Outstanding Recommendations

Assessment of Implementation Report

Alberta Health and Alberta Health Services

Systems to Manage the Delivery of Addiction and Mental-Health Services

(July 2015)

Summary of Recommendations

In September 2021, we completed our assessment of implementation from our 2015 audit of Alberta Health and Alberta Health Services' *Systems to Manage the Delivery of Mental-Health Services*. We found that the four recommendations have been implemented:

Alberta Health

IMPLEMENTED Recommendation:
Use action plan and progress reporting to implement strategy

Alberta Health Services

IMPLEMENTED Recommendation:
Integrate mental-health service delivery and eliminate gaps in service

IMPLEMENTED Recommendation:
Improve information management in mental health and addictions

IMPLEMENTED Recommendation:
Complete assessment and develop waitlist for Albertans who need community housing supports

Introduction

In our 2015 followup audit, we applied the chronic-disease management model[2] to examine how well the health system met the care needs of people with serious mental illnesses. The key feature of that model is patient-centered care—care organized around the needs of patients rather than around the structure of the health system.

We found in 2015 that systems to deliver mental-health services in Alberta should be improved.

We found that Alberta Health had failed to properly execute its then-existing addiction and mental-health strategy, and the department had not done any detailed analysis or reporting on the strategy.

We also found that while Alberta Health Services (AHS) had made important improvements since our original 2008 mental-health audits, for the most part the delivery of frontline addiction and mental-health services remained unintegrated and allowed for ongoing gaps in service continuity that affected healthcare services in the following three areas:

- disjointed care planning and delivery among healthcare providers and programs
- limited sharing of clinical information among service providers within AHS
- uncoordinated frontline delivery of housing support services

We made one recommendation to the department:

Use action plan and progress reporting to implement strategy:

a) use an action plan to implement the strategy for mental health and addictions

b) monitor and regularly report on implementation progress

[2] This model is described on page 3 of our September 2014 report on chronic disease management https://www.oag.ab.ca/reports/oag-health-report-chronic-disease-management-sept-2014/

We made three recommendations to AHS:

Integrate mental-health service delivery and eliminate gaps in service for its own community and hospital mental-health and addictions services:

a) work with physicians and other non-AHS providers to advance integrated care planning and use of interdisciplinary care teams where appropriate for clients with severe and persistent mental illness who need a comprehensive level of care

b) improve availability of mental-health resources at hospital emergency departments

c) improve its system to monitor and ensure community mental-health clinics comply with AHS's expectations for treatment planning and case management

d) improve its processes to identify and evaluate good operational practices used by local mental-health and addictions staff and deploy the best ones across the province

Improve information management in mental health and addictions to make the best use of its current mental-health and addictions information systems by:

a) providing authorized healthcare workers within all AHS sites access to AHS mental-health and addictions clinical information systems

b) strengthening information management support for its mental-health treatment outcomes measurement tools

Complete assessment and develop waitlist system for Albertans who need community housing supports by supporting the work of the cross-ministry housing planning team established under the mandate of the Minister of Seniors:

a) complete its assessment and report on gaps between supply and demand for specialized community housing supports services for mental health and addictions in the province

b) develop a waitlist management system to formally assess the housing support needs of AHS's mental-health hospital and community patients and coordinate their placement into specialized community spaces funded by AHS

In our assessment of implementation completed in September 2021, we found the department and AHS have implemented their respective recommendations.

Health

Recommendation:
Use action plan and progress reporting to implement strategy

IMPLEMENTED

a) use an action plan to implement the strategy for mental health and addictions

Context

In 2015, the prevailing provincial plan to deal with addiction and mental health was Creating Connections: Alberta's Addiction and Mental Health Strategy, which had been released in 2011. This strategy had an accompanying detailed five-year action plan that identified potential quantitative performance measures for each of its priorities and established implementation timelines. In 2015, we found no evidence that this action plan was being followed, and we could not determine what progress had been made in implementing Creating Connections.

