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Presentation to the Lanark Planning Council for Children Youth and Families

April 2, 2015

This presentation is derived, with thanks, from materials prepared by the Children's Treatment Network of Simcoe York

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Child Development Centre

- One of 21 Children's Treatment Centres in Ontario
- Provide services to children and youth with special needs including neurological, physical and/or developmental disabilities
- Catchment area includes KFLA, South Lanark and Southwest Leeds &Grenville

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Special Needs Strategy

- The ministries of **Children and Youth Services**, **Community and Social Services**, **Education** and **Health and Long-Term Care** are moving forward with a strategy to improve services for children and youth with special needs in Ontario guided by the following vision:
- “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.”

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First steps in the Special Needs Strategy

- Developing and implementing a **new standard developmental screen** for preschool children;
- Putting in place **coordinated child- and family-centred service planning** for children and youth with multiple and/or complex needs;
- Developing an plan for **Integrated Delivery of Rehabilitation Services** (OT, PT and Speech)

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Coordinated Service Planning

- Must be **collaborative**, **cross sectoral** and **child and family focused**
- Serves the needs of children and youth with multiple and/or complex special needs and their families
- Involves developing and maintaining relationships with service providers in the service delivery area
- Facilitates consistent knowledge sharing, both amongst service providers and with families of children and youth with multiple and/or complex special needs
- Connect families with the range of services and supports

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Integrated Paediatric Rehab

- Children will receive seamless and efficient speech and language therapy, occupational therapy and physiotherapy services from birth through high school.
- There will be no need to reapply for rehabilitation services when children enter school
- For children with multiple needs, rehabilitation services will be supported by a coordinated service plan

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Single Plan of Care (SPOC)

- Consolidates multiple different care plans
- Provides a **common framework** for setting the direction and focus of the child's care
- Eliminates the need for the family to retell their story
- Goldcare technology has the capability to support, electronically, the single plan of care so that all team members have access to the same information
- All team members across all sectors can jointly define the vision, goals and treatment activities for the child.
- This is the approach used by CTN Simcoe York

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CTN Simcoe York

CTN Vision

- Building brighter futures together for kids with multiple special needs.

CTN Mission

- Through the collective efforts of community partners, we respond to the evolving needs of children and youth with multiple special needs in Simcoe and York by:
    - Providing and enhancing services
    - Championing system change
    - Building capacity

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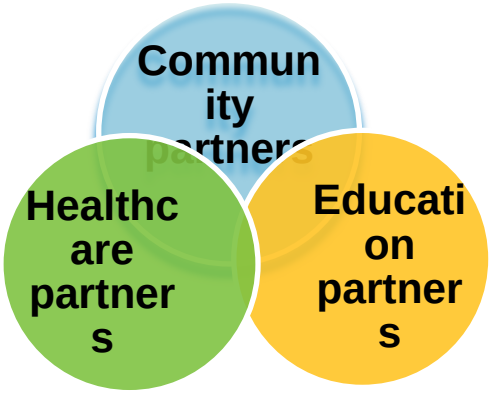
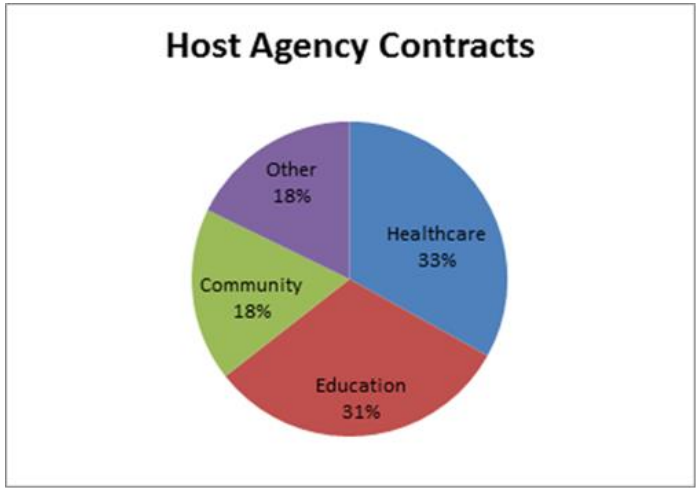
How CTN Works





- Children's treatment centre for York Region and Simcoe County, providing services in home, school and communities and through 10 local shared sites.
- Provide clinical services to more than 6,000 kids/year with multiple special needs.
- 50+ partners: service contracts with 19 partners in community, healthcare and education sectors to provide CTN services

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CTN: Why a Network Model?

