Coordinated Service Planning Brant

Procedure Manual

One Child - One Plan - One Team

Revised April 2023

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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 *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."

A. Purpose

Coordinating Service Planning Brant's 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 Credit First Nation, with Contact Brant serving as the community's designated Coordinating Agency in collaboration with community stakeholders.

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

The 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-centred, coordinated service planning through a collaborative, cross-sectoral seamless approach that is centred on the needs of children, youth and their families:

- A clear contact for Coordinated Service Planning (an identified 'Service Planning Coordinator', also referred to as 'Service 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.

Coordinating Service Planning 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 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 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 the child/youth/family's goals, strengths, and needs, and outlines how services that the child/youth is and will be receiving, are wrapped around the child and family.

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

1. Coordinated Service Planning **Providers** - Agencies that employ dedicated Service Coordinators. They work with the Coordinating Agency to implement the expectations and are accountable to the Coordinating Agency.
2. Coordinated Service Planning **Participants** - Agencies and school boards that provide services and support 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.

   Note:
   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 Coordinating Service Planning Brant model.

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

Note: The Ministry uses the word 'Service Planning Coordinator'; this is also referred to as 'dedicated Service Coordinator' or 'Service Coordinator' in this document. Each Coordinated Service Planning Provider has a unique employee title for their Service Coordination staff.

C. Family-Centered Practice and Service

The Ministry expects family-centred practice and service to guide Coordinated Service Planning with family/child/youth strengths and goals at the centre of the plan.

Service Coordinators will be family-centred 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 by 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 ongoing communication.
- Family choice is respected and they are provided with the tools, including clear and accurate information, to make their own informed decisions.

Also refer to Section G-6, *Principles for Coordinating Service Planning Brant* which outlines Child, Youth and Family-Centered Service; Seamless Service and Information Sharing; and Meeting Diverse Needs.

D. Eligibility for Coordinated Service Planning

Decisions around eligibility and prioritization for Coordinated Service Planning are made by the Coordinating Agency, Contact Brant.

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

- When the child/youth and family's need for service coordination goes beyond the scope of inter-professional collaboration to address, and they would benefit from the added support.

- The child is under the age of 18, or between the ages of 18 and 21 and in school.
- The breadth and cross-sectoral nature of a child/youth's service needs require multiple services, often from multiple sectors and professionals. The child's challenges are related to multiple areas of their development requiring, for example, rehabilitation services, autism services, developmental services, respite supports, behavioural services, mental health services, and health services. They may have ongoing service needs such as severe physical and intellectual impairments and may require the use of technology.
- The family is experiencing challenges which impede their ability to coordinate services for their special needs child including:
    - Coping strengths and adaptability
    - Health and well-being of other family members
    - Literacy and/or language barriers
    - Family/life events which contribute to the family's level of stress
    - Limited social and community support
    - Competing demands of caregiving and employment
    - Financial instability.

E. Overview of Coordinated Service Planning in Brant

The Brant community has taken a systemic approach to the provision of service coordination - service coordination will be implemented by every service provider.

1. The Coordinating Service Planning Brant Model

Service coordination is primarily provided by community staff who offer service coordination support within their professional role.

Coordinated Service Planning for children and youth with more complex needs will be provided by the Coordinating Agency and 5 other community organizations, the CSP Providers.

1.1 *Service Coordination primarily provided by Community Professionals*

Refer to the Brant community's *Coordinated Service Planning Protocol*, available at www.contactbrant.net/professionals.

Staff who offer service coordination support within their professional role will:

- ✓ Communicate regularly with other involved services and clearly identify the primary service coordinator for each family.
- ✓ Refer children and youth receiving service coordination support to Contact Brant and identify the primary staff leading the coordination of services.

  Note: Contact Brant as the Access Mechanism and Coordinating Agency provides a centralized database to confidentially maintain records of services, intake information that can be shared so families do not have to repeat their story, and service plans.

- ✓ Write an integrated service plan to outline how services are wrapped around the family in a coordinated plan of care. Share it with involved services and the family to keep everyone on the same page. It is recommended to use the community-developed *Coordinated Service Plan* template (available at Contact Brant).
- ✓ Provide the written service plan to Contact Brant to include in the child's central record – this enables collaboratively building on the service plan over the years. Contact Brant's record is available to inform current and future providers (with consent).
- ✓ 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 Coordinated Service Planning to receive the support of a dedicated Service Coordinator. Ensure referrals to Coordinated Service Planning include sufficient information so that the family does not need to retell their story.
- ✓ Connect with Contact Brant, as required, for assistance/consultation in delivering service coordination support.

1.2 Coordinated Service Planning for children and youth with more complex needs, provided by *Dedicated Service 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 Service Coordinator is accessed through the referral process to Contact Brant.

Based on family preference, Contact Brant will identify the Coordinated Service Planning Provider agency that will provide the dedicated Service Coordinator:

i. Contact Brant for Children's and Developmental Services
ii. Home and Community Care Support Services HNHB
iii. Lansdowne Children's Centre
iv. Six Nations of the Grand River Health Services
v. Willowbridge Community Services
vi. Woodview Mental Health and Autism Services.

2. *Service Coordinators' Roles and Responsibilities*

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.

Service Coordinators are responsible for implementing the Coordinating Service Planning Brant processes and templates outlined in this Procedure Manual. Service Coordinators will meet the following minimum expectations:

- Act as the family's primary contact. Be knowledgeable and available to discuss the child/youth/family's concerns regarding their service plan.