Our current findings

Replacement provincial addiction and mental-health strategy and work plan introduced

Valuing Mental Health: Report of the Alberta Mental Health Review Committee[3] was publicly released in February 2016; this marked the end of the formal implementation of 2011's Creating Connections and effectively replaced it as the provincial addiction and mental-health strategy at that time. The Valuing Mental Health report made 32 recommendations, with accompanying targeted implementation timelines, to improve Alberta's integrated addiction and mental-health service-delivery system.

Subsequent to this report, Valuing Mental Health: Next Steps was released in June 2017.[4] This document identified 18 "actions", along with activities already underway, that were intended to implement the principles of the 32 recommendations set out in the February 2016 strategy. It also set out a governance structure[5] that was comprised of various committees and task groups, each of which was assigned responsibility for overseeing the implementation of specific "actions" and in-progress activities. The timeline for expected completion of this strategy, as set out in Next Steps, was from spring 2017 to winter 2020.

[3] The Alberta Mental Health Committee was established in 2015 with a mandate to comprehensively review addiction services, mental-health services, and Alberta's mental-health system. Its report was intended to assist the Alberta government to implement a new strategy to strengthen and update addiction and mental-health services for Albertans. https://open.alberta.ca/publications/valuing-mental-health-report-alberta-mental-health-review-committee-2015

[4] https://open.alberta.ca/publications/9781460134771

[5] This comprised stakeholders from across the Government of Alberta; Health Canada's First Nations and Inuit Health Branch; and various service providers, professional associations, and community partners.

A detailed work plan was created to keep track of the implementation progress of the various individual activities and projects (or "sub-actions") initiated to achieve each of the 18 "actions". This plan included information such as:

- which committee, task group, or entity was the identified lead for each "action" and the various individual projects or activities
- target population
- project contact
- key activities and start dates
- expected and completed deliverables and milestone completion dates
- updated implementation status

The work plan was monitored and tracked by a secretariat (consisting of Health and other Government of Alberta staff), which required monthly updates for projects on which Health was the lead and quarterly updates for those which had cross-ministry leads. This work plan was regularly updated and internally distributed between September 2017 and April 2019. Based on the process improvements the department applied up to April 2019, we concluded the recommendation has been implemented.

In April 2019, the Valuing Mental Health: Next Steps strategy was discontinued and has not yet been replaced. Our findings below reflect there currently is not an active implementation plan or accompanying progress reporting taking place. The department has asserted that when a new strategy is released, they will re-engage the processes related to an implementation plan and progress reporting.

No current provincial addiction and mental-health strategy

The department informed us that with the election of a new government in April 2019 came a highlighted focus on dealing with addiction and mental-health issues and a shift toward a recovery-oriented approach to addiction and mental-health care. With this came a plan to develop a new strategy to build off 2016's Valuing Mental Health: Report of the Mental Health Review Committee.[6] Because of this, the Next Steps work plan has not continued to be updated since 2019.

While the detailed work plan is no longer being used, work has continued on a number of individual grant funded addiction and mental-health projects Health is the lead on. The department created its own tracking tool to internally monitor the implementation progress of these ongoing projects. The department told us it will continue to do this until the projects end and expects in many cases the work from these will be tracked and enhanced as part of the current government's focus on a recovery-oriented approach to providing addiction and mental-health care.

In November 2019, the government appointed a Mental Health and Addiction Advisory Council.[7] Its role was to provide guidance and recommendations towards the development of this new mental-health and addiction strategy intended to improve access to recovery-oriented addiction and mental-health care and improved treatment supports. The advisory council's final report, which would be used to develop the new strategy, has been completed and received cabinet approval. However, the date when it is expected to be publicly released has yet to be determined because of the continuing COVID-19 pandemic.

