Procedure Manual

One Child - One Plan - One Team

Revised May 2019

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Service Coordination Brant Procedure Manual

This Procedure Manual is based on the expectations in the provincial *Coordinated Service Planning: Policy and Program Guidelines, June 2017* as well as the locally developed Coordinated Service Plan model created by the Brant Special Needs Strategy Planning Table, and further refined by the Brant Coordinated Service Planning Steering Committee. The collaborative Coordinated Service Planning model developed locally is called *Service Coordination Brant*.

A. Purpose

Service Coordination Brant expectations and outcomes will be consistent regardless of the service provider. This Procedure Manual defines how coordinated service planning will function in the City of Brantford, the County of Brant, Six Nations of the Grand River, and Mississaugas of New Credit, with Contact Brant serving as the designated Lead Coordinating Agency in collaboration with community stakeholders.

This Service Coordination Brant Procedure Manual is meant to be used by Brant Coordinated Service Planning partners as an orientation and reference document for their staff who are providing service coordination supports. It is available electronically from Contact Brant.

This Manual details the expectations outlined in the Memorandums of Understanding between Contact Brant as the Coordinating Agency, and each Coordinated Service Planning Provider and Participant.

B. Background

The province established expectations across sectors for the provision of family-centered, coordinated service planning through a collaborative, cross-sectoral seamless approach that is centered on the needs of children, youth and their families:

- A clear contact for Coordinated Service Planning (an identified 'Service Planning Coordinator') who is accountable for developing and monitoring a Coordinated Service Plan.
- Families not having to repeat their stories and goals to multiple providers.
- A single written Coordinated Service Plan that is evolving and responsive to each child's goals, strengths, and needs.
- Processes and services that recognize each family is unique; that the family is the constant in the child/youth's life; and that they have expertise on their child's abilities and needs.
- Families will know that providers will be communicating about the needs and goals of their child and will be working toward a set of common goals identified in the Coordinated Service Plan.

The Vision is: An Ontario where children and youth with special needs get the timely and effective services they need to participate fully at home, at school, in the community and as they prepare to achieve their goals for adulthood.

The province's *Key Elements* of Coordinated Service Planning are that a child or youth with multiple and/or complex special needs will have:

1. A clear process for being referred to coordinated service planning.
   In Brant, the Coordinating Agency is Contact Brant through which families can access coordinated service planning with seamless referrals from any sector.
2. A dedicated Service Planning Coordinator (also referred to as Service Coordinator) who will lead the development of a coordinated service plan, working in collaboration with families and service providers across sectors.
3. One Coordinated Service Plan that takes into account all of the child/youth's goals, strengths, and needs, as well as all of the services that the child/youth is and will be receiving.

C. Family-Centered Practice and Service

Family-centered practice and service guides Coordinated Service Planning. This includes family and child/youth strengths and goals being at the centre of the plan.

Also refer to Section H 3, *Principles for Service Coordination Brant* that outlines Child, Youth and Family-Centered Service; Seamless Service and Information Sharing; and Meeting Diverse Needs.

Service Coordinators will be family-centered in their practice:

- Respect: each family is unique; the family is the constant in their child's life; and the family has the expertise on their child's abilities and needs.
- The strengths and needs of all family members are always considered.
- Strengthening the capacity of families is done through focusing on solutions.
- Family and child/youth strengths and goals are at the centre of the Plan.
- The priorities and beliefs of children, youth and their families are treated with dignity and respect.
- Families and children/youth receive flexible, individualized service (including flexibility around meeting times, locations, and methods such as in person, over the phone, or via videoconference).
- Each family is engaged, empowered and a partner throughout the decision-making and goal-setting process.
- Individualized, culturally safe*, flexible and relevant services are provided for each family.
  *Cultural safety includes but is not limited to linguistic preferences and cultural practices. It takes into account a way of interacting with children, youth and families that is trauma informed and considers historical and political influences.
- Family-staff relationships are characterized by partnerships and collaboration based on trust, respect, and open on-going communication.
- Family choice is respected and they are provided with the tools, including clear and accurate information, to make their own informed decisions.

D. Eligibility for Coordinated Service Planning

Decisions around eligibility for Coordinated Service Planning, as well as prioritization and the level of intensity of service, is made by the Coordinating Agency.

Children and youth with multiple and/or complex special needs eligible for Coordinated Service Planning:

- Children/youth and families whose need for service coordination goes beyond the scope of inter-professional collaboration to address, and would benefit from the added support.
- Under the age of 18, or between the ages of 18 and 21 and in school.
- *Breadth and cross-sectoral nature of a child/youth's service needs* - Require multiple services, often from multiple sectors and professionals, due to the depth and breadth of their needs as well as challenges related to multiple areas of their development (e.g. rehabilitation services, autism services, developmental services, respite supports, behavioural services, mental health services, medical/health services. They are also likely to have ongoing service needs, such as severe physical and intellectual impairments, often requiring the use of technology.
- *Family experiencing challenges which may impede their ability to coordinate services for their child with multiple and/or complex special needs*, including:
    - Coping strengths and adaptability;
    - Health and well-being of other family members;
    - Literacy and/or language barriers;
    - Other family/life events which may contribute to the family's level of distress;
    - Limited social/community supports;
    - Competing demands of caregiving and employment; and/or
    - Financial instability.

E. Overview of Service Coordination Brant

The Brant community has taken a systemic approach to the provision of service coordination; the outcomes of service coordination will be the same, regardless of service provider.

1. Partners in Service Coordination Brant

The Ministry defines two types of partnerships in Coordinated Service Planning:

- Coordinated Service Planning **Providers** - Agencies that employ the dedicated Service Planning Coordinators work with the Coordinating Agency to implement the expectations and are accountable to the Coordinating Agency.
  Note: The Ministry uses the word 'Service Planning Coordinator'; this is also referred to as 'dedicated Service Coordinator' in this document. Each Coordinated Service Planning Provider has their unique employee title for their staff that are the identified dedicated Service Coordinators.
- Coordinated Service Planning **Participants** - Agencies and school boards that provide services and/or supports to children and youth with special needs are expected to participate in coordinated service planning and work with the Coordinating Agency regarding information sharing, referrals, and participating in the coordinated service planning processes.

Refer to Appendix 1 for the list of Brant CSP Providers and CSP Participants.

2. The Service Coordination Brant Model

The collaboratively developed Brant model for Coordinated Service Planning outlines that service coordination will be provided by community service providers and the Coordinating Agency.

Specifically, service coordination is provided by staff who offer service coordination supports within their professional role (refer to the Brant community's *Coordinated Service Planning Protocol*, available at www.contactbrant.net), or by 'dedicated' Service Coordinators:

2.1 *Staff who offer service coordination supports* within their professional role:
For most children and youth, and usually as the starting point, service coordination in Brant will be provided by a service provider offering service coordination supports within their professional role.

Community staff who offer service coordination functions within their professional role will work collaboratively with Contact Brant to clearly identify the primary service coordinator for each family.

Community professionals providing service coordination supports within their role will:

- ✓ Ensure children and youth being provided service coordination supports are registered with Contact Brant to identify the staff providing the service

coordination supports. This initiates the creation of a single record for each family that will support collaboratively building on provider's service plans over the years – the record in Contact Brant's centralized database is then available to inform current and future providers.

- ✓ Ensure children and youth with multiple and/or complex needs, whose service coordination needs cannot easily be met through inter-professional collaboration, are referred to Contact Brant for a dedicated Service Coordinator; ensure referrals to Coordinated Service Planning include sufficient information so that the family does not need to retell their story.
- ✓ Meet the expectations for Service Coordinators established by the province (See Section 3, Service Coordinators' Roles and Responsibilities).
- ✓ Access Contact Brant, as required, for assistance/consultation in delivering service coordination supports.

2.2 *Dedicated Service Planning Coordinators:*

'Dedicated' Service Coordinators meet the service coordination needs of the more complex children and youth when the level, intensity and complexity of the family's service coordination needs cannot easily be met through inter-professional collaboration.

A dedicated Service Coordinator will be clearly identified through the referral process to Contact Brant at one of the following Coordinated Service Planning Provider agencies:

- Contact Brant
- Family Counselling Centre of Brant
- Hamilton Niagara Haldimand Brant Local Health Integration Network
- Lansdowne Children's Centre
- Six Nations of the Grand River Health Services
- Woodview Mental Health and Autism Services.

3. Service Coordinators' Roles and Responsibilities

Service Coordinators are responsible for providing Coordinated Service Planning services, including:

- Developing the child/youth and family's Coordinated Service Plan.
- Delivering the full cycle of Coordinated Service Planning supports *(refer to Section 4, The Coordinated Service Planning Cycle, and Appendix 2).*
- Implementing the Service Coordination Brant processes and templates.

The Ministry Guidelines state that expectations apply to all Service Coordinators, regardless of whether the individual delivers Coordinated Service Planning full-time or part-time.

The following are the minimum expectations that Service Coordinators will meet:

- Develop a written strengths-based Coordinated Service Plan that addresses the service needs of the child/youth, is driven by the priorities of the child/ youth and family, and that will support participation at home, school and in the community. Refer to Section 8, The Coordinated Service Plan.

- Facilitate the active participation of the child/youth and family in Coordinated Service Planning, including goal setting.
- Facilitate the exchange of information between relevant providers in the children's services, education, and health sectors, to develop and maintain a single Coordinated Service Plan for the child/youth and their family.
    - Facilitate the coming together of relevant providers in the children's services, education, and health sectors to develop the coordinated service plan for each child/youth and their family.
    - Facilitate working relationships with providers across sectors in order to enable their regular contribution into coordinated service planning, as well as obtain and share relevant information regarding services for the child/youth.
- Monitor and review the Coordinated Service Plan at least every 6 months, in collaboration with the child/youth and their family and relevant providers in the children's services, education, and health sectors, as the child/youth and family's needs and services change. Revise the Plan as needed, and at least annually.
- Connect families to relevant services and other community supports/ resources in the service delivery area.
    - Assist the family in navigating and accessing appropriate services and community processes, including Case Resolution as appropriate.
    - Support seamless referrals as new needs and potential supports are identified, facilitating the connection with the provider to reduce the need for families having to repeat their story.
    - Where the primary service coordination responsibilities shift to another staff, support a 'warm transfer' and the family in the process; notify Contact Brant of all changes in the primary staff contact.
- Explore flexible and innovative approaches for service delivery to meet the needs of the child/youth and bring forward any barriers that may exist.
- Be knowledgeable and available to discuss the child/youth and family's concerns regarding the service plan.
    - Act as the family's primary contact.
    - Provide consistent information about service coordination and the supportive role of the Coordinating Agency, as well as distribute the *Service Coordination Brant* promotional materials.
    - The Service Coordinator is not responsible for coordinating all services required by the family (e.g. adult mental health, settlement) but may provide contact information or initiate a referral to help families access other services and supports. The Service Planning Coordinator should communicate clearly about not being responsible for coordinating these family services.
- Facilitate working relationships with providers in the children's services, health and educations sectors, in order to enable their regular contribution

into Coordinated Service Planning and obtain and share relevant information regarding services for the child/youth.

- Actively participate in the Community of Practice as well as training opportunities specific to service coordination offered through the Coordinating Agency.

The Ministry expected communities to develop a 'job description' for Service Coordinators – refer to Appendix 8, *Responsibilities of all Staff Performing Coordinated Service Planning Functions*.

4. The Coordinated Service Planning Cycle

The Coordinated Service Planning Cycle will align with provincial expectations:

1) Referrals to Coordinated Service Planning
2) Intake and Assessment
3) Family strengths and needs identified
4) Assigning a Service Planning Coordinator
5) Family and/or child/youth goals are set and prioritized
6) Provider team (Family Team) is identified
7) Coordinated Service Plan is developed and updated
8) Plan is documented and shared with family and providers
9) Services and goals are monitored.

Refer to the *CSP Policy and Program Guidelines.* Also refer to Appendix 2, *The Coordinated Service Planning Cycle* and Appendix 3, *Service Coordination Process* and *Service Coordination Flow Chart*.

