



**Children's Treatment Network**  
OF SIMCOE YORK

**A Reference Guide**  
*Collaborative Work in Progress*

**November 2006**

# **1. Overview of Children's Treatment Network**

## **i. Backgrounder**

Children's Treatment Network of Simcoe York is a new not-for-profit service delivery model for children with multiple disabilities in Simcoe County and York Region. This unique integrated network model builds on the strengths of existing service providers, including healthcare, recreation, education, social and community resources, to create a revolutionary system that provides **a single point of contact and a single plan of care** for children and youth from birth to 19 who have special physical, developmental, and communication needs.

**The Network model** is an entirely new approach that is based on service providers from different agencies and organizations collaborating and taking a **team approach** to each child's rehabilitation and habilitation needs. The ultimate goal of Children's Treatment Network is to **expand** services available in the community and **link** all regional resources to create a comprehensive rehabilitation system that is easily accessed. The Network will **coordinate** services from many agencies throughout all stages of a child's development.

**Network services** are available to children and youth with a wide range of multiple disabilities and complex conditions that require intensive therapy, specialized equipment or travel to treatment centers outside of the community including: cerebral palsy, muscular dystrophy, brain injury, developmental and learning difficulties, spina bifida, autism or pervasive developmental disorder (PDD), and other long-term medical conditions.

**Services** provided through Network members to these children and youth include: Occupational Therapy, Speech and Language Therapy, Physiotherapy, Recreation Therapy, Social Work, Psychology, Nursing, Orthotics, Audiology, Seating and Mobility, Feeding and Swallowing, Augmentative Communication, as well as additional medical and child development services.

As part of the publicly funded system under the Ministry of Children and Youth Services, Children's Treatment Network services are free.

**1-866-377-0286 to access Coordinated Services and Local Teams** - Parents of children with multiple disabilities can access the Network through a toll free number. The Network comprises over 25 agencies and organizations working together. Services will be provided through Local Teams that are made up of a range of professionals from member agencies. These Local Teams will ensure families have smooth, easy access to coordinated care plans and seamless provision of services. The Network will also work closely with organizations such as Sick Kids and Bloorview Kids Rehab to coordinate specialized services and care, where needed.

**Reducing Waitlists and Meeting Service Gaps** - Over the next two years, Children's Treatment Network will continue to enhance and expand critically needed services available in the community. Initiatives include local access to specialty clinics, equipment and therapies as well as provision of training programs to broaden the range of services available in Simcoe and York. By the end of 2007 a total of 10 Local Teams will be on the ground. Two Resource Centers will further enhance support for children, families and service providers.

**Resource Centers provide more access to a full range of integrated services closer to home** - The first Resource Centre located in The Common Roof in Barrie opened in September 2006 and will bring expanded rehabilitation services and four critically needed specialty services to the area. The specialty services include Augmentative Communication, Feeding and Swallowing, Seating and Mobility and Orthotics. For the first time, over 1700 kids with multiple disabilities in Simcoe County will have another point of access to a full range of enhanced and integrated rehabilitation and child development services, equipment and professionals in one location. The Centre is also home to the first dedicated Pediatric Therapy Gym in Simcoe.

A second Resource Centre located in York Region will begin operations early in 2007 to serve over 2800 York Region kids with special needs.

## ii. **General Key Messages about CTN**

- Children's Treatment Network of Simcoe York represents a giant step forward for kids with multiple disabilities and their families
- Through one point of contact, the Network will provide a single plan of care and coordinate services from many agencies for children and youth from birth to 19 who have special physical, developmental and communication needs
- For the first time, children with special needs and their families have access to a network of coordinated, integrated care that includes the full spectrum of rehabilitation and support services
- The Network is a new service delivery model that links existing services and service providers so they can take a team approach to each child's care
- The Network will expand and add services that are critically needed in the community to help reduce waitlists and meet gaps in "closer to home" services
- The Network serves children and youth with a wide range of disabilities and conditions who require specialized services and supports to participate in activities of daily living, school, and play

- The Network is about removing barriers for families and focusing on the needs of the child. It's not just about health care. It's about connecting to the network of health, education, recreation and social services and creating a coordinated care plan that supports each child through all the phases of their development
- Network members include over 25 agencies and organizations serving kids with special needs. Each child is assessed and assigned a Local Team. Care plan is developed for each child; services are coordinated and provided through Local Teams made up of professionals from member agencies. Care plan is updated and revised as child grows and needs evolve
- Over next 2 years, Network will continue to add and enhance services needed in community. By the end of 2007, 10 Local Teams will be on the ground. 2 Resource Centers - 1 in Simcoe and 1 in York - will further enhance services and support for kids and families
- Simcoe Resource Centre in Barrie opened on Sept. 12, 2006. Centre brings 4 critically needed specialty services to the area and expands access to a wide range of rehabilitation and child development services for over 1700 kids with multiple disabilities in Simcoe
- Another Resource Centre located in York will begin operations early in 2007. It will bring more critically needed services closer to home for over 2800 York Region kids with special needs
- This is the only model of its kind, created specifically for children in Simcoe County and York Region. Services are free.
- Leading international researchers from McMaster University are using the Network model for a research project that examines the effectiveness of an integrated approach on both the system and kids and families
- 1-866-377-0286 Toll Free number to access Network services. For more info visit website at [www.ctn-simcoeyork.ca](http://www.ctn-simcoeyork.ca)

### **iii. Population Served**

The broad population seeking access to children's services in Simcoe and York is welcome to call the CTN single point of Access and be directed through a robust Service Navigation process, to the appropriate program or service. A child becomes a 'CTN' child when they are identified as a child with multiple needs and disabilities requiring a coordinated response on the part of a multi-member Child and Family Team.

The population for service coordination is characterized as children or youth with multiple special needs (e.g. mobility, communication, developmental, behaviour, social-emotional) and their families who have intensive or complex needs for service

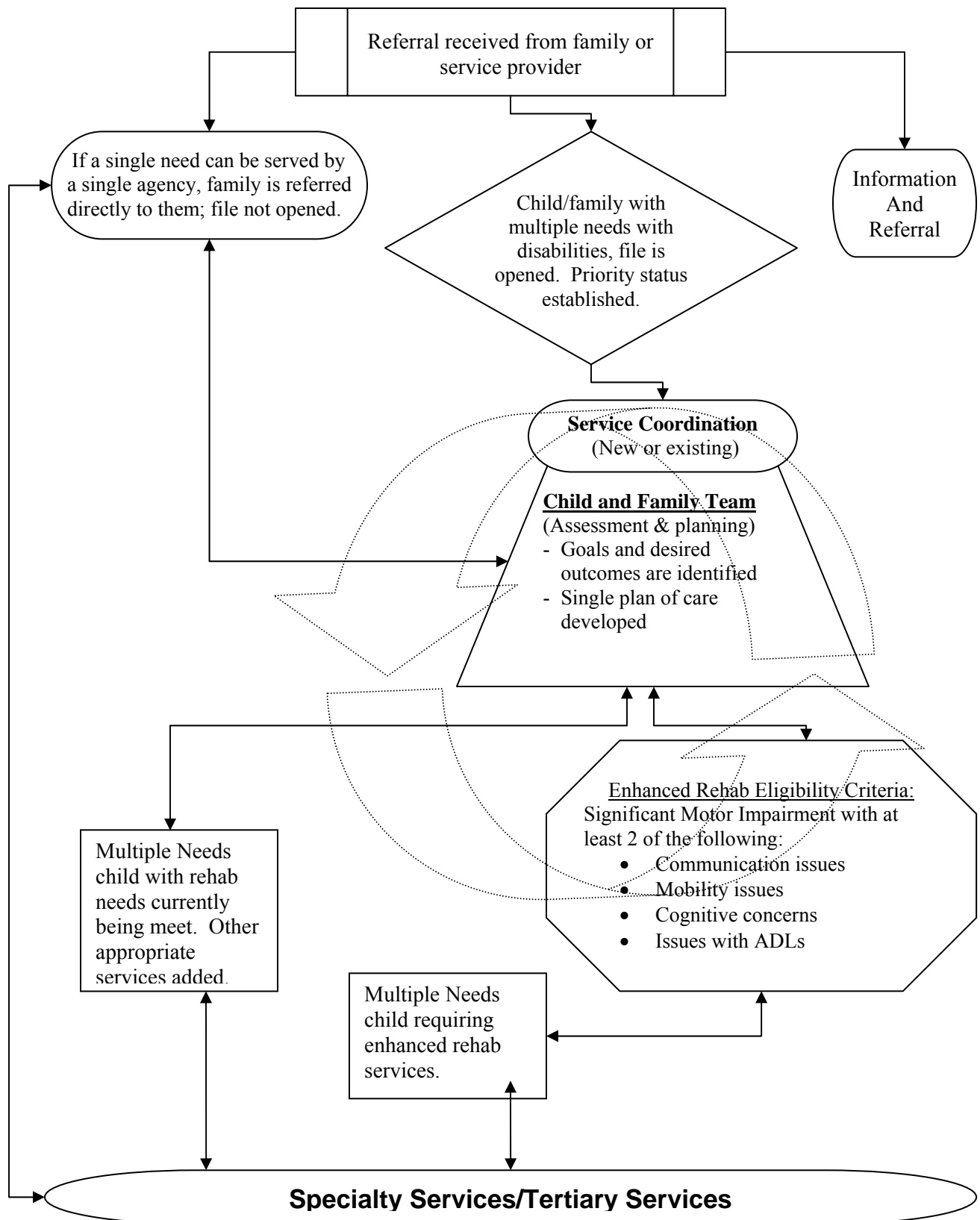
coordination not able to be met by existing levels of case management or service coordination. These children may or may not need enhanced rehabilitation services.