[6] https://albertastrongandfree.ca/policy/

[7] https://www.alberta.ca/mental-health-and-addiction-advisory-council.aspx

While there is still no timeline as to when the new strategy building off 2016's Valuing Mental Health: Report of the Mental Health Review Committee will be developed and released, when it is, the department has indicated it will follow the process of developing and publicly releasing an accompanying implementation plan.

b) monitor and regularly report on implementation progress

Context

In April 2015, the department released an interim public report on implementing Creating Connections. This report provided a high-level view only and contained no detail on what projects associated to the strategy's various priorities and initiatives had been completed or how they had improved the mental-health delivery system. We did not consider this report as an example of adequate assessment and reporting of implementation progress.

Our current findings

A Valuing Mental Health Advisory Committee, comprising over 200 stakeholders, held recurring quarterly meetings between May 2016 and February 2019, during which progress updates for projects initiated to implement Next Steps were provided. Committee members present also provided any required advice and guidance about implementation.

The department publicly released a progress report on Valuing Mental Health: Next Steps, with an accompanying appendix, in February 2019, which can be accessed on the department website.[8] This report described the various activities and initiatives undertaken to that point in time in the four areas for action set out in Valuing Mental Health: Next Steps for which there was some progress to report.[9]

The accompanying appendix provided additional information and progress details about these activities and initiatives, including:

- what would be done
- how it would be done
- what results could Albertans expect to see and when the particular initiative was started
- a progress update

This was the only report put out for the same reason, previously noted, why use of the Next Steps work plan was halted in April 2019. The department advised us that planned system-wide evaluation and reporting on the various activities and projects begun under Next Steps was placed on hold while the government develops its new addictions and mental-health strategy. However, similar evaluation and public reporting is planned to resume subsequent to a new strategy being released.

Also, each of the individual grant-funded projects originally initiated under the umbrella of Next Steps for which Health is the lead on have their own end-of-term evaluation and progress reporting requirements that are still being made internally to the department. These reports will summarize and measure project specific outcomes and outputs. At the point a new strategy is being implemented, we will monitor whether processes are engaged to execute on an action plan.

[8] https://open.alberta.ca/publications/9781460141632

[9] These were 1. Act in partnership: create an integrated system; 2. Act on access: enhance the role of primary care; 3. Act early: focus on prevention and early intervention; and 4. Act on system enhancements, legislation and standards.

Alberta Health Services

Recommendation:
Integrate mental-health service delivery and eliminate gaps in services

IMPLEMENTED

a) work with physicians and other non-AHS providers to advance integrated care planning and use of interdisciplinary care teams where appropriate for clients with severe and persistent mental illness who need a comprehensive level of care

Context

Patients who have chronically severe and persistent mental-health and addictions problems benefit from an integrated approach to treatment, complete with a single comprehensive care plan, multidisciplinary care team, and a robust case-management process.

The fundamental premise of integration is that by acting as one team, healthcare providers can achieve more for their patients than by acting in isolation. An integrated system ensures that providers in various settings and at various levels of care:

- work together to plan and deliver care to each patient
- use and contribute to a single health record
- guide each patient along an optimal care path through the healthcare system
- provide for clear accountability for care outcomes

In 2015, we found that AHS did not have an operational model for integrated case management for its community and hospital mental-health and addictions programs. While AHS had piloted some very promising innovative approaches in a number of communities to identify and provide focused, coordinated treatment to small groups of patients with highest care needs and highest use of AHS resources, the overall model of frontline delivery of addiction and mental-health services in Alberta had not changed significantly. It remained unintegrated and did not support seamless transition and integrated case management between different parts of the healthcare system.

Our current findings

Since 2015, AHS has formed one new complex-care team in each of its five zones,[10] which provides a wide range of integrated services to people with complex care needs and severe persistent mental illness (SPMI). These teams collaborate with a number of different non-AHS partners and stakeholders to provide patient care planning and delivery, including community primary care providers such as Primary Care Networks, physicians, and nurse practitioners; various housing agencies; Persons with Developmental Disabilities (PDD) and its contract agencies; and many others.

Each zone also has various specific initiatives with ties to local Primary Care Networks. These are in areas such as mental-health training, partnerships, and pilot projects to provide care for SPMI patients in locations where there are gaps in services provided by the complex-care teams.

