COMMUNITY CONNECT

FINAL EVALUATION REPORT

MARCH 2022

TABLE OF CONTENTS

Prepared by:

camh
mental health is health

ACKNOWLEDGEMENTS

This report was prepared by the Community Connect Pilot Project team of the Provincial System Support Program at the Centre for Addiction and Mental Health (PSSP at CAMH): Nicole Nosworthy and Matthew Hollingshead. It builds on the contributions of past project team members, including: Stephanie Gloyn, Denise Lamanna, Michele Mitchell, David Phillips, and Nitali Tagger.

Our sincere thanks go out to the teams from the Neighbourhood Group, the Glendale House Withdrawal Management Service at St. Joseph's Health Centre (Unity Health), and Women's Own Withdrawal Management Centre for their commitment to improving the wellbeing of women in need of support. Without their willingness to experiment and follow through on the implementation of the Community Connect model, this work would not have been possible.

We warmly acknowledge the members of the Community Connect Steering Committee, who generously provided their time, support, and guidance throughout the project: Gerry Banks, Julia Bloomenfeld, Jon Bushell, Deborah Gardner, Robin Griller, Amber Kellen, Kelly Lawless, Dana Lythgoe, John O'Mara, Linda Picken, Francesca Serwaa, Lorie Steer, Janet Stevenson, and Martha Williams.

We would also like to thank the Centre for Addiction and Mental Health, who provided financial support for this initiative.

Suggested citation:
Provincial System Support Program. (2022) Community Connect Pilot Project Evaluation Report. Toronto, ON: Centre for Addiction and Mental Health.

COMMUNITY CONNECT OVERVIEW

Community Connect is a short-term case management program for women transitioning from Withdrawal Management Services (WMS) to community-based support. The Community Connect Case Manager begins working with women during their WMS stay, drawing on gender- and trauma-informed approaches to help clients identify the support they need to begin or continue working towards their individual recovery journeys.

The time immediately following discharge from a WMS presents a critical opportunity for reducing the risk of relapse or overdose and ensuring that individuals are connected with the right supports in a timely manner.[2, 5, 10] Staff from community-based organizations often have more flexibility and stronger connections with community partners than their hospital-based counterparts. They can leverage these resources to help clients remain safe and engaged during a time marked by significant vulnerability and potential for positive change.

Community Connect decreases a client's unmet support needs by fostering coordination of care, offering support during service wait periods, and facilitating warm hand-offs to services that meet personal goals. The model's unique foundation of partnership between community- and hospital-based services centers the value of collaboration and service integration in the pursuit of high-quality client-centered care.

A one-year pilot project of Community Connect operated from December 2021 to December 2022 as a partnership between: the Glendale House WMS at Unity Health - St. Joseph's Health Centre, the Women's Own WMS at the University Health Network, the Neighbourhood Group - St. Stephen's Community House, and the Provincial System Support Program at the Centre for Addiction and Mental Health, which provided project coordination and evaluation support.

The Importance of Being Gender– and Trauma-informed

Development of Community Connect was guided by the principles of gender- and trauma-informed practice and a recognition that women who use substances have been consistently underserved by the substance use system. Gender-informed services seek to address how social factors like the expectations of gendered roles and norms or distribution of resources to services for different genders impact how individuals experience and are able to access appropriate supports.[11] For example, intake and care planning for Community Connect considers issues that tend to have more significance for women, including childcare concerns, involvement with Children's Aid Societies, and the safety of potential housing options.

Including trauma-informed practice principles in Community Connect reflects an appreciation that past experiences of trauma are closely correlated with problematic use of tobacco, alcohol, and other substances.[11] Trauma-informed practices allow service providers to appreciate the context in which a woman who has experienced trauma is living her life while avoiding re-traumatization by supporting safety, choice, and sense of control in the course of their care.[3, 4] The trauma-informed care principles of trauma awareness; safety and trustworthiness; choice, collaboration, and connection; strengths based and skill building have been embedded throughout the Community Connect service model.[4] This includes prioritizing the hiring of Case Managers who are women, ensuring that communication happens in safe places and through safe means, and that women are provided with as much information and choice as possible about the care they receive.

For more information about gender- and trauma-informed care, please consult these resources:

- New Terrain: Tools to Integrate Trauma and Gender Informed Responses into Substance Use Practice and Policy (Centre of Excellence for Women's Health, 2018)
- Trauma Matters: Guidelines for Trauma-informed Practices in Women's Substance Use Services (The Jean Tweed Centre, 2013)

The Value of Partnership

The importance of partnership to the Community Connect model cannot be overstated. Despite the growing understanding of substance use as a chronic condition, there is a sense that existing systems of treatment and care largely offer short, disconnected sessions of high-intensity treatment.[7,8] This is often at odds with the reality that recovery is a long-term, personal journey that takes different pathways and sources of support to help improve a person's health, social connections, and wellbeing.[1, 6, 9] Most people will encounter a number of different services and supports over the course of their recovery journeys, and many are left to manage the transitions from one to another on their own.

Withdrawal Management Services offer support for the safe management of withdrawal symptoms and medical complications of individuals with a substance use disorder who are ceasing to use the substance.[2] In Toronto, where Community Connect was created, WMSs are operated by hospitals. They are often framed as

the “first-step” in the continuum of recovery and care but evidence suggests that these services require further support because transition from WMS to community has been identified as a time of increased risk.[2] As stated by the Toronto Central Local Health Integration Network in 2015, there is a need to reform WMS for greater coordination of care, integration of services, and infusion evidence-based standards of care to support clients during high-risk transition periods.[10]

Community Connect enhances existing WMS infrastructure by introducing experienced Case Managers who are employed by community-based organizations. Although the Case Manager works primarily from the WMS, they have the flexibility to spend time offsite in ways that may not be possible or appropriate for WMS staff, such as conducting accompaniments, outreach, or engagement activities.

EVALUATION SCOPE AND METHODOLOGY

This report presents findings from the evaluation of the Community Connect pilot project (CC). The evaluation was led by the Evaluator on the PSSP team and oversight was provided by the project Steering Committee. The evaluation examined the functioning and experiences of Community Connect for the duration of the pilot project from December 2021 to December 2022.

Data was collected from multiple sources. Data collection tools are described in Table 2. Methods included interviews with the women who were supported by Community Connect, monthly interviews with the Case Manager, a focus group with the Steering Committee, an implementation tracker that collected information about barriers and facilitators for the program's implementation, and de-identified client service data.

Qualitative analyses of the interview, focus group, and tracker were conducted using a thematic analysis approach. Quantitative data and descriptive statistics from the client service data were integrated into the qualitative findings where applicable.

Purpose of the Evaluation

The purpose of the evaluation for Community Connect is to:

- Explore the women's experience during Community Connect.
- Explore how Community Connect has impacted women's journeys from WMS to external services
- Explore the facilitators and barriers to implementing Community Connect
- Inform the sustainability of Community Connect

Overarching Evaluation Questions

The evaluation questions are grouped into client, system, and implementation outcomes.

