomes
- Involved 50+ multi-disciplinary professionals at each workshop
- Facilitated with Ontario Centre of Excellence
- Incorporated LEAN Six Sigma methods

Re-imagining the Entry to Intensive Services Final Report, June 2020

"This report presents recommendations for simplifying and enhancing how children, youth and families in Toronto obtain intensive mental health treatment. We recommend that **entry occur through a single point of access and that navigation support be provided to facilitate seamless and effective movement into, through and out of these community services**. We believe this approach will enable children, youth and families across Toronto to access the best treatment in the timeliest manner."

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Project Background

A project charter representing a strategic priority from the Lead Agency's three-year plan (2020-23) was circulated to the Task Force as part of the orientation to the project.

Project Charter: Renew Vision and Branding for Centralized Point of Intake

Priority: ENTRY & NAVIGATION

Why is the project important?	Goals	Stakeholders	
Youth and families advocated for a centralized, streamlined, and supported process to identify and obtain services as part of the Intensive Services Redesign project in 2019-20. Government has introduced Ontario Health Teams and CYMH services will be integrated into that delivery and funding model. Government guidance for OHTs includes centralized access points and navigation support for patients and referral sources. Already in place are data sharing agreements and processes to screen, triage, and refer, and a new pathway to accept third-party referrals, such as from primary care doctors (i.e., SCOPE) has been established. The centralized number and infrastructure were mobilized to facilitate service continuity for walk-in/"talk in" counselling across Toronto in response to the COVID pandemic. Also, in response to the pandemic, City of Toronto's Mental Health Strategy arranged for MHTO to support callers to 211 seeking CYMH service. Toronto CYMH providers have acknowledged that a centralized point of access makes sense from the client perspective but the current MHTO model and operations are inadequate. MOH has confirmed its investment for a central point of access and intake. Resources for marketing have been secured through one-time pandemic response investment.	*What are and who benefits from this project? What does success look like?* Engage an expert consultant to support the development and implementation of a marketing and communications plan to elevate the profile of the Toronto sector and the centralized point of access into these services. Establish a vision and expanded service model for the central point of access to operate for the Toronto CYMH sector, involving a single point of entry, providing intake, clarified and standardized eligibility and matching processes to direct clients to most suitable treatment and navigation support for clients. Children, youth, their families and support services (education, doctors) know where and how to get community-based mental health service and the entry and pathway are straight-forward and easy to use.	*Who should be involved in the project? team members? Who needs to be informed? how do we engage service users?* Families, infants, children & youth who may need CYMH treatment OHTs Primary Care / Scope Education Referral sources Connex Ontario	MHTO Executive CYMH Providers Ministry of Health Ontario Health / CoE MHA LA Consortium CMHO Allied points of access
		SCOPE	
		Inclusions New name, branding, and marketing. Consultation with youth and families and external stakeholders	Exclusions Implementation of new service model (for future)

Deliverables	Timeframe	Stewards	Assumptions	Risks
1. New name, branding, and marketing plan for the central point of access. 2. Compile needs and requirements of children, youth, families, and referral sources (OHTs, Scope, Primary Care, Education, etc.) from consultation with stakeholders. 3. Establish service model (including operations and governance plans) and vision for expanded functions of central point of access. 4. Outreach and marketing for central point of access implemented.	Sep 2021 Dec 2021 April 2022 2021-22	Task Force of key stakeholders to oversee development of new service model	Expert consultants facilitate branding and marketing. The central point of access will have pathways to related access points (i.e., 211, Connex, etc.)	Public confusion about multiple access points

UPDATED TIIMELINE AND STEWARDS – MAY13, 2021

Deliverables

New name, brand, and marketing plan

Consult stakeholders about needs and requirements

Establish service model for centralized intake

Project Mission and Success

Project Mission

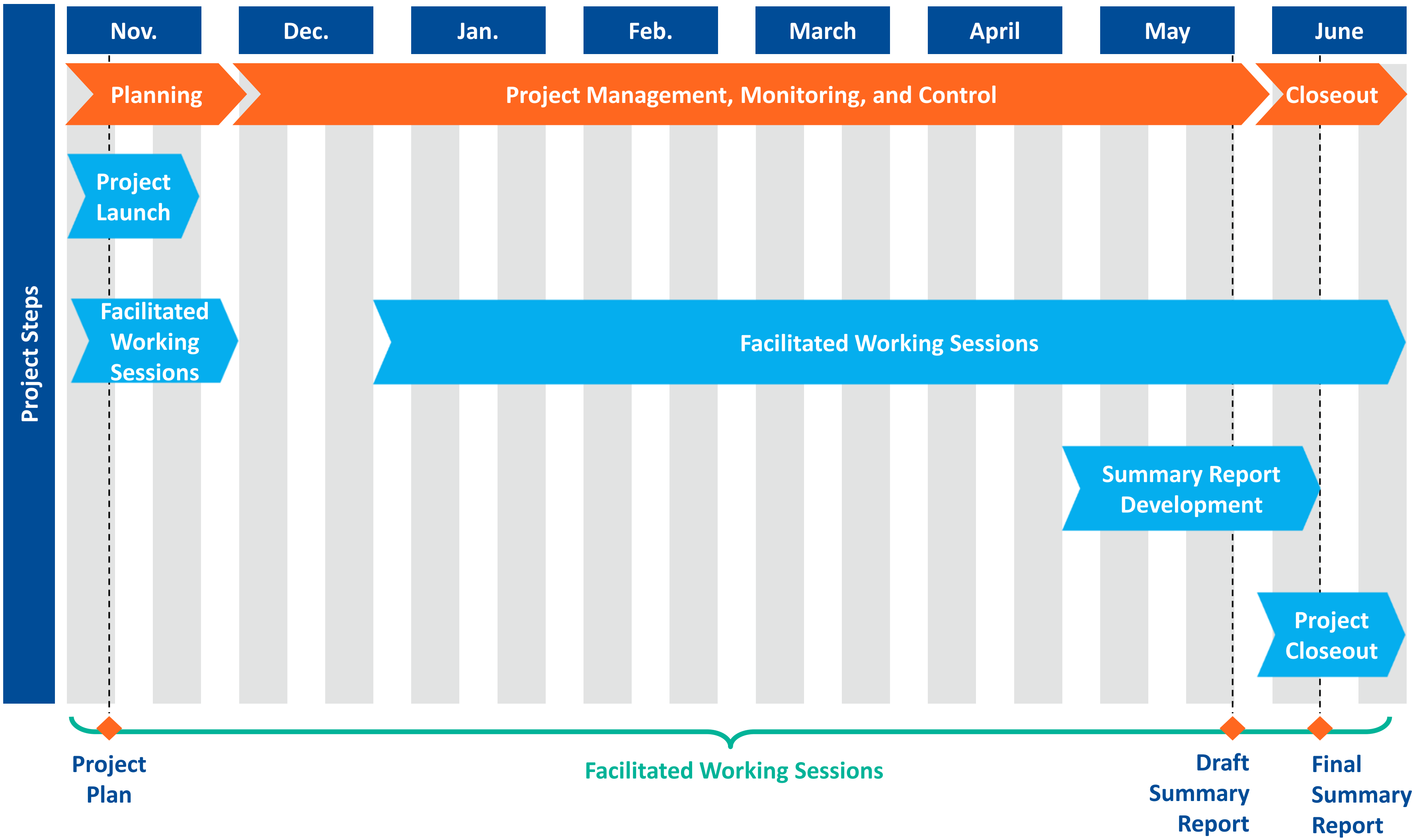
- To partner with the Lead Agency and the Task Force to Renew Vision and Service Model for Centralized Point of Intake ("Task Force") to support the co-design of a service delivery model for Toronto-wide central intake for children and youth mental health services.

Project Success

- Clear direction and understanding of the key parameters for developing and implementing a sustainable model.
- An efficient and thoughtful process that leverages innovative virtual engagement to ensure that outputs are tailored to the needs of the Task Force and informed by the Core Service Provider network.
- Deep and balanced input from key stakeholders in co-designing a service delivery model reflective of the needs of all parties, leveraging leading practices in change management.
- Ownership and confidence that the proposed model will result in client-centered service improvement and outcomes.

Project Overview

Project Timeline



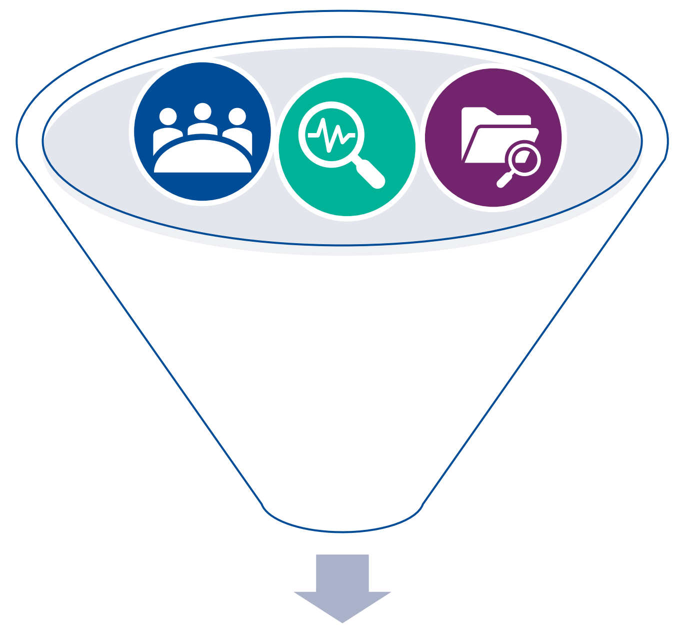
Project Methodology

Optimus SBR conducted facilitated sessions, reviewed data/documents, and conducted an environmental scan to collect inputs that informed the development of the central point of intake for infant, child and youth mental health services in Toronto.

Facilitated Working Sessions with the Task Force– to define the guiding principles, develop key model parameters, functions, outcomes and resource requirements, and collect input on the governance and operational model for the central point of intake model for child and youth mental health services.

Data and Document Review – to understand the background of the initiative, as well as collect data to inform the volume and capacity estimates for the model.

Environmental Scan – to understand leading practices and similar models related to intake, assessment, referral, and single points of entry into child and youth mental health services.



Report, Recommendations and Implementation Plan regarding the Central Point of Intake for Infant, Children and Youth Mental Health Services in Toronto

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Case for Change and Guiding Principles for Model

Case for Change for the Model

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4. Ease of accessibility of data and client information

I understand that as a client/family, I get to see and control my information whenever reasonable and possible.

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I know the providers serving me are working together collaboratively, in partnership with me and have my best interest in mind.

6. Equity, Diversity, Identity Affirming and Inclusion, and Anti-Racist, and Anti-Oppressive lens

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7. Relevant reporting on system needs, gaps, capacity and constraints

I appreciate that data is being collected and reported to help providers better work as a system and meet the needs of families.

Guiding Principles

	Guiding Principle	Model Design Feature	Implications for the Model
1	**The Voice of the Client During the Process Must be Heard and Integrated into the Service Pathway**	• There are clients and families who have had an active and meaningful part in planning this model. • Client and family views and preferences are accounted for throughout the process.	• Make access easy for families, children and youth.
2	**Simple, accessible, streamlined and efficient processes**	• Single call, email or text to the entry point • Can also access through website or e-referral system	• Make access easy for CSPs, families, children and youth, schools, healthcare, CSPs and others
3	**Timely, accurate information sharing and clear understanding of client's needs**	• Entry point has a simple referral form (CSPs know what to submit) • Entry is also accessible to the general public to have initial contact and complete an assessment form • Entry processes build accurate understanding of client's needs	• CSPs know in advance what information is required and what needs to be collected
4	**Ease of accessibility of data and client information**	• Clients get to see and control information whenever reasonable and possible	• Need a system to enable safe and accessible information sharing (e.g. client portal)
5	**Mutually accountable, respectful and collaborative partnerships**	• Well-known process for both CSPs and other service partners • Entry point staff and Service Navigators have direct collaborative relationships with CSPs • Conflict resolution process is in place	• CSPs and partners express mutual accountability for good outcomes and collaboration • Service Navigators build rapport and trust, and hold CSPs accountable
6	**Equity, Diversity, Identity Affirming and Inclusion, and anti-racist, and anti-oppressive lens**	• Entry point resource and Service Navigators must consistently demonstrate this ability and sensitivity	• Anti-racism and anti-oppression training required • Identity Affirming and Culturally Responsive Approaches
7	**Relevant reporting on system needs, gaps, capacity and constraints**	• Entry point entity has IT infrastructure and data systems to capture relevant information (i.e., the minimal requirements on data collection for biggest impact)	• Reporting back to the system on a regular basis

Emphasis on EDI, Anti-Racism, Anti-Oppression

A key part of the design and implementation of the centralized point of intake is the **commitment to Equity, Diversity and Inclusion (EDI) and to anti-racism and anti-oppression**. This means ensuring EDI, anti-racism and anti-oppression principles must be strongly reflected in how the system works, including our processes, tools and decisions.

This model has an opportunity to create equity in the mental health system in Toronto. Its intention is to create ease for those wishing or needing to access mental health services, rather than creating unintended barriers.

The model's processes, tools and decisions need to be flexible to ensure alignment with a commitment of partners to EDI, to our clients and families. Policy and processes will be refreshed in an ongoing manner to ensure delivery of equitable responses and culturally-sensitive approaches.

4

Recommended Entry Point Service Pathway

Overview of Entry Point Service Pathway

Below is a high-level summary of the recommended central point of intake for infant, child and youth mental health services. Anyone who contacts the Entry Point (especially family members or youth) should learn what to expect of the entry process, whichever platform is used. It should be noted that the access point will be bilingual and that services will be adapted to meet the needs of Francophones.

WHO CAN CONTACT

- Children/Youth
- Family Members
- Child and Youth Mental Health Core Service Providers
- Intersectoral Partners e.g., Education, Child Welfare
- Broader Healthcare System

HOW TO CONTACT

- Phone
- Website
- Email
- Text/Chat
- E-Referral Platform
- Email Referral

CONTACT MADE

Initial Contact

Use any of the four methods to make the initial inquiry

Complete Referral

Complete a standard e-referral form either through e-referral portal or online secure form submitted through email

ENTRY POINT SERVICE PATHWAY

Conduct Triage *(screening)*

Assess level of risk and validate eligibility for services; using a flexible yet standard screening tool*.

Assess Service Needs

Use a standard assessment tool agreed upon by CSPs for the purpose of understanding initial clinical needs and matching child/youth to the right service with the right provider. Expectations for the process are discussed with child/ youth/family.

Complete Resource Matching & Referral

Match client to appropriate resources based on client need, choice and multiple other factors. (e.g. using a tool such as interRAI, CA/LOCUS standardized tool)

Service Navigation/Feedback Loops (including Physicians)

*There are multiple ways to assess risk, existing work has gone into a risk register, see appendix

Experiences with Entry Point Service Pathway

Below is a summary of the **client's experience** with the recommended central point of intake for infant, child and youth mental health services.

Initial Contact

- I know about the Entry Point.
- I can contact them directly at any point in my journey.
- I know I'm in the right place.

Conduct Triage *(screening)*

- I understand the process and know someone is working on finding the right help.
- I am kept informed about what happens with myself or my family member.

Assess Service Needs

- I have a full understanding of what I need from services.
- I know myself or my child/youth/family are being assessed through an equitable process that is culturally responsive.
- I know that I will not be required to tell my story multiple times.

Complete Resource Matching and Referral

- I know what is happening next and where my service(s) will come from.
- I am confident that the Central Intake team is matching myself or my family member to the appropriate CSP based on my clinical needs, service offering and capacity.
- I am continuously informed on my progress and transitions throughout my care journey.
- I contribute to decision making and can exercise choice.

Ongoing Service Navigation and Feedback Loop

- I always have someone to check in with when I want to know the status of myself or my family member's referral.

Experiences with Entry Point Service Pathway

Below is a summary of the experience of **Core Service Providers, Intersectoral Partners, Broader Healthcare System and others** with the recommended central point of intake for infant, child and youth mental health services.

Complete Referral	Conduct Triage *(screening)*	Assess Service Needs	Complete Resource Matching and Referral	Ongoing Service Navigation and Feedback Loop
• I understand what the Entry Point is and how to access it to submit my referral. • I have made initial contact because I have a client with a need and I know I'm in the right place based on their needs.	• I don't do the triage but understand how it is done and trust that the Intake Worker knows what to do. • I am kept informed about what happens with my client.	• I don't do the assessment of service needs, but may contribute to it, and trust that the Clinical Assessor knows what to do and what support my client needs. • I am kept informed about what happens with client. • I know my client is being assessed through an equitable process that is culturally responsive.	• I am confident that the CPI team is matching my client to the appropriate CSP based on my client's clinical needs, CSP on level of care required, service offering and capacity. • I am kept in the loop on my client's transition to service.	• I always have someone to check in with when I want to know the status of my client's referral.