5. Referrals to Coordinated Service Planning

Families should not feel like they are repeating their stories unnecessarily and should not have to complete multiple intakes and assessments. Families will experience a seamless sharing of information as part of Coordinated Service Planning.

"Seamless referrals" means the family will not be aware of the process that service providers complete to support a family being connected to and registered for service coordination. With the 'every door is the right door' model and no matter where a family presents first, healthcare providers, educators, and other service providers in Brant will ensure the family is connected seamlessly to Service Coordination by sharing the intake information they have gathered. Seamless referrals will also connect families with the range of services and supports that will meet their child's needs by connecting with appropriate access points for other services.

Through the referral process, the Coordinating Agency will be able to fulfill their role of determining a family's eligibility, identifying the family's priority to receive a dedicated Service Coordinator, identifying the level or intensity of services required, and creating as well as maintaining each family's record in the centralized database.

5.1 *Self-Referral by Families*

Families can self-refer to Coordinated Service Planning by connecting directly with Contact Brant by phone, electronically by email or using the Contact Brant website referral link: https://contact-brant.ontarionow.ca/external-referral, or by visiting the Contact Brant office.

5.2 *Service Provider Referrals*

Referrals to Coordinated Service Planning can be made at any point a child/youth's needs are recognized to be multiple and/or complex, either early on when developmental concerns are first identified, when the family's situation changes, new needs are identified, or new services are added.

Service Providers' referrals should primarily be completed through Contact Brant's secure web-based referral link: https://contact-brant.ontarionow.ca/external-referral, or can be sent in hard copy, by email, fax, or phone. With consent, service providers will complete the referral to Contact Brant on behalf of the family by sharing the family's relevant information on record so that the family does not need to unnecessarily repeat their story.

5.3 *Referrals and Minimizing Families Repeating Their Story*

In order to minimize the need for families having to repeat their story and to provide sufficient information to Contact Brant to determine the child or youth's eligibility, priority, and level of intensity for service coordination, the referral information will include, at a minimum:

- ✓ Basic demographic information about the child/youth including name, birthdate, gender and address
- ✓ Family/caregiver's name, contact information including phone(s) and email, and relationship to the child/youth
- ✓ Reason for the referral
- ✓ Information about the child's strengths and presenting issues/needs. It is helpful to list current services as well as previous and wait listed services
- ✓ Name of the referring staff and agency. Identify if the family has a preference for which agency they want to provide the Service Coordinator
- ✓ Wherever possible, appropriate documentation such as assessments and the current Coordinated Service Plan should be included; these can be securely uploaded as attachments in the web-based referral link.

The Coordinating Agency will accept this referral information in the various formats an organization uses.

Refer to Appendix 8, *Core Information for Referrals;* and *Section H 4.1, Intake and Assessment.*

5.4 *Information Sharing: Privacy, Confidentiality and Consent*

Sharing information, with informed consent, is one of the key goals of Coordinated Service Planning in providing a seamless system of services.

Service Coordinators should be cognizant of the expectation to minimize unnecessary duplicative consent seeking. Service Coordinators can use the Service Coordination Brant *Consent to Share Information between Brant Service Coordination Partners*, Appendix 9, or their own organization's consent template.

Service Coordinators should be knowledgeable on the purpose of requesting consent to share information with other service providers:

- ✓ Families do not having to repeat their story;
- ✓ Development and implementation of the Coordinated Service Plan;
- ✓ On-going information sharing among service providers, including Contact Brant.

Service Coordinators should explain that Contact Brant as the Coordinating Agency maintains a centralized database for Coordinated Service Planning:

- A central record for each family waiting for or receiving Coordinated Service Planning is available to share with involved and new service providers to support the family not having to repeat their story. The record will evolve over the years, building on service plans and the family's changing situation. Each record will include the Referral Information/Intake, which is the family's story; Services (past, present and waiting); Name of the identified Service Coordinator; and the Coordinated Service Plans.
- Enables the creation of a single Wait List for Service Coordination Brant, to meet provincial expectations.
- Provides Brant stakeholders with the number of children and youth waiting for and receiving service coordination, which helps to identify needs and supports planning for the children's services system.
- Enables Contact Brant to report the required data to the Ministry on service coordination on behalf of all Brant agencies.

Families and children/youth will have access to their own record and Coordinated Service Plans through Contact Brant or their Service Coordinator who can access the record from Contact Brant.

Service Coordinators will comply with applicable legislation when collecting, using or disclosing information consistent with the laws of Ontario, including but not limited to CYFSA, PHIPA and FIPPA. Service Coordinators will follow their internal policies and legislative requirements, and respect the consent procedures of other providers.

5.5 Referrals and Assigning a Service Coordinator

Through Coordinated Service Planning, families will know their key contact is their Service Coordinator.

The Coordinating Agency will refer to an appropriate Coordinated Service Planning Provider through the Intake and Assessment process. In referring to a Coordinated Service Planning Provider, Contact Brant will take into consideration:

- Primarily, the family's preference for an agency;

- Provider expertise (based on the child's needs if specific experience or expertise is required; linguistic or cultural needs are identified);
- Existing relationships/services;
- Prioritization for immediate service and the wait list for a specific Coordinated Service Planning Provider.

Coordinated Service Planning Providers will notify Contact Brant of the name of the Service Coordinator assigned. Contact Brant will maintain a record of the primary community professional providing service coordination.

6. The Coordinated Service Plan

The Coordinated Service Plan (CSP) is a written, evolving document for each child/youth and family, as well as all service providers involved in the child/youth's care. As the needs and goals of the child/youth/family change over time, so will their Coordinated Service Plan.

Service Coordinators will use the *Coordinated Service Plan* template (Appendix 6) to document the integrated Plan. Having a common Coordinated Service Plan template is one of the provincial expectations.

- The first written Coordinated Service Plan should be completed ***within 2 months*** of commencing support with a family.
- A Coordinated Service Plan will be reviewed at least every 6 months. Goals will be revisited and confirmed, or revised as needed when Goals change/have been met. Plans will be updated at least annually. Families can expect their Coordinated Service Plan to be a living document that grows and develops with their child
- The Coordinated Service Plan supplements individual treatment/service plans by presenting a ***holistic view*** of the child/youth and their family. The family's priorities ***should inform*** the Goals in the Plan, and the child/youth's services and supports, including education, should identify how they will help meet the goals. The Plan should be developed with the family as well as with involved cross-sectoral services.
- Once the Coordinated Service Plan has been written, the Service Coordinator ***shares the document*** with the family as well as with relevant service providers. The Service Coordinator ensures the Plan is given to Contact Brant to maintain in the family's centralized record. Consent to distribute each Coordinated Service Plan should always be re-confirmed.
- The Service Coordinator ***monitors the coordination of services and goals*** and makes referrals/connections as new needs and potential supports are identified.

6.1 The CSP and Strengths-Based Approach

Service Coordinators will use a strengths-based approach to inform the development and monitoring of the Coordinated Service Plan through:

- ✓ On-going discussion with the child/youth and family;
- ✓ Information gathering and sharing with other service providers;
- ✓ Continuing to conduct a strengths and needs assessment of the coordinated planning.

The strengths-based approach to Coordinated Service Planning identifies areas where children/youth and their families have strengths and where they could be supported. These can be functional strengths such as behaviour and problem-solving skills, or family, cultural and community strengths (for example the involvement of members of the extended family, ties to a cultural community, etc.).

6.2 *The CSP Goals*

Goal setting will be based on what the family and/or child/youth sees as the most important. The Service Coordinator facilitates the active participation of the child/youth and family in identifying their priorities and goals.

Service Coordinators will work with the child/youth and family as well as involved service providers to develop **Solution-focused Goals** in the Coordinated Plan.

- ✓ Goals focus on strengths and solutions rather than the problems.
- ✓ Goals incorporate a clear vision of the preferred future.
- ✓ Goals will be responsive to changes (e.g. new challenges and successes faced by the child/youth and family).

Service Coordinators should apply the concepts of **CanChild's *F-Words*** to discover what really matters to the child/youth and family, outside of the typical therapeutic goals, based on their strengths.

- *Function* - Refers to what people do (e.g., 'play' is what children do). The emphasis should be on promoting activity where children *first* learn to do things in their own way, and then (maybe) develop good skills in those activities. How things are done is not initially considered important; performance improves with practice.
- *Family* – Represents the essential 'environment' of all children; respecting family as partners and providing family-centered services are thus key.
- *Fitness* – Promotion of being physically active and recreational opportunities for children is important rather than exercise programs and remediation.
- *Fun* – Identify what each child/youth enjoys doing and what they want to do. Don't expect that every child will do things 'normally'.
- *Friends* – The quality (not quantity) of relationships is important. What can be done to encourage, empower and enhance a child's opportunities to develop and nurture meaningful peer connections?
- *Future* - Think about the future in a positive way right from the start, and encourage parents to do so. Ask parents and children about their expectations and dreams for the future – do not decide what is impossible.

The connections between these 6 functions makes a difference - engagement and participation in activities meaningful and fun to a child and family can lead to improved physical and social functioning.

Note: CanChild formulated the 'F-words', building on the World Health Organization's definition that 'health is the ability to adapt and to self-manage' as well as the International Classification of Functioning. This concept is different than how professionals have typically addressed childhood disabilities by focusing on the identification of an appropriate diagnosis, which then leads to the 'right' interventions and treatment of the impairment – in other words the focus has been on 'fixing'.

6.3 *The Family's Goals Reflected in Each Service*

The Service Coordinator leads the Family Team (the family, youth and involved services) in the development and updating of the Coordinated Service Plan on a regular basis. The Coordinated Service Plan is different from individual treatment plans as it presents a holistic view of the child/youth and family:

- Initial goal setting can be done with the child/youth and family.
- Facilitate the coming together of the Family Team to develop the single Coordinated Service Plan for the child/youth and family.
    - Planning for coordinated services can be facilitated through case conferences, plan of care meetings, school-based educational planning meetings, etc., as well as regular communication by phone, email and fax.
    - The family and/or the child/youth will determine which service providers should be invited to any meetings. Not all professionals involved in the child's services need to be at meetings depending on the circumstances and the preference of the family. However, the family should be informed that the Service Coordinator will connect with those not in attendance to ensure everyone is working together towards the same goals.
    - Any meetings should be held in a place that will be comfortable and accessible for the family. Ensure supports to aid family involvement (e.g. a translator, support person, conferencing services) are made available as needed.
- Encourage service providers to draw connections between the family's goals and what their services can do. Help services clarify how they can support achievement of the family's prioritized goals.
- Service Coordinators will work with the child/youth, family and service providers to make sure families have the information they need to make informed decisions about services and their Plan. Families, as well as the child/youth (as appropriate), have the final decision over which goals are included in the Plan.
- The Family Team may change over time. The Service Coordinator will continue to identify appropriate stakeholders in the children's services, education, and health sectors for the Family Team throughout the planning process.

6.4 *The CSP: Goals and Transitions*

Families can expect that Coordinated Service Planning will provide an opportunity for the family and service providers to plan for transitions. Transitions may be due to various factors such as, but not limited to, the specialized or multiple/complex needs of the child/youth and family, school entry/exit or teacher/classroom changes, admission to or discharge from a service, staff changes, as well as the transition to adult services. Note: There are specific expectations for transition planning for youth with a developmental disability.

- Service Coordinators will build on the existing Coordinated Service Plan by identifying the steps needed for the child/youth to attain their goals related to any transition, and include these transition plans as a goal(s) in the Coordinated Service Plan.
- Service Coordinators will take into account the young person's goals and needs, as well as the family's needs and priorities at the time of the transition, and ensure the transition planning process is cross-disciplinary, collaborative, comprehensive and team-based.
- It is expected that transitions to and from Coordinated Service Planning, and to and from Service Coordinators, may occur as the service coordination needs of a family change. Transitions to and from a Service Coordinator will occur as needed through a seamless 'warm transfer'.
    - To support a warm transfer, the Service Coordinator will communicate the need for transition planning as far in advance as possible to the family. The exiting Service Coordinator will provide an introduction of the family to the new Service Coordinator/service provider, ensuring information is transferred so that the family does not need to retell their story.
    - The Service Coordinator needs to identify the name of the new Service Coordinator to Contact Brant. Service Coordinators can consult with Contact Brant's Lead Service Planning Coordinator at any time regarding transitions or any other processes related to Coordinated Service Planning.