- Develop a written Coordinated Service Plan.
  This Plan is strengths-based, addresses the integrated service needs of the child/youth, is driven by the priorities of the child/youth and family, and supports participation at home, school and in the community.
  Refer to Section E-4, 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 plan of care for the child/youth and their family.
- Facilitate working relationships with providers across sectors in order to enable their regular contribution into coordinated service planning and share relevant information regarding services for the child/youth.
- Monitor and review the written Coordinated Service Plan at least every 6 months in collaboration with the child/youth/family and relevant cross-sectoral providers. Review regularly as the child/youth and family's needs and services change.
- Revise the Plan at least annually and more often as needed.
- Connect families to relevant services and other community resources.
  - Assist the family in navigating and accessing appropriate services and community processes, including Case Resolution as appropriate.
  - Support seamless referrals as new needs and supports are identified, facilitating the connection with the new provider to reduce the need for families to repeat their story.
- Where the primary service coordination responsibilities shift to another staff, support a 'warm transfer'; 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.
- Provide consistent information about service coordination and the role of the Coordinating Agency, including distribution of promotional materials.
- Facilitate working relationships with providers in the children's services, health and education sectors in order to enable their regular contribution to Coordinated Service Planning.
- Actively participate in the Community of Practice as well as training opportunities specific to service coordination offered through the Coordinating Agency and the provincial Coordinating Agencies Network.

Notes:

i. The Ministry expected communities to develop a 'job description' for Service Coordinators – refer to Appendix 4, *Responsibilities of all Staff Performing Coordinated Service Planning Functions*.

ii. The Service Coordinator is not responsible for coordinating all services required by the family (e.g. adult mental health, settlement) but should provide contact information or initiate a referral to help families access other services and supports.

3. Referrals to Coordinated Service Planning

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

Seamless referrals mean the family will not be aware of the process that service providers complete to support a family being connected to service coordination. 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 their intake information with Contact Brant.

Through the referral process, Contact Brant will fulfill their role of:

- Determining a family's eligibility for Coordinated Service Planning
- Identifying a family's priority (for immediate service or wait list)
- Maintaining each family's record in the centralized database.

3.1 *Self-Referral by Families*

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

3.2 *Referrals by Professionals*

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 referral link: https://contact-brant.ontarionow.ca/external-referral Referrals can be sent in hard copy, by email, fax, or by phone.

3.3 *Minimizing Families Repeating Their Story*

In order to minimize the need for families to repeat their story and to provide sufficient information to Contact Brant to determine the child or youth's eligibility for service coordination, the referral information will include:

- ✓ Basic demographic information about the child/youth including name, birth date, gender and address.
- ✓ Family/caregiver's name and contact information including phone(s) and email, and relationship to the child/youth.
- ✓ Reason for the referral and description of service need.
- ✓ Information about the child's strengths and presenting needs.
- ✓ List current services as well as previous and wait-listed services.
- ✓ Name of the referring staff and organization.
- ✓ Identify if the family prefers an agency 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 referral information in the various formats an organization uses.

Refer to Appendix 5, *Core Information for Referrals;* and *Section G-1, Roles and Responsibilities of the Coordinating Agency/Intake and Assessment.*

3.4 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 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.

Service Coordinators should be cognizant of the expectation to minimize unnecessary duplicative consent seeking. Service Coordinators can use their own organization's consent template.

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

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

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

- A central record for each family waiting, receiving, or discharged from Coordinated Service Planning is available to share with involved and new service providers. The record will evolve over the years, building on service plans and the family's changing situation.

  Each record includes the Referral Information/Intake (the family's story); Services (past, present and waiting); Name of the identified Service Coordinator; and the Coordinated Service Plans.
- Enables a single Wait List for Coordinating Service Planning 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 the community need and supports planning for the service system.
- Enables Contact Brant to report the required data to the Ministry on service coordination on behalf of all Brant agencies.

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

3.5 *Assigning a Service Coordinator*

The Coordinating Agency will refer to an appropriate Coordinated Service Planning Provider following the intake and eligibility process, considering:

- Primarily, the family's preference for an agency
- Provider expertise (based on the child's needs, language or culture)
- Existing relationships with services
- Prioritization for immediate service and the capacity 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 professional providing service coordination.

4. The Coordinated Service Plan

The Coordinated Service Plan (CSP) is a written, evolving document that identifies the coordinated plan of care by stakeholders. It is distributed to the family and all professionals involved in the child/youth's care.

The Coordinated Service Plan supplements individual treatment/service plans by presenting a *holistic view* of the child/youth/family's support. The child/youth's services and supports (community, education and health) identify how they are wrapping services around the family to help meet the family's identified goals.

Families can expect their Coordinated Service Plan to be a living document about how services are working together; it grows and develops with their child. As the needs and goals of the child/youth/family change over time, so will their Coordinated Service Plan.

Having a common Coordinated Service Plan template is a provincial expectation Service Coordinators will use the *Coordinated Service Plan* template (Appendix 7 - Forms) to document the integrated Plan:

- 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, due to changes or when Goals have been met.
- Plans will be updated at least annually.
- Once the Coordinated Service Plan has been written, the Service Coordinator shares the document with the family as well as with involved service providers. The Service Coordinator ensures the Plan is given to Contact Brant to maintain in the family's centralized record and for reporting purposes.
- The Service Coordinator monitors the coordination of services and goals and makes referrals/connections as new support needs are identified.

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.
- ✓ Reviewing the outcomes of the coordinated community planning.

4.1 *The CSP Goals*

Goal setting is based on what is most important to the family/child/youth.

Service Coordinators will develop **Solution-focused Goals** for the Coordinated Plan.

- ✓ Goals focus on strengths and solutions (rather than 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*** when writing the CSP Goals. Discover what really matters to the child/youth and family outside of typical therapeutic goals. Engagement and participation in activities that are meaningful and fun to a child and family can lead to improved physical and social functioning.

- *Function* - Refers to what people do (e.g., 'play' is what children do). The emphasis should be on promoting activities 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.

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'. This concept is different than how professionals typically address childhood disabilities by focusing on the identification of a diagnosis, which then leads to the 'right' interventions and treatment of the impairment through a focus on 'fixing'.

