| Community Care<br>Empowering you to live at home<br>in the City and County of Peterborough | **Central Intake** |
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**Effective Date:** August 8, 2023

**Revision #:** 1

## SCOPE

All employees, students, and volunteers

## RATIONALE

To provide guidance and direction for the coordination of the Central Intake service.

## POLICY

Central Intake – formerly called Supported Referral Coordination – offers a stream-lined approach to intake and assessment for community support services. Community Care Peterborough (CCP) is the lead agency for Central Intake for the northeast cluster, receiving all Home and Community Support Services Central East (HCCSS CE) referrals and linking them with the community support services organization in their region. The approach aims to make intake and assessment a seamless process, in support of the premise that every door is the right door. The process also aims to reduce the number of times a potential client/caregiver has to tell their story, thereby improving the intake experience of individuals, caregivers, and health care partners seeking services by taking an integrated approach to sharing client assessment information.

Central Intake also manages other health care partner referrals, Caredove referrals, and referrals and service inquiries received through CCP email. Information and referral for other services and supports is a key feature of care navigation for Central Intake. CCP aims to connect every individual with the care and supports they need no matter how they attempt to access service or whether it is a service offered by CCP or partner agencies.

## DEFINITIONS

**Northeast Cluster:** Defined by Ontario Health East as the geographic area of City of Kawartha Lakes, Haliburton County, Northumberland County, and Peterborough County. The community support service agencies in this cluster include Community Care City of Kawartha Lakes, Haliburton Highlands Health Services Community Support Services, Community Care Northumberland, and Community Care Peterborough.

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## PROCEDURES

### Eligibility

1. Any individual or caregiver interested in community support services may self-refer or be referred by a third party to have their service eligibility determined based on their support needs and their service request.

### Consent

2. For HCCSS CE referrals, consent to share assessment information and to contact the client or their caregiver(s) is obtained directly by HCCSS CE staff team and is thus implied by receipt of the referral. The Care Navigator or designate documents the date of implied consent based on the referral date.

3. For self-referrals, consent to have their service request reviewed is implied by receipt of the referral.

4. Referrals that are received via the Caredove website require express consent for the individual to proceed with the referral.

5. The Care Navigator/Coordinator speaks with the client or substitute decision maker to arrange services and consent to receive service is implied based on the client or substitute decision maker agreeing to the Service Plan.

6. At the time of intake and assessment the Coordinator/designate will seek express verbal consent from the client or substitute decision maker to ensure that they agree that CCP may collect, use, and disclose personal and/or health information for the purposes of coordinating service.

### Intake, Assessment, and Service Planning

7. The Program Support for the Care Navigation Team/designate will start a new client file for each referral as received or edit the existing client file.

8. The Care Navigator will review the referral documentation and determine if the request:
    a) Requires more information or clarification from the referral source; and/or
    b) should be forwarded to the appropriate external community support services provider for assessment and service planning; or

c) should be forwarded to the appropriate CCP service office for assessment and service planning or assessed directly by the Central Intake Care Navigator.

9. During the review of the referral information the Care Navigator will ensure that they communicate any information to the assessing Coordinator that may be pertinent to understanding the client's individualized care needs.

10. Service Plans will be completed by the assessing Coordinator/Care Navigator in accordance with policy CLI-1-30: Client Service Plans.

11. If CCP determines that a client is not eligible for service(s), the client has the right to appeal the decision in accordance with CLI-1-80: Client Feedback, Complaints, and Appeals. The final decision must be communicated to the client within 30 calendar days of their appeal.

**Care Coordination**

12. The Care Navigator will act as a liaison between HCCSS CE and CCP staff, although any Coordinator may elect to contact HCCSS CE as appropriate about a client referral.

13. The Care Navigator will monitor the status of all referrals received through Central intake with the goal of having a final outcome within 30 calendar days. Coordinators will follow policy CLI-1-20: Client Intake and Assessment and attempt first contact to service inquiries and referrals within 10 business days of receiving the information from Central Intake.

14. CCP staff will document all attempts to follow-up on the referral in the client file.

15. The Care Navigator will prompt Coordinators about the outcome of referrals as they near the 30 day mark.

16. For HCCSS CE referrals, the Care Navigator/designate will report on the outcome of the referral using the Health Partner Gateway (HPG), providing known details. At times the Care Navigator/designate may elect to call or email the HCCSS Care Coordinator with additional information.

17. The Care Navigator will document their actions with the referral in the client in accordance with CLI-1-60: Client Records. They will also document the outcome

of the assessment using the categories established by the Ontario Healthcare Reporting Standards.

**Service Discontinuation**

18. Clients will be discharged from Central Intake when the outcome of the referral is determined or if the referral process is stopped.

## RELATED POLICIES

ADM-3-40: Electronic Health Records
CLI-1-20: Client Intake and Assessment
CLI-1-22: Client Consent
CLI-1-30: Client Service Plans
CLI-1-60: Client Records
CLI-1-80: Client Feedback, Complaints, and Appeals

## RELATED DOCUMENTS

Ontario Healthcare Reporting Standards – Chapter 10 – Community Support Services

## REVIEWS AND REVISIONS

| **Date Approved** (mmm dd, yyyy) | **Comments** |
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| Oct 6, 2022 | Policy developed |
| Aug 8, 2023 | Policy revised |

| **Next Review Date:** | August 2026 |
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