[10] There are five AHS zones: North, South, Central, Edmonton, and Calgary.

AHS also created a Provincial Guidelines working group to advance integrated care planning consisting of provincial and zone AMH representatives. The working group developed a collaborative, integrated team approach that serves as a checklist for complex-care teams on how to best deliver services and collaborate with community partners and stakeholders. Each zone determines which of the two complex-care team models (Assertive Community Treatment[11] (ACT) or Intensive Case Management[12] (ICM)) works best for it. The document includes standardized processes for each model under the following headings:

- Organization of multidisciplinary care teams (ACT) or collaborating-coordinating with other care providers (ICM)
- Develop a communication plan
- Roles and responsibilities
- Monitoring and Reporting

b) improve availability of mental-health resources at hospital emergency departments

Context

Emergency departments are one of the two main entry points into the healthcare system. They are the primary entry point for people in distress, including those with addictions and mental-health problems. In many communities, particularly in rural Alberta, hospital emergency departments have limited access to, and support from, mental-health and addiction services.

In 2015, we found that most emergency departments in the larger urban centres we visited had a mental-health worker on site or on call seven days a week. In contrast, rural emergency department staff may have received some on-call support from therapists at the local community mental-health clinic when it was open (usually weekdays from 8 a.m. to 4:30 p.m.). At all other times, they often had little or no access to adequate or dedicated mental-health support.

Our current findings

AHS has been working to improve the availability of mental-health and addiction resources in underserved hospital emergency departments through the roll-out of a number of projects and activities.

One such initiative was a process to provide acute real-time assessments and support to rural emergency departments using virtual health. In July 2020, a pilot was launched in the North Zone between the Cold Lake hospital emergency department and psychiatrists based in St. Paul. Psychiatrists in St. Paul would interact with and assess mental-health and addiction patients in the Cold Lake emergency department, who were situated in a modified private, quiet room equipped with the necessary technology. This assessment determined if the patients needed to be transported to St. Paul for in-person consultation or admission or if they could be provided appropriate treatment in Cold Lake. Based on an evaluation of this pilot, AHS will be moving it to program status in the North Zone and is planning to pilot the concept in other zones.

[11] ACT provides comprehensive outreach services to adults with SPMI, who experience difficulty engaging in less intensive addiction and mental-health outpatient or community services, and uses an integrated multidisciplinary team approach with shared caseloads and community-based supports.

[12] ICM helps SPMI patients get connected with the treatment and services they need but uses case managers responsible for individual or smaller caseloads who link and coordinate their patients with the unique services they need rather than a multidisciplinary team with shared caseloads.

AHS has also made available additional mental-health and addiction resources in emergency departments across the province, including:

- creating a comprehensive standardized AMH Risk Screen and Suicide Risk Assessment tool for use in rural emergency departments for which there is no addictions or mental-health consult readily available. This tool has been piloted at 23 rural sites across the province. The intent of this is to provide an improved and standardized documentation tool to support nursing staff in their assessments and documentation of addiction and mental-health patients presenting in the emergency department.
- adopting the use of the Columbia-Suicide Severity Risk Scale (C-SSRS) in all emergency departments
- making available take-home Naloxone[13] kits for distribution at emergency departments

A number of these resources, such as the technical infrastructure to support virtual health and C-SSRS, are built into Connect Care, AHS's new clinical information system, which will expand their accessibility at emergency departments. AHS has been rolling out Connect Care since November 2019 to zones and sites and hopes to be fully deployed by 2023. Connect Care will store and provide access to all AHS patients' medical records, care history, and prescriptions and improve access to, and support from, mental-health and addiction services.

c) improve its system to monitor and ensure community mental-health clinics comply with AHS's expectations for treatment planning and case management

Context

In 2015, we found AHS did not have a common set of standard practices for planning and delivering treatment at its mental-health and addictions clinics. We found some zones had developed their own case management practices while others continued to use legacy procedures that predated the creation of AHS in 2009.

