Community Service Coordination Protocol

Revised January 2024

1. Preamble

Research shows that coordination is central to the effective delivery of integrated services. It offers streamlined communication, aligned planning and strategies, and the identification of the right supports. The *Community Service Collaboration Protocol* was developed by the Brant Children and Youth Services Committee in the early 2000s. The Protocol outlined that each staff involved in the provision of services is responsible for taking a role in establishing links among cross-sectoral service providers and ensuring coordination of the implementation of a single plan of care for each child/youth and family.

In 2018, it was revised as the *Coordinated Service Planning Protocol* to align with the tri-Ministry Coordinated Service Planning initiative. 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. These expectations are:

- A clear contact person for service coordination who is accountable for developing and monitoring an integrated service plan across services and sectors.
- Families not having to repeat their stories to multiple providers.
- Families knowing that providers will be communicating about the needs and goals of their child and working together on their behalf.

Furthermore, the province identified that service coordination is primarily provided by community staff who offer service coordination support within their professional role; Coordinated Service Planning is for children and youth with more complex needs when the level, intensity and complexity of the family's service coordination needs cannot be easily met through inter-professional collaboration.

The Coordinated Service Planning Steering Committee, which was originally mandated by the province to support the Coordinating Agency and the community to implement Coordinated Service Planning for children and youth with multiple complex needs, identified in May 2023 the value of becoming a cross-sectoral leadership table to promote service coordination best practices and to address barriers to collaboration in our community. The committee revised its Terms of Reference, changed its name to the Service Coordination Network, and recommended a review of the community's *Coordinated Service Planning Protocol*.

This Protocol recognizes that we live and work on the traditional territory of the Haudenosaunee and Anishinabek. We are grateful for the opportunity to work with communities across this territory, including Mississaugas of the Credit First Nation, Six Nations of the Grand River, and Urban Indigenous peoples. Through strengthening service coordination in our communities, we can further develop mutual respect and relationships and honour the roles we each contribute that will encourage better relationships and allyship. In allyship with Six Nations, this Protocol recognizes the full range of health services that Six Nations Health Services provides for children and youth of Six Nations, including Service Coordination/Coordinated Service Planning. For further learning, refer to the *Indigenous Allyship Toolkit, A Guide to Honouring Culture, Authentic Collaboration and Addressing Discrimination* by the HNHB Indigenous Health Network.

Purpose

This Protocol establishes community expectations for Service Coordination to ensure that community, health, and education services are working together to wrap support around each child, youth and family with a single plan of care. It also defines Service Coordination and a Service Plan for consistent implementation across the Brant community.

What is Service Coordination?

Service coordination is a systematic approach that ensures that the client's needs and preferences are met across the continuum of care and that the communication and information sharing among the client, the family, and the providers are effective and timely. It involves a team approach to develop and implement a care plan that aligns with the client's goals and values. Service coordination also provides access to an array of service options to support appropriate levels of service at the right time.

What is a Service Coordinator versus a Case Manager?

The distinction between a service coordinator and a case manager is that the service coordinator works with and guides the team process and tasks while building collaboration with all parties at the table. Service coordination is a client-centred, consistent-care, holistic approach. A case manager is agency-specific, working with and guiding the service needs of the client specific to that agency. Case management is often directed towards a single concern.

What is a Coordinated or Integrated Service Plan?

A Service Coordination Plan is created involving all professionals involved in the circle of care as well as the child/youth and family. It is a written document that is strengths-based, addresses the holistic service needs of the child/youth, is driven by the priorities of the child/youth and family, and supports the child/youth at home, in the community and the school as appropriate.

Key Pieces of a Written Service Coordination Plan:

The province recommends that a single Service Plan template be used by a community for consistency and clarity. It is thus recommended that service coordinators use the community-developed *Coordinated Service Plan template* (available at Contact Brant).