4.2 *The CSP Reflects the Family's Goals*

The Service Coordinator facilitates the active participation of the child/youth and family to identify their priorities and goals. The Service Coordinator leads the family, youth and involved services (the Family Team) in the development and updating of the Coordinated Service Plan on a regular basis to support a coordinated plan of care:

- 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 – this 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 Service Coordinator will connect with those not in attendance at meetings 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).
- Encourage service providers to draw connections between the family's goals and what they can do to support the achievement of goals.
- Make sure families have the information they need to make informed decisions about services and their Plan. Families, and the child/youth as appropriate, have the final decision over goals included in the Plan.
- Continue to identify appropriate stakeholders in the children's, education, and health sectors to be added to the Family Team.

4.3 Transitions and CSP Goals

Coordinated Service Planning provides an opportunity for the family and service providers to plan for transitions.

Transitions may be due to various factors such as the needs and circumstances of the child/youth and family, school entry/exit, teacher or classroom changes, admission to or discharge from services, staff changes, as well as the transition to adult services.

Note: There are specific additional Ministry expectations for transition planning for youth with a developmental disability. Refer to section 4.3.2.

- Service Coordinators will include goals about transitions, including the steps needed for the transition, in the Coordinated Service Plan.
- Service Coordinators will take into account the child/youth/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.
- Service Coordinators will support seamless transitions to and from a Service Coordinator through a '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 introduce the family to the new Service Coordinator/service provider and ensure information is transferred so that the family does not need to retell their story.
    - The exiting Service Coordinator must identify the name of the new Service Coordinator to Contact Brant.

4.3.1 *Transition Planning to Adulthood*

Transition planning to adulthood is a holistic process that identifies a young person's goals for work, leisure, further education and life in the community. Everyone who supports the young person will work collaboratively to prepare the youth 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 sector services* that a youth may need to access 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.

4.3.2 *Transition Planning and Youth with a Developmental Disability*

Service Coordinators have specific responsibilities for transition planning for youth with a developmental disability, as outlined in the provincially-directed *Transition Planning Protocol and Procedures for Young People with Developmental Disabilities,* and the Ministry *CSP Policy and Program Guidelines, www.contactbrant.net/professionals*

Service Coordinators, in addition to responsibilities outlined in the previous section *Transition Planning to Adulthood*:

- Provide information to the parent and youth about integrated transition planning and the steps needed for the youth to attain their goals until leaving school - build on the existing Coordinated Service Plan.
- Connect with the *school IEP Lead* to participate throughout the planning process.

- Plan for the transition needs and desires of the youth and their family through a *cross-disciplinary, collaborative, and team-based process*. Identify new Family Team members for this integrated transition planning.
- *Facilitate meetings* regarding the 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.
- Starting at age 14, lead the *ongoing review and update* of the integrated transition plan.
- **Use the *Coordinated Service Plan* template** and incorporate the integrated transition plan into the goals.

4.4 *Planning for Discharge*

Service Coordinators should always try to build the family's capacity to coordinate their own services. Establish timelines for goals, and plan for discharge as appropriate.

Service Coordinators will discharge a family when:

- Goals have been met, and there is no need for active planning or review of the Coordinated Service Plan every 6 months.
- The family identifies that Coordinated Service Planning is not required at the current time.
- The family leaves the catchment area.
  With consent, Contact Brant will provide a warm referral including the current CS Plan to the Coordinating Agency in the new catchment area.
- The youth ages out.
- The family cannot be reached after four documented attempts over two quarters with contact being made through the method of contact indicated by the family as well as alternate methods of contact.

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 waitlist. 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. Contact Brant will retain closed records so that families may easily re-engage with Coordinated Service Planning without having to repeat the full intake process.
- Plan a gradual approach to stepping down service prior to discharge. Wherever possible plan for the warm transfer to an involved professional who provides service coordination support in their role.

- Inform Contact Brant when planning to discharge a client. Notify Contact Brant of the date a client is discharged from Coordinated Service Planning and the reason for discharge (for Ministry reporting purposes). Notify Contact Brant if a previously supported family is re-opened.

5. Other Coordinated Service Planning Expectations

5.1 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:

i. Be aware of distinct approaches required to address the needs of First Nations, Métis, Inuit and Indigenous children, youth and families. Connect to local Indigenous services and supports.

ii. Respond to the service needs of French-speaking children/youth/ 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.

iii. 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.).

5.2 Intensity of Supports

Service Coordinators will work with each family to identify the intensity of service coordination support required and may need to be adjusted from time to time. Decisions regarding how frequently a Service Coordinator is engaged with each family will be made jointly by the family and child/youth with the Service Coordinator.

In all situations, a Coordinated Service Plan is developed within the first 2 months; ongoing support will result in the Plan being reviewed at least every 6 months, or more often as needed.

iv. *Brief supports* – Service coordination support should always help families develop the capacity for coordinating their own services, and many can do this with limited initial assistance. A Coordinated Service Plan is developed and there are brief, time-limited supports prior to discharge. Consider transferring to another involved professional who can provide service coordination support within their role.

v. *Intermittent supports* – More intensive support at times, and less intensive at other times. This often reflects support to families experiencing a transition/change in circumstances where they need limited contact afterwards; complete a 6-month review of the Plan.

vi. *Continuous supports* - Some families require Coordinated Service Planning on an ongoing basis due to the complexity and breadth of needs. Families can expect their Coordinated Service Plan to be a

living document that grows and develops with their child often being reviewed and updated on a regular basis.

5.3 Family Feedback

The Brant Coordinated Service Planning stakeholders developed a survey, the *Parent Satisfaction Survey*, for participants to provide feedback.

The Service Coordinator will invite every family to participate in the survey:

- **at the initial 6-month review** of the Coordinated Service Plan and
- **annually thereafter**, as well as
- **prior to discharge**.