6.4.1 Transition planning to adulthood

Transition planning to adulthood is a broad, holistic process that identifies a young person's goals for work, further education and life in the community. Everyone who supports the young person will work collaboratively to prepare the young person and family for the transition to adulthood.

Service Coordinators are responsible for initiating transition planning to adulthood at age 14, and incorporating this into the Coordinated Service Plan goals. Transition planning to adulthood includes:

- *Consideration of all sectors* that a youth may need to access services, such as Health Services, adult Developmental Services, Mental Health Services, further education, etc.

- *Goals for work, further education, and community living* that reflect actual opportunities and resources that are likely to be available and achievable after the young person leaves school.
- *Actions that should be taken year by year* to help the young person achieve their goals. Actions in the transition plan should consider:
  - Developing specific skills, such as the independent use of assistive technology, self-advocacy, or employability skills.
  - Timely application to programs and services.
  - Planning for access to support services and equipment, as well as work placements or post-secondary education.
  - Investigating options for future financial support.
  - Roles and responsibilities of the young person, family, and others in carrying out these actions.
  - Expected outcomes within the planning process that should be evaluated at regular intervals or as needed; and
  - Timelines for the actions.

6.4.2 Specific responsibilities for Service Coordinators related to youth with a developmental disability

As outlined in the *Transition Planning Protocol and Procedures for Young People with Developmental Disabilities,* and the *CSP Policy and Program Guidelines*, Service Coordinators*:*

- Provide information to the parent and youth about *integrated transition planning* which builds on the existing Coordinated Service Plan by identifying the steps needed for the youth to attain their goals until leaving school.
- *Connect with the school IEP Lead* to support the youth and their parents to participate throughout the planning process.
- Plan for the diverse transition needs and desires of the youth and their family. The *process should be cross-disciplinary, collaborative, comprehensive and team-based* with a focus on the young person's goals, supports and information needs. Identify and contact new Family Team members for this integrated transition planning.
- *Facilitate meetings* regarding the single integrated transition plan to identify the young person's goals for work, further education, employability skills, health care needs, life skills, and community living, etc.
- Lead the *ongoing review and update* of the integrated transition plan at regular intervals or as needed; the transition plan should be *updated annually* at minimum.
- **Use the *Coordinated Service Plan* template**. Incorporate the single integrated transition plan into the Coordinated Service Plan goals.

6.5 *The CSP: Goals and Planning for Discharge*

Families may have periods where they need little to no Coordinated Service Planning, or come to a point where they no longer wish to access Coordinated Service Planning.

Service Coordinators should always try to build the family's capacity to coordinate their own services, and establish timelines for goals based on discussions of service coordination being Brief or Intermittent.

Service Coordinators will categorize planning as **inactive** when goals have been met, and there is no need for active planning or review of the Coordinated Service Plan every 6 months. This could be due to the family being satisfied that Coordinated Service Planning is not required at the current time, or the family cannot be reached after four documented attempts over two quarters with contact being made through the best method of contact indicated by the family as well as alternate methods of contact. Service Coordinators should establish a plan for Discharge when the family is identified as 'inactive'. These families should be informed that they will be prioritized for readmission to Service Coordination if they request Service Coordination in the future.

The Service Coordinator will **close** a file when a family leaves the catchment area or the youth ages out. With consent, Contact Brant will provide a warm referral including the current CS Plan to the Coordinating Agency in the new catchment area.

Whether being classified as 'inactive' or 'closed', Service Coordinators will:

- Incorporate the discharge plan into the Coordinated Service Plan.
- Advise families that they may re-engage seamlessly with Coordinated Service Planning again if their needs change (until the age of 18, or until age 21 if the youth remains in school).

  Note: Families previously supported through Coordinated Service Planning who want to re-engage with the service will be prioritized for admission over others on the wait list. Families can re-connect with their Service Coordinator who will inform Contact Brant of the readmission, or connect with Contact Brant to request service coordination again.
- Consider a gradual approach to stepping down service prior to discharging a family. Wherever possible, plan for the warm transfer back to an involved professional who can provide service coordination supports within their role.
- Inform Contact Brant when planning to discharge a client.
- Notify Contact Brant the date a client is discharged from Coordinated Service Planning, and whether it is an inactive file or closure.
- Notify Contact Brant if a previously supported family calls to request Coordinated Service Planning support and the date the family was re-opened.

Service Coordinators can connect with Contact Brant's Lead Service Planning Coordinator at any time for consultation regarding discharge planning.

Contact Brant will retain inactive files so that families may easily re-engage with Coordinated Service Planning, as needed, without having to repeat the intake process.

6.6 *Inclusive, Accessible and Culturally-appropriate*

Service Coordinators will ensure that the Coordinated Service Planning process is inclusive, accessible, and culturally appropriate. Planning and goal-setting will be respectful of the values and meet the diverse needs of children, youth and their families, including but not limited to:

- Be aware of distinct approaches required to address the needs of First Nations, Métis, Inuit and urban Indigenous children, youth and families, and connecting to local Indigenous services and supports.
- Respond to the service needs of French-speaking children/youth and families; identify how to best provide services - e.g., is a translator needed, is the family comfortable receiving services in English; connect to French-language school boards and service providers.
- Engage with the different linguistic and cultural communities within Brant and the service providers who serve them - identify how to best provide services (e.g., translator, is family comfortable with receiving services in English, etc.).

6.7 *The CSP Process and Intensity of Supports*

Service Coordinators will work with each family to identify the intensity of service coordination supports required. Depending on the needs of the child/youth and family, the intensity of Coordinated Service Planning supports will vary and may need to be adjusted from time to time. Decisions regarding how frequently a Service Coordinator is engaged with each family, and if the Coordinated Service Plan will be reviewed more frequently than every 6 months will be made jointly by the family and child/youth with the Service Coordinator:

- *Brief supports* – A Coordinated Service Plan is developed and there are brief, time-limited supports prior to discharge. Service coordination supports should always help families develop the capacity for coordinating their own services, and many can do this with limited initial assistance. Alternatively, an involved professional who can provide service coordination supports within their role can be identified.
- *Intermittent supports* – More intensive level of supports at times and less intensive at other times; a Coordinated Service Plan is developed within the first 2 months, and reviewed at least every 6 months (or more as needed). This often reflects support to families experiencing a transition or a change in family circumstances who need limited contact following the support other than being in contact at least every 6 months to review the Plan. Families can expect their Coordinated Service Plan to be a living document that grows and develops with their child - Plans will be updated at least annually.
- *Continuous supports* - Some families may require Coordinated Service Planning on an on-going basis due to the complexity and breadth of needs. A Coordinated Service Plan is developed within the first 2

months, and reviewed at least every 6 months, or more often as needed. Families can expect their Coordinated Service Plan to be a living document that grows and develops with their child - Plans will be updated at least annually.

6.8 *The CSP and Feedback Using the MPOC*

The MPOC is the provincially directed tool to be used for feedback about Coordinated Service Planning. Families submit all completed tools confidentially (electronically or by postage-paid mail) to CanChild; CanChild will provide quarterly reports to each Coordinating Agency. The MPOC is available in hard copy as well as electronically in French and English. Other languages will be made available in hard copy only.

Following are the Ministry's directions for this evaluation process –
Note: All MPOC documents are available through Contact Brant.

The Service Coordinator will, **at the 6-month review** of the Coordinated Service Plan **and annually thereafter**, or if it is a Brief Service at the time of planning for discharge:

- Introduce the MPOC to the family and provide the family with a paper copy of the *Invitation Letter*.
- Provide a paper copy of the *MPOC* and a postage-paid business reply envelope,
  or
  provide the option to complete electronically - the survey link is on the *Invitation Letter*.
- 2 or 3 weeks later, provide the *follow-up reminder post card* (by mail, or email if your agency is doing this).
- A family should only be asked to do the evaluation one time per year.
  Note: If a child is also receiving services from the Ontario Autism Program (OAP) which also uses the MPOC, the province has prioritized that CSP will ask the family to complete the MPOC.
- Track the number of families you have asked to complete the MPOC. This number must be submitted quarterly to Contact Brant on the Ministry's CSP Reporting Tool for reporting purposes to MCCSS.

A training webinar about MPOC is available for Service Coordinators on the CanChild website: https://canchild.ca/en/resources/47-measure-of-processes-of-care#mpocwebinar

Contact Brant will share all CanChild MPOC reports with the CSP Steering Committee and CSP Providers.

7. Intersection with Case Resolution

The provincially directed Case Resolution mechanism ensures that a community responds to children and youth with complex special needs. Contact Brant is mandated to facilitate the Case Resolution Mechanism in our community.

Refer to the Brant Case Resolution Protocol, available at www.contactbrant.net

Case Resolution reviews *children and youth with complex special needs*:

i. Where additional service coordination and/or supports need to be considered/planned by the community due to the complexity of service needs. Case Resolution Team members are often able to be flexible within their individual agency mandates and work creatively within available resources to collectively meet the needs of these children.

ii. At age 16 and age 17 to consider the integrated transition plan to adult services.

iii. Where services and resources are exhausted and not able to fully meet the service needs; the child/youth is considered 'at risk'; and there is a clinical recommendation for a specialized service to stabilize the situation.

It is expected that children and youth who require Case Resolution will have been supported locally as much as possible by the Coordinated Service Planning process before being referred to Case Resolution. They will thus have an identified Service Coordinator, as well as a written Coordinated Service Plan.

The Service Coordinator will request a Case Resolution review through Contact Brant's Resource Coordinators or Service Planning Coordinators, and consult with Contact Brant throughout the Case Resolution process to ensure all documentation requirements are met.

The Service Coordinator will inform families about Case Resolution with clear and consistent information:

- The Case Resolution Team and the Brant community service system first works collaboratively to address these complex needs within the existing funded services. The Service Coordinator will work in partnership with Contact Brant and other involved service providers to explore all options for existing local and regional services and supports first.
- Consent is required for a Case Resolution review.
  Note: The Case Resolution Team is a multi-disciplinary, cross-sectoral team of senior managers. Forms, including Case Resolution Consent as well as the Service Coordinator's Summary for Case Resolution, are available from Contact Brant.
- **For At-Risk Reviews where Complex Special Needs funding** is sought:
  - Only the Case Resolution Team can make the recommendation to move forward with an application for Complex Special Needs (CSN) funding.
    - Service Coordinators should only inform families about the possibility of specialized services through Complex Special Needs funding once cross-sectoral community planning has identified that the needs of the child/youth are *beyond the current capacity* of the service system and a *specialized service is required,* and there is an *urgency to stabilize the child/youth and decrease the risk of harm* to self and/or others.
  - A clinical plan to stabilize the situation through a specialized support must have been recommended (by professionals in the MCCSS-funded service sector); the clinical plan for the specialized service is

to be time-limited for stabilization. This clinical recommendation is brought to the Case Resolution Team by the Service Coordinator for consideration at the review.

- Document the planning and coordination of services in the child/youth's Coordinated Service Plan, noting where their needs are beyond the locally available services and supports. The Coordinated Service Plan is part of the documentation that Service Coordinators provide for the Case Resolution review.
- If the Case Resolution Team makes a recommendation to access Complex Special Needs funding, Contact Brant must submit a detailed report of the situation and request for Complex Special Needs funding to MCCSS - the approval process then takes at least 30 business days.
- Coordinated planning and service provision will need to continue to address the immediate needs of the child/youth until approval of the Case Resolution recommendations by MCCSS. This means an interim service plan is required – this plan should be identified to Case Resolution at the review.
- If Complex Special Needs funding is approved:
    - The Lead Service Planning Coordinator at Contact Brant will be the lead on all communication and outside resource coordination and will work to support the Service Coordinator who usually continues to be the family's primary contact.
    - The Service Coordinator is responsible for monitoring and updating the Coordinated Service Plan including any new residential or respite services made available through complex special needs funding; this usually means attending Plan of Care meetings with the residential provider or coordinating the respite services.
    - The Service Coordinator, with the Lead Service Planning Coordinator at Contact Brant, are responsible to keep the Case Resolution Team apprised of successes and challenges related to the progress of the specialized service plan.
    - Complex Special Needs funding can only be approved for a fiscal year, from April 1 to March 31. If the specialized service and stabilization is required into the next fiscal year, the clinical plan and associated Complex Special Needs funding needs to be re-approved annually. This review for the next fiscal year is usually completed in January.
    - When the goals outlined in the complex special needs-funded portion of the Coordinated Service Plan have been met, work with the Lead Service Planning Coordinator at Contact Brant to transition the child/youth back into the family home and/or the base-funded service system.