Key pieces to include in a written Service Coordination Plan:

- ✓ Who is involved – name the professionals and their organizations as well as the child/youth, family and other informal support people.
- ✓ Who is responsible for ongoing communication – name the Primary Service Coordinator.
- ✓ Identify the family's goals and how each professional/service provider will contribute to the integrated service plan; the goals should be strengths-based and solution-focused.
- ✓ Include transition plans across the lifespan and any service discharge plans.
- ✓ Include a Crisis Plan when appropriate.
- ✓ Identify timeframes, as appropriate.

2. Guiding Principles of this Community Protocol:

- Children/youth and their families will receive coordinated services when they receive 2 or more services or supports.
- Organizations will ensure that the child/youth and their family have their

identity and cultural needs honoured and integrated into each plan.

- Organizations will ensure their services for children/youth and their families are coordinated and complementary with other involved professionals.
- Child/youth and family voice is the priority. Professionals will fully involve children/youth and families in service planning and exhibit Family-Centered support behaviours, which include recognizing that each family is unique; that the family is the constant in the child's life; and that they have expertise on their child's abilities and needs.
- Integrated delivery of community services is done in partnership with school and health professionals and is done by wrapping services around each family to collaboratively support them.
- Service Coordination should address both informal (family and friends) and formal (funded services, paid support) supports.
- Professionals will support seamless pathways to other appropriate services in a timely manner, as well as a warm transfer to new providers.
- Professionals should be aware of and honour the existing community referral pathways, community Protocols and processes, and understand as well as respect each organization's mandate.
- Sharing information is key to service coordination. Consent to allow agencies to communicate is secured according to each agency's Consent procedures and templates and should be honoured by other organizations so families do not have to provide multiple consents. The agency acquiring consent will ensure current service providers are informed of the consent.
- Service providers are encouraged to be flexible within their mandates and work creatively within available resources to meet the needs of children, youth, and their families.
- Service providers will collectively monitor outcomes of service coordination and revise the individual integrated service plans as needed.

3. Service Coordination in Brant

Provincial guidelines indicate that service coordination is primarily provided by community staff who offer service coordination support within their professional role, with Coordinated Service Planning being for children and youth with more complex needs where the level, intensity and complexity of the family's service coordination needs cannot easily be met through inter-professional collaboration.

Locally, the Lead Coordinating Agency is Contact Brant. Through both their Access Mechanism and Coordinated Service Planning mandates, Contact Brant has a centralized client database to confidentially maintain records of services, intake information, and coordinated service plans that can be shared so families do not have to repeat their stories. Contact Brant provides consultation to professionals regarding service coordination, community processes, and cross-sectoral service options; provides the Community Information website, www.info-bhn.ca, and will attend service coordination meetings as needed. Additionally, Contact Brant facilitates a Service Coordinator Community of Practice, open to all community professionals.

Level 1: Service Coordination by Community Staff within their Professional Role

For most children and youth, community staff who provide service coordination functions within their professional role will ensure inter-professional collaboration:

- Each staff involved in the provision of a service is responsible for establishing inter-professional collaboration through communication with service providers across all sectors and supporting the coordination of each child/youth/family's integrated service plan.
- Inter-agency communication will be initiated by every community professional within 2 weeks when it is identified that a child/youth is involved with two or more services or sectors.
- The purpose of initiating communication is to identify each professional's role and current goals with the client, as well as develop a plan for ongoing communication and integration of services.
- A 'primary* Service Coordinator' from the team of involved professionals needs to be identified; this does not preclude others from continuing their responsibilities for ongoing service coordination.
- Interagency communication and coordination is supported through emails, phone calls, and/or meetings (case conferences, plans of care, etc.) to ensure coordination with other service providers.
- Write a Service Coordination Plan to outline how services are wrapped around the family in a coordinated plan of care; share the written Plan with involved services and the family to keep everyone on the same page.