- **Enhance** existing services and **add needed specialized services**.
  - Focus on children and youth with multiple special needs
- Creation of **local shared service sites** so children receive services closer to home.
- All service providers would work within **integrated child/family teams**, regardless of their service sector.
- Implementation of a **shared electronic client record** that facilitated information sharing and enabled integrated care across organizations and sectors.
- Provide **ongoing professional development/training opportunities** for clinical staff to build capacity of staff to work as inter-professional teams with a focus on **integrated service delivery for families**.

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Levels of Network Participation

- All network partners sign **partnership agreement**:
  - Core
  - Affiliate
- Network partners whose staff participate in the single plan of care process, and/or use the shared electronic record sign an **information-sharing agreement** (covers consent, privacy, use of record).

- Network partners who are contracted to deliver services on behalf of the network, or provide infrastructure supports sign **annual service contracts** with reporting accountabilities identified.

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CTN Partners with Service Contracts

- **6 Community agencies**
- **Local CCAC**
- **3 School boards**
- **6 Hospitals**
- **2 Private providers**
- **Regional/County Early Intervention Service**

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Governance & Leadership

Governance: CTN is a legal entity with its own Board of Directors that acts on behalf of the organization's stakeholders

- Board establishes and assesses the policies, directions, priorities and performance of the organization
- CTN cannot 'govern' other organizations Boards of Directors

Leadership: CTN works collaboratively with identified partners to implement a collaborative and integrated coordinated service planning delivery model.

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Collaborative Leadership

- CTN works closely with network partner organizations across multiple sectors through **collaborative groups that involve representation from all levels**: boards, senior leadership, clinical management and frontline.
- **Ongoing engagement with partners** is a key factor of what differentiates a network from a contracting agency. Provide advice, input and expert opinion on operational/frontline initiatives to system-level/strategic work.
- We rely on partners to **challenge our assumptions and help improve care** across our system and serve as a sounding board and touch point for how things are going throughout the network.
- Provide a **forum for network partners to connect** with one another, bring issues forward and share information.
- Counsel and help determine **indicators of success**.
- **Partners influence decision-making**. Though ultimate decision lies with CTN, we do not make major service-related decisions without support of partners (legal implications are the exception).

Collaborative Groups

Group	Membership and Purpose

System operations group (meets monthly)	• **Senior leaders** from partner organizations
	• Ensure that the **vision and mission** of the network are carried out operationally and strategically through partnered service delivery, and network administration efforts:
	  • Communication and advocacy
	  • Monitoring/evaluating development and improvement
	  • Leadership and Problem-solving
	  • Network planning within a 1-2+ year horizon

Clinical operations group (meets monthly)	• **Clinical managers** • Operational level decisions and processes • Advice/Insight on operational processes
IT consortium (meets quarterly)	• **IT professionals** from network organizations • Determine shared IT priorities • Share information/expertise
Evaluation group (meets monthly)	• **Evaluation staff, researchers, family member(s**) • Provide expert advice, assistance and support to CTN's evaluation activities including framework, data collection instruments, interpretation and reporting, knowledge translation and quality improvement strategies

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Collaborative Groups

Group	Membership and Purpose
Single plan of care coordinator group and single plan of care coordinator managers (meets monthly)	• **Single plan of care coordinators** across the network • Operations details and work flow discussed and agreed upon • Case discussion, waitlist management • Development of consistent practices
Super-users: Shared electronic record experts (meets quarterly)	• **Frontline staff who use the shared electronic record** from various agencies • Provide advice related to functionality, • forum for asking questions , developing training materials
Family Engagement Council (meets monthly)	• **Families, service providers and CTN management** • Advice CTN on activities ,approaches to increase family engagement