- If the plan is to transition a youth from the specialized service into adult services, lead the transition planning and work with the youth/family and adult services to facilitate the transition.
- McMaster Brokerage will be involved when Complex Special Needs funding is requested, and throughout the specialized service. Following are the roles of the Service Coordinator compared to Brokerage:

Brant Service Coordinator	McMaster Brokerage
Primary contact for the parents/guardian, child/youth and involved Brant community service providers. Note: Contact Brant's Lead Service Planning Coordinator is the primary contact with McMaster Brokerage.	Secure appropriate placement for youth in accordance with the community endorsed clinical treatment plan; negotiate the cost and terms of the placement and regularly reviewing these with the contracted agency; provide the budget as well as current expenditures to Contact Brant.
Attend Plan of Care meetings for the child/youth; Ensure a Coordinated Service Plan is developed, actively monitored and updated; Transitional Age Youth planning starting at age 14.	Monitor the placement and youth's progress; Attend CFSA legislated visits (7-day visit, Plan of Care meetings); Review and follow up with any Serious Occurrences, which are then reported to Contact Brant.
When issues with the placement are identified by the family or Brant services, inform Brokerage and Contact Brant.	Contact person for the placement agency. When issues with the placement arise, Brokerage will discuss with the agency, and follow-up with Contact Brant and the community Service Coordinator
Bring updates of the implementation of the Complex Special Needs plan; Attend the Case Resolution review meetings of the child/youth and ensure all required paperwork is completed and submitted to Contact Brant	Attend Case Resolution reviews for the child/youth.
Bring involved local service providers (including Brokerage) and the youth/family together as required for planning or to discuss issues as they arise.	Attend local case planning meetings as appropriate.

8. Wait List Management

Contact Brant manages the single wait list for all dedicated Service Coordinators through the centralized database. The single wait list is managed in a consistent and transparent fashion, with families placed on the waitlist based on the date of first contact with the Coordinating Agency (i.e. on receipt of referral).

If a family is waitlisted for a dedicated Service Coordinator, the professional providing service coordination supports will continue supporting the family until the admission to the dedicated Service Planning Coordinator.

Where a family is wait listed for a dedicated Service Coordinator and there is no identified community staff providing service coordination supports, Contact Brant will provide interim service coordination supports, as needed, to families by

providing information, connecting to community resources and services, as well as, if needed immediately, initiating the Coordinated Service Plan including goals and identifying involved stakeholders.

Families can access their information on how long they can expect to wait for a dedicated Service Coordinator from Contact Brant and/or their community support staff, who can access the information from Contact Brant.

To support wait list management, Service Coordinators or their agency will:

- Notify Contact Brant the date a client starts service.
- Notify Contact Brant the date a client is discharged from service.
- Inform Contact Brant of their availability to accept additional client(s).
- Collaboratively with Contact Brant, review the children/youth waiting for their agency's Service Coordination supports and confirm the client(s) prioritized next for admission.

9. Coordinated Service Planning Reporting Tool for Quarterly Reports

The province requires Coordinating Agencies to submit quarterly reports on Coordinated Service Planning for their community. The province has developed a tool, the *Coordinated Service Planning Reporting Tool* (available through Contact Brant) that CSP Providers are to complete and submit to Contact Brant. The only measures/data elements that are required to be reported by CSP Providers are:

- **Number of Times the Service Coordinator Met/Visited** with the child/youth/family. Meetings/visits involve active engagement between the child/youth and/or family and their Service Coordinator. A meeting/visit is a two-way live communication between a child/youth and their family and their Service Coordinator that takes place face-to-face (in-person) or non-face-to-face (via phone or video conference, email or text) to discuss resources/ supports or other information directly relevant to CSP.
- **Amount of Direct Service** Time Spent by the Service Coordinator towards Coordinated Service Planning. Direct delivery of CSP represents the number of hours in meetings/visits between the child/youth and their family and their Service Coordinator. If a family has one or more children receiving CSP, the number of direct service hours for each child should be counted.
- **Amount of Indirect Service** Time Spent by the Service Coordinator towards CSP. Indirect hours captures the amount of time spent on CSP outside of direct service time such as case planning, behind-the-scenes coordination with partners/service providers, travel, and administrative tasks.
- Additionally, the **number of families <u>asked</u> to complete the MPOC** by the Service Coordinator must be reported.
- **CSP Provider Quarterly Due Dates** for reporting to Contact Brant are:
    - July 15
    - October 15
    - January 15
    - April 15

10. Community of Practice

The Community of Practice for Brant Service Coordinators will provide on-going support, advice, training and opportunities for continued learning amongst all community service coordinators, with the expressed purpose of developing and maintaining best practices and fostering community capacity building through consistent implementation of the Service Coordination Brant model.

Refer to the Community of Practice *Terms of Reference,* available at Contact Brant.

F. Dispute Resolution

The dispute resolution process promotes engagement and communication with the aim of resolving problems quickly, as well as improving service coordination supports to families and system processes through collaborative problem solving.

Service Coordinators will actively participate in dispute resolution with respect to the delivery of coordinated service planning:

The parties with the dispute will identify and resolve the matter between them using the principles of:

- *Mutual Understanding* – Keep each other informed in a timely manner about anything that has an impact on the relationship; try to understand and share feelings for both sides of an issue to find resolution as early as possible.
- *Respect* – Respect each other throughout the dispute resolution process; work towards a common goal and mutual satisfaction; listen to and acknowledge the concern being raised and the resolution being brought forward.
- *Feedback* – Evaluate the relationship and resolution process by providing honest feedback to each other.

Any conflict is best resolved early and at the lowest possible level of escalation. Involve other parties when input or assistance in attaining resolution is required:

- *Stage 1* – Staff from each organization will attempt to manage conflict as close to its source as possible.
- *Stage 2* – Where a resolution cannot be achieved between the staff directly involved, the matter will be addressed at the managerial level between the involved organizations.
- *Stage 3* – Where resolution about systemic issues cannot be achieved between management, the matter will be tabled at the Brant Coordinated Service Planning Steering Committee.

Service Coordinators will follow their organization's internal process and procedures for alerting management about any areas of confusion or conflict, whether about service coordination for an individual family or about systemic procedures, processes and expectations.

Contact Brant's Lead Service Planning Coordinator is available to consult on any Service Coordination Brant process and expectations.

G. Contacts

Direct any communication related to this Procedure Manual to:
Contact Brant for Children's and Developmental Services
643 Park Road North, Brantford
519-752-8228

Attention:
Alison Hilborn, Lead Service Planning Coordinator; alison@contactbrant.net
or
Jane Angus, Chief Executive Officer; jane@contactbrant.net

Also, see following section on '*Other Information You Might Find Useful'* and Appendixes.

Coordinated Service Planning **forms and templates** are available from Contact Brant.

Service Coordination Brant

Together, we will learn and grow together in this collaborative community realization of Coordinated Service Planning.

One Child - One Plan - One Team

Thank you for the part you are playing!

H. Other Information You Might Find Useful

1. A Summary of Service Coordination Brant Goals

- Improve service experiences and outcomes for families of children and youth with multiple and/or complex special needs through one clear access point to information and service coordination, a collaborative cross-sectoral approach, service continuity over time, and the support of an identified service coordinator.
- The child, youth and family is the center of all processes and planning.
- Coordinated Service Planning provides a family-centered process that recognizes that each family is unique; the family is the constant in the child/youth's life; and the family have expertise on their child/youth's abilities and needs.
- Provide individualized culturally safe*, flexible, relevant services for each family.
  *Cultural safety includes but is not limited to linguistic preferences and cultural practices. It also takes into account a way of interacting with children, youth and families that is trauma informed and considers historical and political influences.
- All children/youth and families receiving multiple services should have the option to have their services coordinated and have an identified service coordinator.
- Ensure organizational practices that reduce the need for families to have to repeat their story.
- Services will be more seamless and unduplicated for families.
- Families will be connected seamlessly to the multiple, cross-sectoral services they need as early as possible.
  Jordan's Principle will be implemented to ensure that all children, including children on reserve, will have access to the health and social services they need, when they need them. It will include service coordination, service access resolution, and engagement with First Nations and jurisdictional partners. (Refer to: http://www.afn.ca/uploads/files/jordans_principle-report.pdf)
- A single, written Coordinated Service Plan, unique to each child/youth and family, is developed through partnership with the child, youth and family as well as involved community stakeholders.

2. Resources to Support Coordinated Service Planning

- There is readily available and consistent messaging about service coordination that was developed collaboratively through the Brant Coordinated Service Planning Steering Committee; refer to the Service Coordination Brant brochures and posters available from Contact Brant, and Contact Brant's website www.contactbrant.net
- A Memorandum of Understanding has been signed by each Coordinated Service Planning Provider and Participant with Contact Brant, establishing clear

expectations of all stakeholders and the collaborative approach in the Service Coordination Brant model.

- The Brant Coordinated Service Planning Steering Committee addresses on-going implementation of the Brant model and cross-sectoral coordinated service planning at the system level.
- The Strategic Leadership Table for children and youth ervices also addresses cross-sectoral coordinated planning at the system level, and will receive reports from Contact Brant as presented to the Coordinated Service Planning Steering Committee.
- Refer to the Community Information database, www.info-bhn.ca for programs and resources in the Brant, Haldimand and Norfolk communities. These public records are easily accessible, even from mobile devices, and you can easily print the details listed in a record to give to a family. You can also call 2-1-1 anytime, 24/7 to get this information – the phone service is available in over 150 languages and accesses the local Community Information database to provide their information.
- Refer to the Community Protocols developed by the Strategic Leadership Table and posted on Contact Brant's website in the 'Professionals' tab, www.contactbrant.net:
    - Coordinated Service Planning Protocol
    - Case Resolution Protocol
    - Transition Planning Protocol and Procedures for Young People with Developmental Disabilities, and the Brant Haldimand Norfolk Addendum
    - Infants and Toddlers Living in At Risk Environments Protocol
    - Safety Plan Protocol
    - Suicide Prevention Protocol
- Refer to the Glossary and Definitions in the Appendix
- Refer to the provincial **Coordinated Service Planning: Policy and Program Guidelines**, June 2017, available on the Ministry or Contact Brant websites.
- At any time, please don't hesitate to consult with Maxine Lean, Lead Service Planning Coordinator, at Contact Brant, 519-758-8228 ext. 234, or maxine@contactbrant.net

3. Principles for Service Coordination Brant

a. *Child, Youth and Family-Centred Service*
Coordinated Service Planning is a supportive, proactive, responsive, and child-, youth- and family-centred service. Families and youth are actively and meaningfully engaged as partners and their input is incorporated throughout the system-level planning, delivery and evaluation cycle of coordinated service planning. Child and youth-centred service delivery recognizes that young people may have different perspectives and priorities than their families, and that these perspectives and priorities should be recognized and respected during the planning and delivery of their services. The family and service

providers work together to make informed decisions about the services and supports the child and family receive.

- Family-centered practice and service guides coordinated service planning in Brant. This includes family and child/youth strengths and goals being at the centre of the plan, and their priorities are treated with dignity and respect.
- Service coordination is flexible and is provided at the level required by the family at any point in time; the family is empowered to build skills and competencies to coordinate their own services.
- Confidentiality, consent and choice are explained and respected.
- Service coordination links with all services the child/family may be involved with or need to access, as well as other service planning processes.
- All children/youth and families receiving multiple services should have the option of having their services coordinated across sectors; service providers will provide clear and consistent information about service coordination.
- Families and youth are engaged in planning, implementation, delivery, evaluation, and governance across Coordinated Service Planning processes.
- Service providers place the needs of children, youth and their families ahead of individual organizational priorities, needs and aspirations; each organization works to entrench a culture of child/youth and family-centred service within their organization, the services they provide, and throughout the Coordinated Service Planning process.

b. *Seamless Service and Information Sharing*

Families will experience a seamless sharing of information - with consent, information about a family's strengths and needs will be shared between providers. Families should not feel like they are repeating intake and assessment information or repeating their stories unnecessarily.