The survey is available on SurveyMonkey:
https://www.surveymonkey.com/r/7BPKXCF

It is preferred that families complete the survey online. However, if they prefer a paper version, please scan and email their completed survey to Contact Brant, to Karen Sweeting, karen@contactbrant.net.

Special care should be taken by Service Coordinators to not inadvertently influence participants' feedback.

Survey Messaging	
Objective	Suggested speaking notes
Invite families to participate	• Our agency, community and the Ministry of Children, Community and Social Services (MCCSS) would like to hear about your experience in receiving support from CSP, including what works well and where improvement is needed. • Your feedback is important because it will help us find ways to make the services better for families.
Describe the Parent Satisfaction Survey	• This is a voluntary survey that provides feedback on your family's experience with the Coordinated Service Planning program. • The survey has 11 questions plus a 'Comments' section and takes about 5 minutes to complete. • The survey is available online in English. It is also available in hard copy in the language of your preference. • Any information you provide is confidential - you and your child cannot be identified. • The survey responses are collected by Contact Brant and the data will be shared with the CSP agencies and MCCSS.
Describe next steps	• After this meeting, I will send a survey invitation to you via email. • If you prefer to complete the survey now, I can provide a hard copy (or if applicable) offer you an iPad or computer and a private space/room.

5.4 *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 and planned by the community due to the complexity of service needs. Case Resolution Team members (senior representatives from cross-sectoral organizations) are often able to be flexible within their individual agency mandates to work creatively within available resources to collectively meet the needs of these children.

ii. At age 16 and age 17 to ensure there is an 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.

The province expects 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 work in partnership with Contact Brant and other involved service providers to explore all options for existing local and regional services and supports first.

The Service Coordinator will request a Case Resolution review through Contact Brant 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 community service system work collaboratively to address any complex needs within the existing funded services.
- Consent is required for a Case Resolution review and must be provided to Contact Brant.
  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. The Team makes this recommendation when 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. Service Coordinators should only inform families about the possibility of Complex Special Needs funding following a recommendation by the Case Resolution Team.

- A clinical plan to stabilize the situation through a specialized support plan is recommended by the Case Resolution Team; the clinical plan must be time-limited for stabilization. This clinical recommendation is brought to the Case Resolution Team by the Service Coordinator for consideration at the review.
- The Coordinated Service Plan is part of the documentation that Service Coordinators provide for the Case Resolution review - it should include documentation of current services and describe how the child's needs are beyond the available services and supports.
- If the Case Resolution Team makes a recommendation to access Complex Special Needs funding, Contact Brant then submits an application for Complex Special Needs funding to MCCSS that includes a detailed report of the situation and request. 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 the Case Resolution Team at the review.
- If Complex Special Needs funding is approved:
  - The Manager of Service Coordination at Contact Brant will be the lead on all communication regarding Case Resolution decisions and their recommended CSN service plans. Contact Brant will support the Service Coordinator throughout the process.
  - The Service Coordinator continues to be the family's primary contact and is responsible for monitoring and updating the Coordinated Service Plan which will include the supports approved in the Complex Special Needs-funded plan (e.g., any residential or respite services available through complex special needs funding).
  - The Service Coordinator is responsible to attend Plan of Care meetings with the residential provider and must coordinate the CSN-funded respite services.
  - The Service Coordinator, with the Manager of Service Coordination at Contact Brant, are responsible to keep the Case Resolution Team apprised of the outcomes, successes and challenges related to the specialized service plan.
  - Complex Special Needs funding can only be approved for a fiscal year, from April 1 to March 31. If specialized service and stabilization is required into the next fiscal year, the clinical plan and associated Complex Special Needs funding must be reviewed for approval 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, the Service Coordinator works with the Manager of Service Coordination at Contact Brant to plan for the transition of 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, the Service Coordinator will lead the transition planning, as well as work with the youth/family and adult services to facilitate the transition.
- Contact Hamilton's Complex Needs Placement Coordination service 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 the Complex Needs Placement Coordinator.

<table>
<tr><th>Service Coordinator</th><th>Complex Needs Placement Coordinator (CNPC)</th></tr>
<tr><td colspan="2">Note: Contact Brant's Manager of Service Coordination is the primary contact with Complex Needs Placement Coordination.</td></tr>
<tr><td>Primary contact for the parent/guardian, child/youth and involved Brant community service providers.</td><td rowspan="3"><u>Residential</u>:
Secure appropriate residential placement in accordance with the community-endorsed clinical treatment plan; negotiate the cost and terms of the placement and regularly review these with the contracted agency; provide the budget as well as current expenditures to Contact Brant; monitor the residential 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; contact person for the residential placement agency; when issues with the placement arise, CNPC will address with the agency and follow up with Contact Brant and the Service Coordinator.</td></tr>
<tr><td>Ensure the Coordinated Service Plan includes the CSN goals; actively monitored and updated; ensure Transitional Age Youth planning starts at age 14.</td></tr>
<tr><td><u>Residential</u>:
Attend Plan of Care meetings for the child/youth; when issues with the placement are identified by the youth/family or Brant services, inform Contact Brant so they can communicate with CNPC.</td></tr>
<tr><td><u>Respite:</u>
Coordinate the CSN-funded respite plan with existing services; contract with a Respite Provider if needed; ensure invoices for CSN-funded Respite services are sent to Contact Brant and invoiced to Contact Hamilton. (Note – Contact Brant submits invoices to Contact Hamilton when expenses are approved)</td><td>Manage the CSN budget for the Hamilton-Niagara Region, including paying the contracted residential providers and the respite invoices confirmed by Contact Brant.</td></tr>
<tr><td>Bring updates on the Complex Special Needs plan; attend Case Resolution review meetings of the child/youth and ensure all required paperwork is completed and submitted to Contact Brant</td><td>Attend Case Resolution reviews for the child/youth.</td></tr>
<tr><td>Bring involved local service providers (including CNPC) and the youth/family together for planning; include active planning for the return to locally-funded services.</td><td>Attend local case planning meetings as appropriate.</td></tr>
</table>

5.5 *Wait List Management*

Contact Brant manages the single wait list for all dedicated Service Coordinators as per provincial direction. The 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 Coordinated Service Planning, the community professional providing service coordination supports will continue supporting the family until the admission.