Generally, eligibility for CTN-funded rehabilitation services at the local team or specialized services will be children and youth with significant multiple disabilities in the moderate to severe/very severe range, requiring the linking of multiple services, as characterized below. The determination for enhanced rehabilitation services will occur at the Child and Family Team, and clarity will evolve as CTN gains experience with the population profile and the new model of service delivery.

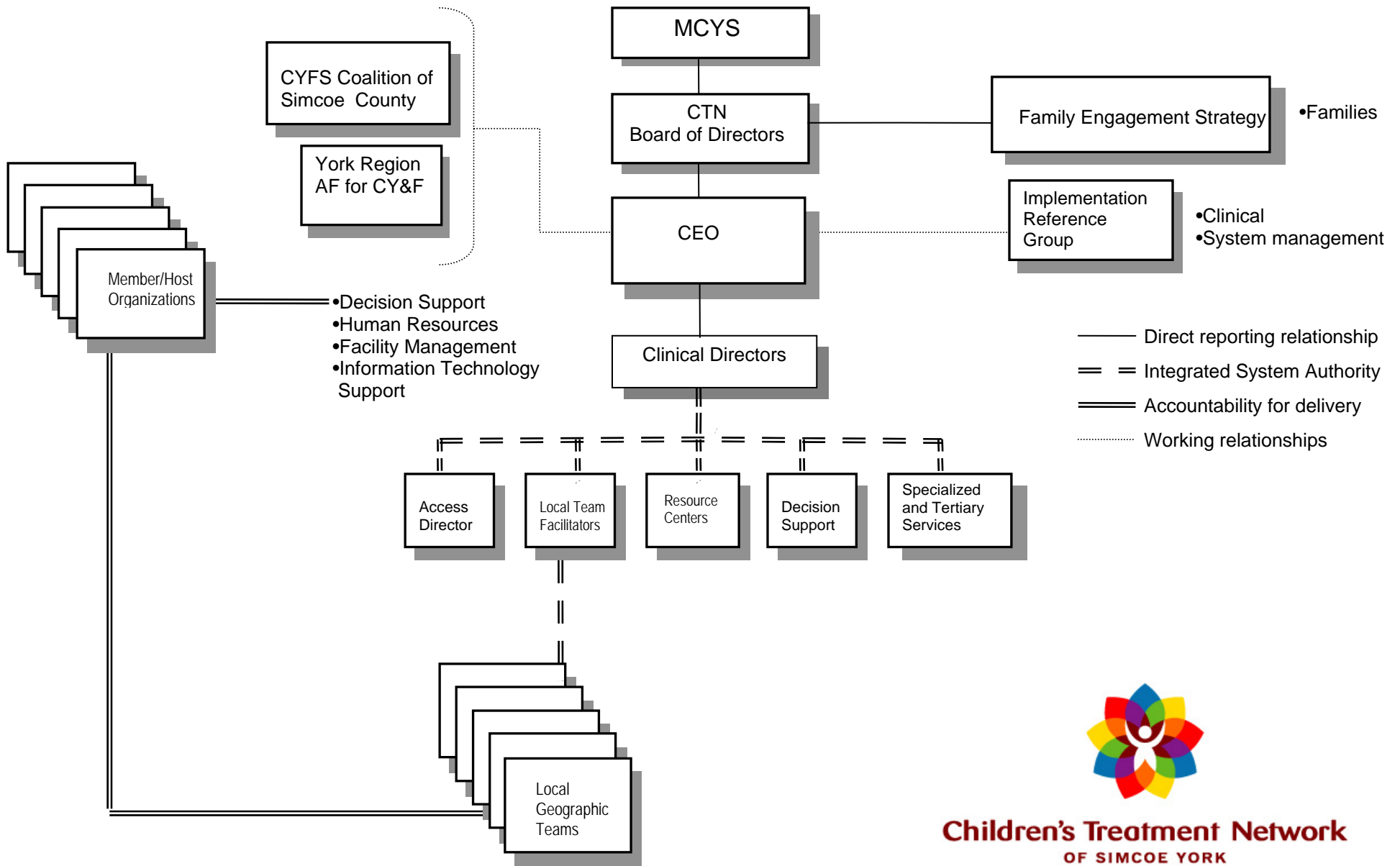
Specialty Clinics will develop a specific target population as they evolve over the first year of operation. Access to enhanced rehabilitation services may be somewhat different for basic therapy and specialized services. In the early stages of implementation, the CTN Clinical Directors will work closely with network partners to clarify access to these services.

- Aged birth to 19 in Simcoe County or York Region
- Significant impairment in the following domains, requiring therapy services: mobility, communication, primarily augmentative, cognitive, ADL, requiring equipment, Acquired brain injury