- Partners in service coordination support the sharing of information regarding the child/youth/family's story and service plans, with consent, to provide seamless referrals and develop service goals.
- There will be a documented Coordinated Service Plan for each child/youth shared, with consent, to inform the provision of each service.
- All eligible children/youth are referred to the Coordinating Agency to support a centralized record for each family that can be shared, with consent, to reduce families having to unnecessarily repeat their stories.
- Seamless referral processes and clear pathways strengthen the delivery of services to be more efficient, less duplicative and better integrated, with fewer intake points and better communication among providers.
- Service coordination includes transition planning; it will contribute and align with other transition plans for the child/youth, including transitions

into/through school or into adulthood; it will incorporate the transition planning as per the *Transition Planning Protocol and Procedures for Young People with Developmental Disabilities*.

c. *Meeting Diverse Needs*

The Coordinated Service Planning process is inclusive, accessible, and culturally-appropriate. It is respectful of the values and meets the diverse needs of children, youth and their families. Service Coordination partners are responsive to the linguistic and cultural needs of the communities within Brant.

- The coordinated service planning process is culturally-appropriate, respects the values and meets the diverse needs of children, youth and their families, including linguistic and cultural needs.
- Service coordination will connect families with the range of services and supports that will meet their child and family's needs.
- Service providers will be aware of distinct approaches required to address the needs of First Nations, Métis, Inuit and urban Indigenous children and youth; this includes providing culturally-appropriate services and linkages to Indigenous service providers and other community resources.*
- Service providers will respond to the service needs of French-speaking children and youth, and their families; this includes engaging with French-language school boards and French-language service providers (which may be outside of the Brant communities), as well as hiring translation services when preferred by the family.
- The different linguistic and cultural communities within the Brant area and the service providers who serve them, are actively and meaningfully engaged as partners; their input is incorporated throughout the planning, delivery and evaluation cycle of coordinated service planning.

*****Jordan's Principle will be implemented to ensure that all children, including children on reserve, will have access to the health and social services they need, when they need them. It will include service coordination, service access resolution, and engagement with First Nations and jurisdictional partners. (Refer to: http://www.afn.ca/uploads/files/jordans_principle-report.pdf

4. Roles and Responsibilities of the Coordinating Agency

Contact Brant as the Coordinating Agency in Brant has oversight over, and is accountable for, Coordinated Service Planning. Contact Brant's Board of Directors holds the governance responsibilities for the agency and its services.

The following is taken from the CSP Policy document as well as the MCYS contractual agreement, the Service Description Schedule, for the Coordinating Agency. The Coordinating Agency is accountable to the Ministry for the delivery of Coordinated Service Planning in Brant:

- Ensuring the delivery of the Coordinated Service Planning Cycle, including but not limited to, intake and assessment, identification of strengths and needs, and have a clear record of the identified Service Coordinator.
- Managing all aspects of Coordinated Service Planning, including risk and complaints management (in relation to Coordinated Service Planning), privacy of information, records management, the single wait list, information management, and performance measurement of the Coordinated Service Planning functions.
    - Reports on Coordinated Service Planning in Brant are submitted quarterly to the Ministry, including the number of families actively receiving supports from a dedicated Service Coordinator, number of families waiting for a dedicated Service Coordinator, the number of active Coordinated Service Plans on record in the centralized database, the length of time waiting for a dedicated Service Coordinator, the number of dedicated Service Coordinators in Brant, the amount of time spent by Service Planning Coordinators on Direct and Indirect Service Hours, and much more.
- The performance of Service Planning Coordinators in Brant, no matter where they are employed, including ongoing training, and reporting on the activities and performance of all Service Planning Coordinators.
    - Facilitate the CSP Community of Practice for professionals providing service coordination functions and dedicated Service Coordinators.
- Ensuring that referral pathways are clear, particularly intersections with children's services, education and health sectors and other community organizations.
- Maintaining responsibility for monitoring and evaluating Coordinated Service Planning, including reviewing existing processes and policies, documenting decisions, and making changes based on ongoing performance monitoring, in keeping with the parameters of the policy guidelines, and other ministry policies/direction.
    - Monitors and reviews the Coordinated Service Plans received to ensure updates are received annually.
    - Coordinates meetings of the CSP Steering Committee at least quarterly.
    - Facilitates meetings with the CSP Providers as needed to support the collaborative approach to implementing and evaluating Coordinated Service Planning
- Developing and maintaining relationships with cross-sectoral service providers and educators in the service delivery area in order to deliver Coordinated Service Planning, recognizing collaborative relationships and considering the expertise of educators and other professionals.
    - The Coordinating Agency will maintain clear processes for collaboration and information sharing among relevant providers in the children's services, education, and health sectors through formal agreements that

address, at a minimum, how and when to refer families, share information and contribute to Coordinated Service Planning.

- Developing a relationship with the local Child and Youth Mental Health Lead Agency for children and youth with mental health needs (Woodview Mental Health and Autism Services), and with the service resolution mechanism (Contact Brant) in order to support the needs of children and youth whose needs exceed locally available services.
- Communicating expectations to partner agencies/organizations about how Coordinated Service Planning will work, including how other providers will be engaged in developing plans.

- Leading outreach and communications activities about Coordinated Service Planning, including:
  - Reaching out to families who may need the service.
  - Reaching out to local agencies that may have a role to play in Coordinated Service Planning, or may be a source of referrals.
  - Emphasizing that Coordinated Service Planning is a proactive support and that families should be referred (or self-refer), before they are approaching crisis whenever possible, to avoid experiencing crisis.
  - Collecting and making available to families up-to-date and transparent information about locally available services, including access, intake processes, and waitlist/wait times.
  - Communicates expectations to partner organizations about how Coordinated Service Planning will work, including how other providers will be engaged in developing Plans.
  - Facilitates the Community of Practice for Service Coordinators to support capacity building and the integrity of service coordination in Brant
  - Facilitates at least quarterly meetings of the Coordinated Service Planning Steering Committee, providing data to support their leadership role as per the Terms of Reference.
- Facilitating consistent knowledge sharing, both amongst service providers and with families of children and youth with multiple and/or complex special needs, regarding the delivery of Coordinated Service Planning.
- Capacity building within the Coordinating Agency and partner agencies.
  - Capacity building at the Coordinating Agency and its partners will be an ongoing part of the service and quality improvement process as new needs and opportunities for improvement are identified.
  - Family-Centred Practice (including family/youth participation, inclusion and engagement, holistic person-centred planning, client confidentiality, and information sharing).

4.1 Intake and Assessment

When a family is referred to Coordinated Service Planning, Contact Brant reviews the referral information, or as needed completes an intake, to assess

the family's situation to determine eligibility, priority to receive a dedicated Service Planning Coordinator, and at what intensity of service.

The Coordinating Agency's assessment will be based on the family's current needs, strengths and capacity. The family's situation and capacity may change over time and re-assessment can occur at any point.

- *Eligibility*: Families will be determined eligible for service coordination based on the Eligibility standards outlined in this document.
- *Prioritization*: Families will be prioritized for service coordination utilizing the Brant *Most in Need Tool,* Appendix 5, as well as the following:
    - Families will be prioritized for immediate admission or wait listed for service coordination at the intake/assessment stage; reprioritization will occur as needs change, as identified by the family, their Service Coordinator, other service providers, and/or the Family Team.
    - Prioritization will be completed using information received from the family and/or referral source and will be based on current circumstances.
    - Prioritization will consider developmental risk factors, current transitional issues for the child/family, family situation including protective and risk factors, geographic location of the home to community resources (i.e. isolation), and available services.
    - When discharged families want to re-engage with Coordinated Service Planning, the Coordinating Agency will prioritize the family for access to a Service Coordinator over families on the waitlist.
- *Intensity*: Some families will develop the capacity for coordinating their own services with limited initial assistance, others may need Coordinated Service Planning as a result of a transition or a change in the family's circumstances, and some may require Coordinated Service Planning on an on-going basis due to the complexity and breadth of needs:
    - Brief supports – A Coordinated Service Plan is developed and there are brief, time-limited supports prior to discharge.
    - Intermittent supports – More intensive level of supports at times and less intensity at other times; a Coordinated Service Plan is developed and reviewed at least every 6 months; Plans will be updated at least annually.
    - Continuous supports - a Coordinated Service Plan is developed and reviewed at least every 6 months or more often as needed; Plans will be updated at least annually.

5. Brant Special Needs Strategy Planning for CSP re No Wait for Supports

The Brant Special Needs Strategy planning identified that there should be no wait for service coordination supports. This will be supported by:

1) Building on inter-professional collaboration and service coordination supports that are provided by community staff within their professional role:

- A professional providing service coordination functions will be clearly identified as the primary service coordinator wherever possible. Refer to the Community Coordinated Service Planning Protocol.
- If a family is waitlisted for a dedicated Service Coordinator, the professional providing service coordination supports will continue supporting the family until Contact Brant is able to identify the admission to the dedicated Service Coordinator, and a 'warm transfer' can be supported. Contact Brant is available to provide consultative supports to the Service Coordinator about service coordination throughout the waiting period.

2) Contact Brant will initiate Coordinated Service Planning at the referral/intake stage, and provide interim supports as needed to a family waiting for a dedicated Service Coordinator where an existing community professional providing service coordination supports is not available, and immediate admission is not prioritized.
3) Contact Brant will commence Coordinated Service Planning supports for families prioritized as needing immediate admission to the service if a dedicated Service Coordinator is not immediately available through one of the Coordinated Service Planning Providers. A 'warm transfer' will be supported when the CSP Provider has a vacancy.

6. Roles and Responsibilities of Coordinated Service Planning Providers and Participants

Each Coordinated Service Planning Provider and Participant is accountable to the Coordinating Agency for Coordinated Service Planning in Brant and will ensure that service coordination and outcomes are consistent and equitable for all families, regardless of the service provider. Each CSP Provider and Participant is also accountable to each other through the Coordinated Service Planning Steering Committee to ensure implementation of the collaborative Brant model.

In collaboration with the Coordinating Agency and other Coordinated Service Planning partners, each Coordinated Service Planning Provider and Participant is committed to participate and collaborate in the approved model for Coordinated Service Planning as outlined in their Memorandum of Understanding signed with the Coordinating Agency.

All stakeholders will provide consistent information about service coordination to families. CSP Providers should link to Contact Brant's website or provide details on their own website, and will distribute the promotional materials developed by the Coordinating Agency about service coordination to the families they serve as well as their employees.

Each Coordinated Service Planning Provider and Participant are governed by their existing governance bodies.

3.1 ***Coordinated Service Planning Providers*** **will**:

- Maintain formal agreements (MOU) with the Coordinating Agency regarding agreed upon expectations with respect to the Provider's role and how they will be accountable to the Coordinating Agency.
- Report quarterly to Contact Brant on the activities of their dedicated Service Coordinators using the provincial *Coordinated Service Planning Reporting Tool* (see Section 9).
    - Report the number of families the Service Coordinators has asked to complete the MPOC survey. (This has been added to the provincial *Coordinated Service Planning Reporting Tool.)*
    - The Coordinated Service Plan must be submitted to Contact Brant each time it is completed/updated; Contact Brant must report, on behalf of Brant, the number of CSPs on record.
    - Inform Contact Brant the date the Service Coordinator first meets with a family on their caseload.
    - Inform Contact Brant the date the family is discharged (Inactive of Closed) from Service Coordination supports.
    - Any relevant documentation, data and performance measures requested by the CSP Steering Committee, including feedback and complaints received about the provision of service coordination so the Steering Committee can address quality improvement.
- Support their dedicated Service Coordinators to participate in training required by the Coordinating Agency. Participate in capacity building as needs and opportunities to improve Coordinated Service Planning in Brant are identified by the Coordinating Agency and Steering Committee.
- Ensure that their dedicated Service Coordinators are aligned with and supporting the Service Coordination Brant processes and model; ensure their dedicated Service Coordinators are oriented to the expectations set out in this Service Coordination Brant Procedure Manual. This will support families to have a consistent experience of Coordinated Service Planning across Brant.
- Use the Service Coordination Brant common tools and forms.
- Support families to have a consistent experience of Coordinated Service Planning across Brant.
- Communicate to children and youth with complex special needs and their families who may be eligible or benefit from coordinated service planning, about Service Coordination Brant and how to access these supports.
- Send referrals for Coordinated Service Planning to Contact Brant including as much relevant information as possible.
- As established by the Special Needs Strategy Planning table, each Coordinated Service Planning partner needs to align their internal organizational policies and procedures with the provincial expectations and the Service Coordination Brant model for Coordinated Service Planning. A key practice to address is internal procedures that will reduce families having to unnecessarily repeat their stories. This includes:

- Sending referrals for service coordination to the Coordinating Agency, with the referral information that includes the family's story that the organization has already gathered.
- Receiving referrals that include the family's story from any organization, and then accepting the information rather going through an internal intake process that requires the family to repeat the information.