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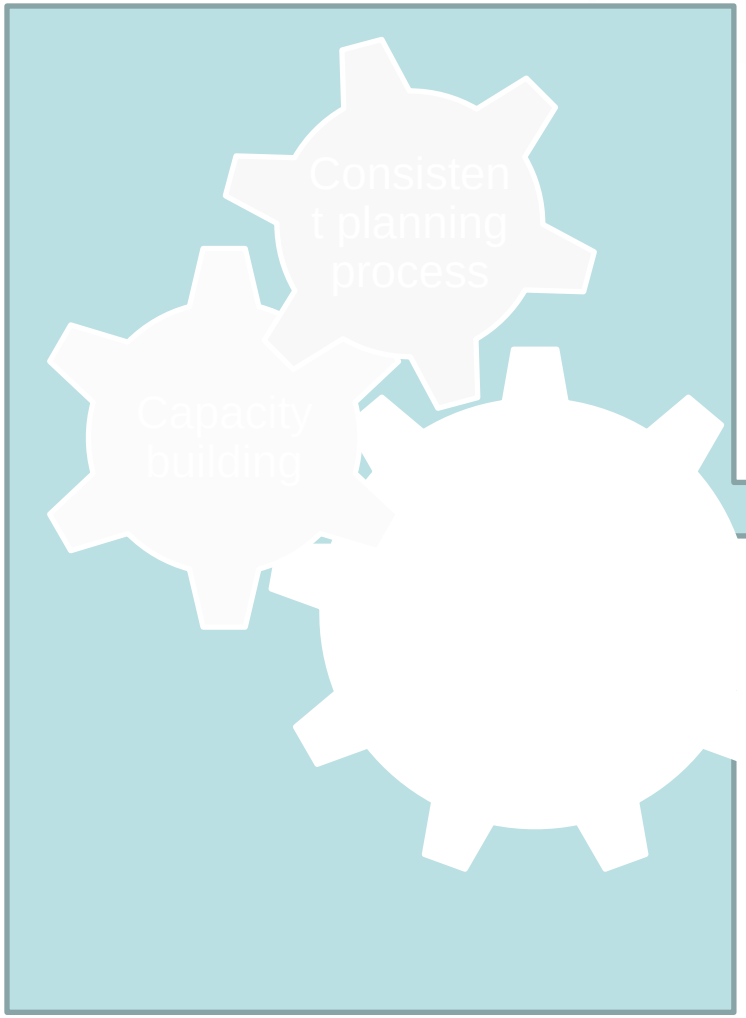
Coordinated Care



Integrated family-centered care

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Shared Electronic Client Record

The Shared Record supports the Single Plan of Care process:

Facilitates team members communication: secure web application allows **access from multiple sites by multiple providers**.

- **Follows the client through transitions** from one system to another and from one provider to another.
- Tracks wait times, waiting lists, statistical information.
- Supported by a **network privacy agreement** and a **network consent to share information**.
- Enables documentation of the plan in **one place for all team members to view and update**.

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Reach and Impact

Enabling collaboration and family-centered care for more than 6,000 families:

- ***Shared electronic client record:***
  - 12,000 records open: 6,000 active, 1,200 staff trained with 500 active users across 30 organizations in health, education and community sectors.

- ***Single, integrated plan of care***. The shared electronic record enables us to:
  - Create a family-centered plan that is focused on the vision the family identifies for themselves.
  - Ensure all providers are working towards the same goals.
  - Better use our resources to help families work on the things that are important to them.

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Shared Electronic Client Record

- Supported by comprehensive work on **privacy and security**.
- **Policies and procedures** are in place that support agreements with over 30 partner agencies.
- Relies on **express consent by the family** for team members to share information for the purposes of delivering services in a coordinated way.

CTN is a Health Information Custodian (HIC) – has a role to collect, protect and disclose health information through staff and agents of CTN.

CTN is also a Health Information Network Provider (HINP) – which enables two HIC's to share information even if we aren't involved directly – preschool speech providers and early interventionists. Responsible to maintain and oversee the shared record.