*Agencies will consider the following when discussing which organization will be the primary Service Coordinator:

- ✓ Family preference.
- ✓ Which agency currently involved with the child/youth can take on the role at the time (staff capacity).
- ✓ When child welfare is involved due to protection issues, they have mandatory responsibilities – each case needs to be individually considered for whether the primary service coordinator will be from child welfare, or another organization which will work collaboratively with the child welfare worker.

Level 2: *Coordinated Service Planning* for Complex/Multiple Needs

Dedicated Service Coordinators through the *Coordinated Service Planning* program provide service coordination for 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.

Note: *Level 1 Service Coordination continues until Coordinated Service Planning can start. There should be a seamless transition to a new Service Coordinator.*

Coordinated Service Planning is accessed through a referral to Contact Brant:

- Community, health and education professionals will refer children and youth with multiple and/or complex needs whose service coordination needs cannot easily be met through inter-professional collaboration 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.
- Based on family preference as well as agency expertise, Contact Brant will identify the *Coordinated Service Planning* Provider agency that will provide the dedicated Service Coordinator:
    - Contact Brant for Children's and Developmental Services
    - Home and Community Care Support Services HNHB (Care Coordinators)
    - Lansdowne Children's Centre
    - Six Nations of the Grand River Health Services
    - Willowbridge Community Services
    - Woodview Mental Health and Autism Services (Wraparound program).

4. Responsibilities of all Service Coordinators

- Act as the family's primary community contact. Be knowledgeable and available to discuss the child/youth/family's concerns regarding their coordinated service plan.
- Facilitate the active participation of the child/youth and family in service planning, as well as the exchange of information between relevant providers in the child/youth services, education, and health sectors to wrap services around the family as well as implement a coordinated plan of care.
- Lead problem-solving discussions with each child/youth/family team regarding access to and the integrated delivery of services and supports; encourage flexible and innovative approaches for service delivery to meet the needs of the child/youth and family.
- Ensure meeting minutes are distributed in a timely manner to all professionals involved as well as the youth/family to support clarity and follow-up.
- Facilitate the development and implementation of transition plans and discharge plans into the Service Coordination Plan.
- Develop a written Service Coordination Plan within the first 2 months of implementing community service coordination.
  It is recommended that service coordinators use the community-developed *Service Coordination Plan* template, similar to the *Coordinated Service Plan* template used by CSP Providers.
- Monitor, review and revise the written coordinated Service Coordination Plan at least every 6 months in collaboration with the child/youth/family and relevant cross-sectoral providers. Review more regularly as the child/youth and family's needs and services change.
- Provide the child/youth and family with information about available services and resources so the family can make informed decisions about the services that will best meet their needs.
- Connect families to services and other community resources in a timely manner through established community access pathways; facilitate the connection with new providers to reduce the need for families to repeat their stories.
- Assist the family in navigating and accessing appropriate community

processes, including Case Resolution (refer to Section 6).

- Where the primary service coordination responsibilities shift to another staff, support a 'warm transfer'.

  Note: The Service Coordinator in the Brant child and youth sector is not responsible for coordinating all services required by the family but should provide information or initiate a referral to help other family members access services and support.

5.1 Service Coordinators' Responsibilities to Connect to Contact Brant

- Identify the primary Service Coordinator to Contact Brant so that the family's key contact is included in the child/youth's centralized record. Update the primary Service Coordinator information if there is a change.
- Provide a copy of the written Service Coordination Plan/*Coordinated Service Plan* and all updated Plans to Contact Brant to include in the child/youth's centralized record – this enables collaboratively building on the service plan over the years. Contact Brant's records are readily available to inform current and future providers (with consent).
- All community professionals are responsible for ensuring that children and youth with complex or multiple needs or where support needs are not easily met are identified to Contact Brant.
  Refer to Appendix A - Community Prioritization Process.

5. Service Coordination and Case Resolution:

Refer to the community's *Case Resolution Protocol*, available on the Contact Brant website, https://contactbrant.net/professionals/

Contact Brant is the provincially identified Case Resolution Mechanism for Brant and facilitates community planning to ensure that children and youth with complex special needs are identified and responded to by the Brant community with appropriate support options. Service providers are encouraged to be flexible within their mandates and work creatively within available resources to meet the needs of children with complex special needs.