Case Study 1

Journey Map: A Youth who Speaks French Reaches out to a CSP

Personas

Ali (Client) | **Lee (CSP)** | **Casey (Clinical Assessor)** | **Carlos (Intake Worker)** | **Jenna (Service Navigator)**

1

"I'm not doing well. I've heard about Youth Agencies, and I know they can help. I'm going to give them a call"

- Ali the client reaches out to a CSP and connects with a **bilingual worker**

2

"Hi, thanks for calling today. Let me understand what you are feeling, and I'll direct you to the correct place"

- Lee works for a CSP, they take the call from Ali and finds out she is looking for some help. **They communicate in Ali's native language (French).**
- Ali is redirected to the weblink for Help Ahead and Lee stays on the phone until Ali completes the necessary information to move into the entry point.

3

"I have a message from Ali that just came through"

- Carlos the Intake Worker will confirm receipt of the initial referral form within 24 hours
- Carlos will review the form and conduct triage. He will determine how quickly Ali needs to be connected to a service.
- If Carlos needs to follow-up with Ali directly, he can do so **and will ensure contact is made in French**.

4

"I'll need to look into some further information to determine next steps "

- Carlos the Intake Worker assesses Ali's level of risk and validates eligibility to determine next steps.
- Carlos will connect with the Clinical Assessor, Casey and assigns Ali to be assessed.
- Carlos will collect any additional information to share with the Clinical Assessor (Casey) including: connections to other providers and if any other previous assessments have been completed.

5

"I'll need to do a full assessment."

- Casey the Clinical Assessor does a full assessment of needs (using an agreed-upon standard tool) within 14 days.

6

"HI Ali, I'm going to give you an update on your recently submitted Referral Form "

- During the two-week period, the Service Navigator, Jenna, updates Ali **in French** on the status of the referral.
- Jenna also looks into other available resources/services in other sectors (e.g. housing) that may be applicable to Ali.

7

"I will be sure to match Ali with the appropriate services based on her needs."

- Following the assessment, the Clinical Assessor, Casey matches client need to appropriate resources based on CSP service offerings and capacity.

8

"We have good news, Ali, I can confirm that we have found the right service that can give you the help you are looking for".

- Jenna the Service Navigator indicates **in French** that a match can be made and asks Ali if she feels its the right fit. If it is, she confirms the match with the CSP and Ali, and explains next steps. If not, they discuss other possible matches.

Case Study 2

Journey Map: Family Physician

Personas

Julian (Client)
Dr. Cassie (MD)
Casey (Clinical Assessor)
Carlos (Intake Worker)
Jenna (Service Navigator)

1

"I'm not doing well. I've come to the doctor's office to get some help with my mental health.

- Julian reaches out to his Family Physician Dr. Cassie.

2

"Hi, thanks for coming in today, I understand you're having some issues with your mental health. I am here to help you"

- Dr. Cassie discovers through her discussion that Julian is a good candidate to refer to the child and youth mental health entry point. She completes a referral form and lets Julian know the process. Dr. Cassie will follow-up with Julian as needed.

3

"I have contact from Dr. Cassie that just came through"

- Carlos the Intake Worker will confirm receipt of the initial referral form within 24 hours.
- Carlos will review the form and conduct triage. He will determine how quickly Julian needs to be connected to a service.
- If Carlos needs to follow-up with Julian and/or Dr. Cassie directly he can do so.

4

"I'll need to look into some further information to determine next steps "

- Carlos the Intake Worker assesses Julian's level of risk and validates eligibility to determine next steps
- Carlos will connect with the Clinical Assessor (Casey) and assigns Julian to be assessed.
- Carlos will collect any additional information to share with the Clinical Assessor such as: connections to other providers and if any other previous assessments have been done.

5

I'll need to do a full assessment."

- Casey the Clinical Assessor does a full assessment of needs (using an agreed-upon standard tool) within 14 days.

6

"I'm going to give you an update on your recently submitted Referral Form "

- During the two-week period, the Service Navigator, Jenna, updates Julian, the client and Dr. Cassie on the status of the referral.
- Jenna also looks into other available resources/services in other sectors (e.g. housing) that may be applicable to Julian.

7

"I will be sure to match Julian the client with the appropriate services based on his needs."

- Following assessment, the Clinical Assessor, Casey matches client need to appropriate resources based on CSP service offerings and capacity.

8

"We have good news, Ali, I can confirm that we have found the right service that can give you the help you are looking for".

- Jenna the Service Navigator indicates that a match can be made and asks Julian if he feels its the right fit. If it is, she confirms the match with the CSP, Dr. Cassie and Julian, and explains next steps. If not, they discuss other possible matches.

Case Study 3

Journey Map: School Teacher

Personas

Casey (Clinical Assessor)

Jenna (Service Navigator)

Ms. Michelle (teacher)

Carlos (Intake Worker)

Becky (Student)

1

"Becky looks like she is really struggling with her mental health, she can't focus in class and I know she isn't receiving help"

- Ms. Michelle notices that Becky is struggling

2

"I'm going to contact CPI"

- Ms. Michelle contacts the entry point on its website, completing an initial form outlining concerns and demographics (can also be done through: phone, email, text/chat).

3

"I have contact from Ms. Michelle that just came through"

- Carlos the Intake Worker will confirm receipt of the initial referral form within 24 hours
- Carlos will review the form and conduct triage. He will determine how quickly Becky needs to be connected to a service.
- If Carlos needs to follow-up with Ms. Michelle or Becky he can do so.

4

"I'll need to look into some further information to determine next steps "

- Carlos the Intake Worker assesses Becky's level of risk and validates eligibility to determine next steps
- Carlos will connect with the Clinical Assessor (Casey) and assigns Becky to be assessed.
- Carlos will collect any additional information to share with the Clinical Assessor (connections to other providers and if any other previous assessments have been done)

5

"I'll need to do a full assessment."

- Casey the Clinical Assessor does a full assessment of needs (using an agreed-upon standard tool) within 14 days.

6

"I'm going to give you an update on your recently submitted Referral Form "

- During the two-week period, the Service Navigator, Jenna, updates Ms. Michelle, Becky and her family on the status of the referral.
- Jenna also looks into other available resources/services in other sectors (e.g. housing) that may be applicable to Becky.

7

"I will be sure to match Becky with the appropriate services based on her needs."

- Following assessment, the Clinical Assessor, Casey matches client need to appropriate resources based on CSP service offerings and capacity.

8

"We have good news, Carlos, I can confirm that we have found the right service that can give you the help you are looking for".

- Jenna the Service Navigator indicates that a match can be made and asks Becky if she feels its the right fit. If it is, she confirms the match with the CSP, Becky, Ms. Michelle and the family (as applicable) and explains next steps. If not, they discuss other possible matches.

Case Study 4

Journey Map: Child Welfare

Personas

Casey (Clinical Assessor)

Jenna (Service Navigator)

Julia (CW Worker)

Carlos (Intake Worker)

Harper (CW Recipient)

1

"Harper looks like she is really struggling with her mental health, and I know she isn't receiving help"

- Julia a CW Worker notices that Harper is struggling.
- ***Note**: Julia, as a CW Worker has two options, she could call the entry point or complete the referral form*

2

"I'm going to contact CPI"

- Julia contacts the entry point on its website, completing an initial form outlining concerns and demographics (can also be done through: phone, email, text/chat).

3

"I have contact from Julia that just came through"

- Carlos the Intake Worker will confirm receipt of the initial referral form within 24 hours.
- Carlos will review the form and conduct triage. He will determine how quickly Harper needs to be connected to a service.
- If Carlos needs to follow-up with Julia or Harper he can do so.
- ***Note**: If Carlos understands that this is a crisis situation, he will divert the client appropriately through an intensive or other urgent pathway.

4

"I'll need to look into some further information to determine next steps "

- Carlos the Intake Worker assesses Harper's level of risk and validates eligibility to determine next steps
- Carlos will connect with the Clinical Assessor (Casey) and assigns Harper to be assessed.
- Carlos will collect any additional information to share with the Clinical Assessor (connections to other providers and if any other previous assessments have been done)

5

"I'll need to do a full assessment."

- Casey the Clinical Assessor does a full assessment of needs (using an agreed-upon standard tool) within 14 days.

6

"I'm going to give you an update on your recently submitted Referral Form "

- During the two-week period, the Service Navigator, Jenna updates Julia and Harper on the status of the referral.
- Jenna also looks into other available resources/services in other sectors (e.g. housing) that may be applicable to the Harper.

7

"I will be sure to match Harper with the appropriate services based on her needs."

- Following assessment, the Clinical Assessor, Casey matches client need to appropriate resources based on CSP service offerings and capacity.

8

"We have good news, Harper, I can confirm that we have found the right service that can give you the help you are looking for".

- Jenna the Service Navigator indicates that a match can be made and asks Harper if she feels its the right fit. If it is, she confirms the match with the CSP, Harper, the CW and the family (as applicable) and explains next steps. If not, they discuss other possible matches.

Legend of Entry Point Service Pathway

The following is the legend used in the illustrative examples on the previous slides.

Legend:

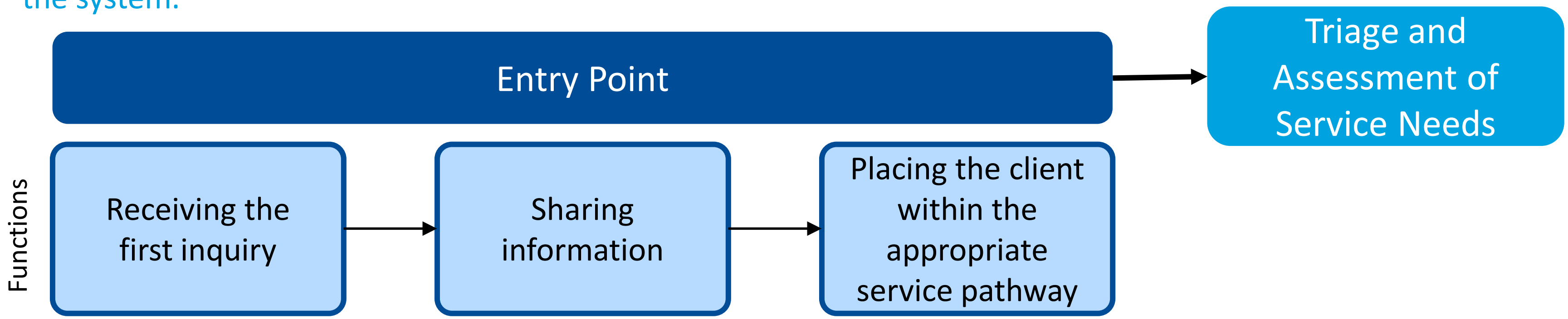
- **Entry Point:** central point of intake for entry into child and youth mental health services in Toronto.
- **Entry Point Intake Worker:** a highly-skilled staff responsible for the ***Entry Point*** and ***Triage*** functions.
- **Clinical Assessor:** a highly-skilled staff responsible for the ***Assessment of Service Needs*** function.
- **Service Navigator:** a skilled and trained staff responsible for ***Resource Matching***, ***Referrals***, and ***Service Navigation*** functions.
- **Service Offering and Capacity:** the Service Navigator leverages a potential technology solution that pulls information from the providers on service offerings and their service capacity. That way, when it comes to Resource Matching, they will find a match and if capacity is open, the match will be complete.
  - *Note:* the ideal technology solution is not yet in use in the system, and part of the implementation work is to assess potential technology solutions that would fit the requirements of the model.
  - In the early stages of establishing the Entry Point, this function could be done by building on the systems already in place (i.e., leveraging the available information such as current vacancy rates in the systems and discharge dates. However, it is important to recall there are some challenges with the accuracy of the current data available).

5

Recommended Key Model Parameters for Entry and Navigation

Entry Point

Entry Point refers to the first point of contact for families and professional providers to get access to general information about available services. It includes the various channels by which people would first interact with the system.



Key Takeaways:

- The three key functions included in Entry Point are receiving the first inquiry, sharing information, and placing the client within the appropriate service pathway.
- The Entry Point is primarily accessed as a first point of contact for anyone – family member, youth, physician, other health provider or any child and youth service provider who is seeking services or supports for a child or youth. The Central Point of Intake acts as the initial inquiry about child and youth mental health services and therefore is a common repository for information about the system, for understanding the caller's needs and for clearly discussing the next steps in the process toward matching a child or youth's needs with the appropriate service provider.
- The Entry Point is intended for those who are asking for any child and youth mental health service, but it is not meant to be a crisis service.

Entry Point

Entry Point refers to the first point of contact for families and professional providers to get access to general information about available services. It includes the various channels by which people would first interact with the system.

Key Functions	Definition (What does it mean?)	Key Parameters	Purpose (what are its intended outcomes?)	Resource Requirements
Receiving the first inquiry	• Receiving notification that there is an interest or need for a wide range of services • For most cases, the first inquiry will come from a client or family directly or someone who is calling openly on behalf of a client or family	• The function will operate not only during normal business hours, but with options for off hours; e.g., if an inquiry is made after hours, there should be a commitment to respond within 48 hours • The function will use a variety of channels, such as telephone, email, text, and online chat	• Understanding the purpose of the initial inquiry and client's needs • Process is easy, timely and simple regardless of the channel • Professional providers, referral sources and clients feel confident they have connected with the right place and know what will happen next to clients • Responses are equitable and culturally-appropriate	• Skilled **Intake Worker** to receive first inquiry (e.g., customer-service orientation, some clinical understanding of MH sector, service navigation skills, etc) • Technology and IT infrastructure to support multi-channels and document information received • Training on common messaging/processes
Sharing information	• Determining whether client meets eligibility criteria • Documenting information received in the call • Collecting client/family consent for next steps • Understanding the client's preliminary needs		• Understanding whether client meets defined eligibility criteria for the full range of MH services • Client information is collected using simple, accurate and consistent language	• Skilled **Intake Worker** • Technology, IT systems and data collection/ documenting systems • Understanding of process • Clear inclusion and exclusion criteria for the full range of MH services

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Entry Point

Entry Point refers to the first point of contact for professional providers and families to get access to general information about available services. It includes the various channels by which people would first interact with the system.

Key Functions	Definition (What does it mean?)	Key Parameters	Purpose (what are its intended outcomes?)	Resource Requirements
Placing the client within the appropriate service pathway	• Understanding the client's preliminary needs and their readiness for mental health services • Assessing the risk-level	• Similarly, operates normal business hours and with off hours, and leverages multi-channels.	• Client and referral sources know the client's direction and next steps • Warm hand-offs and transfers are made where appropriate	• Skilled **Intake Worker** • Technology and IT systems for transitions • Understanding of process, CSP network and MH system • Inventory of available MH services and their eligibility parameters

Staffing for Entry Point

Below are the key takeaways regarding the ideal staff (i.e., highly-skilled Intake Worker) for the Entry Point.

Key Takeaways:

- A highly-skilled **Intake Worker** receives the initial contact or inquiry, discusses the preliminary needs with the client of family and validates that the infant/child/youth likely belongs in the infant, child and youth mental health services pathway and redirects them if not.
- The rationale for a highly-skilled Intake Worker is to ensure that eligible clients get triaged, assessed, and resource matched with the appropriate services as quickly and efficiently as possible.
- The Intake Worker is an employee of the Lead Agency that administers the function.
- ***Some of the key competencies and expertise of the ideal highly-skilled Intake Worker are:***
  - Customer-service orientation and strong interpersonal skills;
  - Deep clinical understanding of mental health – i.e., someone with significant clinical training who understands clinical language coming from different sectors, and who understands the key clinical questions that need to be answered;
  - Understanding of mental health sector/system, particularly in Toronto
  - Service navigation skill ; and
  - Some staff should have bilingual capacity.

Technology for Entry Point (incl. Referral Form)

Below are the key takeaways regarding the ideal technology required for the Entry Point.

Key Takeaways:

- Entry Point requires a **robust, centralized IT platform** (i.e., an online platform) that allows for proper information sharing while protecting client confidentiality. The online platform should also be able to support multi-channels communications with clients, CSPs and other providers.
- The centralized IT platform would also allow for two-way communication between the central entry point and the referring individual, agency or organization.
- ***Some of the key characteristics of the ideal centralized technology platform are:***
    - Overlay and inter-operability with other technologies used by providers;
    - Compliance with privacy, confidentiality and security (e.g., only the right people have access to it, and security audits can be easily done);
    - Allows for multi-channel interactions (e.g., online website, chat, phone, etc);
    - Generates reports, business intelligence and data to better understand retrospective trends);
    - Allows for safe storage of supporting documents;
    - Has a mechanism for clients to receive information or to see a status update of their path/process.
- As previously noted, the ideal technology solution is not yet in use in the system, and part of the proposed implementation work is to assess potential technology solutions that would fit the requirements of the model. Optimus recommends conducting an environmental scan and evaluation of technology platforms already in use by other agencies/sectors. **Ocean** is provided as an example of a centralized technology platform that could be used for the model, however, further analysis and review is required.