Where a family is wait-listed for Coordinated Service Planning and there is no identified community staff providing service coordination support, Contact Brant's Access services will provide interim service coordination support, as needed, to families by providing information, connecting to community resources and services as well as, if needed immediately, initiating the Coordinated Service Plan by identifying goals and involved stakeholders.

Families can access their information on how long they can expect to wait for a Service Coordinator from Contact Brant.

To support waitlist management, Service Coordinators or their agency will inform Contact Brant of their availability to accept additional client(s) and regularly review the children/youth waiting for their agency's Service Coordination supports with Contact Brant's Manager of Service Coordination and confirm the client(s) prioritized next for admission.

5.6 *CSP Provider's Reporting Requirements*

The province requires Coordinating Agencies to submit reports on Coordinated Service Planning for their community. CSP Providers must provide some of these data elements to Contact Brant to support this reporting.

CSP Provider Due Dates for reporting to Contact Brant are:

- October 10 for data from April 1 to September 30
- April 10 for data from October 1 to March 31.

The data elements that are required to be reported by CSP Providers to Contact Brant to support Ministry reporting are:

- **Amount of Direct Service** Time Spent by their Service Coordinator. 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. 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.

In addition, CSP Providers must provide the following data to Contact Brant on a monthly basis for accurate Ministry reporting:

- The date a client starts service
- The date a client is discharged from service, and
- The reason for Discharge from the service:

- Met their CSP Goals
- Family left the catchment area
- Unable to reach the family (See the Ministry-prescribed timelines
- Family requested discharge.

5.7 *Community of Practice*

The Community of Practice for Coordinated Service Planning provides ongoing 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 the consistent implementation of the Coordinating Service Planning Brant model.

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

5.8 *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.

F. 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, Manager of Service Coordination; alison@contactbrant.net
or
Jane Angus, Chief Executive Officer; jane@contactbrant.net

Contact Brant's Manager of Service Coordination is available to consult with Service Coordinators on any Coordinating Service Planning Brant process or expectation.

Thank you for the part you are playing!

Coordinated Service Planning Brant

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

One Child - One Plan - One Team

Also, see the following section on '*Other Information'* and Appendixes.

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

G. Other Information

1. *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 MCCSS contractual agreement, the Service Description Schedule for the Coordinating Agency which outlines 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).
- 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* available from Contact Brant and 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.
  Refer to Section 5.2 Intensity of Supports re Brief, Intermittent and Continuous supports.

2. *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 at least semi-annually to Contact Brant on the activities of their dedicated Service Coordinators (see Section 5.6).
    - 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 from Service Coordination supports. Report the reason for discharge.
- 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 community.
- Ensure that their dedicated Service Coordinators are aligned with and supporting the Coordinating Service Planning Brant processes and model; ensure their dedicated Service Coordinators are oriented to the expectations set out in this Coordinating Service Planning Brant Procedure Manual. This will support families to have a consistent experience of Coordinated Service Planning across Brant and the province.
- Use the Coordinating Service Planning Brant common tools and forms.

- Communicate to children and youth with complex special needs and their families who may be eligible or benefit from coordinated service planning, about Coordinating Service Planning 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 Coordinating Service Planning 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 than going through an internal intake process that requires the family to repeat the information.
- Share information on their services with the Coordinating Agency and other CSP Providers to keep them apprised of programs and services, both new and any changes. This ensures Service Coordinators have up-to-date information on community services to provide to families. Additionally this supports Contact Brant in providing the Community Information website, 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 priorities and needs of each child/youth and family.
- Through its senior leadership, actively participate in the community's Service Coordination Network.
- 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 Coordinating Service Planning process.

- Communicate to children and youth with complex special needs and their families who may benefit from coordinated service planning, about Coordinating Service Planning 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 than going through an internal intake process that requires the family to repeat the information.
- Share information on their services with the Coordinating Agency and other CSP Providers to keep them apprised of programs and services, both new and any changes. This ensures Service Coordinators have up-to-date information on community services to provide to families. Additionally this supports Contact Brant in providing the Community Information website, 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 priorities and needs of each child/youth/family.
- Through its senior leadership, actively participate in the community's Service Coordination Network.
- Participate in capacity building as needs and opportunities to improve Coordinated Service Planning are identified by the Coordinating Agency and community.
- 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.

3. *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.

4. ***Performance Measurement and Data***

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

Contact Brant must report the following data to MCCSS:

Note the items marked in red font are the data elements that **CSP Providers must provide** to Contact Brant:

- Number of new referrals
- Number of referrals self-referred/referred by family
- Number of referrals by school/educator
- Number of referrals by physician/other health provider
- Number of referrals by children's aid society
- Number of referrals by Indigenous organization
- Number of referrals by other sources
- Number of children and youth starting CSP
- Age when start CSP:
  - Age 0 – 4
  - Age 5 – 12
  - Age 13 – 21
- Number waiting for CSP
- Average age at CSP initiation (in months)
- Total wait time (# days) from referral to start date of CSP
- Hours of Direct service
- Hours of Indirect service
- # Discharged that met their CSP goals
- # Discharged due to family leaving catchment area
- # Discharged due to inability to reach family
- # Discharged at the request of the family

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 support. 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 support will continue supporting the family until admission to the dedicated Service Coordinator, and a 'warm transfer' can be supported. Contact Brant is available to provide consultative support to community staff about service coordination throughout the waiting period.