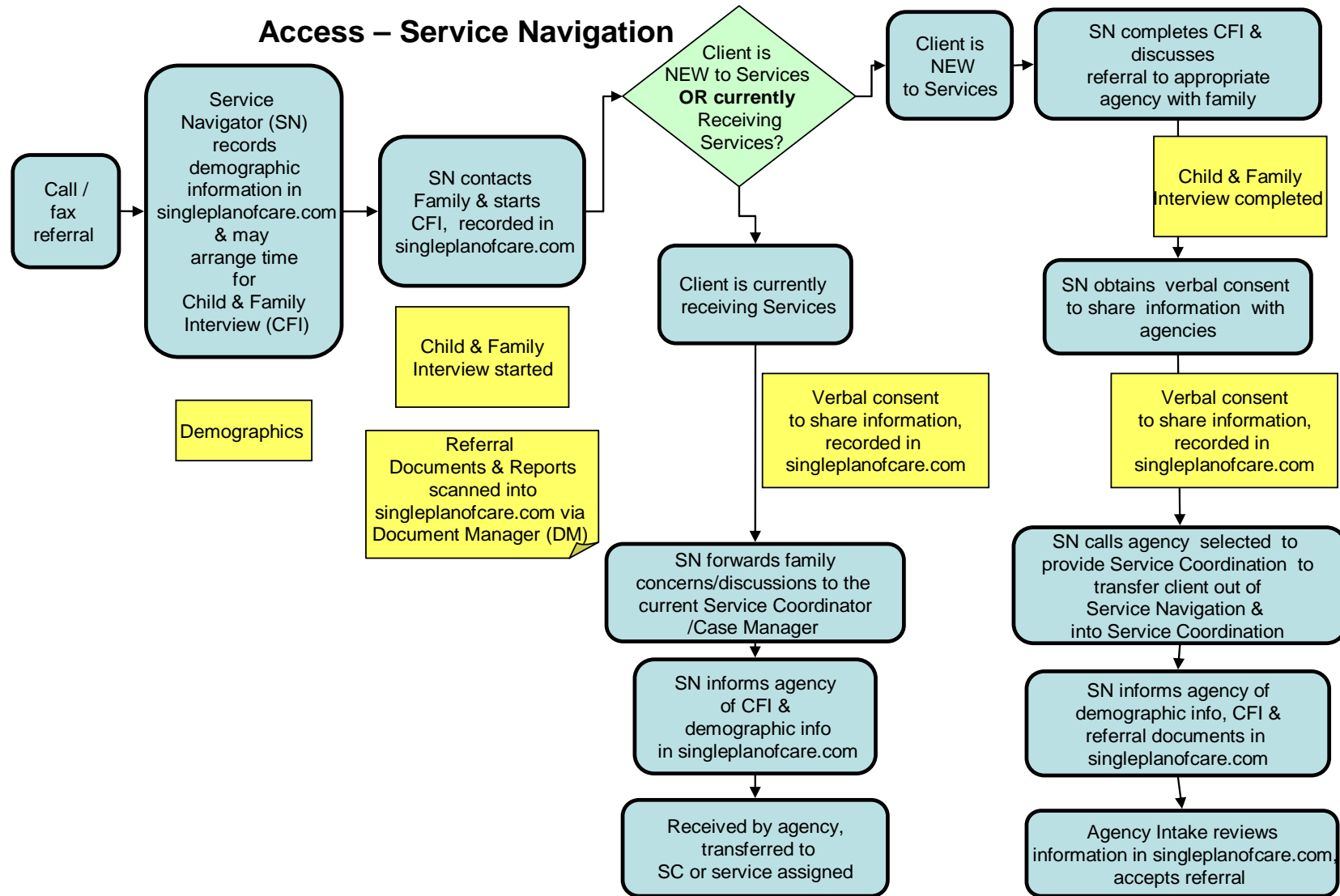
#### iv. Decision Tree



## v. Network Organization Chart

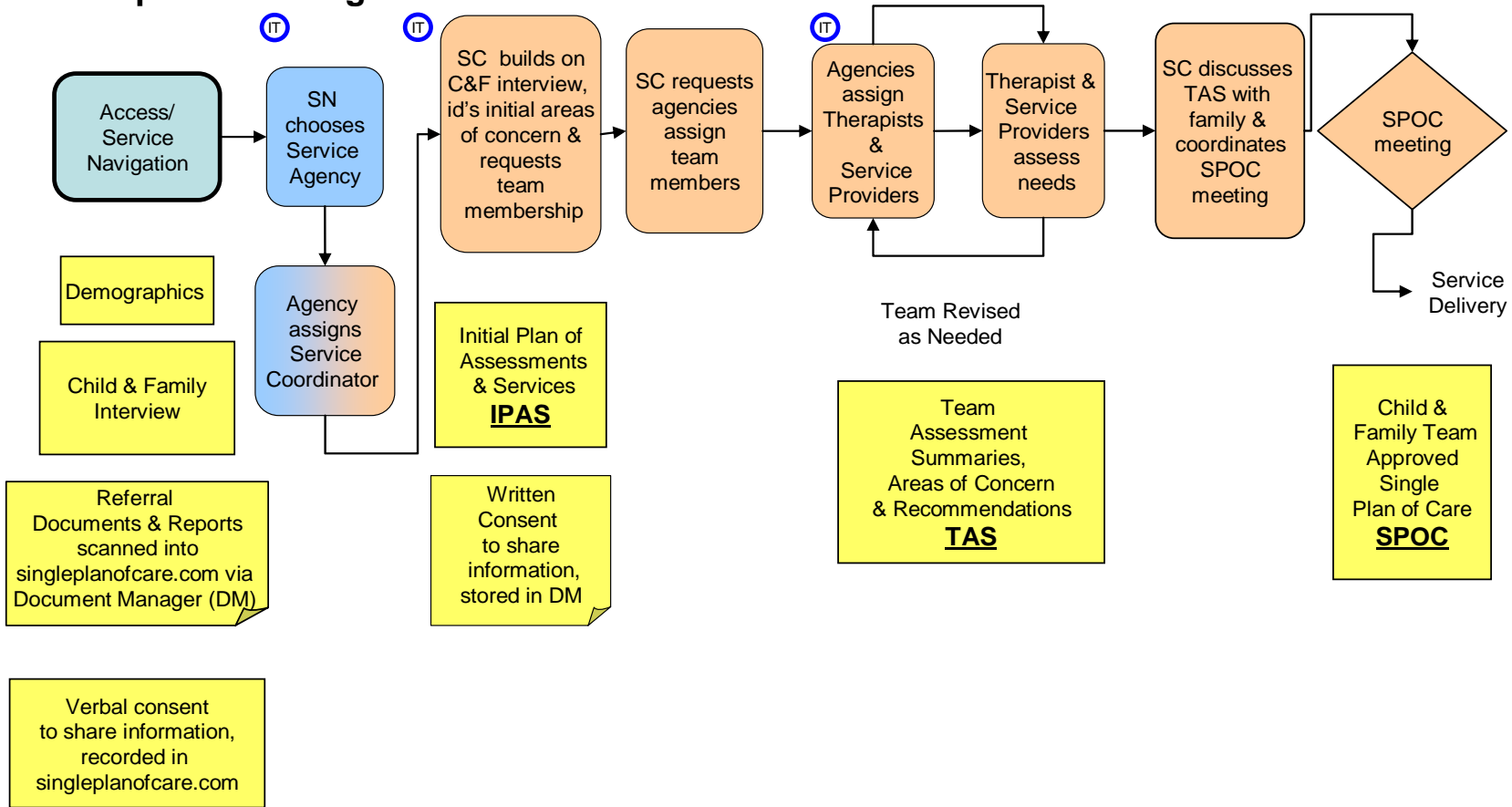


## vi. Process Maps



### Access / Service Navigation

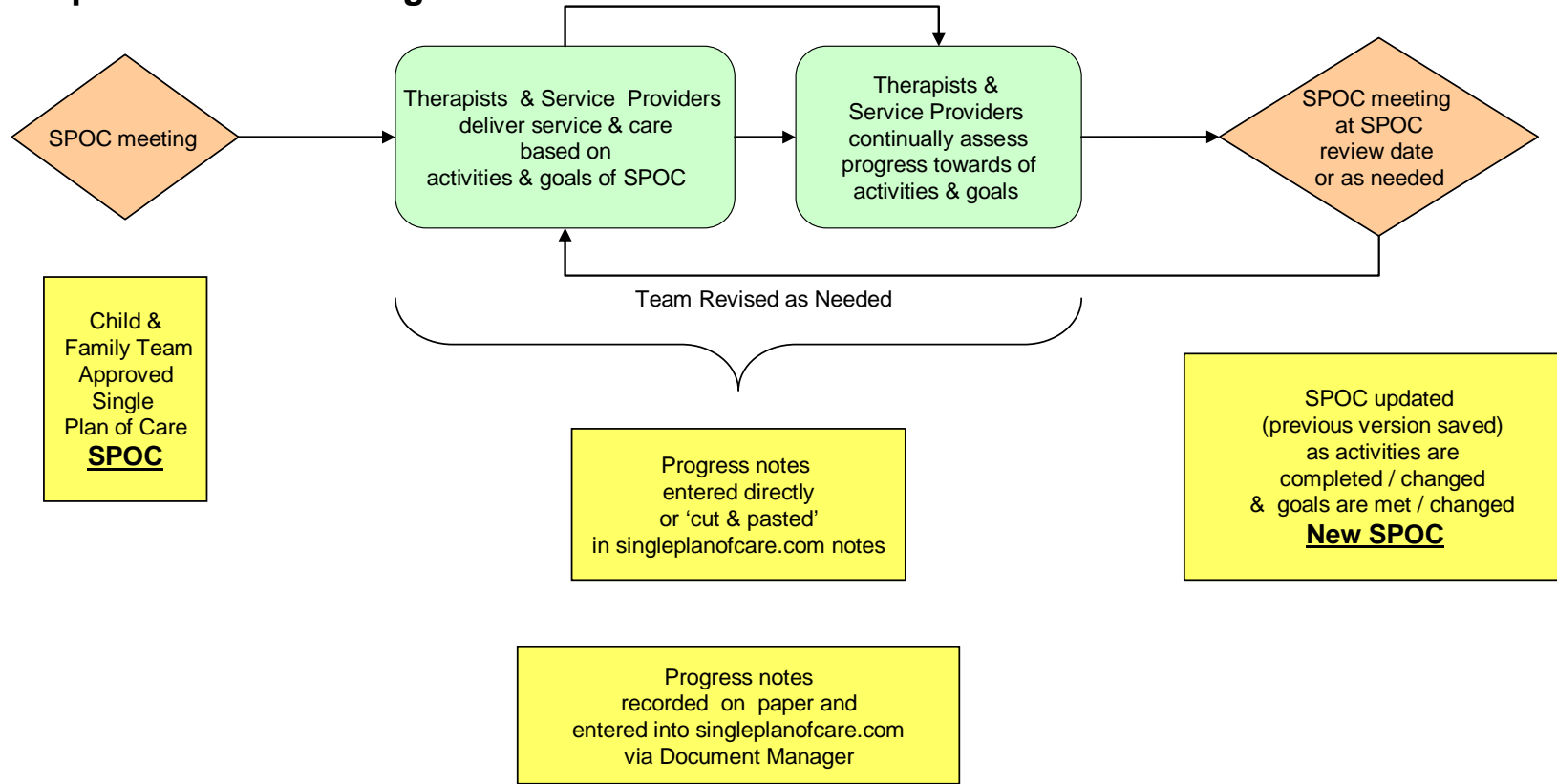
## Development of Single Plan of Care



Internal Transfer with External E-mail Notification



# Implementation of Single Plan of Care



**vii. Anticipated Outcomes: Logic Model**

**Before/After Logic Model of CTN Evaluation**

Objective	Inputs and Activities	Initial Program Outputs	Intermediate Outcomes (12 MOS.)		Longer Term Impacts (24 mos.)
<p><i>To assess the Effectiveness of the Children's Treatment Network</i></p> <ul style="list-style-type: none"> <li>• in general</li> <li>• for particular children and families</li> <li>• Socio-demographic Characteristics of Child (ICD-10) Family (NLSCY)</li> <li>• Body, Structure, Function, Measure of Complexity</li> <li>• ICF-CY</li> <li>• PALS – Severity of Limitation Index</li> </ul>	<ul style="list-style-type: none"> <li>➤ Children's (0-19) Treatment Network</li> <li>➤ Funding</li> <li>➤ Needs assessment (2002)</li> <li>➤ Planning</li> <li>➤ Processes of Care</li> <li>➤ Intake</li> <li>➤ Navigation</li> <li>➤ Coordination</li> <li>➤ Team formation and designated host agency</li> <li>➤ E-record</li> </ul>	<ul style="list-style-type: none"> <li>↑ - Fidelity to Interagency Collaboration</li> <li>- Integration</li> <li>Extent</li> <li>Scope</li> <li>Depth</li> <li>Quality</li> <li>↑ - Network Capacity</li> <li>System Measures</li> <li>↑ - Community Resource Team Function</li> <li>↑ - Number of Therapists and Specialists in System</li> <li>↓ - Staff Turnover</li> <li>↑ - Staff Satisfaction</li> <li>↑ - Staff Work Environment</li> <li>↓ - Staff Absenteeism</li> </ul>	<ul style="list-style-type: none"> <li>↑ Access:               <ul style="list-style-type: none"> <li>- Reduced agency waiting lists, time to service</li> </ul> </li> <li>↑- Volume of Clients/0-19 by Team/host agency</li> <li>↑- Number of Children in Family Teams/plans by host agency</li> <li>↓- trips out of local areas</li> <li>↑- attendance at Therapy Sessions</li> <li>↑- Family Satisfaction</li> <li>↑- Measure of Processes of Care MPOC</li> </ul>	<ul style="list-style-type: none"> <li>↑- Participation in School Recreation Social (Vineland II activity of Daily Living and Communication)</li> <li>↓ Kessler<sup>10</sup> - adult emotions, problems</li> </ul>	<ul style="list-style-type: none"> <li>↑- Child's Quality of Life Scores (Peds QL<sup>TM</sup>)</li> <li>↑ - Behaviour NLSCY<sup>4-18</sup></li> <li>↑- Infant Behaviour (NLSCY 0-60 mos.)</li> <li>↑- Family Functioning</li> <li>↑- NLSCY Parenting</li> <li>↓- Use of Service</li> </ul>

## viii. CTN Staff Contact List

### Contact Us

**Children's Treatment Network of Simcoe York  
Simcoe Resource Centre  
165 Ferris Lane  
Barrie, Ontario  
L4M 2Y1**

**Access Number: 866-377-0286  
Main Administrative Number: 705-719-4795  
Toll Free Number: 877-719-4795  
Admin Fax: 705-726-2870**

<b>Name</b>	<b>Title</b>	<b>Extension (Admin #)</b>
Robert Morton	Chief Executive Officer	284
Michelle Biehler	Director, Access	317
Carolyn Cannon	Executive Assistant	252
Bill Frampton	Clinical Director	283
Sara Koke	Clinical Director	905-726-0976
Sandy Thurston	Director, Evaluation and Planning	303
Simcoe Resource Centre	Medical Room	320
	Gym	321
	Team Room	316-319

## **2. Overview of Access and Service Navigation**

### **i. Access**

The role of CTN Access is to ensure that children with special needs and their families are given accurate information and linked with appropriate services and supports. The common electronic client record is initiated at Access and supports information sharing, service integration, the development of a Single Plan of Care, and the monitoring of service system gaps and trends.

CTN Access is hosted by the Community Care Access Centre of York Region. CCAC Access case managers provide service navigation to families and professionals calling the CTN toll free number. Assistance to families is provided seven days a week from 8:30 am to 8:30 pm. CTN Access also provides a general information function through Information and Referral (I and R). Families calling for general information about such things as childcare, library services, recreational or community programs, are assisted by experienced I and R staff.