Client Outcomes

1. What are the participation and utilization rates for Community Connect?
2. What are the population profiles of the women in Community Connect?
3. How did the women experience the care provided through Community

Connect?

a. Did women receive trauma-informed (TI) and gender-informed (GI) care?
b. Did women feel engaged in and in charge of their care with Community Connect?
c. What type of Community Connect supports do women need? What kinds of support did the Case Manager provide?
d. Did the women feel their participation in Community Connect helped meet their individual care goals?
e. Were communication approaches, technologies, and locations safe and accessible?
f. How did the women respond to the care provided through the Case Manager support?

System Outcomes

1. How did Community Connect impact the transition from WMS to external supports? Did it help with making connections to external supports?
2. How did the COVID-19 pandemic impact women's transition from WMS to external supports?
3. What skills and training support the Case Manager in their role?

Implementation Outcomes

1. What are the facilitators and barriers to implement Community Connect?

Logic Model

he logic model for Community Connect depicts the resources and activities that contribute to the program were expected to lead to short- and long-term client, system, and implementation outcomes.

(Continued on next page.)

Table 1: Community Connect Pilot Project Logic Model				
	Oversight	***Project Management***	***Case Management***	***Evaluation***
Inputs	Members of community based organizations and substance use services	Project Coordinator (PSSP Supervision) Funding provided by CAMH (e.g., materials, equipment, transportation) Honorariums for engagement with PWLE	Full time Case Manager TCAT Supervisor In kind supports (i.e., desk) provided by Glendale House WMS at St. Joseph's Health Centre, and Women's Own WMS	Project Evaluator (PSSP Supervision)
Activities	Develop governance documents (MOU) Supports project planning and implementation through the Steering Committee and Implementation Committee Supports implementation decision making Identifies barriers and/or opportunities for external support referral	Chairs the Steering Committee Develops implementation supports, including coaching plans, evidence-informed practices, and policies Drafts service pathways to standardize service delivery Develops practice profile to identify core elements of the program	Establishes and/or maintains connections with external supports Completes intake assessments with clients Completes data entry based on intake Identifies women's service needs/goals using motivational interviewing and harm reduction approaches Provides transitional support based on client's identified goals	Overseen by Steering Committee Case Manager and Neighbourhood Group collects and summarizes data using Pirouette data management system Assess women's experiences in CC Ongoing monitoring of Case Manager experience Data sharing agreements

Table 1: Community Connect Pilot Project Logic Model *(cont.)*				
	Oversight	***Project Management***	***Case Management***	***Evaluation***
Activities (cont.)	Review and approve service pathways	Organizes trauma-informed and gender informed training for the CM and their supervisor	Overseen by The Neighbourhood Group's Supervisor Monthly check-in meetings with Project Management team	Build capacity for data collection and extraction through coaching and training
Outputs	# of Steering Committee meetings Defined roles and responsibilities MOUs	Pathways and protocols (practice profile, Implementation framework) Knowledge translation/ communication plan Project coordination Partnership development # of Recommendations for sustaining CC	# of client accessing CC Supports provided to clients Data summary spreadsheet # of monthly meetings with Project Management team	Pirouette summary spreadsheet # Quarterly reports # client interviews # focus groups with Steering Committee Final report Continuous monitoring of program implementation Demographic profile of women who access CC Implementation tracking document

Table 1: Community Connect Pilot Project Logic Model *(cont.)*				
	Oversight	***Project Management***	***Case Management***	***Evaluation***
Short-term Outcomes	Increased reach of CC to the intended client base Increased accountability for decision making Promotion of trauma- and gender-informed practices when supporting women with substance use challenges	Increased support of CM Enhanced communication amongst partners Mitigation strategies for any barriers to implementation Strengthened relationships among partners	Proficiency in delivery of TI and GI client support Meaningful connections/ relationships between Case Manager & external supports Participation of women in their care planning and delivery Improved understanding of women's journeys after discharge from WMS Improved understanding of women's service needs Women feel engaged during their experience with CC	Consistent data collection practices and processes Understanding women's and CM's experiences participating in the pilot
Long Term Outcomes	Women feel supported in transition(s) between WMS and external supports Coordination of external referrals (e.g., completion of referrals) and navigation of external supports Women's service needs are aligned with service referrals Women's recovery goals are met			

Data Collection Tools

The data used in the analysis of this evaluation include interviews with the Case Manager and women in the program, a focus group with the Steering Committee, a summary of the Client management spreadsheet, and an implementation tracker. A description of the tools, the number of participants, and the frequency of collection are described below.

Table 2: Data Collection Tools

Tool	*Description*	*Participants*	*Frequency*
Interview with Case Manager	Check-ins occurred between the CM and the Implementation Specialist and Evaluator. The goals of the check-ins were to: 1) identify potential issues related to implementation, 2) provide implementation coaching where appropriate, and 3) ensure integrity of monthly client data collection. Notes were taken based on these three goals, recorded in the implementation tracker, and summarized for the Steering Committee.	Case Manager	Monthly
Interviews with Community Connect Clients	Semi-structured one-on-one virtual interviews were conducted with women who participated in CC. Women who participated in CC were contacted via email or phone to ask to participate in the interview. The virtual interviews were conducted through Webex and a transcript was provided from the recording. The goals of the interviews were to: 1) explore the women's experiences participating in CC, and 2) explore how CC impacted their journeys from WMS to external services.	Four interviews	December 2021

Table 2: Data Collection Tools *(cont.)*			
Tool	***Description***	***Participants***	***Frequency***
Focus Group with Steering Committee Members	Members were emailed to invite them to the focus group. The focus group was conducted through Webex and a recording transcript was reviewed. The goals of the focus group were to: 1) explore barriers and facilitators to implementing CC, and 2) inform the sustainability of CC.	One focus group with five members	February 2022
Implementation Tracker	The tracker was completed by the Implementation Specialist based on facilitators, risks, and barriers for implementation informed by meetings and conversations from the following: Focus group, Glendale House Manager, Steering Committee meeting minutes, Implementation Planning Group meetings, Case Manager check-in meetings, direct communication with TNG Supervisor, Capacity Building Facilitator Debrief, and relevant private communications.	N/A	Continuous
Pirouette Summary Spreadsheet	This spreadsheet contains de-identified client information that was updated from the Neighbourhood Group's client database (Pirouette) by an administrative support person on a monthly basis. The spreadsheet was password protected and sent to the PSSP Evaluator, who stored it on a password protected server. Please see Appendix 1 for data categories included in the summary.	N/A	Monthly

Evaluation Framework

The evaluation framework is organized by the evaluation questions and the sub-questions. It describes the measures, data source, frequency and lead of data collection, and analysis.