Tools and Data Transfer for Entry Point

Below are the key takeaways regarding the ideal tools and data transfer/retention mechanisms required for the Entry Point.

Key Takeaways regarding Tools:

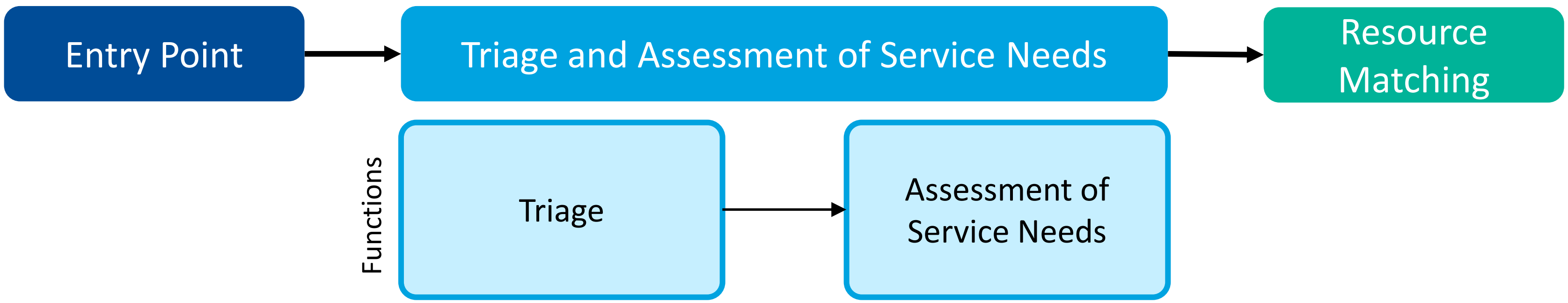
- There should be common tools for the Entry Point that are designed collaboratively, and providers have a strong mandate to use them on a consistent basis. This includes common communications, messaging and branding about the Entry Point and how to access it.
- If leveraging a centralized IT platform, there is also an opportunity to implement an automated response acknowledging receipt that an inquiry has been received (if applicable) and informing the client, family and/or referring provider on where they/the client is in the process.
- ***The key information that should be included in the referral form include:***
  - Client's clinical diagnosis and/or need;
  - Client's service history (i.e., what services have been tried, why they haven't worked);
  - Relevant family history/context; and
  - Client/family choice.

Key Takeaways regarding Information Transfer and Retention (Data):

- A single record is set up for each client. The record is retained at Entry Point but is shareable with others in the clients' circle of care and is linked to the 'Help Ahead' system/pathway and/or to other access points.
- There needs be a rigorous process to collect only the essential client information, rather than collecting too much information that is not used. The process and mechanism needs to be efficient and timely, and purposeful in the data collected.

Triage and Assessment of Service Needs

Triage and Assessment are parts of a staged process to identify, confirm and categorize a clients' needs. Triage tends to be quicker, more cursory, and with the expectation that initial needs are easily identified, while assessment of service needs tends to be more extensive, requires higher-order skills and possible in-person interaction.



Key Takeaways:

- The two key functions included in this step are triage and assessment of service needs.
- An important aspect of both triage and assessment of service needs is the recognition for a step-up and step-down approach to services. This means a recognition that in the ideal model, children and youth start with the least intensive MH services before graduating to more rigorous ones, i.e., a consensus that the system should promote less intrusive services as the starting point for new clients in the system.

Triage and Assessment of Service Needs

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Key Functions	Definition (What does it mean?)	Key Parameters	Purpose (what are its intended outcomes?)	Resource Requirements
Triage	• Documenting initial information about a client's needs • Recognizing if a more in-depth assessment is required • Understanding/validating eligibility for child and youth mental health services	• The function may require a least intrusive approach in trying to match a client's needs to the services that may be available	• Validating client's eligibility and readiness for MH services • Transition to assessment of service needs forchild and youth mental health services	• Skilled **Intake Worker** to conduct triaging (e.g., some clinical skills, understanding of risk management) • IT infrastructure and data collection systems to document information received • Data to understand trends and support surge planning
Assessment of Service Needs	• Collecting detailed information about a client's needs • Documenting/updating client's information into a confidential client record and creating/ updating client's standardized information package • Developing preliminary ideas of child and youth mental health services that would match client's needs • Transferring client to resource matching and service pathway	• Same as above	• Deep understanding of client's clinical needs and broader family/external context • Collecting/validating information to ensure the infant/child/youth is placed with right service and provider • Engaging and building rapport with families in the co-ownership of next steps and service plan	• Highly-skilled **Clinical Assessor** to conduct assessment of service needs (e.g., in-depth clinical skills, highest degree of sophistication to understand other family context and client's holistic needs) • Common tool(s) for assessments

Staffing for Triage and Assessment

Below are the key takeaways regarding the ideal staff required for Triage and Assessment of Service Needs.

Key Takeaways:

- **Triage** should be conducted by the same **Intake Worker**, previously described for Entry Point. Specifically for Triage, the Intake Worker should have some understanding of the broad range of child and youth mental health services and be able to assess the client's initial needs, as well as further validate the client's eligibility for intake of MH services and determine next steps.
- **Assessment of Service Needs** should be conducted by a **Clinical Assessor**. This highly-skilled Clinical Assessor should have in-depth clinical skills, and the highest degree of sophistication to understand the family context/history, and to understand the client's holistic needs.
- The Clinical Assessor is mainly responsible for conducting a deeper assessment of service needs using an agreed upon standard tool within 14 days of the client being deemed eligible for MH-services. As noted, the Clinical Assessor is solely responsible for conducting the assessment function that ensures the child or youth is placed in the right service and provider.
- Similar to before, both the Intake Worker and the Clinical Assessors are employees of the agency that administers the function.

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Technology for Triage and Assessment

Below are the key takeaways regarding the ideal technology required for Triage and Assessment of Service Needs.

Key Takeaways:

- Both Triage and Assessment of Service Needs require a **robust, centralized IT platform** to store tools, document any client information and to collect/store any client documentation received.
- This is the same centralized IT platform as previously used for Entry Point, as some of its key features and characteristic requirements are still the same – e.g., client confidentiality/privacy, ease of usability, safe storage of client information/documents, ability to generate reports, etc.

Tools for Triage and Assessment

Below are the key takeaways regarding the ideal tools and data transfer/retention mechanisms required for Triage and Assessment of Service Needs.

Key Takeaways regarding Tools:

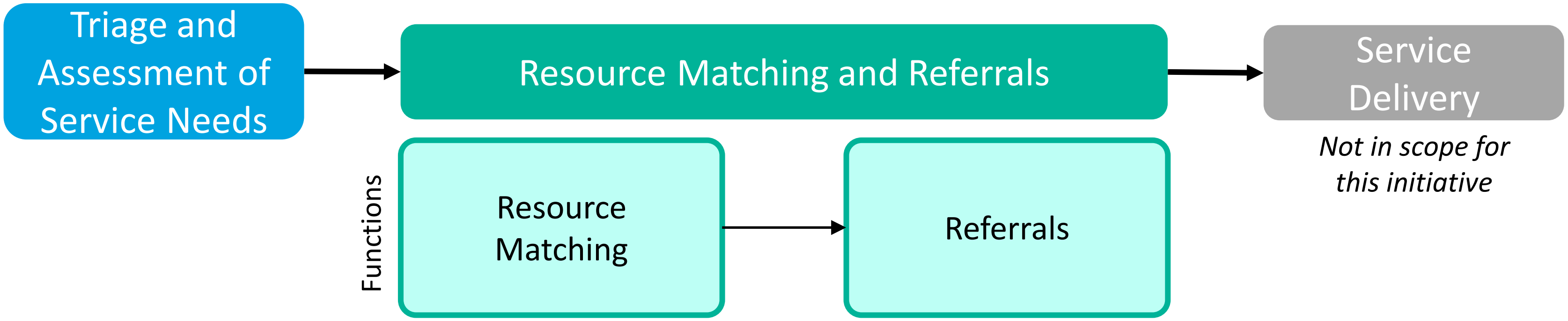
- For **Triage**, the Intake Worker (i.e., also responsible for conducting the Triage function), uses a common tool to conduct triage (specific tool still to be defined) There may be a need for this staff to receive specific training on the use of the common triage tool.
- For **Assessment of Service Needs**, the Clinical Assessor also uses a standardized tool to conduct the assessment and requires specific training on the use of the common assessment tool. The use of the common assessment tool will provide the foundational information for all agencies to build a service plan for each client.
- For both the common triage and assessment tools, there will need to be access in multiple languages.

Key Takeaways regarding Information Transfer and Retention (Data):

- Findings and information collected during the Triage and Assessment of Service Needs functions would be documented and updated into the client's record.
- It will also be important to utilize anonymized client data to better understand system trends and capacity, support waitlist management, and enable system planning.

Resource Matching and Referrals

Resource Matching is the process of matching specific resources/services to the person's needs once they are known. Typically requires clear eligibility criteria and accurate information on resources available.



Key Takeaways:

- Client choice and preference is an important aspect for resource matching, and there should be a review and appeal mechanism in place, specifically if a client gets matched or referred to a program or service that doesn't meet their needs.
- There needs to be a set policy and escalation protocol in place to ensure the infant/child/youth is accepted by the provider best positioned to serve the client. The mechanism needs to ensure that no client is denied access to the right services, if deemed appropriate.
- It will be important to ensure that information on the placement of clients is integrated into the KPIs and the data collection process of the model. This will ensure there is a robust evaluation of systems and processes, and that there is appropriate follow through on identified services for clients.

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Resource Matching is the process of matching specific resources/services to the person's needs once they are known. Typically requires clear eligibility criteria and accurate information on resources available.

Key Functions	Definition (What does it mean?)	Key Parameters	Purpose (what are its intended outcomes?)	Resource Requirements
Resource Matching	• Reviewing findings from the assessment of service needs • Understanding/validating client's eligibility for specific services • Developing a long list of service options to support the client based on need • Connecting clients to the right service~~s~~ and organization • Understanding client choice and preferences	• Key parameters that need to considered as part of resource matching include service/resource availability, wait times, location, costs, eligibility criteria, and acuteness of needs • Need to also consider that resource matching follow the 3 R's principle – right person, right place, right time (for the match that is made).	• Improved accessibility to services • Timely, seamless connections between the client and the service provider~~s~~ • Clients matched to the level of services/programs that meet their needs • Sustainable costs	• Skilled and trained **Service Navigator** staff with extensive knowledge on MH sector and services available • IT infrastructure to document information received and decisions/service matches made • Standardized mechanisms and common tools • Data on waitlist times and availability of services • Inventory of services, programs, locations, eligibility criteria and other details

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Resource Matching and Referrals

Resource Matching is the process of matching specific resources/services to the person's needs once they are known. Typically requires clear eligibility criteria and accurate information on resources available.

Key Functions	Definition (What does it mean?)	Key Parameters	Purpose (what are its intended outcomes?)	Resource Requirements
Referrals	• Understanding capacity/ wait times of programs and services that can address a client's needs • Adding clients to waitlist if appropriate • Connecting clients to providers, and provide a warm hand-off to the right service • Sharing information and documentation with providers • Understanding client choice and preferences • Escalating to a review and appeal process, if required (i.e., if a provider agency denies a matched or referred client)	• This function needs to strongly align with Service Navigation, and the support for clients and families while on waitlist, so that clients are not lost in the system • There should be a review and appeal process in place (from the client's perspective) in case the client is referred to a program that does not align with their needs, or that the provider agency is not well-suited to serve.	• Improved accessibility to services • Timely, seamless connections between CPI and service providers • Service providers receive referrals and clients that they can effectively serve • Clients enrolled in services and programs that address their needs and are aligned to their choices and preferences	• Same as above • Review and appeal mechanisms (mainly from the client perspective but also from the provider perspective)

Staffing for Resource Matching and Referrals

Below are the key takeaways regarding the ideal staff (i.e., trained Service Navigators) for Resource Matching and Referrals.

Key Takeaways:

- A skilled and trained **Service Navigator**, with extensive knowledge of the mental health sector and of services available, is responsible for the Resource Matching functions. The Service Navigator leverages a technology solution that contains information from the core service providers on service offerings and their service capacity. There should be a mutual responsibility between the Entry Point and the core service providers to ensure accurate information about current services and capacity to promote service timeliness and good outcomes for the client.
- When the Service Navigator (assisted by the technology asset) finds a service that matches a client's needs, and if capacity is open, there will be a discussion with the client and the provider agency (CSP) to confirm if it is a suitable match. However, there needs to be a balance between client choice and agencies taking on clients that align with their service offerings and capacity (e.g., it will not be realistic or equitable to place all clients in the same waitlist from a specific agency if that is their choice, when there are other core service providers with capacity that could take the client for service right away).
- Once a service match has been confirmed, the Service Navigator will either do a warm-transfer (if capacity is available) or send a placement request to the appropriate agency if required. Client data and documentation collected to date will be transferred to the agency delivering service to significantly reduce the need for clients to repeat their stories and to do repeated assessments.
- Some suggested that the Service Navigator could be a skilled Child and Youth Worker (CYW) or someone with a Bachelor or Masters of Social Work (BSW or MSW), as well as someone with comprehensive knowledge and experience working in the community mental health and wellness sector broadly and regionally.
- Similar to other roles, the Service Navigator is an employee of the agency that administers the function.

Technology for Resource Matching and Referrals

Below are the key takeaways regarding the technology required for Resource Matching and Referrals.

Key Takeaways:

- The service/resource match is identified through a **technology platform** that has real-time data on each CSP's capacity and vacancies.

- The service match and referral functions also require a **robust, centralized IT platform** to document any client information or updates, such as matched resources, waitlisted services, and referrals sent.
  - This should be the same centralized IT platform as previously used for Entry Point, Triage and Assessment of Service Needs, as some of its key features and characteristic requirements are still the same – e.g., client confidentiality/privacy, ease of usability, safe storage of client information/documents, ability to generate reports, etc.

Tools for Resource Matching and Referrals

Below are the key takeaways regarding the ideal tools and data transfer/retention mechanisms for Resource Matching and Referrals.

Key Takeaways regarding Tools:

- Resource matching requires real-time (or at least regularly updated) information on each CSP's capacity and vacancies as per SLA agreements. This includes information/data on inventory of services and descriptions, service locations, eligibility criteria, waitlist times, availability of services, and other details to help ensure client's get matched to the appropriate resources that meet their needs.

Key Takeaways regarding Information Transfer and Retention (Data):

- Outcomes and discussions from the Resource Matching and Referral functions would be documented and updated into the client's record (i.e., same one as previously used for Entry Point, Triage and Assessment functions).

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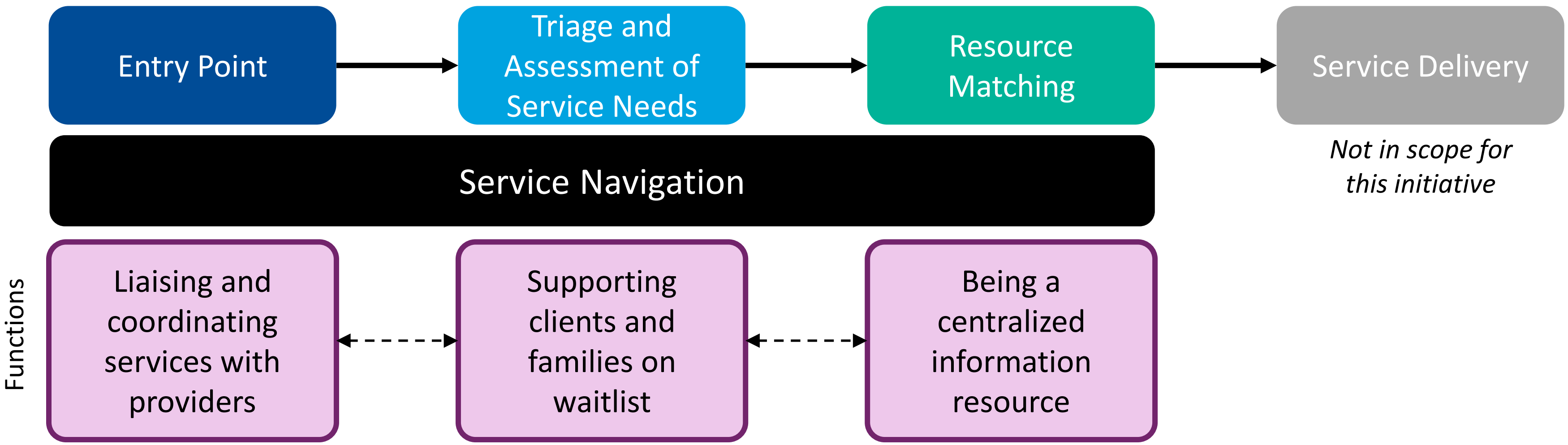
Service Navigation

Service Navigation is the process of helping clients and families understand and navigate the complex system of MH supports and services. It links clients and families to the required health, mental health and community services based on need, and coordinates care/services, leading to a more holistic, person-centred approach to service delivery. It is also the process of being an independent advocate, acting on behalf of children and families.