- Share information on their services with the Coordinating Agency. Keeping the Coordinating Agency apprised of programs and services, both new and any changes, ensures the Coordinating Agency has up-to-date information on community services to provide to families. Additionally this supports Contact Brant in providing the Community Information database, www.info-bhn.ca, which is a public listing of community services and resources, available to all Service Coordinators, organizations and families.
- Ensure dedicated Service Coordinators lead the development of Coordinated Service Planning for families on their caseload, coordinated with all involved stakeholders. Additionally, ensure the organization's staff, actively participate in the development of Coordinated Service Plans for families on their caseload, and explore flexible and innovative approaches for service delivery to meet the identified priorities and needs of each child/youth and family.
- Through its senior leadership, actively participate in the local governance structure, the Brant Coordinated Service Planning Steering Committee.
- Actively participate in issues resolution with respect to the delivery of Coordinated Service Planning in Brant when conflicts arise between providers or between families and providers.
- Support participation in the CSP Community of Practice of the organization's professionals providing service coordination functions and/or dedicated Service Coordinators.
- Recognize that the Coordinating Agency has oversight over, and is accountable for, Coordinated Service Planning in Brant.

3.2 ***Coordinated Service Planning Participants*** **will**:

- Participate in Coordinated Service Planning as appropriate for the clients they serve, and have a formal agreement (MOU) with the Coordinating Agency regarding information sharing and participating in the Service Coordination Brant process.
- Communicate to children and youth with complex special needs and their families who may benefit from coordinated service planning, about Service Coordination Brant and how to access these supports.
- Send referrals for Coordinated Service Planning for families who need the service to Contact Brant.
- As established by the Special Needs Strategy Planning table, each Coordinated Service Planning partner needs to align their internal organizational policies and procedures with the provincial expectations and the Brant Plan for Coordinated Service Planning. A key practice to address

is internal procedures that will reduce families having to unnecessarily repeat their stories. This includes:

- Sending referrals for service coordination to the Coordinating Agency, with the referral information that includes the family's story that the organization has already gathered.
- Receiving referrals that include the family's story from any organization, and then accepting the information rather going through an internal intake process that requires the family to repeat the information.

- Share information on their services with the Coordinating Agency. Keeping the Coordinating Agency apprised of programs and services, both new and any changes, ensures the Coordinating Agency has up-to-date information on community services to provide to families. Additionally this supports Contact Brant in providing the Community Information database, www.info-bhn.ca, which is a public listing of community services and resources, available to all Service Coordinators, organizations and families.
- Participate actively in the development of Coordinated Service Plans for families that they serve, and explore flexible and innovative approaches for service delivery to meet the identified priorities and needs of each child/youth and family.
- Through its senior leadership, actively participate in the local governance structure, the Brant Coordinated Service Planning Steering Committee.
- Participate in capacity building as needs and opportunities to improve Coordinated Service Planning are identified by the Coordinating Agency and Steering Committee.
- Actively participate in issues resolution with respect to the delivery of Coordinated Service Planning in Brant when conflicts arise between providers or between families and providers.
- Support participation in the CSP Community of Practice of the organization's professionals providing service coordination functions.
- Recognize that the Coordinating Agency has oversight over, and is accountable for, Coordinated Service Planning in Brant.

7. Roles and Responsibilities of the Ministry

- Through Transfer Payment Contracts and quarterly reporting, the MCCSS Regional Office holds the Coordinating Agencies accountable for the oversight and delivery of Coordinated Service Planning within the service delivery area.
- The Ministry will update contracts with Coordinated Service Planning Providers and Participants to include expectations regarding Coordinated Service Planning.
- MCCSS will monitor the functioning of local Coordinated Service Planning systems and will bring cross-sectoral and/or provincial issues forward for inter-ministerial resolution as necessary.

8. Performance Measurement and Data

The province outlines that Performance Measurement is a shared responsibility of all participants in Coordinated Service Planning. The Brant Coordinated Service Planning Steering Committee will review data and address quality assurance and improvement.

All Coordinated Service Planning Providers will report quarterly to the Coordinating Agency using the provincial *Coordinated Service Planning Reporting Tool*, by July 15, October 15, January 15, and April 15. Contact Brant must roll up all the data from CSP Providers and submit on behalf of Service Coordination Brant. Data Elements include:

- Number of referrals received for Coordinated Service Planning
- Number of referrals by Source (where a family was referred from for Coordinated Service Planning)
- Number of days waited between referral and the first CSP meeting. (Calculated from the day of referral to Contact Brant, until the first contact with their dedicated Service Coordinator; both are based on the recorded dates in the centralized database at Contact Brant, as provided by the CSP Providers.)
- Number of children/youth leaving active Coordinated Service Planning due to discharge (closed) or being inactive.
  Data provided by CSP Providers who note whether the family is inactive or closed.
- Length of service for families being discharged. (Calculated from the day of first contact with their SPC until their date of discharge; both are based on the recorded dates in the centralized database at Contact Brant.)
- Age of children and youth when they first began to receive CSP. (Based on the date CSP Providers give Contact Brant as the day of first contact by their SPC with a family.)
- Total number of FTE dedicated Service Coordinators in Brant.
- Number of Direct and Indirect Service Hours provided by Service Planning Coordinators.
- Number of meetings by the Service Coordinator with the child/youth/family.
- Total number of individuals waiting for CSP.
- Number of families requested to complete the MPOC.

The province outlines that the MPOC survey is to be distributed to families to collect data on family experiences. Coordinated Service Planning Providers must request their clients complete the MPOC at the first 6 month review of the Coordinated Service Plan, and annually thereafter. The MPOC can be completed electronically, or in paper format and is submitted anonymously to CanChild. CanChild will provide regional and provincial reports (as well as local reports if there are sufficient numbers).

9. More Background Information

The ***Coordinated Service Planning: Policy and Program Guidelines*** *June 2017* provide "operational guidance for Coordinating Agencies and partner providers delivering Coordinated Service Planning for children and youth with multiple and/or complex special needs, so that families will have a more consistent service experience no matter where they live in Ontario." These *Guidelines* built on the

initial direction in the Special Needs Strategy *Guidelines for Children's Community Agencies, Health Service Providers and District School Boards September 2014*.

Coordinated Service Planning is intended to be a supportive, proactive, responsive, and child/youth and family-centred service. This means that families and children/youth are actively engaged and their input is incorporated throughout the planning, implementation, delivery and evaluation of Coordinated Service Planning, as well as in the development and monitoring of the child/youth's Coordinated Service Plan.

Coordinated Service Planning is an ongoing family-centered process that assists families of children with multiple and/or complex special needs in the integration of their services, which may be delivered by several service providers, often from more than one sector. A clearly identified Service Coordinator supports the family's active participation in all aspects of service planning and is the single contact responsible for communication and information sharing with all relevant service providers.

Service Coordination Brant is built upon the existing inter-professional communication and collaboration that is outlined in the community's *Coordinated Service Planning Protocol* (available at www.contactbrant.net). Provincially and locally developed Coordinated Service Planning expectations further advances service providers working together in an effort to ensure they are integrating practice and service delivery for children, youth and families.

Service Coordination is a support in and of itself that is intended to decrease family stress by providing families with a formal voice in the service planning process and by assisting families in navigating and coordinating services for their child.

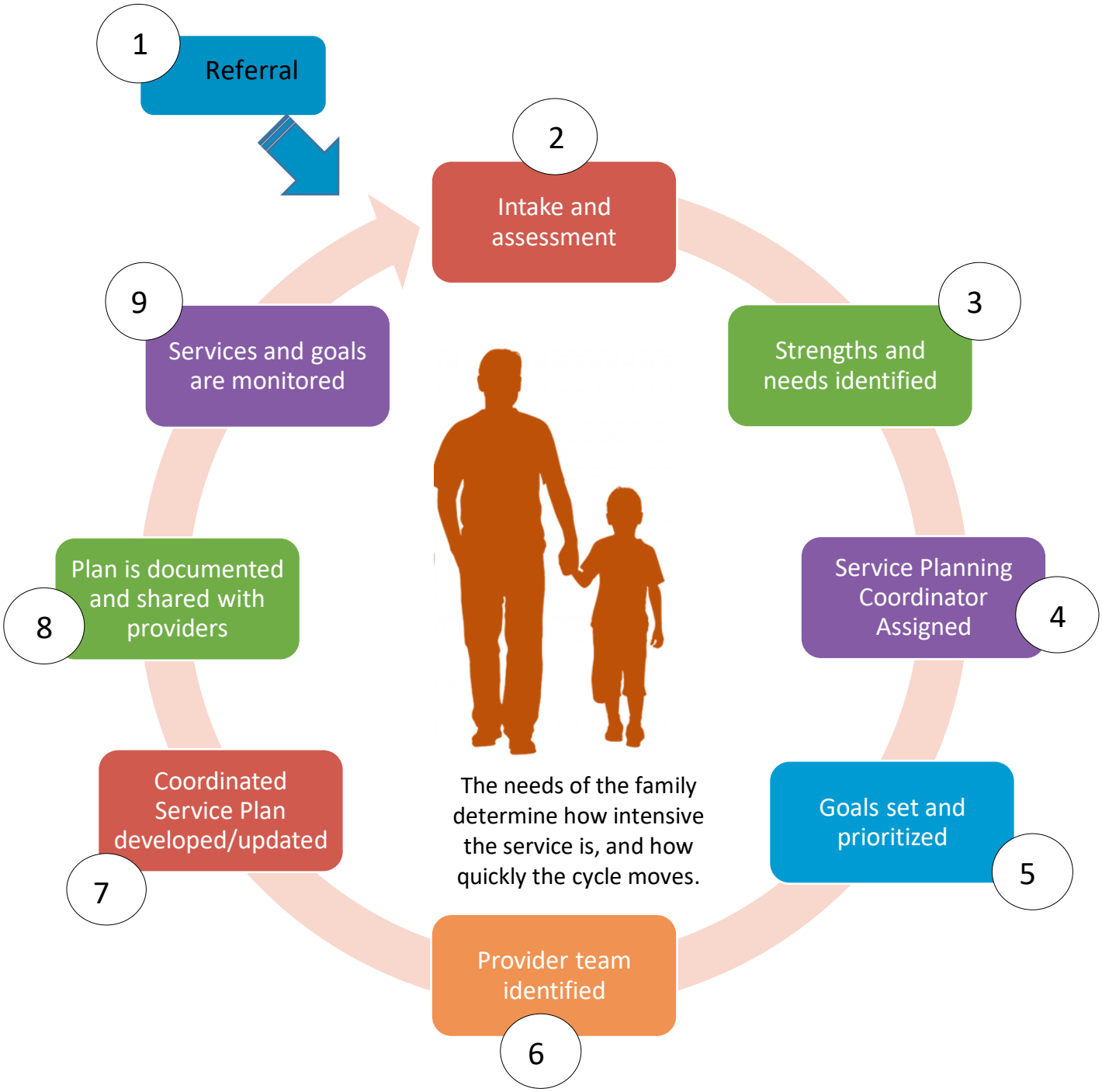
The Coordinated Service Planning Policy document clearly establishes expectations, which are outlined in this Procedure Manual.