Standards for case management in AHS community clinic settings should be the same across the province to ensure consistency in expectations of how patients are to be treated and how their clinical information is recorded.

Our current findings

In July 2020, AHS approved the Documenting Care Coordination procedures. These are standardized province-wide expectations for patient treatment planning and file case management for its addictions and mental-health care (AMH) providers working in community and ambulatory settings. These standards were intended to:

- provide direction to AMH providers when completing clinical documentation and health records for patients in care
- ensure that how patients are treated and how their clinical information is recorded in their files (case management) is the same across the province

Around file case management, the standards set out requirements and processes all AHS employees and medical staff are required to comply with for:

- initial patient screening and assessment to be done, using standardized tools

[13] Naloxone is an opioid antagonist medication that is used to reverse an opioid overdose.

- how individualized treatment plans are to be developed and documented
- care (or case) conferencing[14]
- progress notes[15]
- file closure and discharge summary[16]

AHS has also developed an AMH compliance monitoring tool to help zone management ensure practitioners' compliance with the new documentation procedures and achieve the goal of a more standardized approach to clinical documentation. Some zones are currently using the monitoring tool in conjunction with regular recurring patient file audits while others have delayed implementing it due to COVID-19 but will begin using it later in 2021.

d) improve its processes to identify and evaluate good operational practices used by local mental-health and addictions staff and deploy the best ones across the province

Context

In 2015, we observed a number of improvements and good practices at individual service locations across the province. Some of these were the result of centralized corporate effort by AHS while others were driven mainly by the initiative of local AHS staff.

For example, one community mental-health clinic found that phoning patients to remind them about upcoming appointments helped reduce the number of no-shows, which in turn reduced wait times and improved the use of therapists' time. This simple practice was not a standard practice across all AHS clinics, even though its benefits were clear and is a practice routinely used in a variety of settings, such as dental and veterinary clinics.

We did not see any evidence then that AHS had a process to formally identify and evaluate these good local frontline operational practices and deploy the best ones provincially.

Our current findings

AHS has implemented a number of mechanisms to identify and share operational best practices within the organization. These include:

- zone-level communities of practice (CoP), where practitioners share best practices and learnings between sites. AHS set up an organization-wide SharePoint site that all staff can use to find and join CoPs, exchange information and knowledge through online discussions, or identify colleagues who might be working on similar projects to theirs. This site also includes a directory of CoPs that individuals may join if they are interested.
- holding a series of lunch-and-learn sessions, open to all employees, to present and share findings and results from research or quality-improvement projects relevant to mental-health and addiction practices
- publishing various newsletters to highlight and share best practices specific to research and evaluation findings

[14] This is a routine and important clinical procedure via which the health care team meets at pre-determined times to discuss selected patient circumstances and obtain feedback regarding the proposed treatment.

[15] Progress notes should be used to record progress towards treatment goals, risk management, changes made to the existing treatment plan, discharge summary, or indicate a need for a care conference.

[16] This summary is a key component in transition in care and shall include (a) an analysis of treatment (b) a transition plan and (c) closure summary documentation.

Recommendation:

Improve information management in mental health and addictions

IMPLEMENTED

a) provide authorized healthcare workers within all AHS sites access to AHS mental-health and addictions clinical information systems

Context

When AHS was created in 2009, it inherited various incompatible and dated legacy mental-health and addictions information systems that do not support sharing of patient clinical information. Mental-health workers and addictions counsellors in community clinics do not have access to each other's information systems, even though about half of all people with mental illness have a concurrent drug or alcohol addiction.

Emergency-department staff at both urban and rural hospitals also have no access to these community mental-health and addictions information systems. This means they cannot check whether a presenting patient in distress has a diagnosed mental illness, is a known suicide risk, has a history of violence, has a treatment plan, or whether there is a list of community caregivers to be contacted in an emergency.