Table 3: Evaluation Framework

Main Evaluation Question	*Sub-evaluation Question*	*Measures*	*Data Source*	*Frequency*	*Collected From*	*Analysis*
What are the main questions we want the evaluation to address?	*What are the sub-questions we want the evaluation to address?*	*What specific, observable or measurable information will address the evaluation question?*	*What tool will we use to collect the data?*	*How often will we collect the data?*	*Who provides the data?*	*How will the data be analyzed?*
What are the participation and utilization rates for Community Connect?		• # of clients • # of clients per quarter • Date connected to CC • Date discharged from CC • Level of support required • Referral source	Pirouette summary spreadsheet	Quarterly	Case Manager	Descriptive

Table 3: Evaluation Framework *(cont.)*						
Main Evaluation Question	***Sub-evaluation Question***	***Measures***	***Data Source***	***Frequency***	***Collected From***	***Analysis***
What are the population profiles of the women?		• Age • Race • % with children • % whose primary language is English • # in a relationship • % of Canadian citizens • Level of education achieved • # with legal involvement • % of women who were employed • % with family doctor • % actively connected to external supports	Pirouette summary spreadsheet	Quarterly	Case Manager	Descriptive
How did the women experience the care provided through Community Connect?	a. Did women receive trauma-informed and gender-informed care?	Perceptions of care	Interview with women in Community Connect	End of Project	Clients	Thematic Analysis
			Interview with Case Manager	Monthly	Case Manager	

Table 3: Evaluation Framework *(cont.)*						
Main Evaluation Question	***Sub-evaluation Question***	***Measures***	***Data Source***	***Frequency***	***Collected From***	***Analysis***
	b. Did women feel engaged in, and in charge of their care with Community Connect?	Perceptions of care	Interview with women in CC	End of Project	Clients	Thematic Analysis
	c. What type of CC supports do women need? What kinds of support did the Case Manager provide?	Presenting issue Types of support provided	Pirouette summary spreadsheet	Quarterly	Case Manager	Descriptive
			Interview with women in Community Connect	End of Project	Clients	Thematic Analysis
			Interview with Case Manager	Monthly	Case Manager	Thematic Analysis
	d. Did the women feel their participation in CC helped meet their individual care goals?	Perceptions of care Experiences of women during transition	Interview with women in Community Connect	End of Project	Clients	Thematic Analysis

Table 3: Evaluation Framework *(cont.)*						
Main Evaluation Question	***Sub-evaluation Question***	***Measures***	***Data Source***	***Frequency***	***Collected From***	***Analysis***
	e. Were communication approaches, technologies, and locations safe and accessible?	Perceptions of women on communication with Case Manager	Interview with women in Community Connect	End of Project	Clients	Thematic Analysis
			Interview with Case Manager	Monthly	Case Manager	Thematic Analysis
	f. How did the women respond to the care provided through the Case Manager support?	Perceptions of women about the support they received	Interview with women in Community Connect	End of Project	Clients	Thematic Analysis
			Interview with Case Manager	Monthly	Case Manager	Thematic Analysis
How does CC impact the transition from WMS to external supports? Did CC help with making connections to external supports?		Perceptions of impact on transitions	Interview with women in Community Connect	End	Clients	Thematic Analysis
			Interview with Case Manager	Monthly	Case Manager	Thematic Analysis
		Connections made to external supports	Pirouette summary spreadsheet	Quarterly	Case Manager	Descriptive

Table 3: Evaluation Framework *(cont.)*						
Main Evaluation Question	***Sub-evaluation Question***	***Measures***	***Data Source***	***Frequency***	***Collected From***	***Analysis***
How did the COVID-19 pandemic impact women's transitions from WMS to external supports?		Impact of the COVID-19 pandemic on transitions	Interview with women in Community Connect	End of Project	Clients	Thematic Analysis
			Interview with Case Manager	Monthly	Case Manager	Thematic Analysis
			Tracker	Continuous	All	Descriptive
What skills and training supported the Case Manager in their role?		Skills and training of CM Perceptions of skills	Interview with women in Community Connect	End of Project	Clients	Thematic Analysis
			Interview with Case Manager	Monthly	Case Manager	Thematic Analysis
What are the facilitators and barriers to implement CC?		Facilitators and barriers	Interview with Case Manager	End of Project	Case Manager	Thematic Analysis
			Focus group with Steering Committee	End of Project	Steering Committee	Thematic Analysis
			Tracker	Continuous	All	Descriptive

EVALUATION FINDINGS

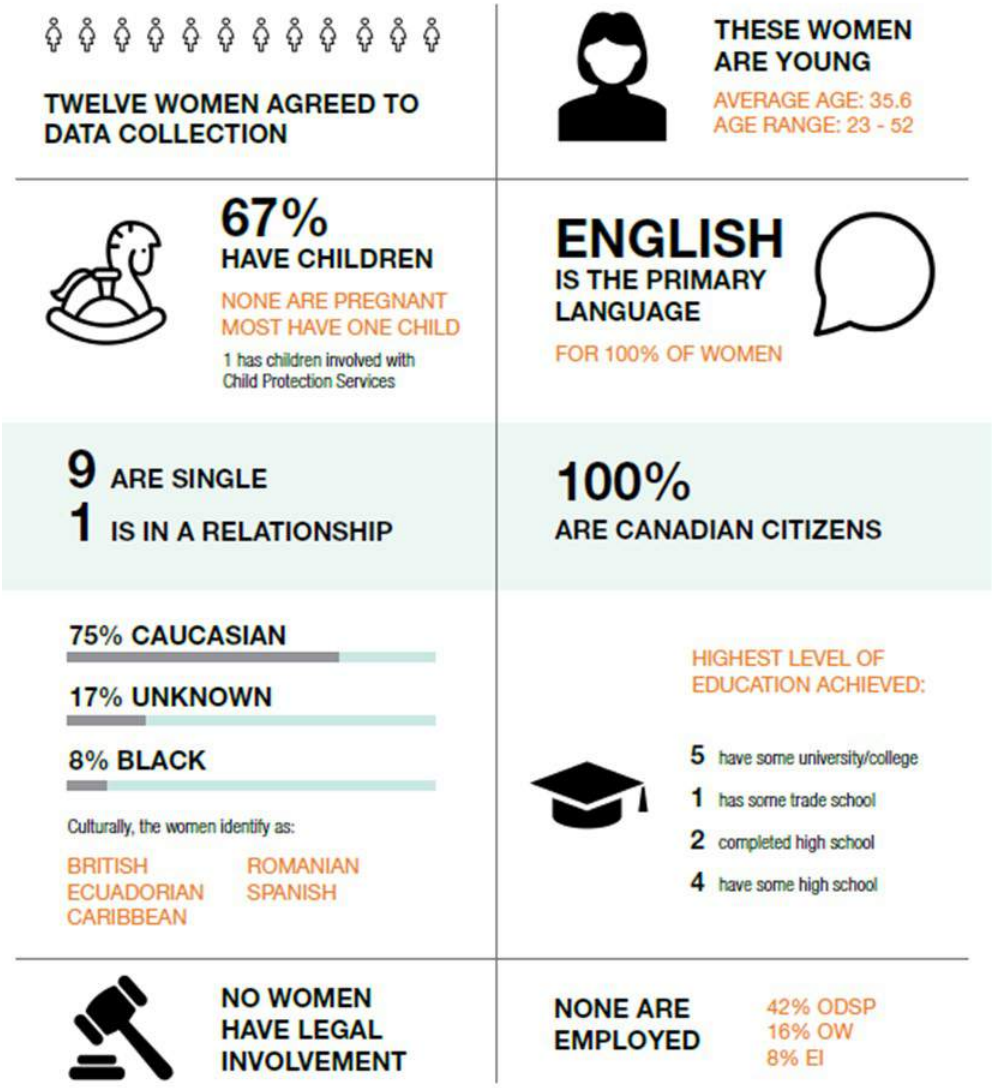
The following findings are based on the analysis of all data collected through the Community Connect pilot project. Each evaluation question has been grouped to address client, system, and implementation outcomes.