Brant Coordinated Service Planning Stakeholders											*Appendix 1*
	CSP Provider	**CSP Participant**	Respite Services	Rehab Services	Autism Services	Healthy Child Development	Child/Youth Mental Health Services	District School Board Programs	Health	Children's Developmental Services	Other
Affiliated Services for Children and Youth		x									Infant Hearing; Blind-Low Vision Early Intervention
Brant County Health Unit		x				x			x		
Brant Haldimand Norfolk Catholic District School Board		x						x			Speech & Language services; mental health services
Conseil scolaire catholique MonAvenir		x						x			Represents Conseil scolaire Viamonde; Speech & Language services; mental health services
Contact Brant	**X**	x	x Access		x Access		x Access			x Access	Coordinating Agency; Access agency for Children and Youth Mental Health, Developmental and Autism Services

	CSP Provider	**CSP Participant**	Respite Services	Rehab Services	Autism Services	Healthy Child Development	Child/Youth Mental Health Services	District School Board Programs	Health	Children's Developmental Services	Other
De Dwa Da Dehs Nye>s		x					x		x		
Family and Children's Services		x									Child welfare
Family Counselling Centre	**X**	x	x							x	Children's Developmental Services
Grand Erie District School Board		x						x			Speech & Language services; mental health services
HNHB Local Health Integration Network	**X**	x	x				x		x		School health services
Lansdowne Children's Centre	**X**	x	x	x	x	x				x	Children's Treatment Centre
New Credit School		x									
Six Nations Health Services	**X**	x				x			x		
Six Nations Schools		x									
Woodview Mental Health and Autism Services	**X**	x	x		x		x				Lead Child & Youth Mental Health Agency

The Coordinated Service Planning Cycle *Appendix 2*

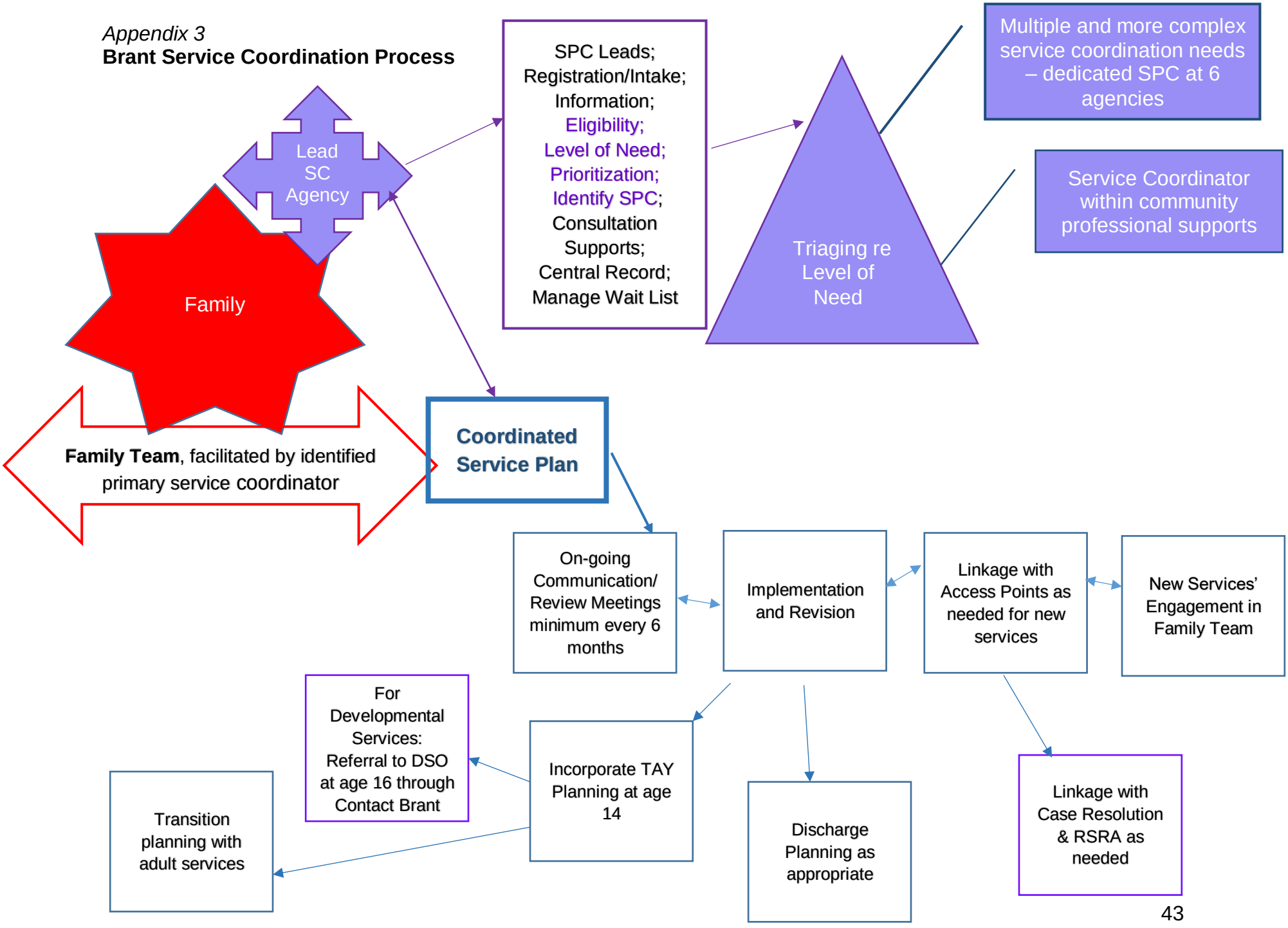
Coordinating Agencies are expected to work with their partners to provide the following, in a clear and consistent way:

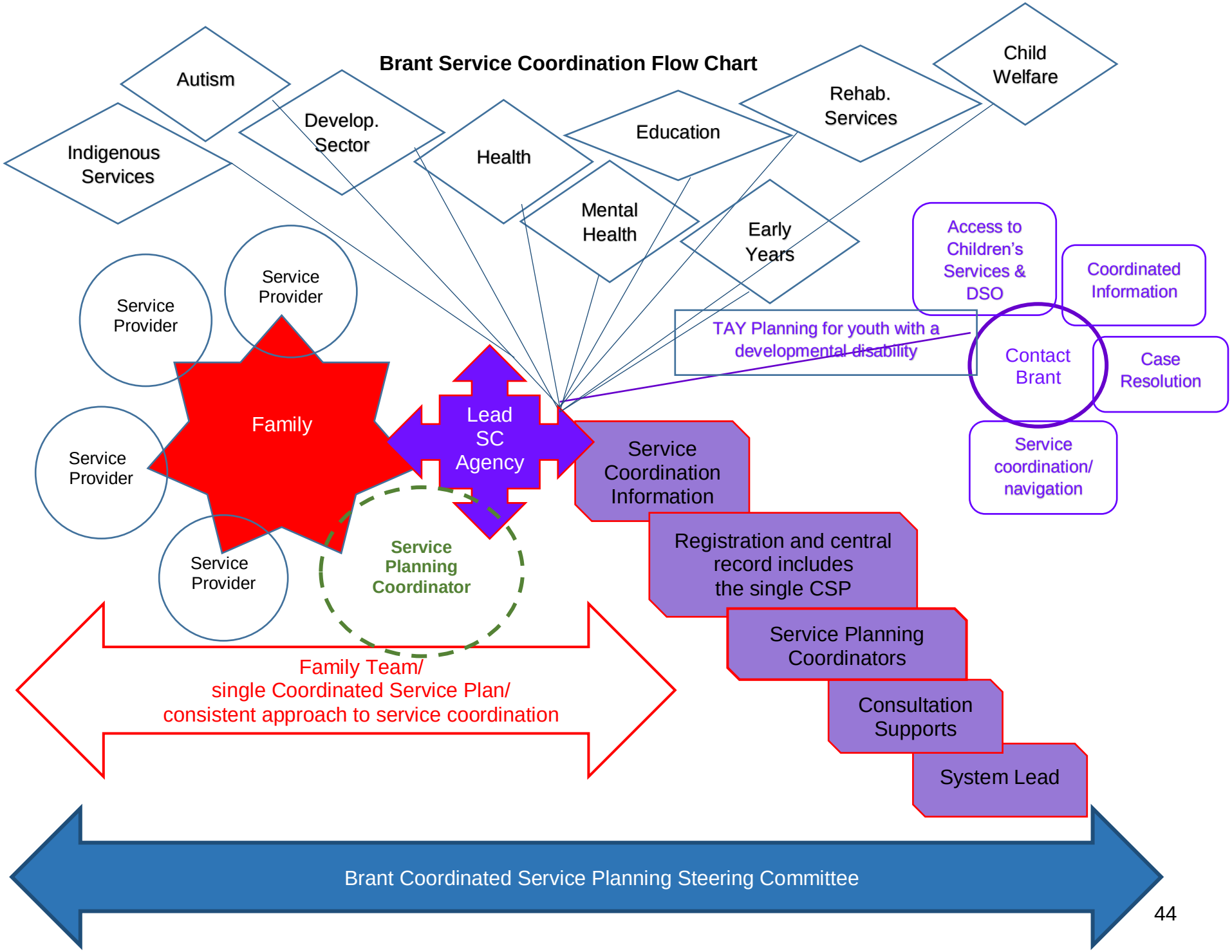


A family's file may be made inactive at any time during the cycle when the family and service provider decide that Coordinated Service Planning is no longer needed by the family.
A family can re-engage with Coordinated Service Planning if new needs develop or circumstances change.

Appendix 3

Brant Service Coordination Process




Brant Service Coordination Flow Chart
Autism
Develop. Sector
Health
Education
Rehab. Services
Child Welfare
Indigenous Services
Mental Health
Early Years
Access to Children's Services & DSO
Coordinated Information
TAY Planning for youth with a developmental disability
Contact Brant
Case Resolution
Service coordination/ navigation
Service Provider
Service Provider
Service Provider
Service Provider
Family
Lead SC Agency
Service Planning Coordinator
Service Coordination Information
Registration and central record includes the single CSP
Service Planning Coordinators
Consultation Supports
System Lead
Family Team/
single Coordinated Service Plan/
consistent approach to service coordination
Brant Coordinated Service Planning Steering Committee

Responsibilities of all staff performing Coordinated Service Planning Functions

Family-Centered Practice

- Facilitates the active participation of the child/youth and family in coordinated service planning, including goal setting.
- Is knowledgeable and available to discuss the child/youth and family's concerns, if applicable, regarding the service plan.
- Assists the family in navigating and accessing appropriate services and community processes.
- Explores flexible and innovative approaches for service delivery to meet the needs of the child/youth.
- Where the primary service coordination responsibilities shift to another staff, supports a 'warm transfer' and supports the family in the process.

Coordinated Service Plan

- Develops, with appropriate consent, a written strengths-based Coordinated Service Plan driven by the priorities of the child/youth and family that addresses the needs of the child/youth and family; includes transition planning.
- Facilitates the coming together of relevant providers in the children's services, education, and health sectors in each service delivery area, to develop and maintain a single coordinated service plan for the child/youth and their family.
- Monitors, reviews, and updates the Coordinated Service Plan, in collaboration with the family and relevant providers in the children's services, education, and health sectors, as the child and family's needs and services change.
- Documents the Coordinated Service Plan including using the community-developed Coordinated Service Plan template.
- Ensures regular reviews at least every 6 months, and as required or upon request. Update each Plan at least annually.

Communication

- As the identified service coordinator, acts as the family's primary contact, and facilitates communication amongst Family Team members.
- Facilitates working relationships with providers in the children's services, health and educations sectors, in order to enable their regular contribution into coordinated service planning, and obtains and shares relevant information regarding services for the child/youth.

Consistent Experience in Service Coordination

- Acts in accordance with the service coordination Guiding Principles (as outlined in the Memorandum of Understanding)
- Ensure registration of the child/youth at the Coordinating Agency, and provide the Coordinated Service Plan and updates to the Coordinating Agency.
- Provides consistent verbal and written community-developed information about what families can expect from service coordination and the complimentary supportive role of the Coordinating Agency.

