Access to Care | Right Care | Right Time | Right Place

Coordinated Access

What is Coordinated Access?

Patients in transition from one level of care to another need to understand all of the care options available to them and how best to access services in relation to their individual circumstances. Partners across the continuum of care are responsible for working together to provide patients/clients with the best possible information with which to make their decisions.

Coordinated access is the phrase used to describe the new admission process to assisted living, supportive housing, adult day programs, complex continuing care and inpatient rehabilitation. Individuals, their families and health care providers (including their family physician) will access these services by contacting the CCAC Care Coordinator and then working together to get needed services in place.

Patients/clients, their families and care teams are empowered by this process. Having access to all of the information and resources that they need enables them to make informed decisions and participate more fully in their care. Additional benefits include:

- a single number to call for referral to multiple services
- detailed information on the type of service available in each area
- consistent eligibility guidelines and admission processes
- equitable access to services across the region through a centralized waitlist

Health and Community Service Providers benefit by caring for patients/clients who need their respective levels of care, enabling them to work to their maximum level of professional skill and expertise. Further benefits include:

- detailed information on the services available in each area
- use of best practices among partners in the development of consistent eligibility guidelines and admission processes
- development of and use of consistent eligibility guidelines and admission processes will support efficient use of resources and will aid in understanding future demand for these services
- service vacancies accessible to Primary Care and Health Service Providers electronically through a Waitlist Management Tool (in development)

What benefits do Care Coordinators bring to the process?

The Coordinated Access process has been used to facilitate admission for clients to long-term care homes in the South West for more than 15 years and has been established more recently for other services across the South West LHIN, (Adult Day Programs, Transitional and Restorative Care Units, Sakura House Residential Hospice). Care Coordinators are responsible for:

- maintaining detailed information and knowledge about the services available in each area
- assessing needs and sharing information with patients/clients about services that are available at any point in time
- using available information about services combined with an individual's health status and personal decisions to build a plan of care
- working with the interdisciplinary Health and Community Service Provider teams to apply consistent eligibility guidelines and admission processes
- maintaining a "real time" electronic waitlist for Primary Care Professionals and Health and Community Service Providers to access when required

How do team members work together using Coordinated Access?

Referral 	• An individual is identified as potentially benefitting from specialized service or community care • Referral is made to the CCAC by a health care professional in the hospital or in the community, a friend/family member or the individual themselves.

Assessment and **Reassessment** 	• A CCAC Care Coordinator will work collaboratively with the individual, their family and hospital/primary care team to assess the individual's needs through active listening and discussion and to develop a plan of care that will outline:
	  ○ type of service
	  ○ length of time
	  ○ Health and/or Community Service Provider
	• Jointly, the Health and/or Community Service Providers and the CCAC Care Coordinator review the individual's abilities and needs with respect to the eligibility criteria and consider resources that are required to meet the individual's specific needs (including specialty equipment)
	• The CCAC Care Coordinator monitors the patient/client's progress to ensure that the care plan is effective and will reassess as scheduled or as needed

Admission 	• The Health and/or Community Service Provider accepts or declines (with rationale) the individual as a patient/client and determines how best to provide care for the patient/client utilizing their respective expertise
	• *If the appropriate service is not available or the client is deemed an inappropriate candidate for the intended service, the CCAC Care Coordinator will work with the individual to explore alternatives which may include*
	  ○ *receiving service in a different community, or*
	  ○ *deciding to wait for services to become available*
	  ○ *considering alternate health or community service*

Ongoing Services and/or **Discharge**	• The Care Coordinator maintains contact with the patient/client, their family and care team to ensure that the care plan is meeting the needs of the individual • In cases, where the care plan is only available for a limited time, the care coordinator will work with the patient/client and their care team to reassess the patient/client's need

Why is Coordinated Access being implemented?

This work supports a high performing system that focuses on: reducing wait times and improving utilization for Rehabilitative Services, Assisted Living/Supportive Housing and Adult Day Programs and reducing the number of clients/patients designated as Alternative Level of Care in hospital beds.

For more information, contact the Project Co-Leads:

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