Client Outcomes

Evaluation Question 1: What are the participation and utilization rates for CC?

12 women participated in Community Connect during the pilot project. 6 were referred from the Glendale House WMS and 6 from the Women's Own WMS.

Evaluation Question 2: What are the population profiles of the women in Community Connect?



Evaluation Question 3: How did the women experience the care provided through Community Connect?

a. Did women receive trauma-informed and gender-informed care?

The lack of support resources (i.e., housing, residential treatment, legal supports) that use a gender-informed lens or are meant specifically for women was described by partners as representing a significant service gap in Toronto. As a result, many women fall through the cracks and are not able to access services that could support them. Early in the project, it was decided that gender- and trauma-informed lenses would be critical tools to ensure that women were adequately supported and engaged throughout the process of receiving care.

The following steps were taken to promote the use of these lenses in decision-making and practice:

- Steering Committee members were introduced to the principles of gender - and trauma-practice through an in-person session with one of Canada's leaders in these areas (pre-pandemic);
- Gender- and trauma-informed practice training was offered to the Case Manager, the program's Supervisor, and all Glendale House WMS staff by a qualified and experienced facilitator.

In describing their support experiences with the Case Manager, all women indicated receiving gender-informed care. The Case Manager provided gender-informed care by creating a safe and respectful environment and relationships with participants. While every case was different, based on each of the woman's needs, the Case Manager looked for opportunities to provide clients with support to improve their socio-economic status (e.g., providing supports for employment), safety (e.g., helping a client recover belongings from an abusive partner), or addressing systemic issues that create barriers for women (e.g., open hours and childcare options).

According to some SC members, additional women's organizations, even if not involved in WMS operations, should have been engaged to participate in the project and share knowledge. This could have included seeking their membership on the Steering Committee or consulting them at appropriate stages of development and implementation.

"The project was an excellent demonstration project of the systemic and social benefits of gender-based withdrawal management services and this can be uploaded and practiced by community based organizations and larger healthcare institutions across the City, the province and nationally." - Steering Committee Member

b. *Did women feel engaged in and in charge of their own care in Community Connect?*

The women indicated that the care they received was client-centered and they felt in charge of and engaged in decision-making. The Case Manager routinely walked clients through treatment information and potential outcomes, including the pros and cons of any issue to help them make informed decisions. Once a decision was made, the Case Manager would walk the women through the steps of accessing supports, including where to go and what documentation was needed. In spite of feeling engaged in their care, it was indicated that conducting sessions on the phone due to pandemic-related public health measures was often very challenging. This was especially true when assessments were long and tedious, making it more challenging to keep the women engaged for longer periods of time.

Women interviewed as part of the pilot project's evaluation reported that the Case Manager acknowledged and responded to their preferences and needs while ensuring that their values and goals guided case management decisions. For example, the Case Manager helped one woman to complete the lengthy GAIN assessment (required to access substance use treatment), but also allowed space for the woman to pursue her preferred route of applying to treatment centres herself.

c. *What type of Community Connect supports do women need? What kinds of support did the Case Manager provide?*

The supports needed and the supports provided by the Case Manager varied for each woman depending on their situation. Table 4 shows the presenting issues for the 12 women in Community Connect.

All women interviewed reported receiving supports that they identified as priority and set as their own personal treatment goals.

Table 4. Presenting issues for Community Connect Clients

Presenting Issue	#
Substance Use	7
Housing	3
Mental Health	5
Employment	1
Treatment	4

The Case Manager was able to elicit the information needed from clients to understand their needs without overwhelming them. The interviewed women elaborated on the supports they received from the Case Manager. Some of the supports the Case Manager provided include:

- Making connections to community supports, discharge planning, and supporting unhoused women through transition to shelters
- Sending information about full time job opportunities that are suitable for the clients and connecting them to and following up with employment services
- Identifying support resources (e.g.: treatment centres, housing)
- Conducting assessments or completing admission packages to help women access services or treatment. For example, the GAIN was long and tedious. One woman explained how she could have not completed the GAIN without the Case Manager's support.
- Case Manager provided accompaniment to facilitate referrals
- Provided supportive informal counselling while in the community and waiting for the completion of referrals
- Developing recovery plans together
- Writing letters of support (i.e., Employment Insurance Letter of Support)

The Case Manager described the typical process of connecting with a women by introducing herself, describing the program, conducting an intake assessment to identify their needs, concerns, and resources, and developing a plan to achieve their personal goals. The Case Manager also followed up every week with the women to check-in around further goals or working towards discharge. While the typical length of service ranged from 3 - 5 months, the Case Manager let women know that they could always connect again for additional support even after their discharge from the program.

d. Did the women feel their participation in Community Connect helped meet their individual care goals?

The Case Manager supported the women to achieve their personal goals. It was important to the Case Manager to avoid defining what success meant for the clients of Community Connect. Each woman has their unique recovery goals based on their circumstances and immediate needs and strengths. Leaving this space allowed the Case Manager to develop more authentic relationships with the women.

The women indicated that the Case Manager was flexible and able to identify what supports were needed to help them to achieve their goals. In addition, they indicated how the check-ins with the Case Manager were continuous, even after they had left WMS and were in treatment. Even after a treatment goal was achieved, the Case Manager engaged in follow-up outreach communication (via email and telephone) to see if they needed any other supports.

e. Were communication approaches, technologies, and locations safe and accessible?

The women reported feeling that the communication approaches were tailored to their needs. The Case Manager also attended many community meetings in accordance with the needs of the women (e.g., pick-up documents, accompaniments to appointments). The women reported using email, text messaging, and phone calls for daily communication, outreach, and follow-up. One woman described how helpful it was in her overall health to have the Case Manager text her while she waited for treatment to begin. Otherwise, they would have had no one to talk to because they felt that their family did not understand their substance use.