This community response is part of the ongoing service coordination work of the community. It is expected that as a child/youth is identified with complex and/or multiple needs and there are challenges in meeting the child's support needs, there will be ongoing coordination and planning by stakeholders. Through Case Resolution reviews, it is expected that the community will collectively develop creative solutions within the finite allotment of resources to reduce the immediate risk to the health and safety of each child/youth and their family.

Step 1: Case Resolution Community Problem-Solving Reviews:
Additional service coordination and/or supports need to be considered by the community due to the complexity of support needs or the individual situation. Case Resolution Team members are often able to be flexible within their individual agency mandates and work creatively within available resources to collectively meet the needs of these children and youth.

- Situations that are emergent, complex and require multi-disciplinary coordination, including a quick community response.
- Review of the integrated transition plans for youth who are aged 16 and

17 and are identified as ‘Emergent’ or ‘At Risk’ (refer to Appendix A).

Step 2: Case Resolution Complex Special Needs Reviews:
The Case Resolution Team may consider an application for Complex Special Needs funding when appropriate.

- Situations that are urgent, complex and critical requiring multi-disciplinary responses and specialized intervention to reduce the imminent risk of harm to self or others; services have been exhausted due to complex health, multiple diagnoses, or critical mental health issues, and these support needs exceed the capacity of the service system; and the provision of clinically recommended specialized service includes resource implications.
- Ongoing review of Coordinated Service Plans, progress, and outcomes for children and youth approved for Complex Special Needs funding.

6.1 Service Coordinator Responsibilities regarding Case Resolution:

- Ensure the child/youth has been referred to the Contact Brant Access process, and that the emerging situation is identified to Contact Brant.
- Ensure a referral has been made to Coordinated Service Planning.
  The Ministry expects that children and youth who require Case Resolution will have been supported as much as possible by the Coordinated Service Planning process before being referred to Case Resolution. They will have an identified Service Coordinator and a written *Coordinated Service Plan*.
- The primary Service Coordinator will attend all Case Resolution reviews.
- Follow up on goals identified by Case Resolution and update the *Coordinated Service Plan* to include the Case Resolution/Complex Special Needs goals.

6. Service Coordination and Transition Planning

Service Coordination 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.

- 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’.
- 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 Service Coordination Plan goals.
  - 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, including developing skills, application to programs and services, financial support, etc.

Note: There are specific additional Ministry expectations for transition planning for youth with a developmental disability. Refer to the provincially directed *Transition Planning Protocol and Procedures for Young People with Developmental Disabilities*, available on the Contact Brant website, https://contactbrant.net/professionals/

7.1 Ministry expectations for transition planning for youth with a developmental disability:

- Provide information to the parent and youth about integrated transition planning and what is needed to help the youth attain their goals by the time they leave school.
- Connect with the school to participate in 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.
- 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.
- Incorporate the transition plan into the Service Coordination Plan/*Coordinated Service Plan*.

7. Service Coordination and FASD (Fetal Alcohol Spectrum Disorder)

As part of the provincial FASD Strategy under the Coordinating Agency mandate, Contact Brant provides FASD Service Coordination to children and youth with FASD or suspected FASD and their families. FASD Coordinators support access to services, provide strategies to caregivers, help navigate the cross-sectoral service systems (health, education, youth justice, community and social services, etc.), and provide capacity-building sessions to families, caregivers and professionals.

FASD Service Coordination is accessed through a referral to Contact Brant.

8. Service Coordination & Ontario Autism Program's Urgent Response Service (URS)

As part of the provincial Coordinating Agency mandate, Contact Brant provides the Ontario Autism Program's Urgent Response Service for children and youth in the Hamilton-Niagara Region who have a new or recently escalating high-risk behaviour that meets the provincially identified threshold for the service. A short-term, inter-disciplinary response is put in place to decrease further escalation of harm to self, others, or property.