### **ii. Service Navigation**

The Service Navigator provides the initial contact for the family and after completing a multi-domain interview assists the family to access the appropriate services, supports, and information by linking them with the appropriate service agency or, in the case of a child with multiple needs, linking them with an appropriate service coordinator.

The Service Navigator:

- engages the family with the children's service system
- responds to the child and family's needs in a respectful manner consistent with the principles of family centered care
- is knowledgeable about available services and supports
- is respectful of other service providers and agencies and works in a collaborative way to ensure the child and family receive the required services
- develops the preliminary plan with the family in accordance with the family's concerns and visions
- assists the family to understand the CTN model and the range of services available
- protects the child and family's privacy
- is transparent in all communications
- is sensitive to diversity and works to support the family's religious and cultural practices
- is flexible and individualizes care to every child and family
- is readily able to identify child and family risk factors and understands duty to report obligations
- transfers care to other providers in such a way as to instill confidence in the process and in the Children's Treatment Network

CTN Access maintains responsibility for the client until such time as an appropriate service coordinator or service is available. At times this may involve several calls with the family and the network of agency providers in order to determine the most appropriate agency to meet the long term needs of the child and family.

When a child's needs can be met by a single agency and service coordination is not required. Information is shared and the client is transferred to the children's service agency to provide the necessary assessment and intervention.

### **iii. Guiding Principles for Access**

The following principles guide the development of CTN's Access Process

- From a Family Perspective
  - Single call, once
  - Holistic
  - Timely and accurate response
  - Prioritize, and provide options/choice
  - Obtain right services
  
- From a System Perspective
  - System information and trending capability
  - Transparent decision-making/prioritizing
  - Equitable
  - Responsive to diversity
  - Flexible
  - Respectful of privacy

### **iv. Access Process**

Caller calls 1-866 toll free Number

Call is received by Reception at CCAC York Region.

Receptionist answers "Hello, Children's Treatment Network, how may I help you?"

If family or professional indicates a service need, call is forwarded to Service Navigation. (If call is general in nature call is forwarded to Information and Referral)

Initial Demographic information is taken and entered into electronic client record, client file is initiated

Service Navigator (SN) contacts the family and explains the CTN model of service integration, completes the demographics, and begins the CTN Child and Family Interview (CFI). The SN then proceeds following the steps outlined below in accordance with the situation.

**1. If client is New to services:**

- SN completes CFI
- Asks family to forward any relevant reports
- SN identifies and discusses most appropriate service or service coordination agency with family
- SN obtains verbal consent and documents consent was provided
- SN forwards the demographic information and the Child and Family Interview by fax or if connectivity is available uses email to alert the agency that a new client has been transferred and that they should view the client's information in the electronic client record.
- Reports and referral information are scanned into electronic client record and filed as they are received by the SN. The SN alerts the agency that new information is available or faxes the relevant documents to the children's service agency.
- Agency Intake reviews information in the electronic client record and assigns appropriate service coordinator or service provider

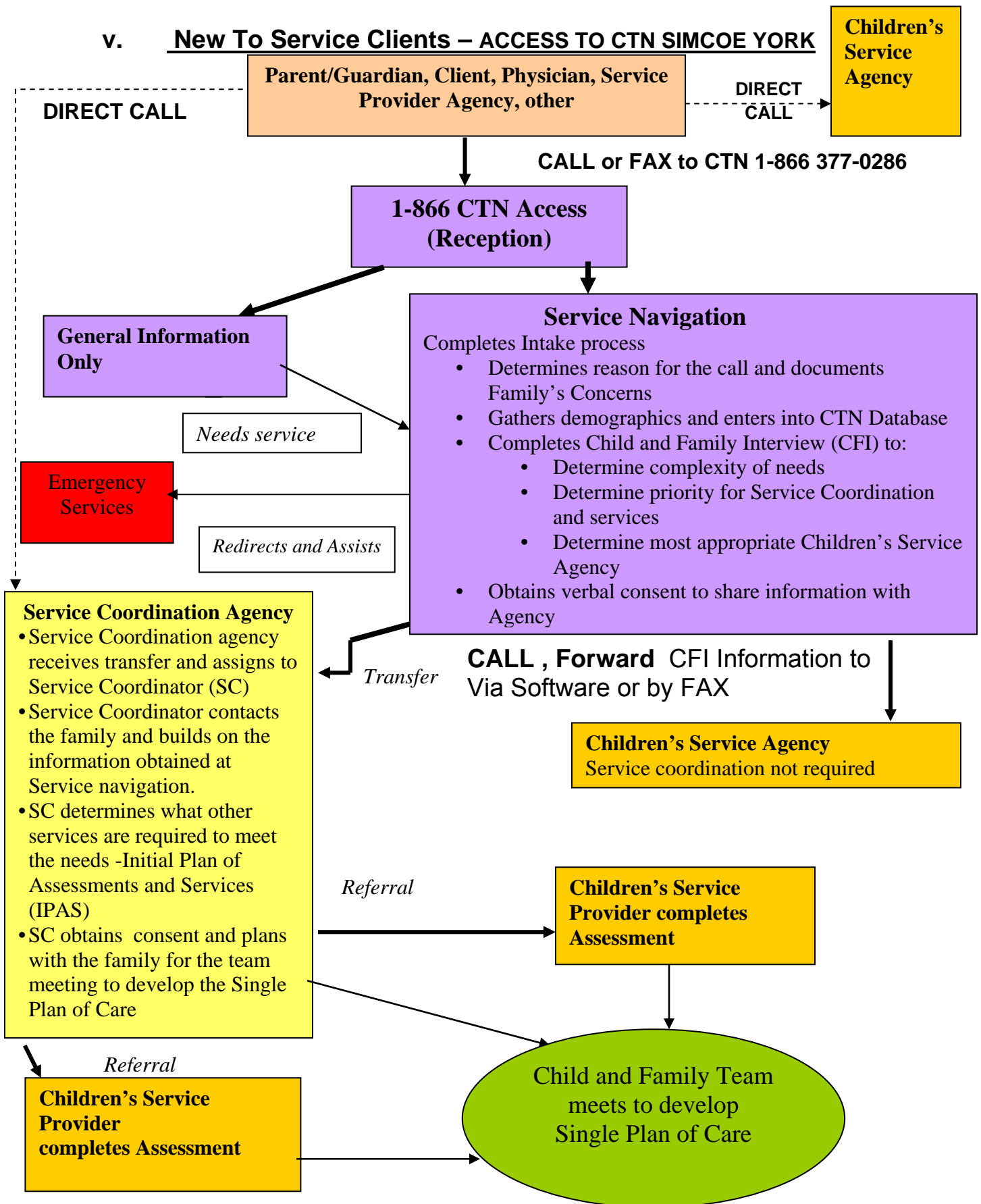
**2. If client is already receiving Services from a Network Partner:**