Key Takeaways:

- The three key functions included in Service Navigation are liaising and coordinating services with CSPs; supporting clients/families while on the waitlist; and being a centralized information resource.
- Service navigation is a process that happens in conjunction with and during the entire access process including Entry Point, Triage and Assessment of Service Needs, and Resource Matching and Referrals. It does not follow a sequential pathway similar to the other model parameters.
- Key aspects of service navigation are being the key point of contact between clients, families and providers throughout the client journey, as well as having the tools, data and expertise to have a holistic understanding of the MH sector and the services available within the system.

Service Navigation

Key Functions	Definition (What does it mean?)	Key Parameters	Purpose (what are its intended outcomes?)	Resource Requirements
Liaising and coordinating services with providers	• Developing/validating a service plan for client • Knowing services, programs, system capacity and wait times very well • Knowing providers that can best serve children/youth based on availability, location and client's needs • Sharing information and documentation collected to date with providers • Supporting clients and families through entire process	• The function will operate on regular business hours but some coordination on evenings and weekends may be important for some families. Not a 24/7 function.	• Understanding of system trends, gaps, capacity, availability and constraints • Clear understanding of services available • Clients fit for program/ services (e.g., knowing who is in each program and whether client will work well with existing group) • Enhanced practices/ sharing of best practices between providers	• Skilled and trained **Service Navigator** staff, potentially a CYW or BSW, with experience working in the community MH sector, particularly in Toronto • Technology and IT infrastructure to support information exchange, coordination and collaboration with providers across multiple channels • Data on waitlist times (ideally, in real time) and availability of services

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Service Navigation

Key Functions	Definition (What does it mean?)	Key Parameters	Purpose (what are its intended outcomes?)	Resource Requirements
Supporting clients and families on waitlist	• Sharing links to webinars, reading materials, articles and other resources that clients and families may find helpful while on waitlist • Staying regularly connected and providing updates to clients and families • Promoting peer support groups for parents/families • Understanding whether client's needs change while on waitlist (e.g., step-down) • Acting as a touchpoint liaison when client placements breakdown and/or throughout difficult transitions in and out of services	• The function will operate during normal business hours, but some support on evenings and weekends may be beneficial given families' availability. • The function will require a combination of higher and lower-touch modalities (e.g., in-person, informal calls, email, chat function)	• Clients and families feeling supported/connected while waiting for services • Clients and families having access to other resources to help them cope • Understanding of whether something changes in clients' circumstance while on the waitlist (e.g., become more/less acute, withdraw referral, etc) • Being a resource broker, and understanding other social determinants impacting the client or family while waiting	• Same skilled person as above • Technology and IT infrastructure to enable connection with families through multiple-modalities (e.g., text, phone, email)
Being a centralized information resource	• Sharing MH system knowledge • Understanding system resources, services, capacity available and wait times • Knowing inclusion and exclusion criteria for services	• Same as above	• Reducing barriers for clients, families and providers hoping to access the full range of MH services • Holistic understanding of MH system • Ability to provide information and share knowledge in a timely way	• Same skilled person as above • Data on waitlist times (ideally, in real time) and availability of services • Inventory of services, programs, locations, eligibility criteria and other details

Staffing for Service Navigation

Below are the key takeaways regarding the ideal staff ideal staff (i.e., trained Service Navigators) for Service Navigation.

Key Takeaways:

- A skilled and trained **Service Navigator** (i.e., the same one as previously described for Resource Matching and Referral functions) stays in touch with the client/family once an inquiry has been made and provides regular updates on where the client's journey is and what are the expected next steps (if appropriate).
- They also provide updates to the referral source on the status of the referral and where the client is in their journey towards mental health services.
- As previously noted, the Service Navigator is an employee of the agency that administers the function.

Technology for Service Navigation

Below are the key takeaways regarding the ideal technology required for Service Navigation.

Key Takeaways:

- Service Navigation requires a **robust, centralized IT platform** (i.e., an online platform) that allows for proper information sharing while protecting client confidentiality. The Service Navigator will use this technology platform to document any interactions with the client, family, CSPs and/or other providers.
- The online platform should also be able to support multi-channels communications with clients, CSP and other providers. This includes:
  - Information exchange with clients/families through multiple modalities; and
  - Coordination, collaboration and information exchange with providers through multiple modalities.

Tools for Service Navigation

Below are the key takeaways regarding the ideal tools and data transfer/retention mechanisms for Service Navigation.

Key Takeaways regarding Tools:

- Similar to resource matching, service navigation also requires each CSP's information/data on inventory of services and descriptions, service locations, eligibility criteria, waitlist times, availability of services, and other details to keep clients, families and providers informed about a client's journey through child and youth mental health services.
- As previously described, there should be a mutual responsibility between the Entry Point and the core service providers to ensure accurate information about current services and capacity to promote service timeliness and good outcomes for the client.

Key Takeaways regarding Information Transfer and Retention (Data):

- Interactions with clients, families and/or providers would be documented and updated into the client's shared record (i.e., same one as previously used for Entry Point, Triage and Assessment, and Resource Matching and Referral functions).

6

Recommended Operational and Governance Model

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High-Level Model Parameters

The recommended model for centralized access to infant, child and youth mental health services in Toronto has four key parameters: **Entry Point**, **Triage and Assessment**, **Resource Matching and Referral**, and **Service Navigation**. Note that Service Delivery is not in scope for this initiative.

Service Navigation: the process of helping clients and families understand and navigate the complex system of MH supports and services. It links clients and families to the required, mental health and community services based on need, and coordinates care/services, leading to a more holistic, person-centred approach to service delivery. It is also the process of being an independent advocate, acting on behalf of children, youth and families.

Service Navigation

Entry Point → Triage and Assessment of Service Needs → Resource Matching and Referral → Service Delivery *(not in scope for this initiative)*

Entry Point: the first point of contact for families and professional providers to get access to information about available services. It includes the various channels by which people would first interact with the system. Key functions included are receiving the first inquiry, sharing information, and sending client in the right direction.

Triage and Assessment: parts of a staged process to identify, confirm, categorize and prioritize a clients' needs. **Triage** tends to be quicker, more cursory, and with the expectation that initial needs are identified, while **Assessment of Service Needs** tends to be more extensive, requires intake skills and possible in-person interaction.

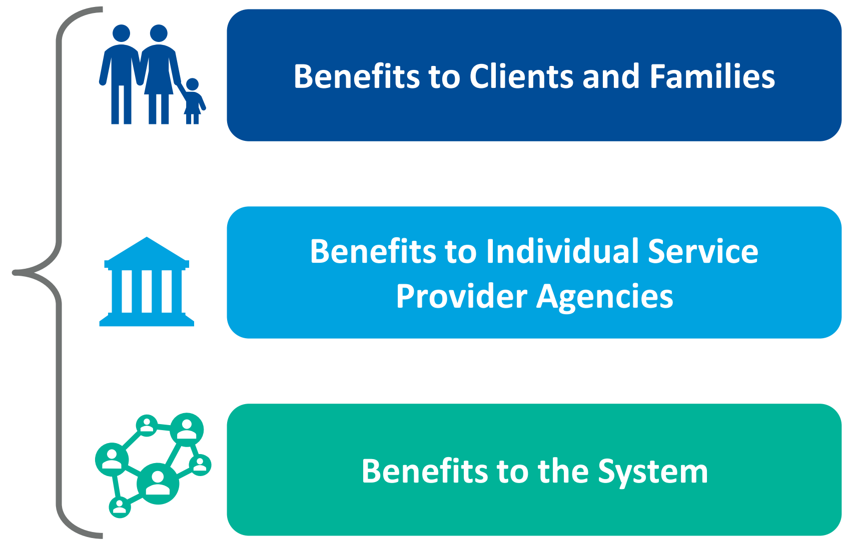
Resource Matching: the process of matching specific resources/services to the person's needs once they are known. Typically requires clear eligibility criteria and accurate information on resources available. The client can contribute to decision making and can exercise choice. **Referral**: a referral to another provider, which typically does not involve resource matching.

Centralized Governance Model

Optimus SBR recommends a **centralized governance and operational model** for access to infant, child and youth mental health services, as it brings several benefits to clients, families, and the system, and is strongly aligned to the model's key guiding principles.

A **Centralized Governance Model** is a governance/ operational model where only one of the provider agency oversees and administers all aspects of the centralized point of intake model for services.

This includes operational responsibilities on the staffing, technology, tools, reporting, evaluation, communication and promotion of the model, plus central coordination to support the partnership.



Informed by best practices and the desired objectives/outcomes of the model, Optimus SBR recommends that governance, administration and delivery of the model be housed with **the Lead Agency for infant, children and youth mental health in Toronto**. This is in alignment with the Lead Agency's mandate for developing and operationalizing system-wide changes to improve access, experience and mental health outcomes for Toronto's diverse communities.

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System Alignment

In addition to the benefits listed in the previous slide, a centralized governance and operational model led by the Lead Agency is strongly aligned to broader transformation initiatives in Ontario's mental health sector, such as 811 Health Connect Ontario.

Client and Families
Core Service Providers
Education
Child Welfare
Justice
Broader Healthcare
Other Stakeholders

Help Ahead

'Help Ahead' Central Point of Intake for Child and Youth Mental Health Services → Service Delivery of Child and Youth Mental Health Services

Entry Point and Navigation for **<u>Intensive</u>** Child and Youth Mental Health Services → Service Delivery of **<u>Intensive</u>** Child and Youth Mental Health Services

Entry/Access Point for Other Related Services → Service Delivery of Other Related Services

A centralized governance and operational model also aligns to other existing successful models with similar intake functions, such as triage/screening, assessment, and resource matching. Please refer to the Appendix for a brief description of similar select comparable intake models.

7

Implementation Plan

Overview of Implementation Activities

Optimus SBR has identified various activities required for the successful implementation of the entry-point model, per our recommended future state. Some activities will be the sole responsibility of the Lead Agency as the oversight and administrator for the model, while other activities will require an interdisciplinary, multi-agency working group to provide input and/or support.

Lead Agency Activities:

Branding, Promotion and Communications

Activities to raise awareness about the central point of intake, incl. ensuring stakeholders are informed about any changes to processes.

Staffing

Activities to define the staffing requirements and capabilities, and to source, recruit, retain and train the staff delivering the entry model functions.

Technology

Activities to identify the ideal technology solutions that meet that meets the model requirements/functions and allows for proper, safe information sharing.

Change Management

Activities to ensure Change Management principles and strategies are applied in order to continue building support for the model and enable its transformation.

Building Knowledge of CSP Services

Activities to ensure that appropriate staff at the Entry Point gain a deep understanding and familiarity of the full range of programs and services that are offered by each CSP.

Working Group Activities:

Strategy and Governance

Activities to develop formal contractual relations between those funding, delivering, and supporting the model, and define how partners will work together.

Tools and Eligibility

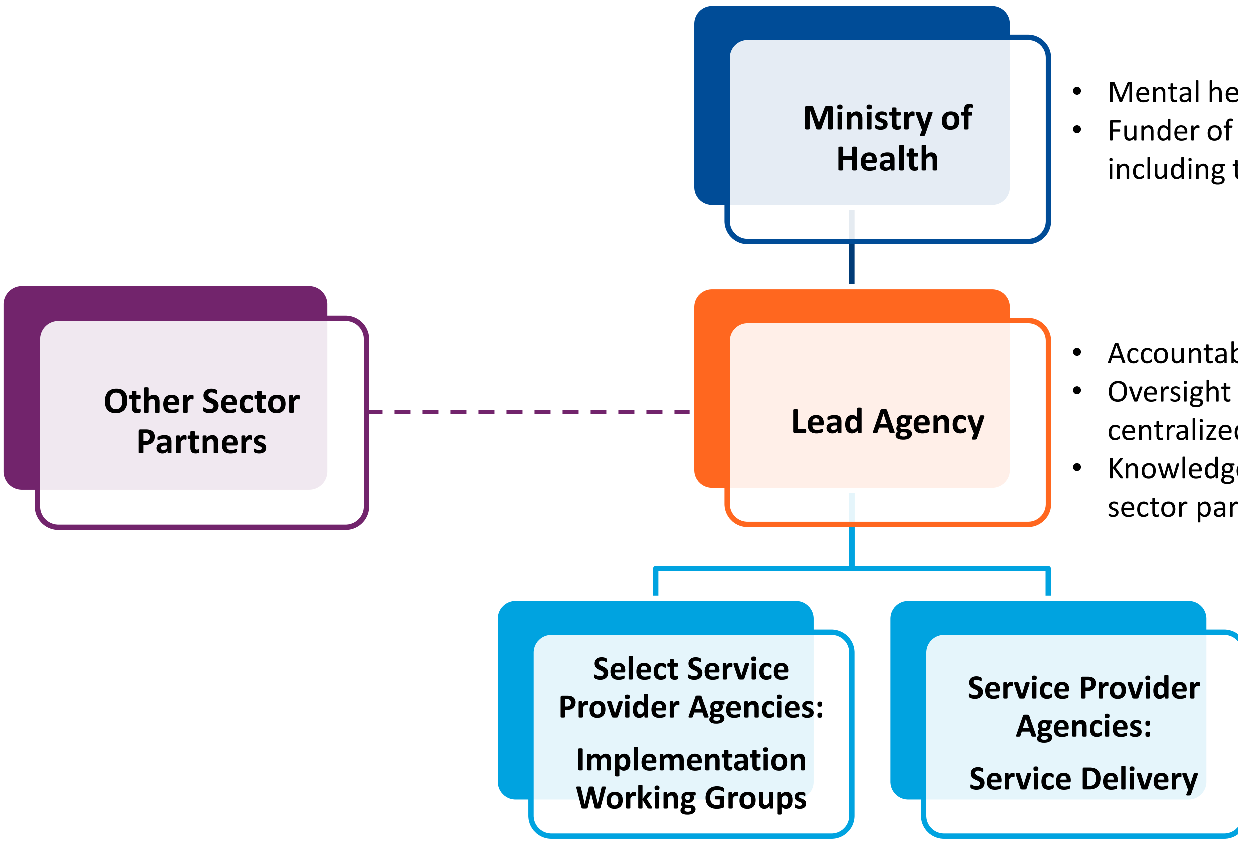
Activities to identify standardized tools that will be used to operationalize the identified model functions.

Data, Reporting and Evaluation

Activities to identify and/or create mechanisms that enable accountability, transparency, understanding of system strengths and areas for improvement.

Implementation Governance Structure

The following illustration represents the proposed governance structure for the Central Point of Intake to infant, child and youth mental health services.



Ministry of Health

- Mental health system oversight
- Funder of child and youth mental health services, including the entry point and navigation

Lead Agency

- Accountable for overall system planning
- Oversight and administration of all aspects of centralized point of intake model for services
- Knowledge exchange and coordination with other sector partners, as required

Select Service Provider Agencies: Implementation Working Groups

Participation in some implementation working groups related to the centralized point of intake model for child and youth mental health services (i.e., Strategy and Governance, Staffing, Tools, and Data, Reporting and Evaluation)

Service Provider Agencies: Service Delivery

Service delivery for child and youth mental health services

Change Management

Change Management

Description: Activities to ensure Change Management principles and strategies are applied in order to continue building buy-in and support for the model and system transformation.

Implementation Activities:

1. Develop a Change Management Framework to create/sustain buy-in and support for the entry point model amongst partner provider agencies.
2. Apply an action-focused Change Management Framework to mitigate potential issues related to inter-agency dynamics, and organizing people around the new model.
3. Develop communications and key messages grounded on change management principles for providers, partners and other stakeholders.

Responsibility: Lead Agency	**High-Level Timelines**: Fiscal Q1 – Q2 for core planning and initial activities (plus a number of ongoing initiatives to promote sustainability)

Dependencies and Considerations:

- While the specific activities noted above are likely to occur in the near term (i.e., next 1-2 months), it is important to consider that change management principles and practices will need to be applied on an ongoing basis pre- and post-launch of the model. The recommended model is a significant shift from how individual core service providers currently conduct entry to infant, children and youth mental health services, and the successful implementation of the model will require providers to continuously build trust amongst each other, which will take time.