Our current findings

AHS began uploading certain historic client-specific treatment-related information from the legacy information system used by its mental-health clinics (ARMHIS)[17] into Netcare[18] in 2018. This was done since it was not technologically feasible to give non-clinic AHS staff access to ARMHIS due to its incompatibility with other information systems in use. By uploading this data to Netcare, it made the information available to all authorized staff at AHS sites providing patient care with access to this province-wide system. Management told us this helps provide AHS staff with a better understanding of continuity of care for mental-health patients who needed treatment outside of previously attended AHS clinics.

AHS has been unable to subsequently do the same with ASIST,[19] a different legacy information system used in its addictions clinics, which predates to when they were a part of the Alberta Alcohol and Drug Abuse Commission[20] (AADAC). AHS has prepared and submitted a Privacy Impact Assessment[21] (PIA) to the Office of the Information and Privacy Commissioner of Alberta (OIPC). Upon acceptance of the PIA by the OIPC, AHS can then upload historic client treatment data from ASIST into Netcare.

17 Alberta Regional Mental Health Information System (ARMHIS).

18 Alberta Netcare is a provincial electronic health record system. Various healthcare providers submit key patient health information to Netcare, which is combined into a single integrated patient record that can be accessed by authorized healthcare providers through a secure internet connection. Netcare does not provide a patient's full medical record, but it includes information such as laboratory test results, diagnostic images and reports, hospital visits, surgeries, drug alerts, and immunizations.

19 Addiction System for Information and Service Tracking (ASIST)

20 AADAC was absorbed into the then newly formed AHS in 2009.

21 A PIA is a process of analysis that helps to identify and address potential privacy risks that may occur in the operation of a new or redesigned project, such as demonstrating how the privacy and security of individually identifying personal or health information would be ensured.

In the meantime, AHS has been deploying its new single-point-of-access, province-wide electronic clinical-information system (Connect Care) in stages since November 2019 and hopes to be finished by sometime in 2023.[22] Addiction and mental-health patients treated at AHS clinics and other AHS facilities using Connect Care have their current treatment information and other records of care entered into it. This data is accessible by healthcare professionals at all other AHS sites who have access to Connect Care and who may need this information for future treatment of that particular patient. Once Connect Care is fully operational, Netcare will no longer be used.

b) strengthen information management support for its mental-health treatment outcomes measurement tools

Context

In 2015, we found AHS's initiative to introduce standardized outcomes measurement may be hindered because it did not have an efficient system to collect, enter and process the patient assessment data gathered by individual clinicians. AHS's system was paper based, and the assessment results for every patient were entered twice. Clinicians first recorded their patient assessments on paper, which was collected and stored at their local clinics until someone had the time to enter the data into an electronic database.

Program staff complained that this paper process was cumbersome; did not support easy, timely, and complete data capture; and caused data-entry backlogs. We found that required assessments were not always done, particularly post-treatment assessments. Without timely electronic data entry, local managers cannot effectively monitor and ensure clinician compliance with outcome measurement requirements.

Our current findings

For those zones where AHS's electronic clinical information system Connect Care is currently deployed and operational, MH and addiction staff can use its built-in suite of standardized outcome measurement tools to enter and process patient assessment data. These tools include the Health of the Nation Outcome Scales (HoNOS), Health of the Nation Outcome Scales—Child and Adolescent (HoNOSCA), CORE, Level of Care Utilization System (LOCUS), and the Columbia suicide risk screen.

Where Connect Care is not yet available, AHS is using the HoNOS Data System (HDS) for those zones that primarily use this outcome measurement tool. HDS allows clinicians direct electronic entry of a client's HoNOS or HoNOSCA assessment results into a searchable database. It also has a built-in reporting feature to show a client's progress over time through outcome scores and historical trends. One zone uses assessment tools other than HoNOS or HoNOSCA and utilizes an alternative electronic data entry system to capture patients' outcome scores.

However, as Connect Care is rolled out to additional zones and clinics, its functionality will become the standard to be used by clinicians to enter and process patient assessment data.