- SN completes relevant parts of the CFI and identifies any new needs/concerns with the family
- SN obtains verbal consent to forward information to the service coordinator or service provider involved and documents that consent was provided.
- SN forwards the CFI by fax or if connectivity is available uses email to alert the agency that there is new information about the client and that they can view the client's information in the electronic client.
- Any reports and referral information received by the SN is scanned into the electronic client record. The agency is notified about the new information.

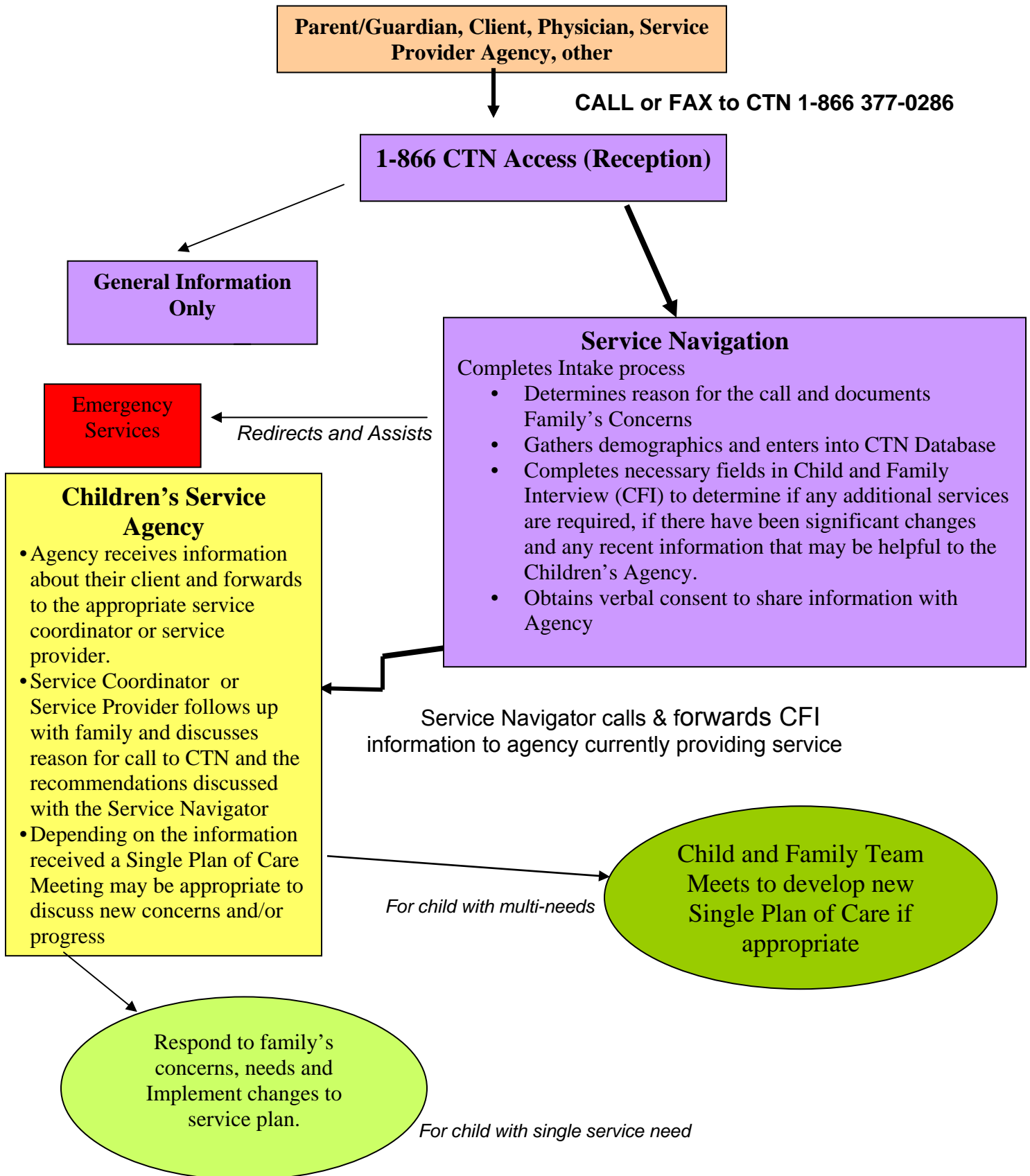
**3. If client is no longer receiving active services from a Network partner but had had information entered into the electronic client record in the past:**

- SN confirms client's current demographic information with the client's previous information stored in the electronic client record. A new file is not initiated.
- SN discusses reason for call and documents in the electronic client record the family's new concerns and current needs
- If client has not received services in the past two years SN completes a new CFI in order to identify any new needs or concerns.
- SN identifies and discusses most appropriate service or service coordination agency with family
- SN updates consent
- SN forwards the demographic information and the CFI by fax or if connectivity is available uses email to alert the agency that a client has been transferred and that they should view the client's information in the electronic client record.
- Reports and referral information are scanned into electronic client record and filed as they are received by the SN. The SN alerts the agency that new information is available or faxes the relevant documents to the children's service agency
- Agency Intake reviews information in the electronic client record and assigns appropriate service coordinator or service provider

v. **New To Service Clients – ACCESS TO CTN SIMCOE YORK**



vi. Already Receiving Services - ACCESS TO CTN SIMCOE YORK



## **vii. Service Description for CTN Access**

### **Purpose**

The Access function for CTN services serves as a coordinated mechanism to screen clients as comprehensively as possible, and provide service navigation based on the needs of the child and family, so that the right resources and services can be delivered and coordinated as quickly as possible and as close to home as possible.

### **Functions**

- 1. Service Inquiry**
  - Responding to inquiries from families, service providers and others with a view to determining appropriate next steps which might include screening for CTN services; and/or other services.
- 2. Referral**
  - Screening for eligibility to children's services.
  - Preparation of unique electronic client record.
- 3. Intake Interview**
  - Conducting an initial needs assessment, including a scan of existing information, for purposes of transferring the child/family to the right configuration of resources to meet their priority needs. This information may go to a service coordinator to establish a Child & Family Team, to network partner agencies or to organizations external to CTN.
- 4. System Navigation**
  - Assisting client/family to coordinate resources.
  - Providing short term resource support for families who are awaiting referral to CTN child and family team for service coordination.
  - Assisting client and family to navigate the children's service system and locate resources and services as appropriate while waiting for longer term services and supports, including service coordination.
- 5. Transfer Client/Family to Service Delivery Team**
  - Ensuring timely and smooth transfer for ongoing service delivery.
- 6. Electronic Client Record Management**
  - Initiating the electronic client record in the CTN clinical software application for all clients following initiation of a service request. Initially, PMI will provide a client file until the CTN clinical software application is available.
  - Obtaining records from other service providers and scanning these into the electronic file, as needed for service navigation.
  - Auditing for incomplete, inaccurate, or missing information from the Access and service navigation process
  - Closing the client file where appropriate.