URS is accessed through a referral to Contact Brant.

9. Supporting Access to Services:

All professionals should support children, youth and families to directly access the services that they need in a timely manner without having to repeat their stories to multiple providers.

Understanding the Access Pathways in Brant **:**

- Contact Brant is the Access Mechanism for Brant's child and youth developmental and complex needs services (including Coordinated Service Planning, FASD Service Coordination, and cross-sectoral service needs), for CPRI (Child and Parent Resource Institute), and for the DSO (Developmental Services Ontario for youth ages 16 – 18), as well as provide connection to other appropriate services.
- Contact Brant is the Lead Organization and single point of access for the Ontario Autism Program's Urgent Response Service in the Hamilton-Niagara Region.
- Lansdowne is the SmartStart Hub and entry point/main door for services for families with concerns about their child's development and day-to-day functioning in Brantford/Brant, Six Nations of the Grand River and Mississaugas of the Credit First Nation (and Haldimand and Norfolk) and ensures seamless and coordinated connections to other appropriate child and youth services in this area.
- Lansdowne is the main door for Autism Services in Brant as a funded provider for Ontario Autism Programs.
  (Note: AccessOAP is the provincial access mechanism for Autism services – Lansdowne or Contact Brant can help people connect to this service).
- Six Nations Health Services is the access for a range of health and well-being services for children, youth and their families. Services include, but are not limited to, Service Coordination/Case Management, Autism supports, FASD, Occupational Therapy, Social Work, Speech-Language Pathology, Nutrition.
- St. Leonard's Crisis Services are available 24/7.
- Woodview is the access point to child and youth mental health services in Brant.

10. Protocol Review:

This Protocol will be reviewed annually by the Service Coordination Network.

Appendix A

Community Prioritization Process

If a child/youth is identified by any professional as 'Emergent' or 'At Risk', they should be referred to Contact Brant. Together, the service coordinator and Contact Brant will plan to facilitate a case planning meeting of the current professionals involved. Consider including senior managers who have decision-making authority, as well as other service providers who may be able to offer services and/or support the planning.

Following are the 4 levels of prioritization and appropriate action, as identified by the Brant community.

a. **Maintaining** – Services provided meet the needs of child/youth and family, or waiting for services is manageable.

Action: The response should be to continue the provision of service and communicate with other services involved to ensure the integration of services. If waiting for services, they will continue on the waitlist for service(s).

b. **Percolating** – Multiple needs of the child/youth indicate that more services may be needed.

Action: Response should be continued provision of services; referral to additional services needed; communicating with other services involved to ensure integration of services; and calling a case planning meeting as needed.

c. **Emergent** – Supports provided are not sufficient to meet the child/youth's needs; supervision and support needs of the child/youth are not easily met or not fully met/the support needs are stressing the service system; the family/caregiver is nearing exhaustion with the care needs/concern re family breakdown.

Action: Response should be continued provision of services; referral to additional services/advocacy for priority access to services in a timely manner; *timely communication to ensure integration of services; refer child/youth to Contact Brant/call Contact Brant to identify the current situation; facilitate a community case planning meeting that potentially involves management and services/ sectors not currently involved that could provide supports or planning; ensure there is a primary Service Coordinator if not already identified; refer to Coordinated Service Planning if appropriate; consider a request for Case Resolution for community problem-solving.*

d. **At Risk** – The child/youth is at high risk of harm to self/others that cannot be stabilized with current supports; the system cannot meet all support needs to keep the child/youth and others safe; the service system and family supports have been exhausted and specialized supports are needed.

Action: Response should be continued provision of services and planning for additional services; ensure ongoing communication with services to ensure integration of services; identify the situation to Contact Brant; facilitate a community case planning meeting; refer to Coordinated Service Planning if not previously done; consider a request for Case Resolution when there is a clinical recommendation for specialized support to stabilize the situation.