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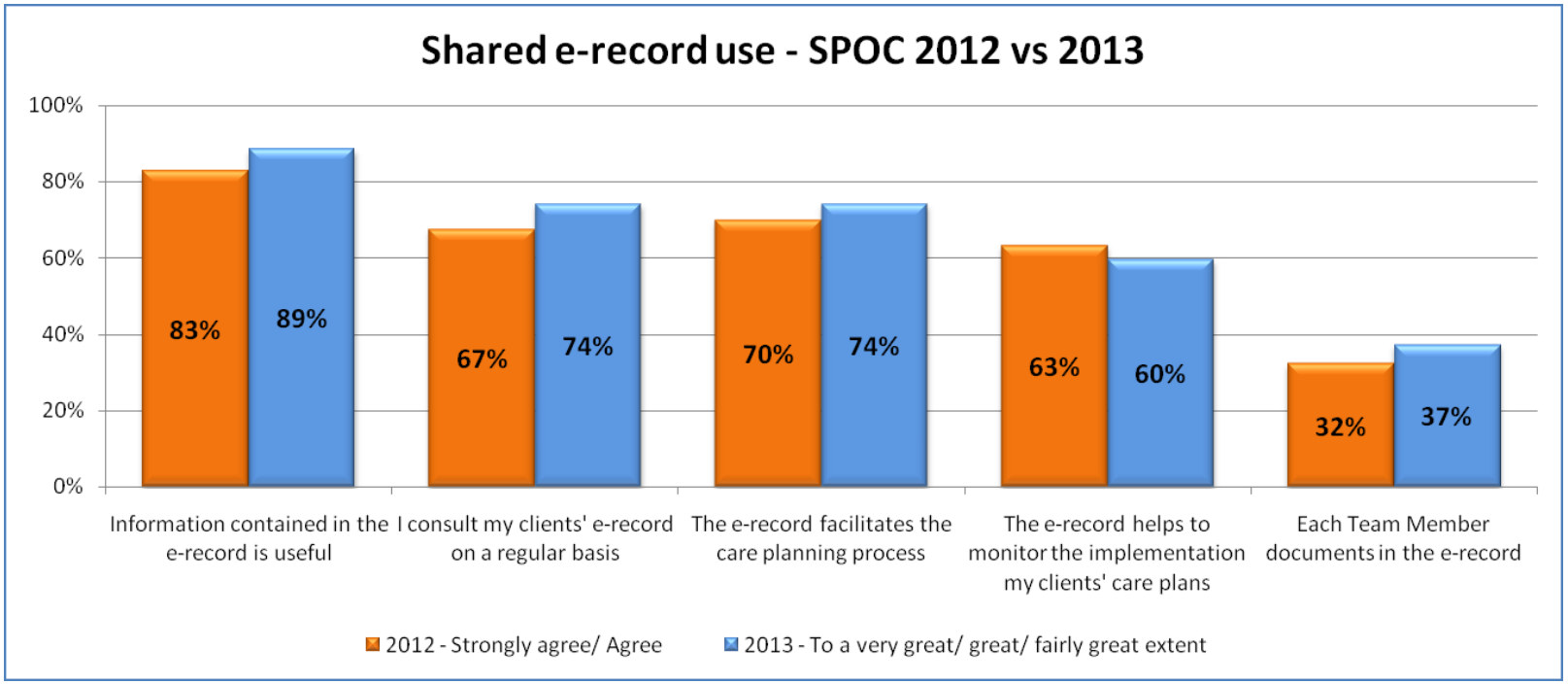
Shared Electronic Client Record 2012-2013



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Shared Electronic Client Record

Learnings:

- Implementation – **incremental, identify 'champions'** accept that some will always resist practice change.
- Record supports **inter-professional practice**.
- Record can help to drive **consistent practice** across service partners.
- Move to a shared record takes time – **frontline need to see value**.
- **Buy-in increases as more staff participate** – creates an increased demand on resources for training, help desk, system maintenance and privacy.
- **Data reporting is key** – information out to partners supports system wide review and shared problem solving.

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Capacity Building

- Interprofessional practice is enhanced by opportunities to learn and practice together.

- CTN has taken lead in providing cross sector training events focused on enhancing the skills of all team members to work better together.

- Trainings to date have included :
  - SMART Goals (Specific, Measurable, Achievable, Realistic and Timely)
  - Inter-professional Practice Approach
  - Single Plan of Care Process
  - Solution Focused Coaching Approach
  - Use of Child and Adolescent Needs Assessment Tool (CANS)

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Single Plan of Care (SPOC) Process

- A structured, family-centered process.
- Recognizes client and family as members of the team.
- Enhanced when team members are familiar with interprofessional practice and the benefits of working together.
- Relies on the shared record to document the consent, plan and the progress.