## **7. Collect, manage, and provide system-wide service information**

- Providing utilization reports on a system wide and regional basis to assist CTN leadership manage resources and wait lists.

### **Role of the Service Navigator**

The CCAC will employ staff as service navigators who will work closely with the CTN Access Director (initially Project Manager for Access).

The Service Navigator is the primary contact at Access for the client/family and provides assistance connecting the client/family to appropriate resources including service coordination. In this role, the Service Navigator:

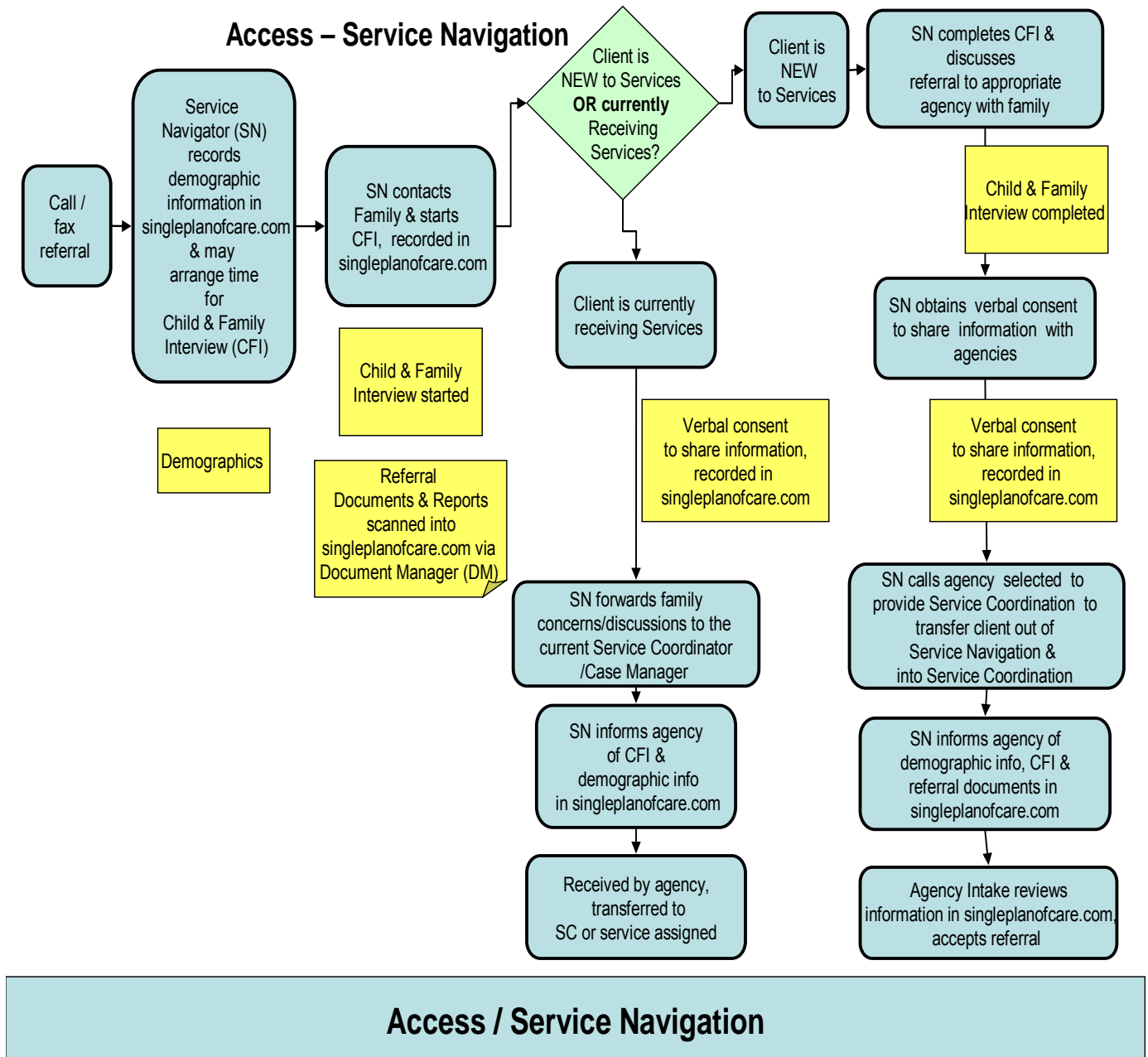
- responds to initial service inquiry
- screens for eligibility and when not eligible directs inquiries to most appropriate agency
- if eligible, starts electronic file with consent, records demographic information, and completes referral to determine next steps
- completes the Child and Family Interview (CFI) to determine need and identify risk, and set priorities using existing tools
- identifies agency to assume service coordination and makes referral on behalf of family
- Assists the family to understand the range of services available through the children's service systems in Simcoe and York
- collects information from previous assessments and service providers with consents to build electronic client record
- obtains consent to share information with the Service Coordinator and the child/family team
- may provide short term support while awaiting service coordination to be in place which includes development of an initial support plan with the child and family and providing relevant information to the child and family in the interim
- advocates on the child and family's behalf
- refers to the local team facilitator to assist in determining the most suitable service coordinator and participants on the child and family team if no service coordinator identified
- acts as the continued contact for the client/family local team around Access issues
- ensures that Electronic Client Record data is accurate, current and comprehensive
- assists the CTN management team in data management and analysis

### **Skills**

- Familiarity with the children's service system including special need resources
- Excellent customer service skills
- Excellent interviewing and assessment skills
- Excellent negotiation or mediation skills
- Problem solver, good judgement
- Excellent oral and written communication skills
- Knowledge of relevant legislation such as Child & Family Service Act (CFSA)
- Takes initiative and can work as a member of a team as well as independently

- Service coordination, case resolution and case management experience is an asset
- Appreciation for multiple cultures and languages
- Proficient with information service systems

### viii. Information



## ix. Child & Family Interview

Client Identification Information (brought forward from demographics to include: Child Unique Identifier, child's last name, first name, middle name, gender, DOB, HCN, version code, address street number, address street name address apartment number, RR, PO Box, city/town, postal code, home phone number, if available)

Auto stamp date and time Child Interview was Initiated

Service Navigator Interview Process Log and Comments

---

---

Verbal Consent to Collect and Maintain Information

Yes No

First Name of person giving consent

Last Name of person giving consent

Relationship to child – drop down

Information about Child

---

---

Service History—

Is your child receiving Services at this time?

Yes No

If yes, what services is the child receiving at this time?

Service 1	Agency 1	Concern being addressed	First name of contact	Last name of contact	Contact Phone Number
Service 2	Agency 2	Concern being addressed	First name of contact	Last name of contact	Contact Phone Number

Did your child receive services in the past to address this concern or other concerns?

Yes No N/A

If yes,

Past Service	Agency	Concern addressed	First name of contact	Last Name of Contact	Date of Service
Past Service	Agency	Concern addressed	First name of contact	Last Name of Contact	Date of Service

Appropriate to continue with Interview? Yes No

Comments \_\_\_\_\_

If No, Interviewer to proceed to Family Functioning Section

## Diagnostic Information

Has your child been given a diagnosis?

Yes No

If yes,

What is the diagnosis DD	Who made the diagnosis	When was the diagnosis made	How old was your child when the health or developmental problem was first diagnosed
--------------------------	------------------------	-----------------------------	---

Is there a second diagnosis? \_\_\_\_\_

Yes No

If yes,

What is the diagnosis	Who made this diagnosis	When was this diagnosis made	How old was your child when this diagnosis was made
-----------------------	-------------------------	------------------------------	---

What is the diagnosis	Who made this diagnosis	When was this diagnosis made	How old was your child when this diagnosis was made
-----------------------	-------------------------	------------------------------	---

What is your understanding of all the diagnoses? \_\_\_\_\_

Do you have testing and/or diagnostic information such as reports available?

Yes  No  N/A

If yes, please list possible sources for reports and information

Source of Report	Date of Report
------------------	----------------

Source of Report	Date of Report
------------------	----------------

Is there a member of the child's family with this condition?

Yes No N/A

If yes, provide relationship \_\_\_\_\_

Does your child have a Family Physician?

Yes No

First name of Physician	Last name of Physician	Phone number of Physician
-------------------------	------------------------	---------------------------

Does your child see a Paediatrician?

Yes No

If yes,

First name of Paediatrician	Last name of Paediatrician	Phone Number of Paediatrician
-----------------------------	----------------------------	-------------------------------

Does your child see any medical specialists?

Yes No

If yes,

First name of Medical specialist	Last name of Medical specialist	Phone number of Medical specialist	Area of specialty
First name of Medical specialist	Last name of Medical specialist	Phone number of Medical specialist	Area of specialty

Allergies

Does your child have any allergies?

Yes  No

If yes, list allergy and treatment action required

Allergy	Treatment or Action Required
Allergy	Treatment or Action Required
Allergy	Treatment or Action Required

Medications

Does your child take any medication(s) on a regular basis?