Branding, Promotion, Communications

Branding, Promotion and Communications

Description: Activities to define the entry model's branding and raise awareness about the entry point, including ensuring stakeholders are informed about changes to processes and tools.

Implementation Activities:

1. Define branding for the model of the new 'Help Ahead' central point of intake.
2. Develop a Marketing and Promotion Strategy, as well as key messages and promotional materials about the model.
3. Launch communications and education with provider agencies delivering mental health services, as well as with School Boards, healthcare providers and others who may refer clients to the entry point for child and youth mental health services.
4. Develop a Client and Family Engagement Framework, outlining mechanisms and opportunities for engagement during model launch as well as an ongoing strategy for continuous improvement (e.g., experience surveys).

Responsibility: Lead Agency, with likely some services from a professional marketing firm	**High-Level Timelines**: Fiscal Q2 – Q3

Dependencies and Considerations:

- Consider an opportunity to align the branding and promotion strategy of the new 'Help Ahead' (central point of intake) model with the strategy for the intensive model as they have similar implementation timelines and are targeting similar audiences.
- Also consider that with a single point of entry, promotion and awareness of the model will be key to its success, as a broad range of stakeholders from varied sectors will need to have a clear understanding of its purpose, mechanisms, and processes/tools for accessing it.
- Activities related to branding, promotions and communications may require some financial investment.
- Children, youth and families will need to be engaged to understand their preference related to how they receive promotion and communications about Help Ahead.

Staffing

Staffing

Description: Activities to define the staffing requirements and capabilities, and to source, recruit, retain and train the staff delivering the model functions.

Implementation Activities (i.e., Working Group Mandate):

1. Define a competency framework and develop job descriptions for staffing required (e.g., Intake Worker, Clinical Assessor, Service Navigator and others- this includes identifying and/or validating the required skills, certification and knowledge base for the roles.
2. Assign existing staff and/or recruit and hire new staff to the required roles (as applicable).
3. Provide training and supporting educational materials to staff.
4. Develop a longer-term staff retention strategy to ensure sustainable staffing of the model.

Responsibility: Lead Agency, with potentially some input from select core service providers as needed; may also require some input on HR-related matters	**High-Level Timelines**: Fiscal Q1 – Q3

Dependencies and Considerations:

- Staffing implementation activities #1-3 are critical and **<u>must</u>** be in place prior to the model launch. Selection of staff with the appropriate skills, capabilities and training will play a key role in ensuring a positive, streamlined experience for clients, families, providers and others interacting with or referring to the model.
- Consider opportunities to leverage job descriptions and documentation from organizations that already conduct regional or local single-point-of-entry and perform similar responsibilities to the ones outlined in the model.
- Engage with patient and or family advisors to create a panel that will assist with recruitment of appropriate staff for the model.

Technology

Technology

Description: Activities to identify the ideal technology solution that meets the entry model requirements and functions and allows for proper, safe information sharing.

Implementation Activities:

1. Articulate the business requirements of the desired technology solution in significant detail.
2. Conduct an environmental scan of available technology solutions and assess the interoperability of potential technology solutions with existing solutions currently used by providers e.g., as part of the scan, look closely at the ROCK model in Halton, which utilizes effective technology to support their intake functions.
3. Select and contract the preferred technology vendor and implement the technology solution.

Note – the technology chosen should support the development of integrated documentation across sites and providers, if possible. This will be in the best interest of supporting robust client experiences, and documentation of services and outcomes.

Responsibility: Lead Agency only	**High-Level Timelines**: Fiscal Q3 – Q4 (or later)

Dependencies and Considerations:

- While the selection and implementation of the ideal technology solution is not critical to the model launch, it will bring several efficiencies, including minimizing the time/effort required for manual processes and administrative tasks. It will also streamline sharing of client information and understanding of system gaps, capacity and constraints.
- The rollout of the model could happen without the ideal technology solution in place, with a plan to implement it over time. It is also important to consider that its implementation will need to be accompanied by appropriate training and troubleshooting support for staff using the technology for different functions.
- Feedback on the user experience related to potential technology solutions will be necessary to identify optimal solutions.

Building Knowledge of CSP

Building Knowledge of CSP

Description: Clinical Assessors and/or Service Navigators need to have in-depth knowledge of the full range of programs and services that are provided by the complete list of Core Service Providers in the Toronto area. This knowledge will enable them to match client needs to the right program or service.

Implementation Activities:

1. Staff who will be conducting Resource Matching must be fully aware of the options available to children, youth and families to ensure that the process of matching specific resources/services to the person's needs is handled accurately and smoothly.
2. Each Clinical Assessor and/or Service Navigator should be assigned 5 to 10 CSPs of which they are required to become intimately familiar with each CSPs eligibility criteria and the full complement of programs and services that are offered by this specific CSP.
3. Once each Clinical Assessor and/or Service Navigator has gained this deep knowledge, the group of Assessors and Navigators should meet on a regular basis as a team to share this knowledge and to update their team members on any new service offerings by any of the CSPs.

Responsibility: Lead Agency only	**High-Level Timelines**: Fiscal Q3 – Q4 (or later)

Dependencies and Considerations:

- It is likely that the Clinical Assessors and/or Service Navigators will come to the Central Point of Intake will some experience in intake processes and knowledge of the current service system and its CSPs. This knowledge can be used as a starting point for the assignment of staff to learn about each CSP
- The successful implementation of building knowledge of the CSPs will require providers to continuously build trust with the Central Point of Intake, which will take time.

Strategy and Governance

Strategy and Governance

Description: Activities to develop formal contractual relations between those funding, delivering or supporting the model, and defining how partners will work together.

Implementation Activities (i.e., Working Group Mandate):

1. Further define the major service parameters and smaller entry features (as required) and understanding the inventory or services available across the system.
2. Organize funding allocations.
3. Develop service level agreements (or similar) and undertake contracting using a formal MOU.
4. Define mechanisms for conflict resolution, and for the review and appeal mechanism.
5. Define a decision-making framework.

Responsibility: Interdisciplinary, multi-agency Working Group	**High-Level Timelines:** Fiscal Q1 (primarily), potentially some fiscal Q2 if required

Suggested Working Group Composition: Lead Agency, plus Ministry/funder leaders, and senior-level leaders and representatives from select core service providers who deliver a significant amount of child and youth mental health services in Toronto. This working group may also require legal advice at times.

Dependencies and Considerations:

- These implementation activities are critical and **must** be in place prior to the model launch. Decisions/outputs from this group will have an important role in informing and influencing the implementation activities in the other working groups, and will be equally as critical to defining how partners and broader stakeholders will work together to realize the shared vision of the model.
- Also consider an opportunity to align the strategy and governance initiatives for the new 'Help Ahead' (central point of intake) model with the intensive services entry point, as ultimately, both models will need to intersect, with the entry to intensive model being a sub-stream/nuanced specialty of the broader 'Help Ahead' model.
- Ongoing patient and family advisory will be required to weigh into decision making.

Tools and Eligibility

Tools

Description: Activities to identify and/or develop the common tools that will be used to perform the identified model functions.

Implementation Activities (i.e., Working Group Mandate):

1. Define eligibility criteria/clinical checklist for child and youth mental health services. The Working Group should also establish age and capability levels for obtaining consent directly from children, youth and families.
2. Develop the standard referral form.
3. Define/develop the standard tool for the assessment of service needs.[1]
4. Create and distribute an inventory of child and youth mental health services, including list of providers, location, types of services/programs, capacity, eligibility, and other important program characteristics to support effective resource matching.

Responsibility: Interdisciplinary, multi-agency Working Group	**High-Level Timelines**: Fiscal Q2 – Q3

Suggested Working Group Composition: Lead Agency plus a representative group of core service providers, ideally at a Manager-level who understand both the operations and the clinical requirements for the tools.

Dependencies and Considerations:

- Implementation activities #1-4 are critical and **must** be in place prior to the model launch. It will be important that they are co-developed by a representative group of core service providers to create buy-in. Without general agreement on the tools, providers may have challenges trusting the information received from the entry point, which may result in duplicative effort and/or pushback in accepting eligible clients.
- While implementation activity #5 is not critical prior to model launch, it will enable timely, accurate, and effective resource matching, and will be important for understanding system gaps and constraints.
- Children, youth and families will need to be engaged to test and provide feedback related to available tools.

[1] Note that the assessment of service needs refers solely to the assessment function to ensure the child or youth is placed in the right service and provider.

Data, Reporting and Evaluation

Data, Reporting and Evaluation

Description: Activities to identify and/or create mechanisms that enable transparency, accountability and clear understanding of system strengths and constraints.

Implementation Activities (i.e., Working Group Mandate):

1. Establish a data collection/reporting process, including defining system-level information collected, reporting frequency and how information is used for overall system planning.
2. Create and implement an Evaluation Framework that focuses on quality, outcomes and client experience, as well as EDI, anti-racism and anti-oppression principles.
3. Develop a mechanism for regular performance management.
4. Develop a framework/mechanism for ongoing stakeholder engagement, feedback collection and continuous improvement.

Responsibility: Interdisciplinary, multi-agency Working Group	**High-Level Timelines**: Fiscal Q3 – Q4 (or later)

Suggested Working Group Composition: Lead Agency, plus Director-level research and evaluation representatives from select core service providers, and Ministry/funder representatives. May also want to consider including external research and evaluation SMEs (e.g., Wellesley Institute).

Dependencies and Considerations:

- While the implementation activities related to data, reporting and evaluation are not critical prior to model launch, they should be completed in early stages (i.e., within the initial months of model launch at most), as they enable transparency, accountability and clear understanding of system strengths and constraints. Without them, it will be challenging to realize some of the longer-term benefits of the model, including effective resource allocation, better waitlist management, and improved coordination across services.
- There is potential that there will be an opportunity to have a client voice incorporated ass an ongoing role in evaluation.

Implementation Plan

Prioritization of Implementation Activities

The following diagram summarizes and prioritizes the proposed implementation activities based on their ease of implementation and impact to clients, families, and the broader mental health system. We also advise that the working groups for the intensive and broader CPI initiatives be combined.

Lead Agency Activities

1. Change Management
E.g., develop and apply Change Management Framework, and develop communications and key messages based on CM principles

2. Branding, Promotion and Communications
E.g., define branding, develop Marketing and Promotion Strategy, launch communications, and develop Client Engagement Framework

3. Staffing
E.g., define competency framework, develop job descriptions, assign/hire and train staff, etc.

4. Technology
E.g., conduct environmental scan of technology solutions, and select/contract preferred solution

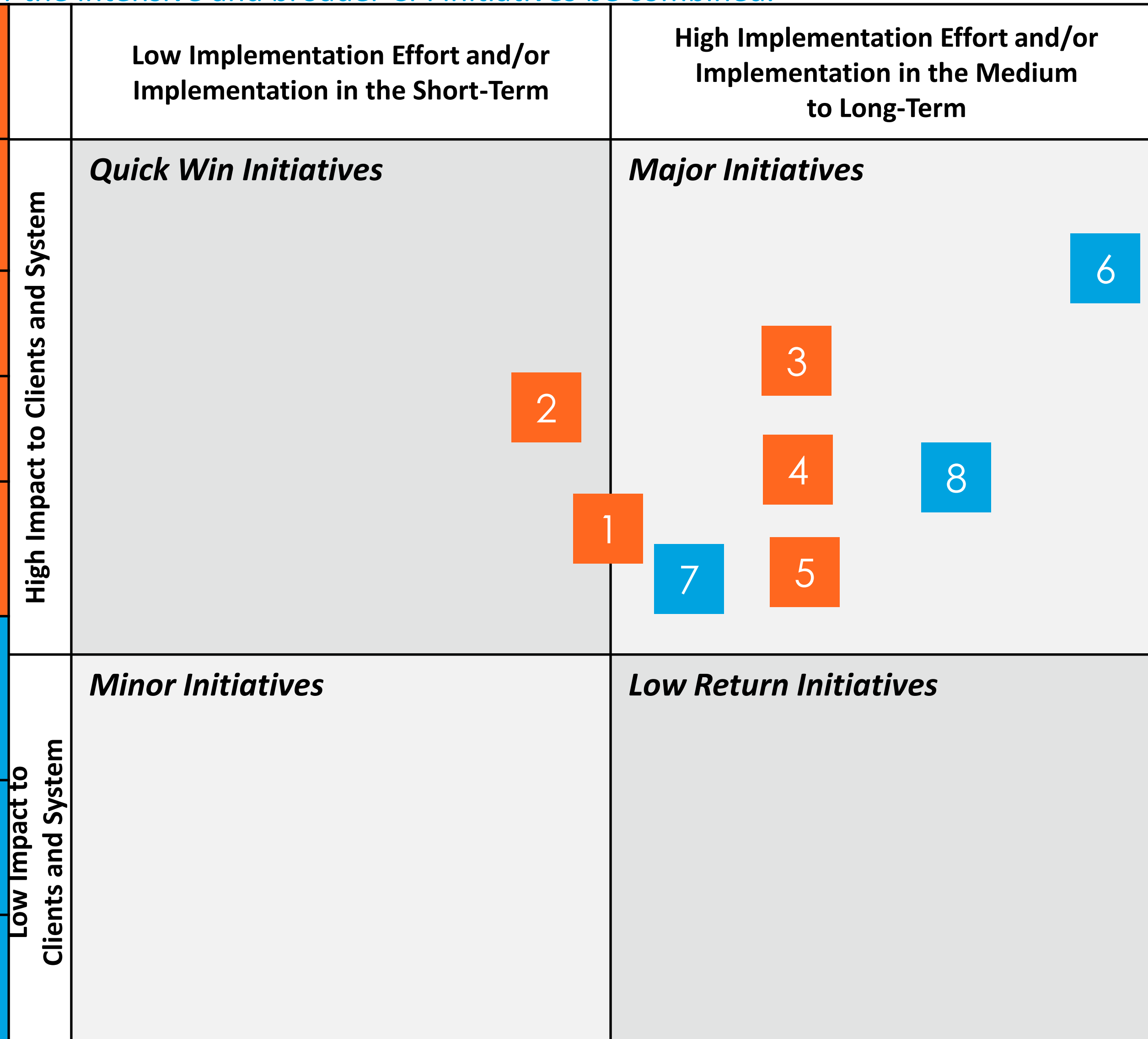
5. Building Knowledge of CSP Services
E.g., Activities to ensure that staff at the Entry Point gain an understanding the full range of programs and services offered by each CSP.

Working Group Activities

6. Strategy and Governance
E.g., further define service parameters, organize funding allocations, develop service level agreements (or similar), define mechanisms for conflict resolution and decision-making, etc

7. Tools
E.g., define eligibility clinical checklist, develop standard referral form, define standard tool for triage and assessment of service needs, etc

8. Data, Reporting and Evaluation
E.g., establish a data reporting process, create and implement Evaluation Framework, define mechanism for continuous improvement, etc



Executive Summary

Implementation Timelines

The following is the high-level timelines for conducting the implementation activities. We also advise that the working groups for the intensive and broader CPI initiatives be combined. Tentative launch would be Fall 2023.