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SPOC Process

CTN ACCESS
- Opens shared record
- Completes assessment
- Obtains consent
- Refers for SPOC coordination if eligible

SPOC meeting
- Aim for full participation
- Use time to plan together
- Client and family are key members of the team
- Determine goals, tasks and activities

Shared electronic record
- Visions, SMART goals and activities documented in the shared record for all to monitor

Monitor and next steps
- SPOC coordinator monitors plan and works with family and team to determine when another meeting is needed

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SPOC Key Concepts

- **Team requires someone to take the lead** and to pull everyone together.
- Focus of the plan needs to be on the **visions of the child and family**.
- Goals should be large enough to engage multiple team members – **function and participation focused** - not discipline specific.
- Families need **different levels of support at different times** (transitions, hospitalizations).
- Some team members may be able to fade out, while others will be more involved.

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SPOC Coordinator

- Leads the process ensuring that client and family's visions are the focus of assessments and interventions.
- Gathers team together annually to complete a SPOC at a minimum.
- Updates CANS, Consent to Share Information as appropriate.
- Makes referrals for additional services should plan or status indicate.
- Ensures that team members not authorized to access the shared record are still kept up to date and invited to participate.
- Monitors the plan.
- Ensures that the family feels supported.
- Works with the family to address issues that come up.
- Have various experience and backgrounds including education, social work, and nursing.
- Caseloads of 40 families per FTE.

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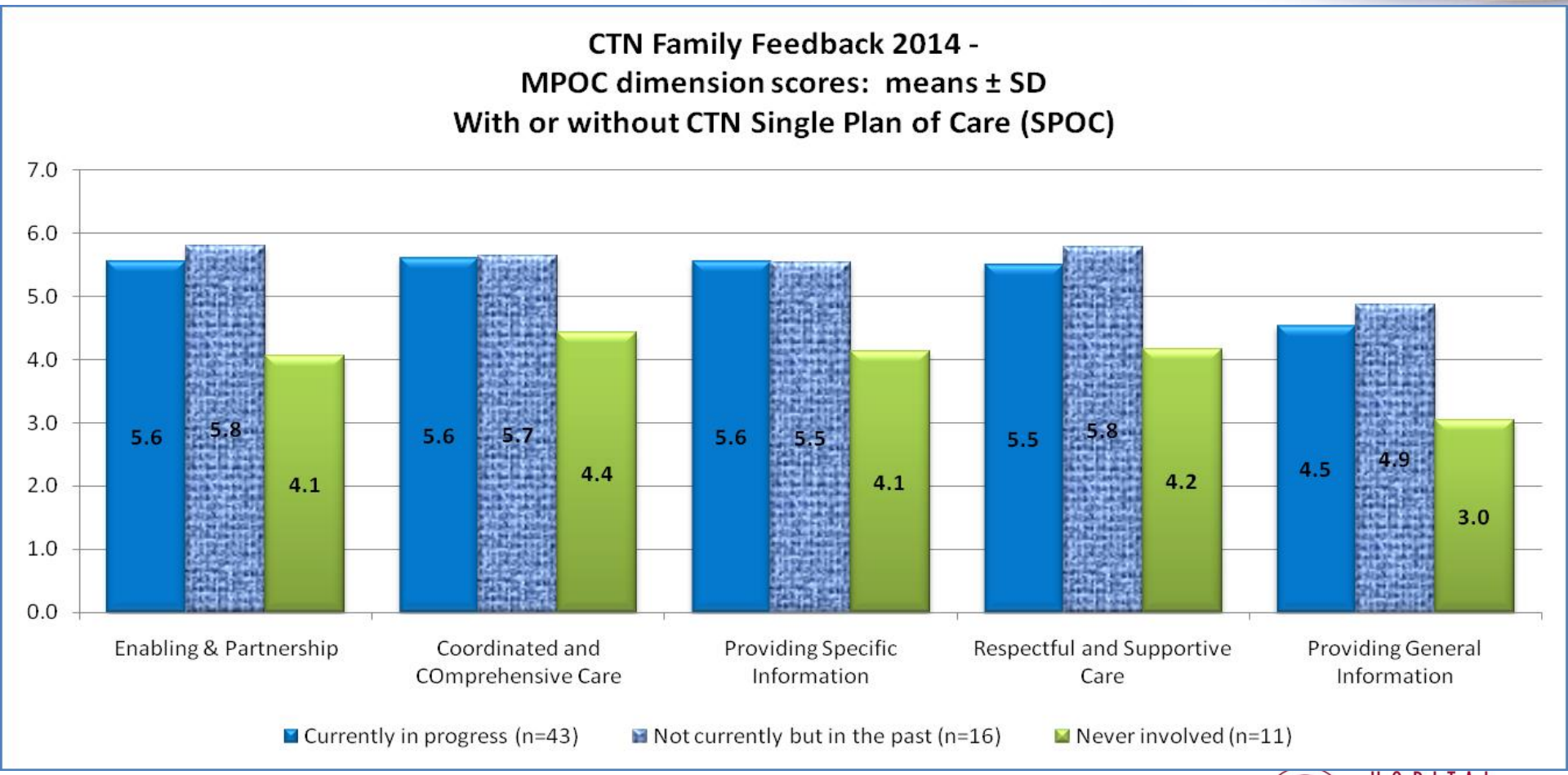
Family Satisfaction