Although a promotional poster and pamphlet for Community Connect were created and distributed, some women who participated in the project suggested that they could have been more consistently used to increase awareness of the service for women who could benefit from it.

f. How did the clients respond to the Case Manager support?

Some of the women described feeling empowered to seek treatment and stay on the path of recovery because of the Case Manager's support. The Case Manager described Community Connect as helping to save the lives of the women. One woman described feeling a renewed sense of independence through being supported to recover her belongings from an ex-partner and starting treatment. All women reported feeling helped and supported by the Case Manager and often described feeling unable to access comparable support from other services or programs. One woman described telling other women in WMS about the Case Manager because they were so helpful.

The relationship and trust that was built with the Case Manager was described as the main reason the women felt so comfortable receiving care. Overall, they described a positive experience with the Case Manager who

reportedly listened without judgement and was easy to talk to, which resulted in the women feeling safe when speaking about their situations (e.g., mental health concerns) and priorities. They felt understood because the Case Manager was patient, compassionate, and accessible. The Case Manager collected a manageable amount of information to determine support needs in a way that was easy to understand, straightforward, and did not put undue pressure on clients. The Case Manager's communication was open and transparent. One woman described her as a "lifeline" who provided the support she needed. Another woman explained how the relationship with the Case Manager during the transition was what allowed her to adhere to her personal goals and prevented her from using substances. The Case Manager was very in-tune to the women's needs and able to anticipate what suggestions would be useful.

The Case Manager was also described as providing a social connection because she was someone to talk to and was also good listener. The Case Manager often provided informal counselling support during periods of time when clients were on waiting lists for services. Women described feeling grateful for the Case Manager as a resource during a time in their journey when they had few alternative resources or supports.

System Outcomes

Evaluation Question 4: How does Community Connect impact the transition from WMS to external supports? Did Community Connect help with making connections to external supports?

The women described the biggest outcome of their participation in Community Connect as being supported during the transition from WMS to other services in a system that is uncoordinated and difficult to navigate. The women indicated that they had improved knowledge of and connections to a variety of recovery resources in the community.

The community-based services and supports the women connected with varied. Off the 12 women seen, 75% were connected to other community based organizations (e.g., Glendale House Addictions Worker, Jean Tweed recovery group), and 25% of the women were not. While the Case Manager did provide support to women during their transition, many external factors prevented the women from actually connecting to services, such as COVID-19 pandemic restrictions and lengthy waitlists (see below in "Barriers to Implementation" section for more discussion).

For the women who were connected to other services it was unclear if the staff from outside organizations were working collaboratively with the Case Manager for their care. One woman felt the care would have been more impactful if the Case Manager had communicated information about their care plan to the staff at the community services they subsequently accessed. However, early on in the project, “coordinated care planning" was reframed as "care planning." Coordinated care refers to a very specific way of working which was not found to be necessary as the pilot project unfolded.

Some women described experiencing confusion about where to find the Case Manager in-person because her time was split between two WMSs and community-based work. This was also a pressure felt by the Case Manager, who expressed feeling that splitting her time in this manner limited her ability to remain connected to and form relationships with women across the two sites. However, those concerns were mitigated by the Case Manager’s willingness and ability to follow-up and meet with women once they were discharged from the WMS and had re-entered into their communities.

During the project, questions arose regarding the difference between "discharge" from Community Connect and completion of a referral to an external support or service. All women interviewed reported being unsure of whether or not they had actually been discharged from the Case Manager’s caseload, in part because the Case Manager continued to reach out to women who were connected to treatment services. None of them could recall a formal discharge discussion with the Case Manager.

Evaluation Question 5: How did COVID impact women’s transition from WMS to external supports?

The impacts of the COVID-19 pandemic presented significant barriers for the implementation of Community Connect. The start of the pilot project was delayed by several weeks due to a closure at the Glendale House WMS. Staff were reassigned to other departments at St. Joseph’s Health Centre to screen staff and guests and the Glendale House building transitioned to temporary housing for hospital staff unable to safely return home following a shift.

Upon the reopening of Glendale House and at the beginning of the pilot project, further barriers were encountered. Infection Prevention and Control procedures and other public health measures limited Glendale House’s capacity to 6 women's beds and 6 men's beds, with common areas closed and group programming cancelled or limited. At Women’s Own WMS, where client needs were reported to

be more acute, the typical 3-5 day stay in withdrawal management was sometimes not long enough for women to adequately stabilize and determine next steps. The Case Manager reported that these conditions led some women to remain in undesirable circumstances for longer than intended, while others put off their recovery planning out of concern that the supports they needed would not be available. These factors combined to increase concerns that women who use substances were exposed to further marginalization and stigmatization over the course of the pandemic.

The Case Manager added that women were more likely to have had to wait for external services while COVID-19 public health restrictions were in place across the sector. When many restrictions lifted in Ontario during November 2021, the Case Manager's workload changed and began to include more support for clients seeking immediate connections to external services (i.e. shelter support) rather than the 3 – 5 month support period initially envisioned for the program. The Case Manager described the pace being faster than anticipated, which did not allow as much time for rapport-building and needs identification with the women as intended.

Evaluation Question 6: What skills and training support the Case Manager in her role?

Hiring a Case Manager with pre-existing knowledge of and relationships among community-based support agencies provided an essential foundation for the role. The success of many referrals depends not only on formal processes being followed, but also on the trust between various support professionals involved. The pilot project's Case Manager previously worked with the Toronto Community Addiction Team (TCAT) with the Neighbourhood Group, and had completed student placements with Street Health and the Elizabeth Fry Society. These experiences lent her a broad knowledge of recovery supports and services available for women across the city as well as a strong foundation for working from a harm reduction approach. The Case Manager also described making efforts to continuously learn about and make new connections with relevant services in the city, despite the limited number of options available to women.

The Case Manager also had professional training via a Bachelor of Social Work, which was a requirement of the job description, and was completing a Master's degree in Counselling Psychology. Existing familiarity with trauma-and gender-informed ways of working were bolstered by a specialized capacity-building series, provided to the Case Manager as a part of the pilot project.

Clients interviewed as a part of the pilot project evaluation specifically mentioned the Case Manager's interpersonal skills as contributing to their positive experiences in the program. These included a clear communication style, a professional but approachable manner, being available, and meeting clients with calmness, patience, kindness, and a lack of judgment.

Implementation Outcomes

Evaluation Question 7: What are the facilitators and barriers to implement Community Connect?

Implementation Facilitators

Flexibility in scheduling project meetings

In response to the pandemic related restrictions for in-person meetings, the Steering Committee meeting schedule changed from monthly meetings (during the design of the model), to quarterly meetings (throughout the pilot project). In addition, the meetings moved to the online Webex platform. While virtual meetings helped to maintain momentum and essential accountability for the project's functioning, it may have resulted in barriers for some members to feel connected to each other. Steering Committee members indicated that while convenient, the virtual meetings prevented them from fully participating in the meetings. For example, virtual meetings prevented members from connecting with the Project Coordinator and other committee members before or after the meeting to ask additional questions or have more spontaneous, natural conversations.