[22] https://albertahealthservices.ca/assets/info/cis/if-cis-cc-infographic-site-implementation-timeline.pdf

Recommendation:

Complete assessment and develop waitlist system for Albertans who need community housing supports

IMPLEMENTED

a) complete its assessment and report on gaps between supply and demand for specialized community housing supports services for mental health and addictions in the province

Context

Availability of an appropriate and supportive living environment is not a nice-to-have benefit, but a prerequisite for successful treatment and management of mental illness and addictions in the community. It is also a key consideration in deciding whether a patient can be safely discharged from the hospital. Housing-support needs cover the entire spectrum, from in-home supports for relatively high functioning individuals to secure facility living for people with severe mental illnesses. To this end, in 2015 we found AHS provincially funded 550 mental-health community spaces that provided varying levels of housing support services to its clients.

In 2015, AHS was working to complete an assessment of gaps between supply and demand for mental-health and addictions housing supports. This assessment was intended to provide a comprehensive assessment of mental-health and addictions housing needs by community and number of spaces and support levels required.

Our current findings

AHS completed its assessment and report in early 2017 on the gaps between supply and demand of community housing beds for Alternative Level of Care patients.[23] This report provided various categories of information broken down both globally (provincially) and in more detail for each of AHS's five zones.

This same type of information and reporting on supply, demand, and management of AHS-funded community-housing beds is now regularly available on an ongoing basis (both quarterly and annually) since AHS expanded the use of the web-based centralized referral and booking system it had previously been using in the Calgary zone.

[23] The Canadian Institute for Health Information (CIHI) defines these as individuals who no longer require acute-care services in a hospital setting but wait in acute-care beds for placement in a more appropriate setting, such as home or residential care in the community.

b) develop a waitlist management system to formally assess the housing support needs of AHS's mental-health hospital and community patients and coordinate their placement into specialized community spaces funded by AHS

Context

In 2015, we found that AHS did not have a formal mechanism to coordinate placement of its community and hospital patients with the appropriate housing support services available in the 550 mental-health community spaces it funded directly. Locally and centrally, AHS did not maintain a comprehensive waitlist of people who needed mental-health housing. Individual mental-health workers in the community and in hospitals often relied on their own relationships with community housing providers to find placements for their patients, often independently and in competition with their colleagues.

The only exception we saw was in the Calgary zone, where a web-based centralized referral and booking system was used to manage placement into specialized community housing funded by AHS. All housing referrals for patients from mental-health workers were directed through one central intake coordinator, who assessed each client and placed them on waiting lists for a suitable contracted site or service provider.[24] Each site notifies the coordinator as vacancies arise, who in turn provides the facility operator with the contact information of the next suitable candidate. Once housed, the individual is removed from all waiting lists.[25] The coordinator regularly monitors all waiting lists and provides updates to referring mental-health workers and clients as needed.

Our current findings

AHS has expanded the use of the web-based centralized referral and booking system it had been successfully using in Calgary to its other four zones to create a common province-wide waitlist management system. AHS now uses this system to track availability and coordinate placement of mental-health patients into the inventory of contracted specialized community housing service providers and beds it has in each zone. As of mid-2021, AHS has 1,274 funded and contracted community spaces across all five zones and a variety of external service providers that it manages through this system.[26] This waitlist management system is also being used to generate detailed zone-specific quarterly and annual standardized data reports for zone and provincial AHS leadership. These reports include various metrics for each of the services providers contracted by each zone and contain information in the following six areas:

- client numbers
- client flow intervals
- bed vacancy days
- waitlist overview
- number of denials
- discharges

[24] If the coordinator felt an individual was not a suitable candidate for AHS contracted housing, they would provide the referring source with other non-AHS-funded community housing options available in the area.

[25] Most sites will do their own secondary intake with a prospective client to ensure the client is a good fit for that location. This is especially true in group-home settings where operators want to be sure newcomers don't upset any existing dynamics and harmonies.

[26] These numbers by zone are: Edmonton (746); Calgary (456); North (9); Central (31); South (32)