Lead Agency Activities

1. Change Management
E.g., develop and apply Change Management Framework, and develop communications and key messages based on CM principles

2. Branding, Promotion and Communications
E.g., define branding, develop Marketing and Promotion Strategy, launch communications, and develop Client Engagement Framework

3. Staffing
E.g., define competency framework, develop job descriptions, assign/hire and train staff, etc.

4. Technology
E.g., conduct environmental scan of technology solutions, and select/contract preferred solution

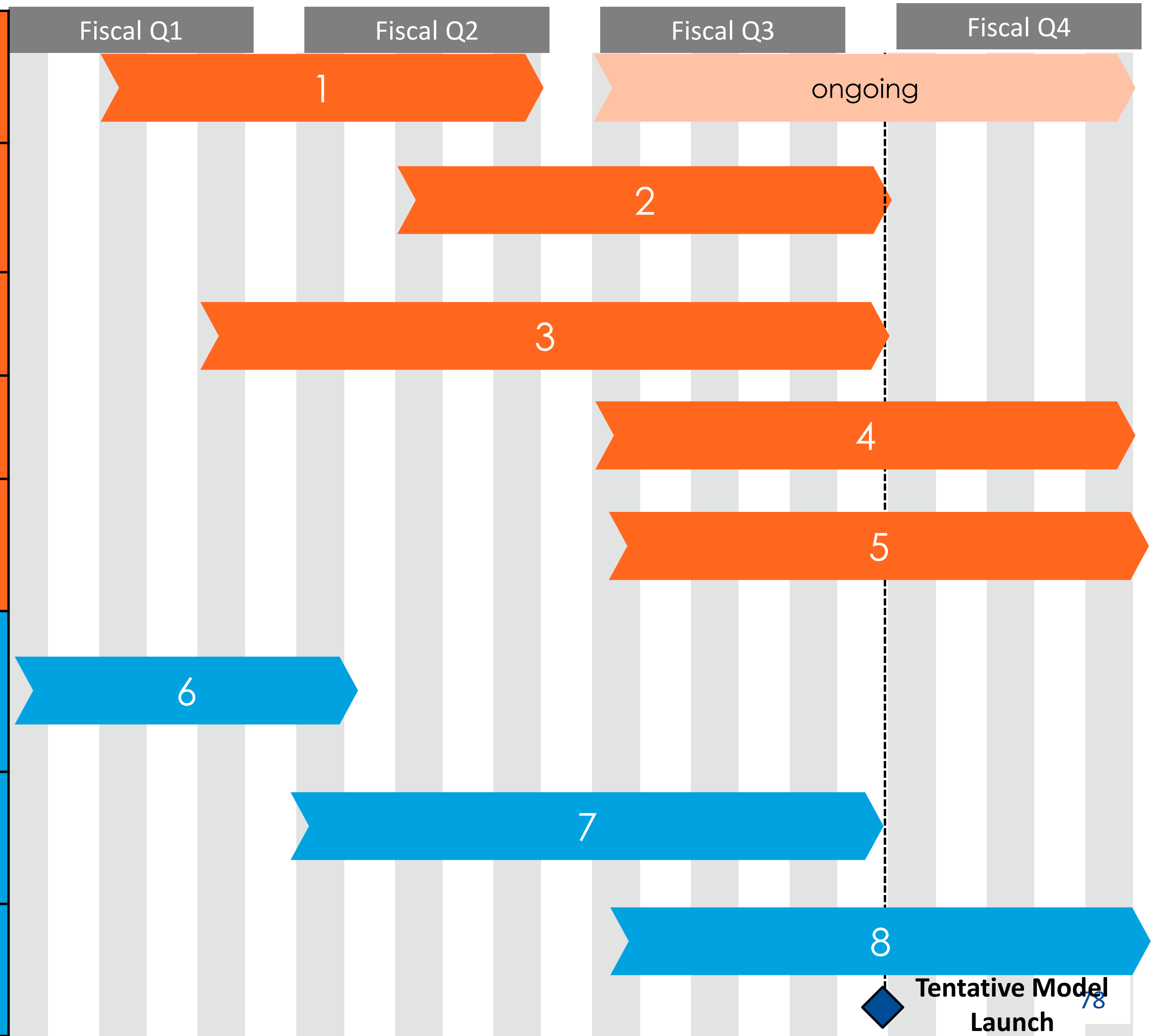
5. Building Knowledge of CSP Services
E.g., Activities to ensure that staff at the Entry Point gain an understanding the full range of programs and services offered by each CSP.

Working Group Activities

6. Strategy and Governance
E.g., further define service parameters, organize funding allocations, develop service level agreements (or similar), define mechanisms for conflict resolution and decision-making, etc

7. Tools
E.g., define eligibility clinical checklist, develop standard referral form, define standard tool for triage and assessment of service needs, etc

8. Data, Reporting and Evaluation
E.g., establish a data reporting process, create and implement Evaluation Framework, define mechanism for continuous improvement, etc



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Key Implementation Questions

Service inverntory:

- *How do we maintain an up-to-date service inventory to keep up with any service changes by CSPs?*

Age of consent:

- *At what age can a child or youth be offered service without the consent or knowledge of their parent(s)?*

8

Key Performance Indicators

Overview of Key Performance Indicators

Optimus SBR has developed a recommended listed of outcomes-based **Key Performance Indicators (KPI)** to track and measure progress towards the desired vision of the model. The following KPIs were developed in alignment with the model's guiding principles.

Client and Family Experience and Satisfaction

Metrics related to clients and families' overall experience with the central point of intake, including feeling that providers are treating them with dignity and respect, and are taking an interest in their history/background.

Response Time of Entry Point to the Right Service and Provider

Metrics related to the overall efficiency, effectiveness and timeliness of the entry point, including ensuring that clients are being matched and directed to the most appropriate service.

Partner and CSP Engagement and Satisfaction

Metrics related to the providers' overall experience accessing the entry points, including sharing of data and information, and feeling that providers are working collaboratively with their client's best interest in mind.

Knowledge, Understanding and Promotion of the Model

Metrics related to external partners, clients and families having a clear understanding on how to access the central point of intake for services should they need it.

Understanding of System Gaps, Capacity and Demand

Metrics related to data collection and reporting to help providers work better as a system and meet the needs of clients and families.

Note: Additional performance indicators may be tracked and reported on a regular basis as part of the implementation and ongoing operation of the central point of intake (CPI) model for child and youth mental health services.

Examples of Key Performance Indicators

Optimus SBR has developed a recommended listed of outcomes-based **Key Performance Indicators (KPI)** to track and measure progress towards the desired vision of the model. The following are examples of metrics and KPIs that should be regularly tracked and reported.

Client and Family Experience and Satisfaction

Metrics such as clients and families feeling:

- Their choices and preferences are addressed;
- Heard, understood and connected; and
- Clients' overall perception of the services received.

Partner and CSP Engagement and Satisfaction

Metrics such as CSPs experience:

- With the overall process (ease, timeliness, responsiveness, etc); and
- With knowledge transfer and data/information sharing mechanisms.

Response Time of Entry Point to the Right Service and Provider

Metrics such as:

- Answer rate/speed for outreach calls, emails and texts; and
- Click throughput and click conversation from website
- Average elapsed time between model functions (e.g., from triage to assessment of service needs, to resource matching, to service intake).

Knowledge, Understanding and Promotion of the Model

Metrics such as:

- Number of clients/families self-referring into the model;
- Number of referrals received from various referral sources (e.g., Mental Health providers, School Boards, physicians, other professionals); and
- Number of referrals received that meet eligibility criteria.

Understanding of System Gaps, Capacity and Demand

Metrics such as:

- Number of children/youth receiving MH services, by program, geography, age, etc;
- Average wait time for MH services; and
- Trends related agency-specific referral acceptance/declines.

Note: Additional performance indicators may be tracked and reported on a regular basis as part of the implementation and ongoing operation of the central point of intake (CPI) model for child and youth mental health services.

10

Appendix

- Sample Job Description for Intake Worker
- Examples of Similar Models
- Findings from Environmental Scan
- Findings from Stakeholder Focus Groups
- Findings from Risk Register and Voice of the Client

Sample Job Description for Intake Worker

The following is a **sample** job description for the Intake Worker. It was developed leveraging the existing job description for similar role for the Complex Special Needs Program at Lumenus.

Summary of Qualifications and Experiences:

- MSW or equivalent education and experience working with child and youth mental health services, and their families
- Experience in counseling, consultation and advocacy

Summary of Skills and Knowledge:

- Superior knowledge of medical, psychiatric, psychological, developmental diagnoses and their impact on managing complex children in the community
- Superior assessment skills with particular emphasis on assessing risk and potential for family breakdown
- A demonstrated commitment to both excellent clinical and community-centered work
- Demonstrated ability to work independently and within a team environment
- Highly developed communication skills, both written and oral
- Interpersonal skills, including advocacy, consensus/team building, facilitation, negotiation and conflict resolution
- Ability to manage in a fast-paced environment, juggle multiple priorities while adhering to expected timelines
- Ability to understand budgeting concepts

Summary of Behavioural Competencies:

- **Client Focus:** Anticipates and adapts to client needs
- **Teamwork:** Fosters teamwork
- **Communication and Interpersonal Relations:** Adapts communication style and methods to suit different people
- **Quality, Innovation and Change:** Continuously strives to meet or exceed personal, organizational and program goals and objectives. Actively seeks improvements to program/service outcomes/process
- **Problem Solving and Decision Making:** Employs advanced problem-solving techniques, analyzing and interpreting information accurately before making decisions
- **Results, Orientation and Maintaining Direction:** Develops and implements plans within area of responsibility and ensures the delivery of excellence
- **Personal and Team Development:** Manages own and team performance; provides coaching, feedback and support for individual and team development
- **Organizational and Environmental Awareness:** Continuously aligns position to overall objectives of the organization
- **Negotiation:** Considers the audience to customize an approach that will gain support
- **Resource and Fiscal Management:** Makes positional decisions that align with organizational resource and financial limitations.

Appendix

Examples of Similar Models

The following section provides a high-level description of similar centralized intake models in Ontario.

While the models highlight similar intake functions, such as triage/screening, assessment, and resource matching, it is important to note that no model is entirely identical to the one being recommended for mental health services.

Optimus SBR recognizes the model for centralized intake for infant child and youth mental health services in Toronto is unique, given the specific population group it serves. However, there are best practices and similarities from other successful models that were considered for the design and implementation of this one.

Examples of Successful Similar Models

Mississauga Halton Central Intake Program – one-Link		
Description: The Mississauga Halton Central Intake Program is for individuals who have specific needs including mental health and addictions (one-Link). All services can be accessed by physician and healthcare provider referral, and limited services are available through self-referral.		
Summary of Intake Functions: Information • Intake • Screening • Assessment • Resource Matching • Referral Management		
Basket of Services: Addictions and Mental Health, Diabetes, Diabetes Foot Care, Musculoskeletal issues		
Governance:		
Oversight: MH LHIN	**Funding**: MH LHIN via Halton Healthcare Services	**Number of Partners**: 16
Organizational Structure:		
FTEs: Resides within MH LHIN	**Staff Type:** (not available)	
Operations:		
Number of Locations: 1		
Technology/Access Points: Phone, Fax, and Electronic referral		
Tools: standardized referral form for each intake area; LOCUS screening tool for mental health		

one-Link
Connecting you to addictions and mental health services

Examples of Successful Similar Models

The Access Point
The Toronto Mental Health and Addictions Access Point

The Access Point

Description: A single point of access to mental health and addictions, supportive housing and individual support services for intensive case management and assertive community treatment. Intended for those with significant and persistent mental health needs.

Summary of Intake Functions: Information • Intake • Screening • Resource Matching • Referral Management

Basket of Services: Intensive case management, Assertive community treatment teams, Supportive housing, and Early Psychosis

Governance:

Oversight: Steering Committee	**Funding**: Central and Toronto Central LHINs	**Number of Partners**: 51

Organizational Structure:

FTEs: 13 FTEs within arms length from Toronto Central LHIN and City of Toronto	**Staff Type:** Reception, Service Navigator, Team Lead, PSW, and Executive Director

Operations:

Number of Locations: 1

Technology/Access Points: Phone, Fax, Online, Walk-In

Tools: Screening tool used by reception during initial call; LOCUS is used to determine level of care by the Service Navigator

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Examples of Successful Similar Models

Community Navigation and Access Program

Toronto Seniors Helpline

CNAP/Seniors Helpline

Description: The Community Navigation and Access Program (CNAP) is a network of over 30 community support service agencies in the Toronto area who are collaborating to improve access and coordination of support services for older adults, their care providers and health care stakeholders.

Summary of Intake Functions: Information • Intake • Screening • Assessment • Referral Management

Basket of Services: 25+ social services and home and community-care related services

Governance:

Oversight: Executive Committee	**Funding**: Toronto Central LHIN	**Number of Partners**: 30+

Organizational Structure:

FTEs: 8 FTEs within WoodGreen as the lead agency	**Staff Type:** Administrative and Social Workers

Operations:

Number of Locations: 1

Technology/Access Points: Phone, RM&R (hospital), Walk-In and Online Chat

Tools: The RAI suite of tools are in use by member agencies for screening and assessment; inter-RAI is used well for non-crisis screening.

Examples of Successful Similar Models

Toronto 211/Find Help

Description: Ontario's 211 system and Find Help/211 Central's specialty lines ensure professional, 24/7, live answer, multi-lingual and multi-channel (phone, text, chat, email, TTY) navigation of the complex system of health, social and human services.		
Summary of Intake Functions: Information • Intake • Resource Matching (select)		
Basket of Services: several services related to Food, Employment, Health, Mental Health, and Recreation		
Governance:		
Oversight: Board of Directors	**Funding**: Province (majority), United Way and City of Toronto	**Number of Partners**: 100+
Organizational Structure:		
FTEs: independent non-profit body with 40 FTEs	**Staff Type:** Administrative, Information Specialists, Students, and Volunteers	
Operations:		
Number of Locations: 1		
Technology/Access Points: Phone (211), Text (21166), Online live chat		
Tools: Software system "iCarol" handles referrals and tracking		

Appendix

Key Milestones

Key Milestones

May-June 2018

- Community Consultation
- Report
- Recommendations

Sept-Oct 2018

- CYMH Agency Approval
- ROCK Board Approval
- System Investment

Sept 2018-Mar 2019

- TRA
- MOU
- Governance for HIMP
- Recruit Staff
- Soft launch (Internal Programs)

Apr-Dec 2019

- Map CYMH Services
- Launch Operations Committee
- Create QI and Communication Plans
- Development of Guiding Process Documents for Staff (Playbooks and Practice Guides)

Jan-Mar 2020

- Begin on-boarding process with MOU Partners
- Launch QI & communication plans

Apr 2020-Mar 2021

- Introduce e-referral
- Solidify reciprocal referral process with adult mental health
- Continue QI & Communication
- Develop sustainable KPIs
- Improved client information system (portal and client queue)
- Electronic connectivity with partner client information systems (Caseworks and EMHware)

Apr 2021-Forward

- Expand Operation Committee to include Community Partners (Advisory Committee)
- Continue with QI & Communication - time study work

Access and System Navigation

Access & System Navigation

Radius Child & Youth Services
PREVENTION - INTERVENTION - RESEARCH

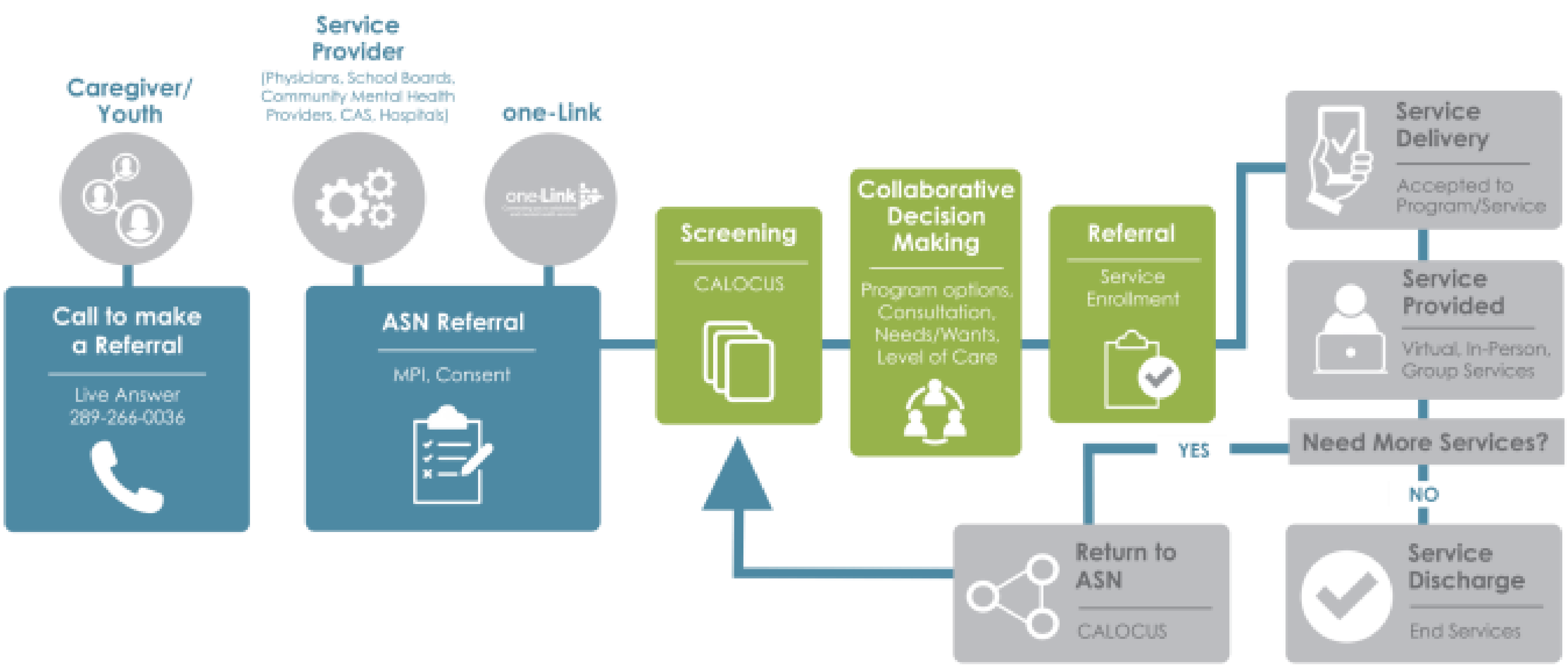
Nelson Youth Centres
Changing Young Lives