Strong project management and support

Steering Committee members described being highly supported by the PSSP Project Management team. This was achieved by ensuring inclusivity in membership, consistent providing gentle reminders, employing collaborative decision making, and documenting processes and decisions. In addition, the cyclical nature of the quarterly structure helped to maintain transparency and accountability. Quarterly reports that summarized pertinent data and highlighted issues and opportunities were used to further discussion and consideration.

Planning and communicating about the end of the project was also important for the success of the project's implementation. The PSSP team was deliberate about communicating the timeline of the pilot project and the nature of PSSP's involvement at different points along the process.

"The tone of the project and the planned next steps have progressed with a sense of mutual respect and gratitude thanks to the leadership of the CAMH team", Steering Committee Member

There was ongoing professional development with subject matter experts speaking and group exercises to encourage shared understanding of equity-based services. The engagement of PWLE was critical and an environment was established that encouraged active participation.

Commitment, collaboration, and relationship with partners

Several factors contributed to establishing Community Connect despite the disruptions caused by the COVID-19 pandemic. These included the commitment, collaboration, and relationships of partners. For example, a relationship with Women's Own WMS was established in May 2021, despite their upcoming closure at the end of September 2021. This allowed the Case Manager to offer Community Connect to a group of women with urgent support needs at a time of significant importance for the WMS. The strength of the Case Manager's work led the former Program Coordinator at Women's Own to broker a relationship with the project in her new role at the recently opened Women's WMS at Michael Garron Hospital. This introduction allowed Community Connect to continue after the conclusion of the pilot project.

Sustaining Community Connect

Interest in expanding the availability of Community Connect after the conclusion of the pilot project was generated largely as a result of the strength of the Case Manager's work and existing relationships between project partners. When Women's Own closed in September 2021, its former Program Coordinator joined the new women's WMS at Michael Garron Hospital (MGH) and initiated an opportunity to integrate Community Connect into their developing service model. The Neighbourhood Group expressed their interest to continue supporting Community Connect, and in January 2022, the two organizations finalized a Memorandum of Understanding to offer the service to clients at the new MGH women's WMS.

Implementation Risks and Barriers

Achieving a full caseload

When Community Connect was launched, several factors contributed to a slow start for clients joining the Case Manager's caseload. Firstly, it takes time for new programs to promote their services and recruit participants. Secondly, several COVID-19 outbreaks occurred during the period of Community Connect. When outbreaks occurred, new intakes could not be accepted by Glendale House, the primary referring agency to Community Connect at the time. As a result, the Case Manager had a smaller caseload than expected. Thirdly, after Glendale House reopened following its closure at the beginning of the pandemic, many of the women visiting the WMS had service connections in the community and did not require transitional case management support. This was different from the profile of women coming into the WMS prior to the pandemic. The cause remains unclear, but was believed to have been influenced by a number of factors related to the pandemic (i.e., hesitancy to visit congregate settings, limited activities accessible while in WMS).

To increase referrals to Community Connect, a phased approach for outreach was used: the Patient Care Manager, Addiction Services (Glendale House Withdrawal Management Service), connected the Case Manager with St. Joe's Mental Health Emergency Support unit to see if women were visiting the ER could benefit from the Case Manager's services. More specifically, the Case Manager was connected with all hospital staff who provided substance use supports within the ER. However, these connections did not result in an increase in the Case Manager's caseload. These programs were experiencing similar issues regarding patients already being connected with community-based services as was the case for women using the WMS during this time period.

Efforts to generate referrals to the Case Manager from within St. Joseph's Health Centre were also unsuccessful during the project. Some women were avoiding the hospital because of the pandemic, or, had needs related to "finding some quiet space" which were met by pandemic-specific services such as the city-run COVID-19 Recovery and Isolation hotel.

At the direction of the Steering Committee, connections were made with Street Haven (where there was an agreement to refer to the Community Connect, although no women with suitable support needs emerged);

Sistering (contact unsuccessful); Toronto Drop-in Network (expressed interest but Community Connect did not align with their needs or priorities); Women's Own (relationship established, see details below).

Challenges for the Engagement of WMS staff in capacity building

From April to June 2021 a six part trauma- and gender-informed capacity building series was offered virtually for the Case Manager, her supervisor, and the Glendale House WMS staff by Kathryn Mettler. While positive feedback about the sessions was received from the all participants and the Case Manager was able to apply the material to her practice, there were some challenges related to being able to consistently engage WMS staff. These included scheduling issues (many WMS staff are shift workers), general stress related to working through the pandemic, the voluntary nature of the sessions, and the limitations of online education sessions.

Integration of Case Manager into WMS Functioning

Formal and informal opportunities for the Case Manager to become fully integrated with the both WMS sites were limited by pandemic-related IPAC procedures and restrictions. For example, prior to the pandemic there were spaces where staff could hold discharge and service planning meetings with clients and other support personnel. There were also common areas for staff where they could eat and take breaks together. These spaces are important for building professional and personal relationships that can strengthen the care offered to women, but they were largely unavailable throughout the pilot project due to room capacity limits, physical distancing requirements, and the prohibition of shared indoor dinning spaces. The split between different sites and community-based work further contributed to this barrier by limiting the total time that the Case Manager was onsite at each WMS.

Inclusion of Peer Support

The initial design of Community Connect and its implementation plan for the pilot project included a Peer Leader role, meant to support the Case Manager both onsite at the WMS and in communities. However, implementing partners decided that due to IPAC restrictions on the number of people allowed in the WMS and general uncertainty related to the pandemic, this role would not be implemented. Further, despite shared interest in offering peer support, funding was not available to expand the program through the Community Connect work at Michael Garron Hospital. Nevertheless, the

importance and value of peer support was raised consistently by project partners and highlighted as a priority for future implementation of the model.

Slow referrals to community services

The Steering Committee focus group indicated that one of the strengths of Community Connect was the warm transfers made to community-based services. Providing warm transfers supported women by encouraging a sense of connectedness between service providers, which can be critical for longer-term integration of supports. However, finalizing connections with external support services was challenging throughout the project. These challenges were related mainly to the general lack of supports and services available for women, which were exacerbated by the severity of pandemic-related restrictions. When restrictions are tighter, referrals are harder. All service providers across all social service sectors reduced service capacity and moved to virtual services in response to COVID-19 IPAC requirements and public health restrictions. This limited access for clients seeking services and increased the length of time that they had to spend on waiting lists. Some services closed waitlists and services altogether.