2) Contact Brant will initiate Coordinated Service Planning at the referral/intake stage and provide interim support as needed to a family waiting for a dedicated Service Coordinator where an existing community professional providing service coordination support is not available.
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. *Principles for Coordinating Service Planning Brant*

- One clear access point to information and service coordination, a collaborative cross-sectoral approach, service continuity over time, and having an identified service coordinator will improve service experiences and outcomes for families of children and youth with multiple and/or complex special needs.
- The child, youth and family is the center of all processes and planning.
- Coordinated Service Planning is 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 be offered the option to have their services coordinated by an identified service coordinator.
- Organizational practices are established to reduce the need for families to have to repeat their story.
- Services are more seamless and unduplicated for families.
- Families will be connected seamlessly to the multiple, cross-sectoral services they need as early as possible.
- A single, written Coordinated Service Plan is best practice, developed through a partnership with the child/youth/family and involved community stakeholders.

7. 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 Coordinating Service Planning Brant

brochures and posters available from Contact Brant, and Contact Brant's website www.contactbrant.net

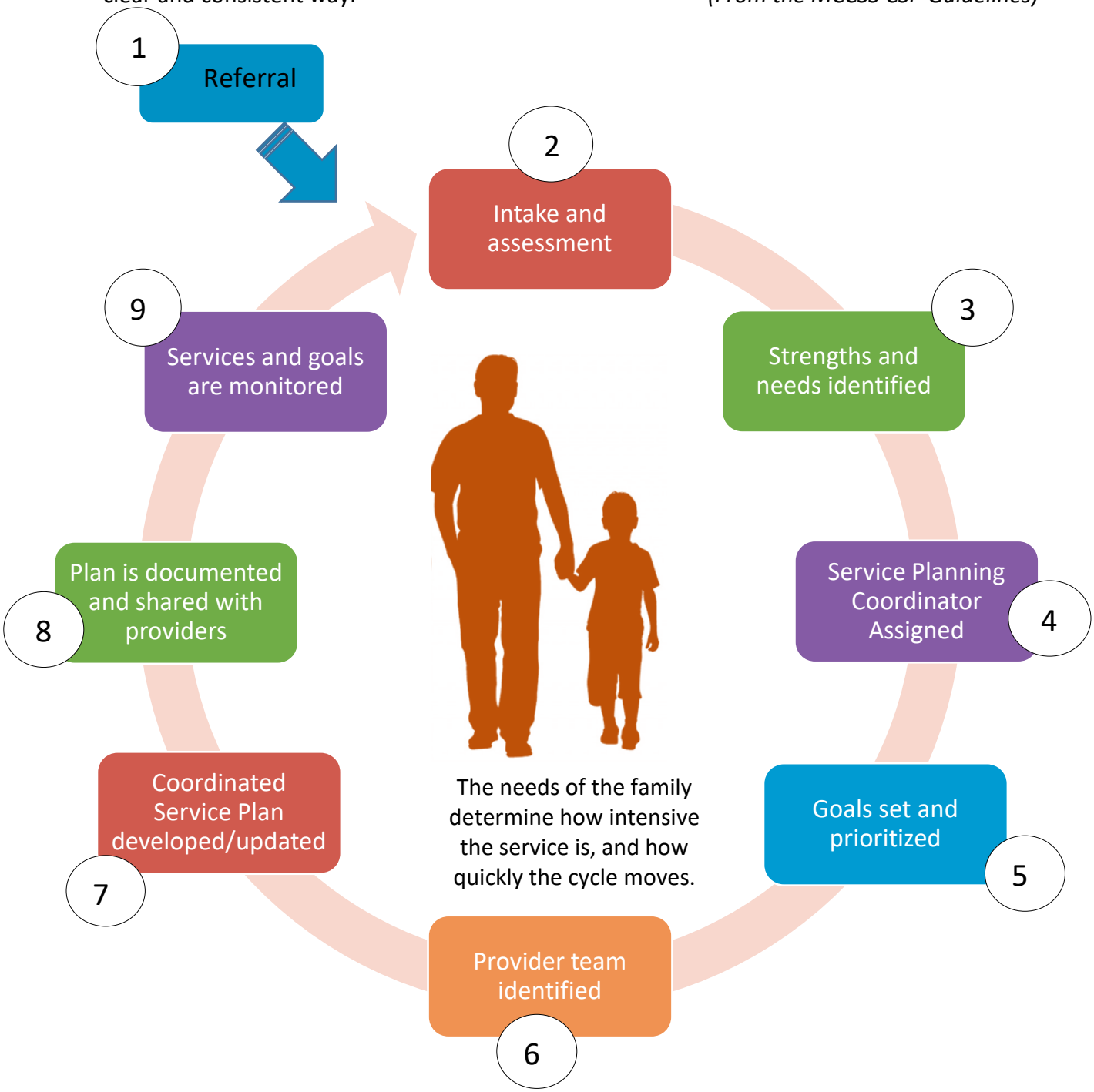
- The Brant Service Coordination Network addresses the ongoing implementation of cross-sectoral coordinated services at the system level.
- The Strategic Leadership Table for children and youth services also addresses cross-sectoral coordinated planning at the system level and will receive reports from Contact Brant as presented to the Coordinated Service Planning Steering Committee.
- Refer to the Community Information website, www.info-bhn.ca for programs and resources in the Brant, Haldimand and Norfolk communities. These public records are 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 Ontario 211 phone service is available in over 150 languages. To provide their service, Ontario 211 accesses this local Community Information database, managed by Contact Brant.
- Refer to the Community Protocols developed by the community 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
- Jordan's Principle can be applied for to ensure that all children, whether living in an Indigenous community or not, have access to the health and social services they need when they need them. Access includes service coordination, Case Resolution, and engagement with First Nations and jurisdictional partners. (Refer to: http://www.afn.ca/uploads/files/jordans_principle-report.pdf
- 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 Contact Brant, 519-758-8228.