One Call, All Access for Child & Youth Mental Health

289-266-0036

Access and System Navigation

Access & System Navigation



Appendix

Key Components: Client Flow

Key Components: Client Flow

Live Answer Access Line

One number for youth/families and service providers to call

One Universal Electronic Referral Form

With embedded consent – to be completed by Service Providers

E-Referral

Between two client information systems – CaseWorks and EMHware

Multiple Avenues

To submit referral – Live Answer calls, fax, electronic referral portal for Service Providers

300+ Providers registered to date

CALOCUS

One Standard Assessment Tool

Equitable Access to Service for Families

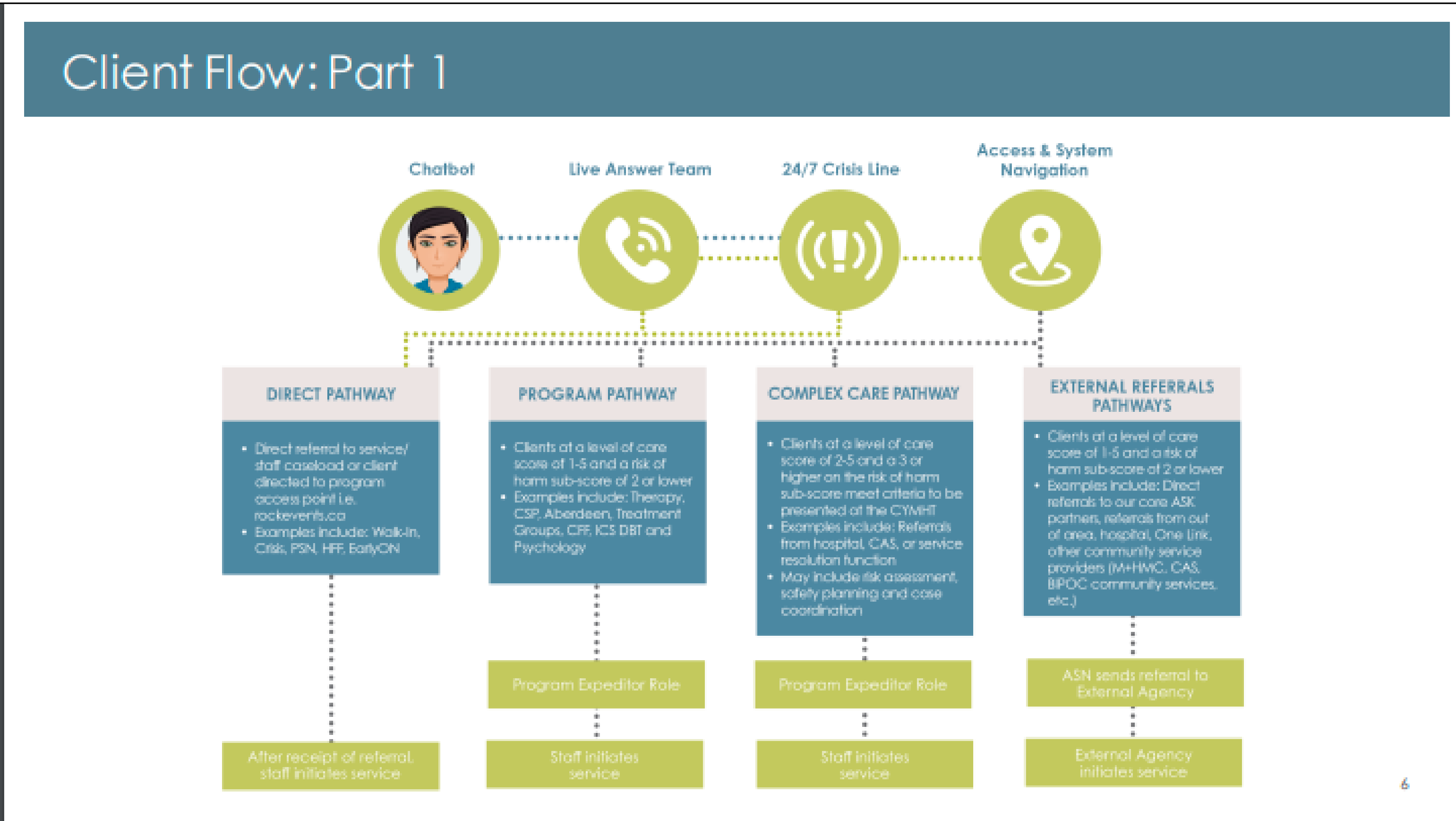
Imbedded Interpretation

Ability to refer into system

And gain access to a variety of services offered by the community

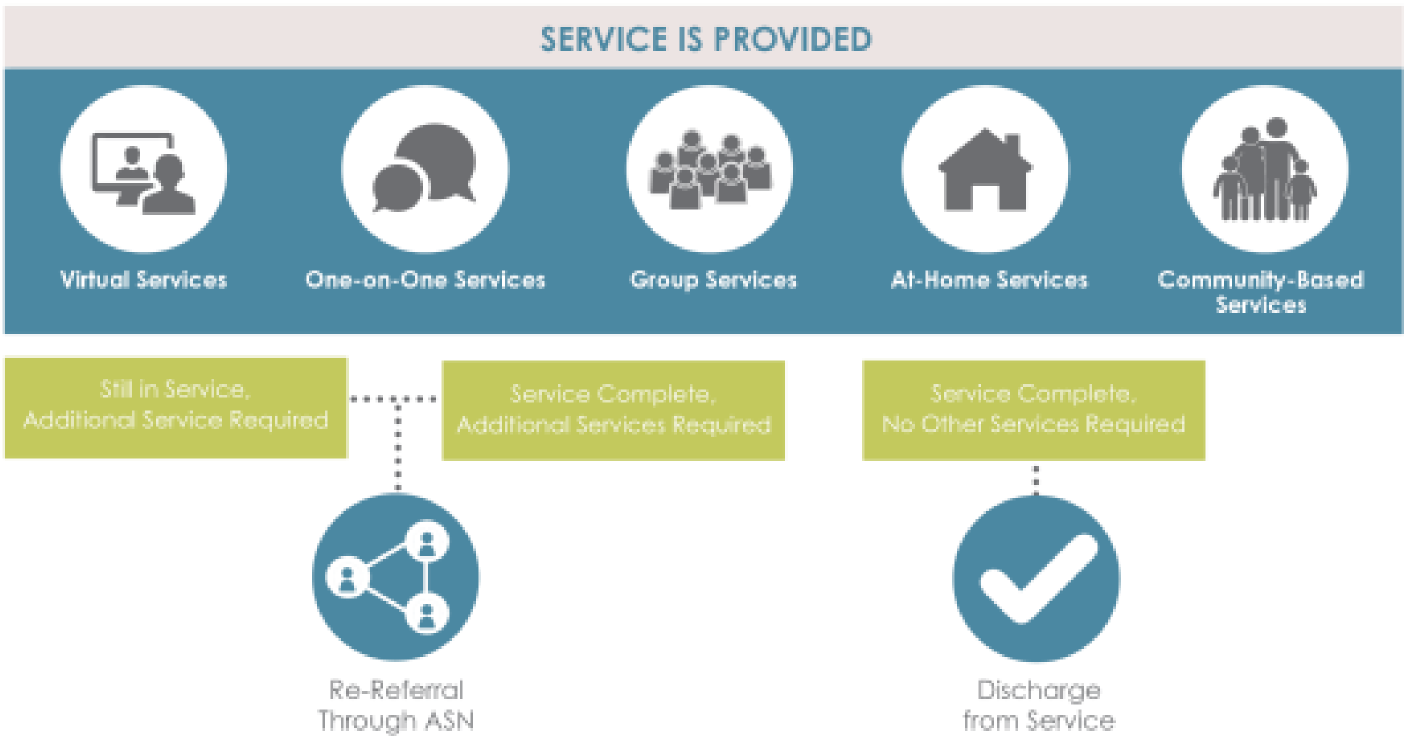
Appendix

Client Flow: Part 1



Client Flow: Part 2

Client Flow: Part 2



Appendix

Key Performance Indicators

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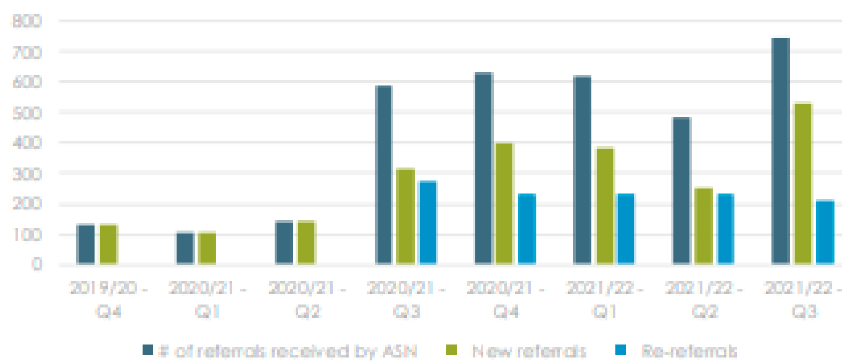
ROCK
REACH OUT CENTRE FOR KIDS

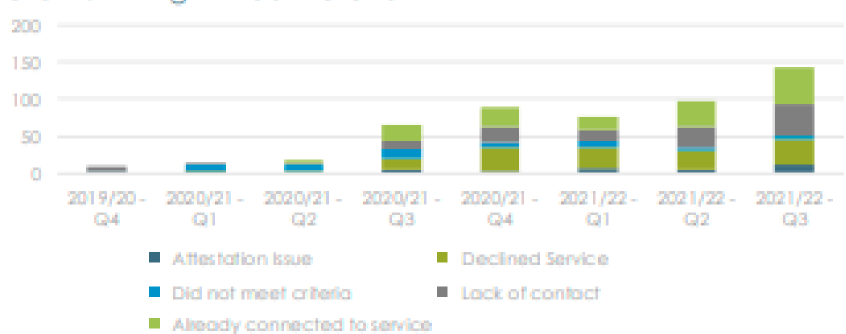
Key Performance Indicators

Indicator	2021/22-Q3
# of referrals received by ASN	743
New referrals	531
Re-referrals	212
# of referrals to program/service	613
# of clients exiting without referral	144
Attestation Issue	11
Declined Service	34
Did not meet criteria	6
Lack of contact	43
Already connected to service	50
Average days in queue	13.7

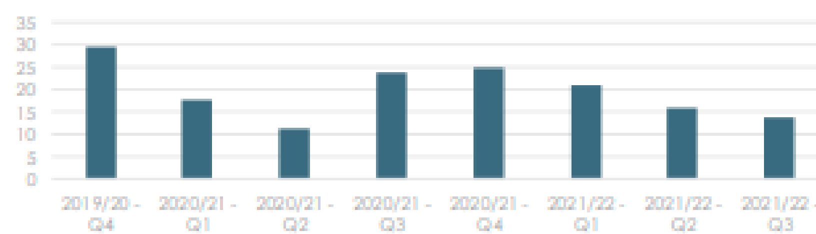
Referral Trends



Clients Exiting without Referral



Average Days in Queue

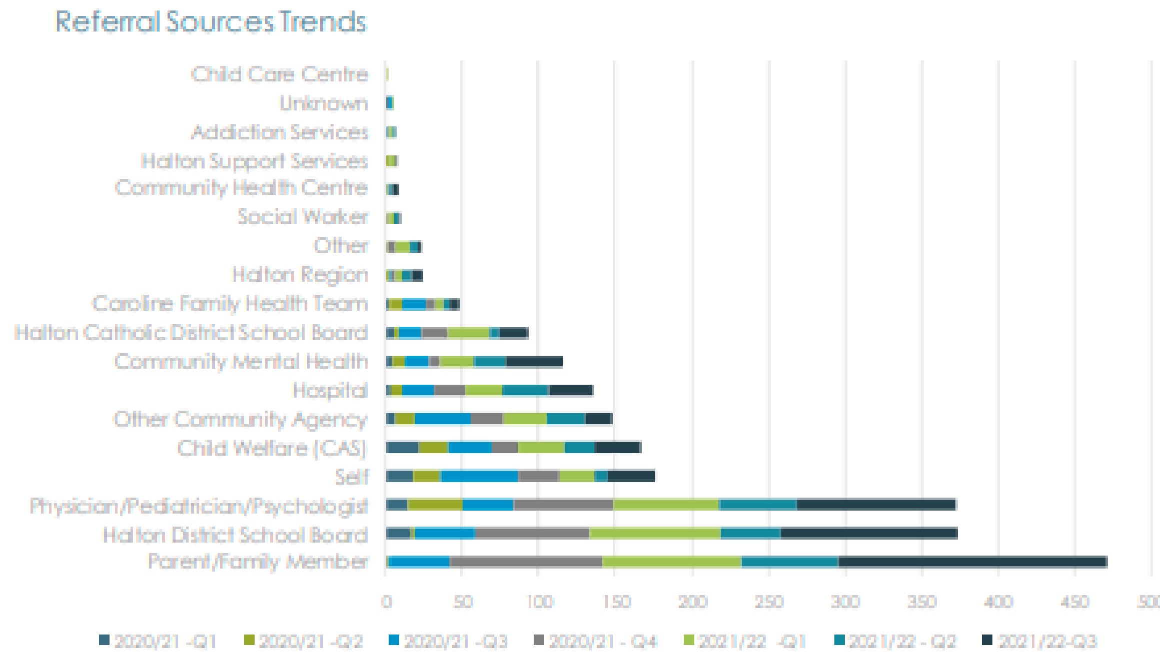


Appendix

Key Performance Indicators

Key Performance Indicators

Referral Source	2021/22-Q3
Parent/Family Member	176
Halton District School Board	116
Physician/Pediatrician/Psychologist	104
Self	31
Child Welfare (CAS)	30
Other Community Agency	18
Hospital	29
Community Mental Health	38
Halton Catholic District School Board	19
Caroline Family Health Team	6
Halton Region	7
Other	2
Social Worker	2
Community Health Centre	4
Halton Support Services	1
Addiction Services	
Unknown	
Child Care Centre	



Continuation and Sustainability

Continuation and Sustainability

- Governance and Operational Committees in place, Community Advisory Group meet on an on-going basis
- Continued growth of the system- expansion and continuous QI
- Stay abreast of current technologies and opportunities – ever evolving, continuing to meet the needs of the community
- Monitor client service levels, KPIs and QI plans to understand when resources (funding and staff) will be needed to meet service demand

Appendix

Findings from Environmental Scan

The following section summarizes the key findings from the environmental scan conducted in Fall 2021 to better understand leading practices related to intake, assessment, referral, and single points of entry into child and youth mental health services. This information was used in the intensive services work.

Research Areas for Environmental Scan

The environmental scan focused on collecting insights from published literature and online research on the following research areas.

1 Delivery Model Parameters

1. What are the leading practices in organizations in Toronto and Ontario that deliver similar services. In particular, what are the leading practices related to intake, assessment, referral, single points of entry and service navigation?
2. Related to a single point of entry, how does it work on behalf of a network of agencies? What has worked and hasn't in terms of single entry, and why? What are some of the potential risks related to single entry?

2 Governance and Leadership Structure

1. What types of governance and leadership structures support a network working with various partners?
2. What are the key roles and responsibilities for planning and delivery of service model?
3. What are the features that enable various individual agencies to work together as a network (for single entry point)?
4. What system evaluation measures and outcomes are monitored?

Delivery Model Parameters

The following table summarizes some of the key findings on delivery model parameters, particularly those related to intake, assessment, referral, single points of entry and service navigation, and their relevancy for consideration for this initiative.

Article/ Source	Key Findings (from specific programs)	Relevancy/Consideration

Trajectory of Youth Mental Health Services in Laval, Quebec	• There are two types of paths for access to MH services in Laval:
	• ***Requested Path***, including referrals sources from:
	    • The community (e.g., school, partners, health/social services, early childhood centres, community groups)
	    • Medical services (e.g., First line Pediatric doctors, Home Psychosocial)
	    • *All referrals in the requested path are directed to the “Liaison Officers” who partner with Youth Mental Health*
	• ***Lines of Collaboration****, including partnerships with* youth mental health services, home psychosocial, psychiatric teams and other family and childhood services.
		• A new role of Liaison Officer, particularly to connect and educate physicians and other intersectional stakeholders referring children and youth for mental health services.