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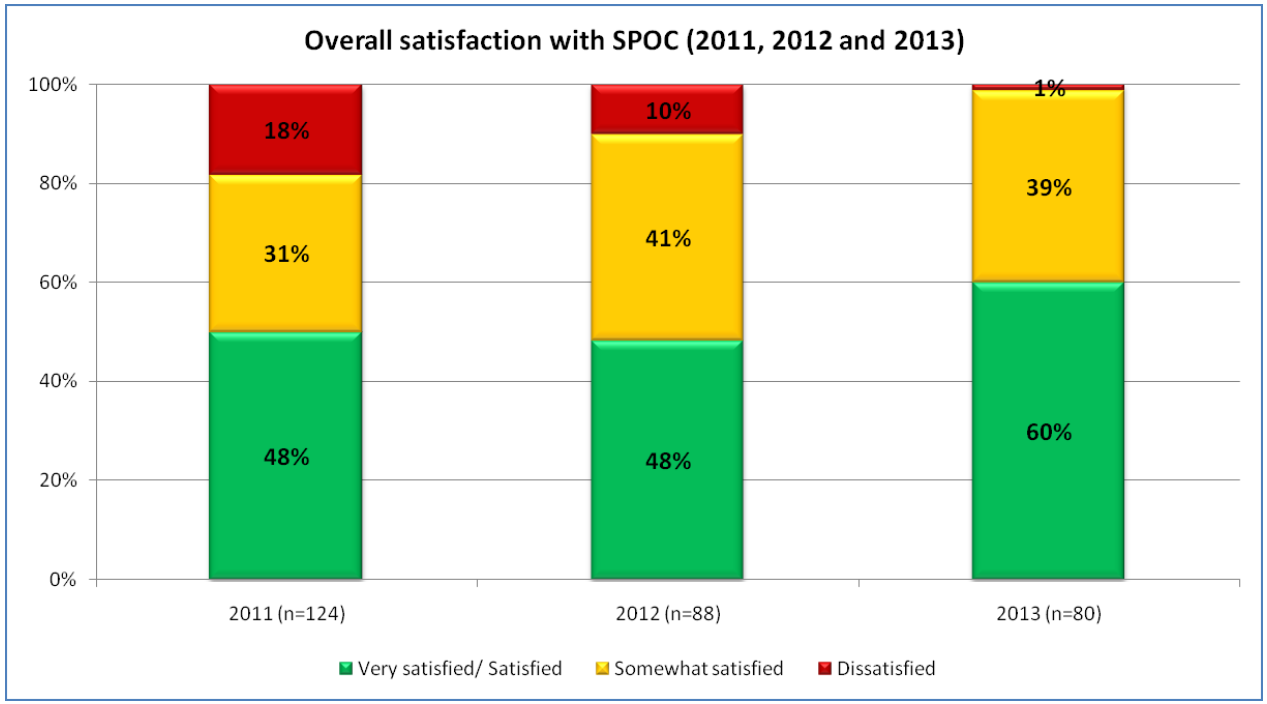
Provider Satisfaction with SPOC