Appendix 5

MOST IN NEED SUMMARY TOOL

Name:_____ **DOB:** _____

PRIORITY:

- ❑ **Maintaining/Planning** – services provided seem to meet needs of child/youth and family, or waiting for services is manageable.
  Response should be continued planning and integration of services.
- ❑ **Percolating** – multiple needs; on the radar that more services may be needed. *Response should include planning and integration of services; referral to new services*.
- ❑ **Emergent** – stressing system, need more supports; stressing family system.
  Response should include identification to Contact Brant; planning and integration of services; referral to new services; senior community stakeholders at case planning.
  - □ Stressing service system
  - □ Stressing family system
  - □ Supervision needs not easily met
  - □ School placement in jeopardy
- ❑ **At Risk** – child/youth at high risk of harm to self or others; system services have been exhausted; family supports stressed.
  Response should include identification to Contact Brant; planning and integration of services; referral to new services; immediate community case planning with senior community stakeholders.
  - □ System cannot easily meet all needs met
  - □ Stressing family system
  - □ Supervision needs not easily
  - □ School placement in jeopardy

SUMMARY OF CURRENT SITUATION:

- ❑ Attention, impulsivity
- ❑ Cooperativeness
- ❑ Conduct/behaviours
- ❑ Anxiety
- ❑ Depression
- ❑ Addiction concerns
- ❑ Self injurious behaviours
- ❑ Family dynamics/situation
- ❑ Abuse (past or present)
- ❑ Trauma
- □ FACS involvement
- □ Developmental disability
- □ Autism Spectrum Disorder
- □ FASD/FAE Query
- □ School issues
- □ Sexual behaviours
- □ Justice involvement
- □ Complex medical
- □ Other:_____

TIMING PRIORITY FOR SERVICE:

Urgent = high risk; priority referral to services due to imminent risk of harm: □ to self □ to others.

Referral = wait listed.

PROGRAM	Urgent	Referral

Person Completing: _____ **Date:** _____

Service Coordination Brant

Coordinated Service Plan

Child/Youth Name: **Address:**	**Date of Birth** (DD/MM/YYY): **Date of Plan** (DD/MM/YYY):

Parent/Legal Guardian: **Name** and **Relationship**	**Address** (if different from child/youth)	**Phone(s); Email**
Language(s) Spoken		
Interpreter Required?	☐ Yes ☐ No Comments:	

Present Situation of Child/Youth and Family: (Brief highlights)

-

Family Team (Identify those involved: youth, family, friends; all service providers, school, health professionals)

Name	Relationship/ Organization	Role	Phone/ Email	Involved in Development of Plan (Y/N)

Child's Strengths, Interests and Needs:

-

Family's Strengths, Needs and Priorities (include cultural priorities; *hopes and dreams; what would help the family the most; any barriers to service?*):
•

How the Family Team will support the integration of services with the child/youth and family's priorities		
Family's Priority/Goal	**Who is Responsible to do What**	**Timeline**
	•	•
	•	•
	•	•
Anticipated CSP Discharge Date (DD/MM/YYYY); discharge plan		

Ensure expectations in the Plan are meaningful to and based on the family's/youth's priorities.

Coordinated Service Planning Meeting Dates in the development of this Plan**:**

-

The above plan includes transition planning for a youth age 14+:

☐ Yes it has been initiated ☐ No it has not been initiated ☐ No child is under age 14

- **Sector(s) for Transition Planning** (Select all that apply):
  ☐ Developmental ☐ Health ☐ Mental Health ☐ Other (specify):

This Plan has been provided to the following:	**Date**
Parent/Guardian *(Name)*:	
Contact Brant	

Completed by: **Agency:**

Service Coordinator's Signature: _____
(Signature confirms finalized with child/youth and family)

Core Information for Referrals

The intent of Coordinated Service Planning in Brant is 'no wrong door' and to support families not having to repeat their story - thus the agency where a family first presents for service will capture core information and, with consent, share this information with the Coordinating Agency (Contact Brant) as well as involved stakeholders.

The following outlines the ideal 'core information' to be collected, wherever possible, to reduce families having to repeat their story to other providers.

At a minimum, the items in red are required for referrals to other providers:

1. Date of contact
    a. Date family called, was referred
    b. Date of collection of information
    c. Who was involved in the collection of information
    d. Relevant Assessments completed
    e. **Referral Source** (parent, service provider – Referent's name & agency)
    f. **Staff name making referral, and Agency**
2. Client Demographics
    a. **Child/youth's Name** (First, Last, Preferred name)
    b. **Date of Birth**
    c. **Gender** and Gender Identity
    d. **Indigenous Status** and Community
    e. **Ethnicity/cultural identity**
    f. **Preferred language(s)**
    g. **Interpreter required?**
    h. **Address including postal code**
    i. **Resides with….**
    j. **Phone**
3. Relations
    a. **Names of parents/caregivers,** specifying relationship and primary contact
    b. **Guardianship** - parent(s), shared custody, FACS including wardship status
    c. **Address** including postal code
    d. **Phones** (home, work, cell)
    e. **Email** (and permission to contact by email)
    f. Siblings Names
    g. Siblings Dates of Birth
    h. Siblings Address if different
    i. Who makes decisions on behalf of the child/youth
    j. Family cultural considerations
    k. Source of family income (e.g., employment, OW, ODSP, etc as well as Sources of Support e.g., ACSD, SSAH, ADP, etc.)

4. Present Situation
    a. **Description of what is occurring currently with child/youth/family**
    b. **What does family hope to have happen with this referral**
    c. **Safety Concerns/Risk Factors**
    d. Strengths
    e. Social/Life Skills and Social/Recreational Involvement
    f. Communication Skills/Needs
    g. Special Support Needs
    h. Behavioural/Emotional Issues
    i. Family Supports (informal supports/significant others)
    j. Legal Issues
5. Education
    a. **School/Day Care**
    b. **School Board**
    c. **Grade**
    d. IPRC designation/IEP
    e. School attendance, progress, special supports, etc.
6. Health
    a. **Medical Conditions** and Health History
    b. Historical assessments/diagnosis (date, by whom)
    c. Prenatal/Child Development
    d. Medication
    e. Allergies
    f. Doctor(s)
    g. Health Card (if required by service provider where referral to be sent)
    h. Family Health History
7. Services
    a. **Current Supports**
    b. **Previous Supports**
    c. **Referent's identified needs for this Referral**
    d. **Any other concurrent referrals being made by Referent**
    e. Community Resources/Services Suggested
8. **Consent**
9. Attach relevant documents (e.g., Intake, Assessments, Consent form, Service Plan, Most in Need Tool, etc.)

CONSENT TO SHARE INFORMATION
between Brant Service Coordination Partners

In respect of _____, _____
(Child/Youth's Name) (Date of birth)

_____
(Address)

Coordinated Service Planning is a commitment between Brant organizations who serve children and youth with multiple needs, to support their families with a clear point of contact for all the services they are receiving, and provide a single service plan that identifies what is important to the family.

To make a referral to a service, or to work together on behalf of your child and family, we need your permission to communicate between the various organizations involved with your family about your child's needs, progress, and planning.

Your consent allows for agency staff to communicate with each other.

Your consent allows for agencies to share written reports (such as an intake, service plans, and assessments).

In Brant, Contact Brant is the lead Service Coordination Agency and is mandated to keep information of Coordinated Service Planning clients on file. Contact Brant protects the privacy of your information - All information is treated as confidential and is not released or discussed with any other persons or organizations without consent, unless required by law.

I give my consent to the organizations that I have checked and initialled on the second page of this form to **talk with each other about the services my child is receiving, being referred to, or is waiting for, as well as my child's needs, progress and planning**.

I give my consent to share the reports listed that I have checked and initialled on the second page of this form with these same organizations.

I understand that organizations will not willingly disclose information without permission, unless required by law.

I understand that the information collected is stored at Contact Brant as required by their provincial funders, the Ministry of Children Community and Social Services.

I also understand that information collected is used in a non-identifying summary form for community planning, quality assurance, and Ministry reporting.

This consent will remain in effect for one year from date of signing. I understand that I may cancel this consent in writing at any time.

Print **Name of Staff** who reviewed & received Consent with Consenter(s):	**Organization**:
Date Consent Reviewed:	**Signature of Staff**

Consent to Share with:	✓ **Purpose:** Referral to Service(s)	✓ **Purpose:** On-going communication	✓ **Initial to Approve consent as checked**	**Initial if consent is Declined**
Affiliated Services for Children and Youth				
BHNCDSB - specify school:				
Brant County Health Unit				
Brant Family and Children's Services				
Community Care Access Centre HNHB				
Conseil scolaire catholique MonAvenir - specify school:				
Contact Brant				
CPRI (Child & Parent Resource Institute)				
De Dwa Da Dehs Nye>s (Aboriginal Health Centre)				
Developmental Services Ontario HNR				
Family Counselling Centre of Brant				
GEDSB - specify school:				
Lansdowne Children's Centre				
McMaster Children's Hospital				
Physician (Family/Specialist): Dr.				
Six Nations of the Grand River specify agency:				
Six Nations/New Credit Schools - specify school:				
St. Leonard's Community Services				
Woodview Mental Health and Autism Services				

	Report	**Source of Report** and **Date**	**Initial Consent to Share Report**
❑	Intake Report		
❑	Coordinated Service Plan		
❑			

List any specific instructions by Consenter:

Print Name of Consenter:	Relationship:	Print Name of Consenter:	Relationship:
☐ Verbal Consent OR ☐ Written Consent – Signature:		☐ Verbal Consent OR ☐ Written Consent – Signature:	
Date:		Date:	

Glossary and Definitions

SNS – Ontario Special Needs Strategy for Children and Youth, a collaborative provincial initiative of the Ministry of Children and Youth Services, Ministry of Community and Social Services (now called the Ministry of Children, Community and Social Services), Ministry of Education, and Ministry of Health and Long Term Care

CSP - Coordinated Service Plan: child's individual plan compliments IEP/includes TAY Plan or Coordinated Service Planning an inclusive, holistic, accessible and culturally appropriate process which improves service experiences and outcomes for children and youth with multiple and/or complex special needs and their families through the support of a Service Planning Coordinator who will connect them to the multiple, cross-sectoral services they need as early as possible, and monitor their needs and progress through a Coordinated Service Plan

Lead CA – Lead Service Coordination Agency/Coordinating Agency: Contact Brant

SPC/SC - Service Planning Coordinator = dedicated Service Coordinators who support families of children and youth with multiple and/or complex special needs by acting as the identifiable point of contact and being responsible for developing a coordinated service plan that recognizes all of their service needs and builds on their child/youth's strengths

CSP Providers – Agencies employing dedicated Service Planning Coordinators/ Service Coordinators

CSP Participants - Agencies and school boards that provide services and/or supports to children and youth with special needs and that are expected to participate in coordinated service planning

COP - Community of Practice: collaboratively developing and maintaining best practices

MIN - Most In Need Tool; Brant's prioritization tool

MOU - Memorandum of Understanding

CSN - Complex Special Needs Funding as approved through Case Resolution

CTC - Children's Treatment Centre (Lansdowne Children's Centre)

DSB - District School Boards

IEP - Individual Education Plan

TAY - Transitional Aged Youth; eligible for TAY Planning starting by age 14; incorporated in the CSP

SLT – Strategic Leadership Table, the Brant cross-sectoral system planning table for children and youth services

CSP Steering – Brant Coordinated Service Planning Steering Committee

TOR -Terms of Reference

SHPS - School Health Professional Services includes Occupational and Physio Therapies

DSO - Developmental Services Ontario

MPOC – provincially directed tool to gather feedback from families on CSP

SIPDDA - Services and Supports to promote the Social Inclusion of Persons with Developmental Disabilities Act

EMHware - centralized data base at Contact Brant; Service Provider Portal available through this secure web-based program

Core Information – The family's story; the intake information - gathered by the first agency where a family presents for service and made available when referring to services including to Coordinated Service Planning for a dedicated Service Coordinator