Yes  No

If yes,

Medication	Dosage	Reason for Medication
Medication	Dosage	Reason for Medication
Medication	Dosage	Reason for Medication

Surgeries

Has your child had any surgical procedures?

Yes  No

If yes,

Surgical procedure	Reason for procedure	Date	Length of Hospital Stay	Comments
Surgical procedure	Reason for procedure	Date	Length of Hospital Stay	Comments

Hospitalizations

Yes  No

If yes,

Reason for Hospitalization	Date	Length of Hospital stay	Comments
Reason for Hospitalization	Date	Length of Hospital stay	Comments

Vision

Do you have any concerns about your child's vision?

Yes  No

If yes, comments\_\_\_\_\_

When was your child's most recent vision test? Results

Hearing

Do you have any concerns about your child's hearing?

Yes  No

If yes, comments \_\_\_\_\_

When was your child's most recent hearing test? Results

Does your child have recurring ear infections?

Yes No

If yes, how has this been treated? \_\_\_\_\_

Nutrition Feeding and Eating

Child's Current Weight

Child's Current Height

How is your child fed? - DD

Do you have concerns about your child's nutritional status, their growth and/or weight?

Yes  No

If yes, comments \_\_\_\_\_

Does your child have difficulty with ....

Gagging  Yes  No

If yes, comments

Swallowing  Yes  No

If yes, comments

Choking  Yes  No

If yes, comments

frequent chest infections or pneumonia  Yes  No

If yes, comments

Are you concerned about your child's diet?  Yes  No

If yes, describe your child's diet.

Immunizations

Up to date Yes No

If No, explain why \_\_\_\_\_

General Health

Do you have any concerns in the following areas?

Breathing Yes No If yes, comments

Sleeping Yes No If yes, comments

Frequent colds, illnesses? Yes No If yes, comments

Activity Level? Yes No If yes, comments

Seizures? Yes No If yes, comments

Other general health concerns? Yes No If yes, comments

## Child's Abilities

### **Communication**

Do you have concerns about how your child communicates?

Yes  No

If yes, comments \_\_\_\_\_

If yes,

Does your child seem to understand language like other children his/her age?	Yes	No	N/A	Comments
Do others have difficulty understanding your child when he/she speaks?	Yes	No	N/A	Comments
Does your child have difficulty pronouncing sounds or words?	Yes	No	N/A	Comments
Does your child use signs, pictures or devices to assist with communication	Yes	No	N/A	Comments

When your child speaks, what is the average number of words in an average sentence?

\_\_\_\_\_ Please give an example of something your child might say \_\_\_\_\_

### **Listening**

Do you have concerns about how your child listens?

Yes  No  N/A

If yes, comments \_\_\_\_\_

If yes, your child can

Concentrate on an activity	Yes	No	N/A	Comments
Respond when you talk to him/her	Yes	No	N/A	Comments
Do what you have asked him/her to do?	Yes	No	N/A	Comments

### **Mobility**

Do you have concerns about how your child moves?

Yes  No

If yes, comments \_\_\_\_\_

If yes, your child can

Sit without assistance	Yes	No	N/A	Comments
Stand without assistance	Yes	No	N/A	Comments
Walk without assistance	Yes	No	N/A	Comments
Ride a trike or bike without assistance	Yes	No	N/A	Comments
Play ball without assistance	Yes	No	N/A	Comments

### **Feeding**

Do you have concerns about how your child feeds themselves?

Yes  No

If yes, describe your concerns \_\_\_\_\_

If yes, your child can

Use his/her hands to finger feed	Yes	No	N/A	Comments
Use a spoon or fork without assistance	Yes	No	N/A	Comments
Drink from a bottle/cup/glass?	Yes	No	N/A	Comments
Use a straw?	Yes	No	N/A	Comments
Sit still while eating?	Yes	No	N/A	Comments

### **Dressing**

Do you have concerns about how your child dresses themselves?

Yes  No  N/A

If yes, comments \_\_\_\_\_

If yes, your child can

Undress him/herself without assistance	Yes	No	N/A	Comments
Put on sweaters, shirts without assistance	Yes	No	N/A	Comments
Put on pants without assistance	Yes	No	N/A	Comments
Put on socks and shoes without assistance	Yes	No	N/A	Comments
Do up/undo fasteners without assistance	Yes	No	N/A	Comments
Tie shoes without assistance	Yes	No	N/A	Comments

### **Toileting**

Do you have concerns about how your child toilets themselves?

Yes  No  N/A

If yes, comments \_\_\_\_\_

If yes, your child can

Indicate when they need to use the potty or toilet	Yes	No	N/A	Comments
Get to the bathroom or potty without assistance	Yes	No	N/A	Comments
Get on/off the toilet without assistance	Yes	No	N/A	Comments
Wipes without assistance	Yes	No	N/A	Comments
Wash and dry hands without assistance	Yes	No	N/A	Comments

### **Bathing and Hygiene**

Do you have concerns about how your child performs bathing and hygiene activities?

Yes  No  N/A

If yes, comments \_\_\_\_\_

If yes, your child can

Brush teeth without assistance	Yes	No	N/A	Comments
Get in/out of shower or bath without assistance	Yes	No	N/A	Comments

Wash hair and body without assistance	Yes	No	N/A	Comments
Apply deodorant/makeup	Yes	No	N/A	Comments
Apply hygiene products	Yes	No	N/A	Comments

### **Playing with Toys**

Do you have concerns about how your child plays with toys?

Yes  No  N/A

If yes, comments \_\_\_\_\_

If yes, your child can

Ask for toys	Yes	No	N/A	Comments
Manipulate toys	Yes	No	N/A	Comments
Use toys in a variety of ways	Yes	No	N/A	Comments

### **Playing with Others**

Do you have concerns about how your child plays with others?

Yes  No  N/A

If yes, comments \_\_\_\_\_

If yes, your child can

Share toys	Yes	No	N/A	Comments
Let others know what he/she likes	Yes	No	N/A	Comments
Play pretend games	Yes	No	N/A	Comments
Play board games	Yes	No	N/A	Comments
Follow rules of a game	Yes	No	N/A	Comments
Does your child have friends he/she plays with on a regular basis?	Yes	No	N/A	Comments
Does your child become frustrated when playing with others?	Yes	No	N/A	Comments

### **Playing on Playground**

Do you have concerns about how your child plays on a playground?

Yes  No  N/A

If yes, comments \_\_\_\_\_

If yes, your child can

Use the swing	Yes	No	N/A	Comments
Use the climber/slide	Yes	No	N/A	Comments
Play in the sand	Yes	No	N/A	Comments
Move over uneven ground	Yes	No	N/A	Comments
Stay without wandering off	Yes	No	N/A	Comments

### **Recreation and Leisure**

Has hobbies/activities that he/she participates in and enjoys	Yes	No	List
---	-----	----	------

Do you have concerns about how your child participates in recreational activities?

Yes  No  N/A

If yes, comments \_\_\_\_\_

Has your child had difficulties participating in recreational /social/cultural activities?

Yes  No  N/A

If yes, have these difficulties been due to any of the following?

Child's Health	Yes	No	N/A	Comments
Child's physical condition	Yes	No	N/A	Comments
Child's Behaviour	Yes	No	N/A	Comments
Transportation	Yes	No	N/A	Comments
Cost/Finances	Yes	No	N/A	Comments

**Vocational Activities**

Do you have concerns about how your child participates in work activities?

Yes  No  N/A

If yes, comments \_\_\_\_\_

If yes, your child

Has been able to find a suitable job	Yes	No	N/A	Comments
Is able to get to and from his/her job	Yes	No	N/A	Comments
Complete the job tasks assigned	Yes	No	N/A	Comments
Can access the washroom	Yes	No	N/A	Comments
Communicates his needs	Yes	No	N/A	Comments

**Special Equipment**

Does your child use any specialized equipment to move, communicate, complete school work and/or participate in leisure activities?

Yes  No  N/A

If yes, please tell me about the equipment

Type of equipment	Purpose	How long have they been using this equipment
Type of equipment	Purpose	How long have they been using this equipment

Comments related to child's use of equipment \_\_\_\_\_

**School/Nursery School/Day Care Concerns**

Do you have any concerns about how your child is managing their school work?

Yes  No  N/A

Comments \_\_\_\_\_

Does your child.....

Attend school regularly?	Yes N/A	No	Comments
Like to go to school?	Yes N/A	No	Comments
Have friends at school?	Yes N/A	No	Comments
Join in school activities such as recess, clubs, and field trips?	Yes N/A	No	Comments

### Social Emotional Development

Do you have concerns about your child's social and emotional development?

Yes  No

Comments \_\_\_\_\_

Does your child .....