Kinark Child and Family Services (Durham Region Central Intake System)	**Centralized Intake Team:** • Kinark has a Central Intake team that supports all Kinark’s programs, plus its partnering agencies in Durham Region. • It provides one main access point for clients where they can be referred to the most appropriate services based on their unique needs. It includes a dedicated team that promotes client accessibility and flexibility to support their service needs. • However, community partners may have unique intake requirements that are not consistent with its standardized process, and technological improvements could be made to improve client access to service.	• Centralized intake that is relevant to the individual agency, but also collects pertinent information to support resource matching with other partnering agencies in the region.

Delivery Model Parameters *(continued)*

The following table summarizes some of the key findings on delivery model parameters, particularly those related to intake, assessment, referral, single points of entry and service navigation, and their relevancy for consideration for this initiative.

Article/ Source	Key Findings (from specific programs)

Evaluation of the Durham Central Intake System *(developed by the Durham Children's Alliance Committee)*	• The Central Intake System emerged in 2005 as the result of a unique collaboration between multiple community stakeholders and service providers. It acted as the central point of access for families seeking children's mental health services in the Central East Region, as well as the catchment areas associated with the partnering service providers including far regions of Northern Ontario.
	• **Main goals of implementation of Central Intake System:**
	    • Streamlining delivery of children's MH services in Durham;
	    • Improvement in access to children's MH services;
	    • Supporting partner agencies in conducting intake and BCFPI interviews - redirecting/ maintaining resources dedicated to the delivery of direct services; and
	    • Improving and maintaining high quality intake services.
	
	• This evaluation report also outlined that the Canadian Health Services Research Foundation suggested that a central system is the first step to better managing wait times and creating a "fair" system within health care. It also suggested the use of a **centralized waitlist provides several benefits including**:
	    • Prioritizing patients in the greatest need;
	    • Using tools that can assist with prioritizing need; and
	    • Providing standardized data for management purposes.
	• Although research on central intake services is limited, the research that does exist indicates both client and professional satisfaction with such services, e.g.:
	    • High levels of client satisfaction regarding timeliness, ease of access and responsiveness; and
	    • General professional satisfaction regarding response times, appropriate referrals, adequate info received.

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Delivery Model Parameters *(continued)*

The following table summarizes some of the key findings on delivery model parameters, particularly those related to intake, assessment, referral, single points of entry and service navigation, and their relevancy for consideration for this initiative.

Article/ Source	Key Findings (from specific programs)	Relevancy/Consideration
Huron Perth Centre for Children and Youth – *Timely Access*	**Centralized Intake Process:** • In 2015, Huron Perth Centre launched a new 'front door response', combining the core basket services, funding-crisis, brief services, case coordination and access intake to develop a service called ***Timely Access***. They developed a team of clinicians and administrative staff for the service response. • Since then, they have centralized their intake process, making available one clinician on a daily schedule available across their two county areas. This staff person picks up requests for services on that day. He or she intends to respond as timely as possible at least within 2-3 days to all requests for service. **Service Navigation:** • Clinicians on their *Timely Access* team connect with the family and can provide up to 3 face-to-face brief service sessions in a 6-8 week period. At the end of this brief intervention, the family could be referred to other community resources, to in-house counselling and therapy, or Intensive services where there might be a wait or the family is invited to call back when/if the family requires additional support.	• Related to central intake, a "shared-service" model in which several agencies share a clinician one day a week to do a collaborative intake approach (i.e., a shared intake process) • Related to service navigation, a brief service (such as targeted consultations) is another way to use service navigators

Delivery Model Parameters *(continued)*

The following table summarizes some of the key findings on delivery model parameters, particularly those related to intake, assessment, referral, single points of entry and service navigation, and their relevancy for consideration for this initiative.

Article/ Source	Key Findings (from specific programs)	Relevancy/Consideration
St. Clair Child and Youth Services	**Central Intake, Service Navigation and Warm Transfers, including:** • Walk-In Therapy Clinics that act as intake for the agency's programs and Services • Early Years Programs has an Intake Worker completing the phone intake and scheduling a clinic appointment at the time of the call • SDQ administered at Walk-In or at first point of contact • EMHware – collects client demographic information (strengths, presenting problems, needs, risk, etc.) • No Wrong Door – a community-wide protocol to ensure a soft hand-off to the most appropriate service providers • Child, youth and parent engagement in treatment – Collaborative note taking and treatment planning – clients leave with a copy of the plan • Clients are informed about waitlists and are made aware that they may return to Walk-In if needed during the waiting period	• Clear pathway for intake identified for the community and stakeholders • Timely access to services • Culturally appropriate • Smooth transition from Clinics to "Brief in 3 Program" – clients are provided with the date and time of the appointment along with the name of the clinician *(note – this is useful information to be provided to families)*

Delivery Model Parameters *(continued)*

The following table summarizes some of the key findings on delivery model parameters, particularly those related to intake, assessment, referral, single points of entry and service navigation, and their relevancy for consideration for this initiative.

Article/ Source	Key Findings (from specific programs)	Relevancy/Consideration
Hands – TheFamily HelpNetwork.ca	• Ongoing discussions about an intake process that is acceptable across the continuum of care from acute care of children and adolescents by MOH child and adolescent mental health mandate to community based CYMH and looking at a tool to truly triage clients. • Some of the key challenges and ideas discussed included but were not limited to: i. Resources being used at the front end to complete the needs of level 1 and 2 clients, leaving a significant wait for those who have moderate to severe needs as they must wait; ii. Assessing whether intake could be completed on an iPad in the waiting room; iii. Acknowledgement that a standardized intake is very important to inform at a triage level; and iv. Recognition that access is not just about completing an intake, but it is about beginning the services the client needs. In addition, clients and community will remain disgruntled if intake is clear, but accessing services still involves a lengthy wait time.	• Consideration for triage of potential clients (children and youth) by level of need • Consider iPads (or similar) as a viable IT solution to support intake • Getting to a standardized intake/assessment tool is important but requires effort, investment and planning • Related to [iv in the previous column], this is an essential feature of a well-working access point – its not just about access, but rather the initiation of services

Governance and Leadership Structure

The following table summarizes some of the key findings related to governance and leadership structure, the roles, responsibilities and effectiveness of working collaborative as a network.

Article/ Source	Key Findings

Evaluation of the Durham Central Intake System *(developed by the Durham Children's Alliance Committee)*
 	
Note – this evaluation report is from Sept. 2009. BCFPI findings outlined in this report may be outdated.
	Governance and Leadership Structure:
	• Durham Central Intake has active support of board members and/or senior management through a **Steering Committee**. This committee provides leadership in the management and direction of the central intake process for Durham Region.
	• The committee has a responsibility to enhance and support service system accountability and performance relative to intake for child and youth mental health services in Durham Region. Responsibilities are to:
	    • Manage the process and procedures of the intake service;
	    • Oversee the provision of BCFPI data to Children's Mental Health Ontario via participating service provider organizations as needed; and
	    • Address all practice/service issues related to the intake process in a timely and fair manner.
	• The Steering Committee membership consists of representation from each of the seven partnering agencies, representation from The Ministry of Children and Youth Services, a member of a regional community stakeholder(s) and a supervisor/manager from Kinark Child and Family Services.
	
	System Evaluation Measures and Outcomes Monitored
	• Surveys, quantitative data and interviews (qualitative data) to conduct this evaluation, focused on the following criteria and measures:
	    • **Client factors**, including satisfaction with service (ease of access, timeliness, responsiveness), perception of being matched to right service, and increased connection to community services
	    • **Partner factors**, including service satisfaction/facilitation, increased understanding of client accessing service, appropriateness of services, timely feedback, increased direct services to clients, increased integration of community services
	    • **Program objectives**, including efficiency (e.g., rapid response to voice mail, short call back times) and effectiveness (e.g., referrals matched to client needs)

Appendix

Findings from Stakeholder Focus Groups

The following section summarizes the key findings from intensive services work. This includes the focus groups conducted with core service provider organizations, as well as youth leaders and educational sector stakeholders. The focus groups were conducted virtually in Fall 2021 and focused on collecting input to inform the development of a single-entry point and navigation for child and youth mental health services. This work applies broadly to the Central Point of Intake model.

Please refer to the Summary Report from October 2021 for additional information.

Initial Questions for Input from Stakeholders

Optimus SBR engaged leaders and representatives from core service provider organizations, as well as youth leaders and educational sector stakeholders to collect input on the following 8 research questions to inform the development of a single-entry and navigation model for intensive services. These concepts apply broadly to the CPI model.

Vision and Core Operating Principles

What is the vision and core operating principles for the entry to and navigation of intensive child and youth mental health services?

Governance and Leadership Structure

What type of governance and leadership structure will be required for the oversight and administration of the single entry and navigation model?

Accountability and Commitment to Vision

What is the best way to ensure core service providers remain accountable to the shared vision and core operating principles?

Eligibility Criteria and Geographical Reach

What should be the eligibility criteria and geographical reach of the desired single entry and navigation model?

Access Points and Processes

What should be the key access points for accessing services? What are the key processes required for triage, screening, intake, referrals, transfers and resources matching?

Hours and Locations of Services

What would be the ideal hours of operation and locations of services?

Waitlist Management

How should waitlists be managed? (e.g., first-come first-serve, priority determined by need)

IT, Data & Infrastructure

What are the key IT and infrastructure requirements to deliver and manage the single entry and navigation model? How should client data be stored and shared?

Key Takeaways

The following table summarizes the key takeaways from the focus groups conducted with core service provider organizations, as well as youth leaders and educational sector stakeholders for the intensive service model. These apply broadly to the CPI model.

Research Areas	Key Takeaways
Governance and Leadership Structure	• Governance and leadership structure for a single-entry model will require collaboration and partnership between mental health core service providers and the educational sector stakeholders, particularly for children/youth in Section 23/Day Treatment programs (also referred to as ECPP - Education and Community Partnership Program). • An ideal governance model includes voices and representation from youth and families, and balanced/fair representation of agencies delivering mental health services. • There is some hesitation about a single, central governance and accountability structure given the diversity of communities and providers across Toronto. • There is some ambiguity about the role of the Lead Agency in owning/leading vs. enabling/supporting/participating in broader mental health sector initiatives.
Accountability and Commitment to Vision	• An MOU or formal agreement is seen as an effective mechanism to ensure core service providers and intersectional stakeholders remain accountable to the shared vision and core operational principles mechanisms of a single entry and navigation model. • There is a desire for strengthened collaboration and collective ownership amongst core service providers and intersectional stakeholders, primarily within the education sector. • There is a desire for a mechanism that ensures continuous feedback and evaluation of the new system-outcome measures.
Eligibility Criteria and Geographical Reach	• There is a desire for clear eligibility criteria for entry to intensive child and youth mental health services, and that access to services be based on clearly defined inclusion/ exclusion factors informed by data and evidence. • From a geographical reach perspective, there is general agreement that services within Toronto and closer to a client's home are preferred, but consideration must be provided to ensure that agencies are not limiting services available based on location alone.

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Key Takeaways

The following table summarizes the key takeaways from the focus groups conducted with core service provider organizations, as well as youth leaders and educational sector stakeholders for the intensive service model. These apply broadly to the CPI model.

Research Areas	Key Takeaways
Access Points and Processes	• There is a desire for flexible, multi-modality mechanisms for accessing mental health services to connect families through their desired method of communication. • There is some desire for a standardized, consistent tool based on best practices to support triage, screening, assessment, and intake for services. • There is a desire for resource matching to consider what the child truly needs so that core service providers can better support them. • Trust in the partnership and the collaboration between provider agencies is seen as an important factor for streamlined referrals and ease in transfers of services. • There is a desire to ensure that clients will not have to re-tell their stories; thus, desire for streamlined intake process with information sharing throughout.
Hours and Locations of Services	• Ease and convenience of hours of operations and locations are seen as some of the top priorities by youth accessing mental health services. • There is some agreement that hours of operation for a single-entry point will depend on how children, youth and families with urgent needs or crisis will be managed. • There is general agreement that hours of operation of service navigators need to be responsive and meet the needs of clients and their families. Flexibility of after business hours for service navigators may be seen as more important than for entry to services.
Waitlist Management	• There are mixed perceptions on strategies for managing waitlists. Some see a “first-come, first-serve” model as the fairest strategy, while others recognize the ability to prioritize those who may have more acute/urgent needs or who may be in crisis.
IT, Data and Infrastructure	• There is a strong desire for more transparent, timely/real-time and safe sharing of client information, as well as metrics and information on waitlists, service capacities, and availabilities between agencies and intersectional stakeholders. • However, client consent, data encryption and IT security are critical elements required for sharing of confidential and/or sensitive client information.

Appendix

Findings from Risk Register and Voice of the Client

The following section summarizes the key findings from intensive services work. This includes the 'Risk Register' that was developed in December 2021 with the CPI Task Force. This may continue to be iterated to reflect the current risks with the CPI Model in the illustrative examples on the previous slides. The 'Voice of the Client' exercise was completed in November 2021 and the information from this session is also included below. The Voice of the client work was based on dimensions of quality including: 'effectiveness, efficiency, safe, client-centered, timely and equitable'.

Appendix

Risk Register

A ‘Risk Register’ was developed in December 2021 with the CPI Task Force, this may continue to be iterated to reflect the current risks with the CPI Model ed in the illustrative examples on the previous slides.

Risk	Impact	Mitigation Strategy
Referrals bypassing central point of intake	Inequitable access to service Inappropriate referrals Unable to register and track Client experience negatively impacted	
Eligibility criteria for service and triage		
Lack of confidence and trust in central Intake assessment and authority to make decisions		
Technology		
Identify language and cultural needs right in the beginning instead of redirecting francophone clients to mainstream services.	Client not matched with right services can negatively impact client experience and trust in the system	
Scope and scale of change	Potential disruption of client experienced during the change period. There will likely be confusion, redundancies and gaps.	
Identifying equity needs	Create barriers for diverse communities	
Out of date inventory of services	Incorrect referrals to service Clients experience a delay in obtaining needed service	
Standard assessment form	No mandated assessment form. No consensus of best tool to use.	
Clients need to retell story	Parents and clients retelling their story can negatively impact client experiece and builds distrust in the system.	Build confidence among staff across sector about the initial assessment tool, allowing them to rely on the outcome of the assessment to improve client experience.
HR challenges, attracting and retaining staff to staff Centralized Intake staff.	Could impact capacity of the core service providers to service for cleints and to further refer them.	
Clients do not use the CPI because presenting issues may be senstive or stigmatized	Some clients might not feel comfortable and may not access to Centralized Intake for instance the HIV/AIDS.	
Prescriptive responses	Clients may not feel meaningfully supported .	
Not flexible with care pathway approaches	Might create confusion and families likely to drop off the system	Re-entry into service that honours previous and alternative points of entry for instance if the client has a well-established connection with a previous service provider.
Financial risk, funding not determined yet.	No clarity to CSP around whether it is new funding or existing funding can have unintended consequences for service providers.	
Intersections with other systems such as Autism		
Technology being too elaborate and incompatible with other client information system		Smaller technology options more mental health specific options could be considered.
Roles and responsibilties		
Governance		
Decision making		

Appendix

Voice of the Client

A 'Voice of the Client' exercise was completed in November 2021 based on dimensions of quality including: '*effectiveness, efficiency, safe, client-centered, timely and equitable*'.

Customers	What is critical to quality?	How we will measure
Optimus- Gary	A simple easy process	Client satisfaction/ Clients only tell their story once
Kensington Health OHT- Edward	Client's ability to know status of their referral at all times (ie. Portal) A linear process- reducing contact point/ assessments to only what is necessary for the referral	A reliable feedback mechanism Client satisfaction Measure of time to service Use of technology such as ManageEngine software- provides a clear outline of client journey (i.e., initial request, date, response by team, open/closed/resolved)
CAS- Paul	Timely access to supports	Ability to identify who is not connected and reason
Core service provider- Laurie	Warm, welcoming point of contact Respect for cultural needs and language Fast and streamlined access	Client experience
Core service provider- Lydia	Must consider how we do outreach to clients who will not come to a centralized point of access Requires a central data bank where data can be easily accessed by CSPs	Right match of client to agency Reduced time CSP spent on intake/ increased time on client intervention
	Reduce CSP time and resources to do intake Refers clients that are appropriate for the CSP	
PLEO- Elyse	Transparency- how/why decisions and recommendations are being made Collaboration- equal voice in confirming input and next steps Ongoing, flexible process- proactive check-ins, ability to update	Client access portal usage Client feedback
The Access Point- Karen	Timely connection Low barrier, responsive to client needs Connected to best service to meet need Transparency and accountability	Population based outcomes Outcomes by service types
Centre Francophone- Estelle Duchon	Identify Language and cultural need right in the beginning and redirect to appropriate services	Client access and experience