Wait times for services

Long wait times for community and in-residence women's services were a challenge that was only exacerbated by the limits imposed due to COVID-19 public health restrictions (i.e. reduction in capacity limits or cancellations of in-person programming). Though the Case Manager sought to mediate these challenges by providing supportive counselling, making connections with virtual treatment groups, and consistently following up with desire services, increased wait times for many services sought by Community Connect clients did put pressure upon the short-term focus of the program.

Data collection and administrative duties

Data collection and information sharing about the women in WMS and Community Connect posed a few challenges to the evaluation of the pilot project. First, sharing database access between organizations is often prohibited due to privacy legislation. This inability to share data introduced barriers for better understanding the needs of Community Connect's clients as compared with those more generally experience by women visiting a WMS. Second, because databases could not be shared with the Community

Connect project team, the data from the client information system had to be anonymized and summarized into a spreadsheet so that it could be shared with the evaluator. However, transferring it from the client database to the spreadsheet was a cumbersome process and sometimes created delays in sharing the summary spreadsheet with the evaluator in time to meet quarterly reporting deadlines. It was important for the PSSP team to have the monthly spreadsheet according to a predictable schedule to ensure that information could be reviewed and any issues addressed in a timely fashion.

The Case Manager expressed concerns related to maintaining client files from two different WMS locations. Because the recording system used by Community Connect relied on paper-based intake forms, the introduction of the second WMS site found the Case Manager having to transport client files more than she was comfortable with. The Case Manager resolved this issue by working with their Supervisor and onsite WMS contacts to ensure that files could be stored in a secure location until they needed to be retrieved, prior to visiting TNG offices to complete administrative work.

Project Team Consistency

During the project, there were many changes of members on the project team and Steering Committee which had impacted the momentum of the project. For example, in the six months preceding the start of the pilot project, the PSSP Implementation Specialist responsible for project management changed three times due to overlapping parental leaves. In addition, the PSSP Evaluator left unexpectedly just prior to the end of the pilot project. Any change in the project team represents a risk for continuity of existing plans, momentum, and stakeholder relationships. Fortunately, these risks were minimized by ensuring overlap between successive roles whenever possible, clear documentation of major decision points, and personal introductions to key stakeholders.

Similarly, two Steering Committee members stepped down at the end of their terms. The two members were leaders in the sector and held senior positions in their organizations. They brought with them a breadth of knowledge, experience, and connections. A new SC member was recruited, but full engagement with the project was challenging as they joined the project at a stage wherein oversight for plans were already in motion, the SC meeting schedule was already set, and communication was hindered due to the fact that it could only take place virtually due to pandemic restrictions.

Sustaining Community Connect

Despite the efforts of the Glendale House Manager to promote the Community Connect model within the Unity Health infrastructure, the hospital system did not adopt Community Connect to augment their WMS programming at the conclusion of the pilot project. Rather they preferred to leverage internal resources to provide Case Management support. However, the SC indicated that trying to directly convince the hospital that relying on their own internal mechanisms to provide this type of service delivery was highly problematic without additional sources of pressure and support.

OPPORTUNITIES FOR ACTION

This section presents a number of opportunities for improving the service quality and expanding the reach of Community Connect in the future. These opportunities are based upon key actionable themes that emerged during analysis of the pilot project findings. The are organized from the most-related to direct service (#1) to the most related to systems-level coordination (#7). They were developed by the PSSP project team and reviewed by volunteers from the Steering Committee.

1. Preserve Focus on Prioritizing Support for Women

It will be important to avoid a one-size fits all approach that limits the Case Manager's ability to offer gender-informed supports to women that may not otherwise be available (i.e. prioritizing safety concerns or family reunification). The systemic factors that led the pilot project to focus on women continue to persist. These include the recognition that substance use supports for women tend to be under-resourced, and that substance use issues and recovery priorities take on different dimensions for women than they do for men.

This recommendation is reinforced by findings from the pilot project, which suggested that already lengthy wait times for community-based supports and in-residence treatment programs for women became longer due to restrictions imposed due to COVID-19. The importance of informal supportive counselling for women while waiting for referrals to other services also underscores the value of offering support that prioritizes the needs and experiences of women.

2. Prioritize Case Manager Integration with Existing WMS Structures and Practices

Improving the integration of the Case Manager into all appropriate aspects of a WMS's existing structures and practices is a straightforward way to build on the success of Community Connect. This could include involving the Case Manager in regular WMS team huddles, encouraging case conferencing or care planning between the Case Manager and WMS staff, and adapting WMS service procedures to include the Case Manager as a matter of standard practice.

Enhancing opportunities for informal relationship building can also improve trust and the potential for better outcomes for clients. This includes ensuring that the Case Manager has access to shared staff break and meal spaces, as well as including the Case Manager in appropriate team building or professional development activities.

3. Create Space for Peer Support

Although the Peer Leader role was not included in the pilot project, integrated peer support is a feature that should be included in future implementations of Community Connect. Peer support was named as a best practice when working with marginalized groups for increasing client trust and enhancing harm reduction supports for recovery-oriented services.

The addition of peer support to the Community Connect care team would also improve the program's ability to respond to the needs of clients in both the community and WMS settings by reducing pressure on the Case Manager to be in different places at the same time.

4. Expand Scope of Community Connect to all WMS Locations

The ability of Community Connect to support women transitioning from WMS back to their communities is limited by the number of WMS sites from which the program operates. Relationships should be formed with each organization that provides WMS services for women to establish the framework necessary for a dedicated Case Manager to offer Community Connect services.

The basic elements of Community Connect could also be adapted to offer the service to structurally marginalized or equity seeking client groups at WMS locations that do not offer services for women.

5. Establish an Oversight Group

Expanding Community Connect to multiple WMS locations with dedicated Case Managers will require the establishment of a centralized Oversight Group to ensure that consistency is maintained across sites. This will be especially true if multiple community organizations are employing the Case Managers.

In addition to ensuring a base level of consistency across sites, the Oversight Group would coordinate evaluation activities to track progress and service goals, troubleshoot implementation or resourcing challenges, and encourage the replication of the model to other WMS locations.

The structure of this group should be informed by equity principles. For example, practices and procedures that encourage the active and meaningful participation of individuals with relevant lived and living experience should be

outlined. This include the dedication of funding to recruit, train, supervise, and fairly compensate people with relevant lived and living experience. Decision-making and membership structures that prioritize the principles of gender- and trauma informed care should also be implemented.

6. Secure a Collaborative Funding Pathway

Funding for collaborative, partnership-based programming like Community Connect requires dedicated funding pathways from established sources capable of ensuring multi-year commitments (i.e. regional Ontario Health Teams, the Ontario Health Mental Health and Addictions Centre of Excellence, established granting agencies).

Though the pilot project would have been impossible without funding from CAMH, reliance on hospitals as the primary funding source for an initiative that leverages community service expertise to enhance hospital-based service transitions can contribute to an unequal power dynamic between service partners. A centralized oversight body should draw on available and emerging information about the benefits of Community Connect to leverage relationships with appropriate funding bodies to generate reliable program resourcing.