Brant Coordinated Service Planning Providers and Participants											*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	Child/Youth 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
Child & Family Services Grand Erie		x									Child welfare
Conseil scolaire catholique MonAvenir		x						x			Represents Conseil scolaire Viamonde; Speech & Language services; mental health services
Contact Brant	**X** Coordinating Agency		x Access & Service Coordin-ation		x		x Access & Service Coordination			x Access & Service Coordination	Access Mechanism for child & youth Mental Health, Developmental Services; FASD Coordination; Lead for OAP Urgent Response Service

	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		
Grand Erie District School Board		x						x			Speech & Language services; mental health services
Home & Community Care HNHB	**X**		x				x		x		School health services
Lansdowne Children's Centre	**X**		x	x	x					x	Children's Treatment Centre: OAP Provider
New Credit School		x									
Ogwadeni:Deo		x									Child welfare
Six Nations Health Services	**X**					x			x		
Six Nations Schools		x									
Willowbridge Community Services	**X**		x							x	Children's Developmental Services; Adult DS; Mental health services
Woodview Mental Health and Autism Services	**X**		x				x				Lead Child & Youth Mental Health Agency

The Coordinated Service Planning Cycle *Appendix 2*

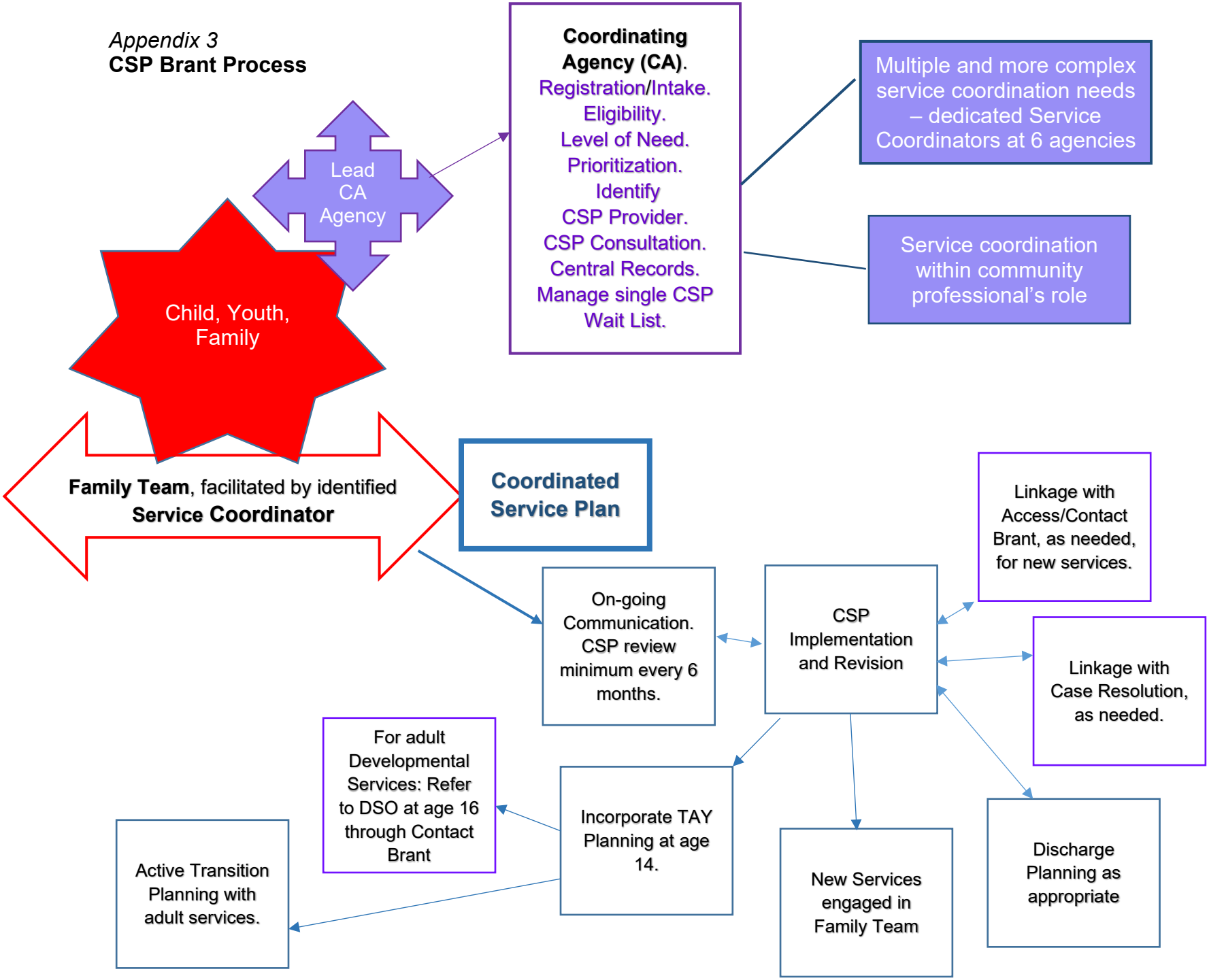
Coordinating Agencies are expected to work with their partners to provide the following, in a clear and consistent way: *(From the MCCSS CSP Guidelines)*