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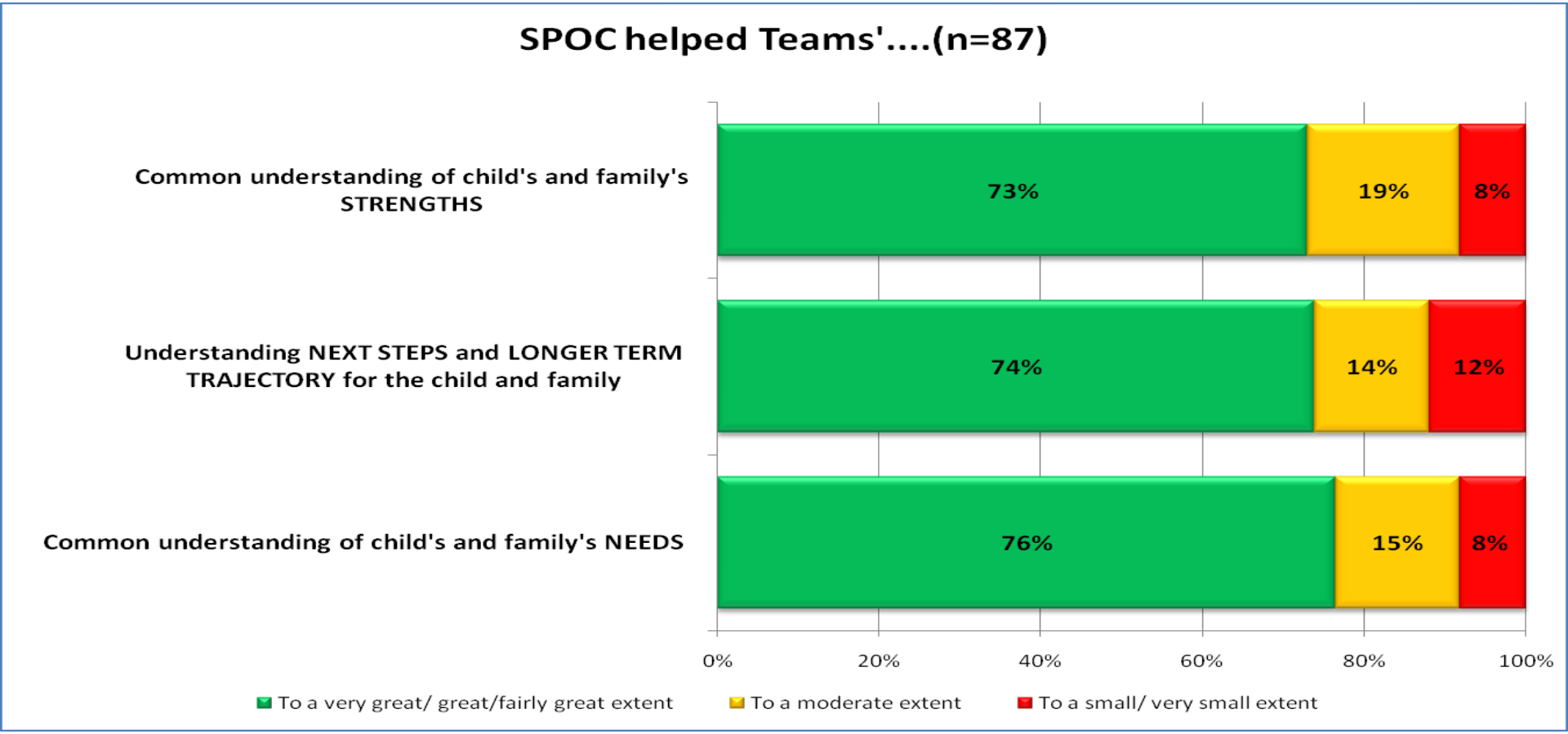
Impact of SPOC on Teams (2013)



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QUESTIONS and DISCUSSION