7. Negotiate Data Sharing Access

Maintaining and expanding a high quality service across multiple sites will require clear and transparent data sharing practices. Long-term, collaborative service relationships between hospital and community-based organizations will require creative and user-friendly ways to access and share appropriate client information, particularly through the use of shared database access. These practices should adhere to PHIPA requirements, contribute to improved care planning, reduce duplication of data entry, and facilitate evaluation and monitoring of program functioning and outcomes.

Conclusion

Though this report marks the official conclusion of the Community Connect pilot project, Community Connect will continue to be offered through a partnership between the Neighbourhood Group and the Women's WMS at Michael Garron Hospital. The Opportunities for Action and other findings from this report will be used to inform this offering, and can guide further expansions of the program.

REFERENCES

1. Blodgette, J. C., Maisel, N. C., Fuh, I. I., Wilbourne, P. L., & Finney, J. W. (2014). How effective is continuing care for substance use disorders? A meta-analytic review. Journal of Substance Abuse Treatment, 46, 87-97.
2. Canadian Centre on Substance Use and Addiction. (2019). Withdrawal Management Services in Canada: The National Treatment Indicators Report (2015-2016 Data). Ottawa, ON: Canadian Centre on Substance Use and Addiction.
3. Centre of Excellence for Women's Health. (2017). Trauma-informed Practice Principles.
4. The Jean Tweed Centre. (2013). Trauma Matters: Guidelines for Trauma-Informed Practices in Women's Substance Use Services. Toronto, ON.
5. Kahan, M. (2015). Management of substance use disorders in primary care. Toronto, ON: Women's College Hospital.
6. Marlatt, G.A., Blume, A.W., and Parks, G.A. (2001) Integrating Harm Reduction Therapy and Traditional Substance Abuse Treatment. Journal of Psychoactive Drugs, 33:1, 13-21.
7. McCollister, K. E., French, M.T., Freitas, D.M., Dennis, M.L., Scott, C.K., & Funk, R.R. (2013). Cost Effective Analysis of Recovery Management Check-ups (RMC) for adults with chronic substance use disorders. Results from a 4-year randomized trial. Addiction, 108, 2166-2174.
8. McCollister, K., Yang, X., & McKay, J. R. (2016). Cost-effectiveness analysis of continuing care intervention for cocaine dependent adults. Drug and Alcohol Dependence, 158, 38-44.
9. Padwa, H., Urada, D., Gauthier, P., Rieckmann, T., Hurley, B., Crèvecouer-MacPhail, D., Rawson, R.A. (2016). Organizing Publicly Funded Substance Use Disorder Treatment in the United States: Moving Toward a Service System Approach. Journal of Substance Abuse Treatment, 69, 9–18.
10. The Potential Group. (2015). Access and Integration: Transforming Pathways for Services for Substance Use and Addiction. Toronto, ON: Toronto Central LHIN.
11. Schmidt, R., Poole, N., Greaves, L., and Hemsing, N. (2018). New Terrain: Tools to Integrate Trauma and Gender Informed Responses into Substance Use Practice and Policy. Vancouver, BC: Centre of Excellence for Women's Health.

APPENDICES

Appendix 1: Evaluation Data Summary Categories

De-identified sociodemographic and service-related information was collected and evaluated by the PSSP Evaluator to better understand the population group being reached and to assess if Community Connect was having the desired effects.

Not all information that was collected was able to be used in the evaluation of the pilot project, mainly due to incomplete or unavailable data.

Evaluation Data Summary Categories

Data Element	Reason for Collection
Anonymous Client ID #	Used to anonymously track and organize client data.
Client Age	Determine the age distribution of women participating in the program.
Relationship Status	Provide insight into client backgrounds, social circumstances, and support needs.
Primary Language	Language the client was exposed to from birth provides information about client history and identity.
Preferred Language	Improve understanding around how support materials are meeting the needs to of the population. This is an essential for the delivery of care
Citizenship	Understanding the citizenship of clients will help to improve the kinds of supports the program should be connecting with.
Race	Race/ethnicity data collected as it pertains to the social determinants of health (SDOH)
# of Children	Establish if clients are parents to better appreciate their circumstances and support needs.
# of Other Dependents	Establish if clients are providing care to any individuals to better appreciate their circumstances and support needs.
Primary Care Physician Details	Connecting with primary care is important for understanding the social determinants of health.

Evaluation Data Summary Categories (cont.)

Data Element	Reason for Collection
Pregnant (Y/N)	Inform whether links to specialized substance use programming are required.
Pregnancy Supports Needed	Inform whether links to specialized substance use programming are required.
Involved with child protection services? (Y/N)	Improve understanding of client group to improve the kinds of supports the program should be connecting with.
Supports needed for child protection services?	Help to guide care planning and coordination of supports.
Area/ Neighbourhood	Area of the city or province in which the client resides.
Housing Type	Type of residence that the client is living in. Field can also be used to clarify the nature of a client's housing situation (e.g. hostel/shelter).
Other Details of Living Arrangement	Indicates who, if anyone, the client is living with.
Presenting Issues	Multiple issues can be identified to provide a better understanding of what services and supports are most valuable.
Actively Engaged/ Connected with Other Community Supports (Y/N)	Determine if clients have any relevant pre-existing support relationships.
Name and contact details for existing community supports	Contact details of pre-existing support relationships to support care planning.
Baseline - Education Level	Improved understanding of the social determinants of health.

Evaluation Data Summary Categories (cont.)

Data Element	Reason for Collection
Baseline - Employment Status	Client's employment status at the time of program admission. Understanding client's employment status at the time of program admission will help to determine supports needed.
End of Service—Employment Status	Indicates client's current employment at the end of program.
Baseline - Legal Status	Improved understanding of the social determinants of health and contribute to care planning.
Date of Referral to Community Connect	Track and organize program statistics.
Source of Referral to Community Connect	Better understand where referrals to Community Connect are coming from (helpful if there are multiple possible referral sources).
Outbound Referral - Date	Date the client was referred to another organization. Important for calculating wait times.
Outbound Referral - Target Organization Name	Which organization(s) the client is being referred to.
Outbound Referral - Reason for Referral	Reason the client was referred to another organization.
Outbound Referral – Receipt of Referral was Acknowledged by Target Organization	Useful for tracking effectiveness of referrals to different organizations.

Evaluation Data Summary Categories (cont.)

Data Element	Reason for Collection
Outbound Referral – Client Began Service with Target Organization	Useful for tracking effectiveness of referrals to different organizations.
Caseload Capacity Scale Rating (update as required)	Useful for determining ability of the Case Manager to accept new clients and retain a balanced caseload.
Date of Discharge from WMS;	Useful for managing caseload capacity.
Date of Discharge from Community Connect	Useful for managing caseload capacity.