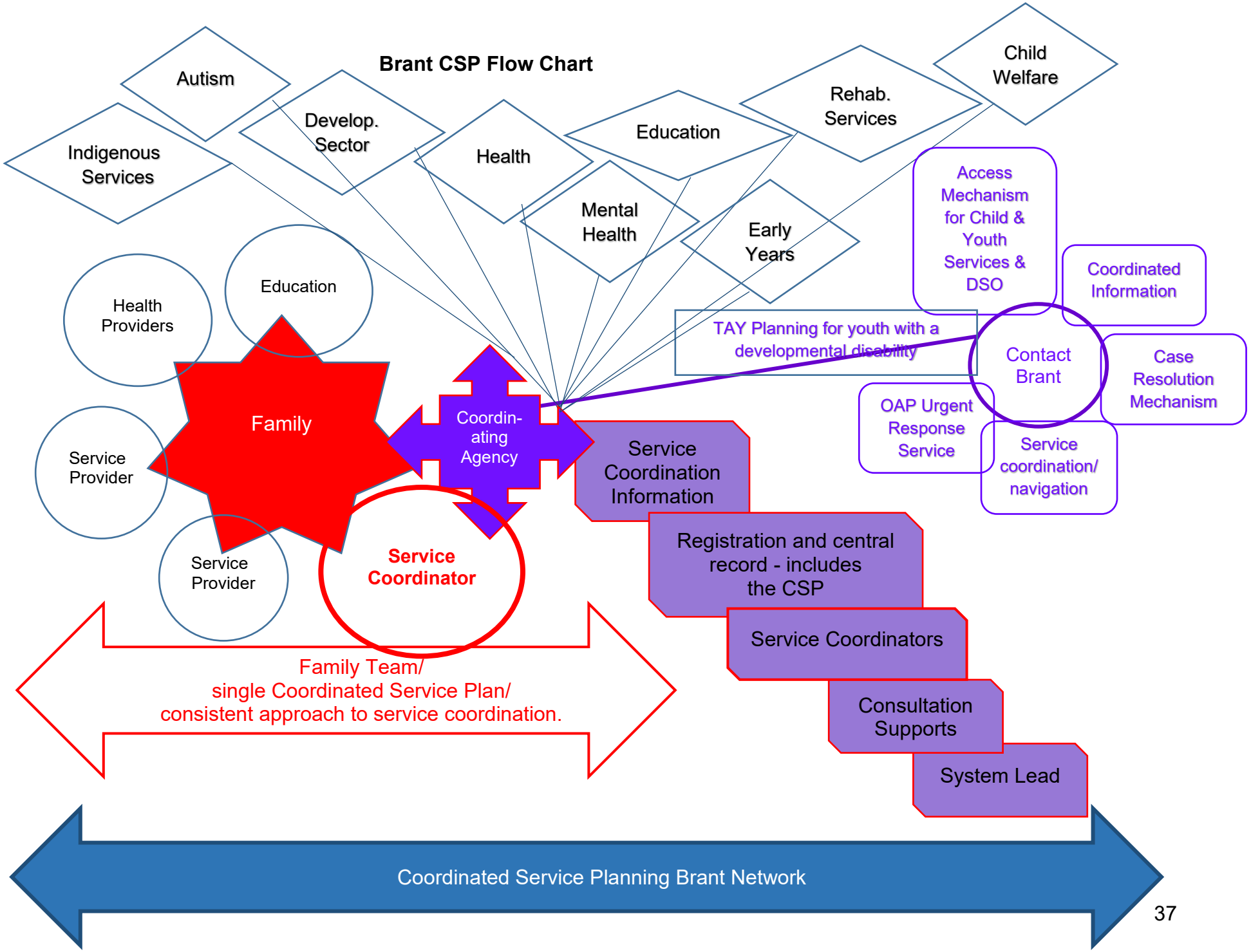


A family's file may be made inactive at any time during the cycle when the family and service provider decide that Coordinated Service Planning is no longer needed by the family.
A family can re-engage with Coordinated Service Planning if new needs develop or circumstances change.

Appendix 3

CSP Brant Process




Brant CSP Flow Chart
Autism
Develop. Sector
Health
Education
Rehab. Services
Child Welfare
Indigenous Services
Mental Health
Early Years
Access Mechanism for Child & Youth Services & DSO
Coordinated Information
TAY Planning for youth with a developmental disability
Contact Brant
Case Resolution Mechanism
OAP Urgent Response Service
Service coordination/ navigation
Health Providers
Education
Family
Coordin-ating Agency
Service Provider
Service Coordination Information
Service Provider
Service Coordinator
Registration and central record - includes the CSP
Service Coordinators
Consultation Supports
System Lead
Family Team/
single Coordinated Service Plan/
consistent approach to service coordination.
Coordinated Service Planning Brant Network

Responsibilities of all staff performing Coordinated Service Planning Functions

From the Ministry Guidelines

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.

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. Core Information is the family's story to be included in the intake information gathered by the first agency where a family presents for service and made available when referring to services including Coordinated Service Planning.

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.)

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 and clinical plans of care - includes TAY Plan.
CSP - 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 support 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 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 Network – Brant Coordinated Service Planning Network – leadership in service coordiantion

TOR -Terms of Reference

SHPS - School Health Professional Services includes Occupational and Physio Therapies

DSO - Developmental Services Ontario

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

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

Appendix 7

Coordinated Service Plan

Ministry Guidelines expect the use of a common template.

Coordinated Service Planning Brant

Coordinated Service Plan

Child/Youth Name: **Pronouns:** **Address:**	**Date of Birth** (D/M/Y)**:** **Date of Plan** (D/M/Y)**:**

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

Present Situation of the Child/Youth and Family
(Include: *cultural priorities*; *hopes and dreams; what would help the family the most?; any barriers to service?*)

-

Family Team

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

Relationship / Organization and Role	Full Name	Phone & Email	Involved in Plan (Y/N)	Plan Shared with (Y/N)

Child and Family's Strengths, Interests, Needs and Priorities:

-

Family Goals

F-Words	Family Goals	Who is Responsible to do What?	Timeline Details
Choose an item.	•	•	•
Choose an item.		•	•
Choose an item.		•	•
Choose an item.		•	•

The goals above include an **Integrated Transition Plan** for youth **14+**: ☐ Yes ☐ No

CSP Plan Meeting Dates		Next CSP Plan Review Date
•	•	
•	•	
•	•	•
•	•	
•	•	

Completed by:

Agency:

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