Console or calm easily?	Yes N/A	No	Comments
Adapt easily to new situations or experiences?	Yes N/A	No	Comments
Share his/her feelings readily?	Yes N/A	No	Comments
Feel good about him/herself?	Yes N/A	No	Comments
Understand his/her difficulties?	Yes N/A	No	Comments
Seem happy most of the time	Yes N/A	No	Comments
Seem to get along with other children?	Yes N/A	No	Comments
Participate in activities outside of home ie. Sports, crafts, lessons?	Yes N/A	No	Comments
Use alcohol?	Yes N/A	No	Comments
Use drugs?	Yes N/A	No	Comments

### Family Functioning

Please tell me a little about your family situation. \_\_\_\_\_ How many children are in your family? \_\_\_\_\_ How many children are currently living at home (including the child with a disability)? \_\_\_\_\_

Child 1	Age	Gender
Child 2	Age	Gender
Child 3	Age	Gender
Child 4	Age	Gender

Who is the primary caregiver of the child in the family? \_\_\_\_\_

Is there someone who helps your family by providing support, or assistance in caring for your child/ children?

Yes  No

If yes, comments \_\_\_\_\_

Do you ever feel overwhelmed providing care?

Yes  No

If yes, what strategies do you use to assist you to cope with care? \_\_\_\_\_

What has been helpful? \_\_\_\_\_

Does anyone within your family have a health condition that interferes with the caring of your child/children?

Yes  No

If yes, comments \_\_\_\_\_

Are there cultural practices that are important for us to be aware of?

Yes  No

If yes, comments \_\_\_\_\_

Are there religious practices that are important for us to be aware of?

Yes  No

If yes, comments \_\_\_\_\_

What is the highest level of education that you (and your spouse) completed?

Check one level for each parent

Parent /Guardian 1

No schooling

Elementary school (grade 1-8)

Some high school (grades 9-11)

Completed High School (grade 12 or 13)

Some college or technical training (at least 1 year)

Completed college or technical training

Some university (at least 1 year)

Completed University degree

Parent /Guardian 2

No schooling

Elementary school (grade 1-8)

Some high school (grades 9-11)

Completed High School (grade 12 or 13)

Some college or technical training (at least 1 year)

Completed college or technical training

Some university (at least 1 year)

Completed University degree

Do you have any financial concerns related to caring for your child?

Yes  No

If yes, comments \_\_\_\_\_

Which category listed represents your total family income before taxes? Please include income from sources such as wages, salaries, commissions, pensions, family allowance, rental income, and so forth. Check one only.

Less than  
 \$15,000  
 15,000 – 29,999  
 30,000 – 44,999  
 45,000 – 59,999  
 60,000 – 74,999  
 75,000 - 89,000  
 more than  
 90,000

Do you receive any additional funding to assist with caring for your child?

Yes  No

If yes,

Special Services at Home (SSAH)	Yes	No	Comments
Assistance for Children with Severe Disabilities (ACSD)	Yes	No	Comments
Respite Enhancement Funding	Yes	No	Comments
Ontario Disabilities Support Program(ODSP)	Yes	No	Comments
Ontario Works	Yes	No	Comments
Easter Seals	Yes	No	Comments
March of Dimes	Yes	No	Comments
Other	Yes	No	Comments
Other	Yes	No	Comments

Do you have any other forms of financial coverage that may assist in providing some services?

Yes  No

If yes, comment \_\_\_\_\_

For parent/guardian 1 (caller)

What do you consider to be your current main activity? Check one only.

- Caring for family
- Working full time for pay or profit
- Working part time for pay or profit
- Caring for family and working for pay or profit
- Recovering from illness/disability
- Looking for work
- Going to school
- Retired
- Other

For other Parent/Guardian 2

What do you consider to be your spouse's/partner's current main activity? Check one only

- Caring for family
- Working full time for pay or profit
- Working part time for pay or profit
- Caring for family and working for pay or profit
- Recovering from illness/disability
- Looking for work
- Going to school
- Retired
- Other

Safety of Child

To your knowledge has your child ever been physically abused?  Yes  No If yes, Comments

To your knowledge has your child ever been sexually abused?  Yes  No If yes, Comments

Has your child ever witnessed physical abuse between adults?  Yes  No If yes, Comments

Is the use of alcohol, drugs or gambling a concern for anyone in your home?  Yes  No If yes, Comments

Home Environment

Where does your child live? DD (Parental home, Foster Home, Group Home, Other)

What type of home does your child live in? DD (House, Apartment, Other)

Does your housing situation present any difficulties for your child and/or your family?

Yes  No  
If yes, comments \_\_\_\_\_

Do you have concerns related to transportation for your child and family?

Yes  No  
If yes, comments \_\_\_\_\_

Additional Information

Is there any additional information that we have not covered that you would like to share and feel may be important?

Yes  No

If yes, comments \_\_\_\_\_

Service and Follow-up Recommendations

\_\_\_\_\_  
\_\_\_\_\_

Consent to Share and Disclose Information

Verbal Consent to share information with the following organizations and agencies for the purpose of determining the initial plan of care

Yes No

If yes,

Agency /Organization Name	Consent <input type="checkbox"/> Yes <input type="checkbox"/> No	Exclusions Yes No	Exclusion Identification	First Name	Last Name	Relationship to Child (DD)	Date Consent Given
Agency /Organization Name	Consent <input type="checkbox"/> Yes <input type="checkbox"/> No	Exclusions Yes No	Exclusion Identification	First Name	Last Name	Relationship to Child (DD)	Date Consent Given

Auto stamp of Service Navigator Name

Auto stamp Service Navigator Agency Phone Number

Service Navigator Extension \_\_\_\_\_

Auto Stamp date and time Interview completed and saved

### **3. Overview of Local Teams**

#### **i. Local Teams**

Mechanisms are needed at both the organizational and system level to support front line staff from multiple organizations to coordinate and/or integrate their work with children in child and family teams. The CTN Implementation Reference Group is the system level mechanism, and Local Teams are the mechanism at the organizational level, to bring staff and supervisors from community agencies and schools together locally.

#### **What are the local teams?**

- A *geographical pool* of like-minded peers who share common goals for children, youth and families
- A '*community of practice*' that needs to know what each other knows
- A local context for implementing both Child and Family teams and the system level policies of the Network
- a locally-managed *system of care* focusing on subsets of children with high level of needs
- a framework to bring organizations together within a domain and establish common working practices
- Local teams focus on *values, culture, practice and knowledge*, while child and family teams focus on tasks, goals, and timelines in the single plans of care of individual children, youth and families

#### **What are the functions of the local teams?**

- To oversee/clarify the *elements and roles* of a local collaborative system of care
- To create a *local culture* of shared values and goals
- To create a *working climate* of ongoing dialogue and support for each other in coordinating and collaborating to serve children and families with significant or complex needs
- To monitor a *mutual accountability* for implementing best practice and agreed upon model of delivery
- To support improvement in quality through training, educating and mentoring
- *Collaborative problem-solving* and conflict resolution
- Address policy *issues that cut across agencies* and affect child and family teams in the geographical area
- Identify local issues that require a system level response from the Network

#### **What outcomes do we hope the local teams will achieve**

- Increased collaboration among agencies partnering locally
- Increased supportive and adaptive relationships
- Reduced duplication of effort
- Increased staff satisfaction and reduced burn out
- Increased capacity of child and family teams to set single plan of care and achieve goals
- Increased family empowerment and quality of life

## **Characteristics**

Local teams are not 'teams' in the traditional definition, but are intended to be:

- Informal
- Inclusive and fluid membership, according to needs and issues
- Local uniqueness
- Respect for both interdependence and when dependence not warranted
- Shared language, repertoire, routines, tools, resources
- Has existing options for facilitating work together – co-locations, existing teams (e.g. EI, Compass), clinics
- Lead but not managed
- Focus on knowledge, practice, quality, collaboration and communication

## **How will the teams evolve?**

- Building initial awareness
  - Who is our local team (do we have an EI or a Compass team already)
  - Find common ground (team building)
  - Determine functions the team will perform in CTN implementation
  - Identify strengths, skills and gaps
  - Identify or develop some shared routines (e.g. meetings, training)
  - Problem-solving
- Coalescing
  - Developing a practice model and performance indicators, policies, process
  - Establish a training plan and initiate learning, coaching
  - Ongoing dialogue, problem-solving, team-building
  - Support joint structures for screening, assessment, child & family teams for various sub-sets of kids/families with complex needs
- Mature and Active
  - Build capacity for core and specialty services and service coordination
  - Continue to develop integrated practices
  - Evaluate team functioning
  - Extend linkages and functioning with other local teams
  - Streamline practices

## **ii. How will the Local Teams Work**

### **Local Team Facilitators**

Each Local Team will have a part-time facilitator to support it in its role and functions. The job description for the facilitators is outlined on the next page:

## **Definition**

Local Team leaders facilitate and support integrated planning, assessment and service delivery in the local team, and represent their geographical team at the network level.

## **Role and Responsibilities**

- facilitates/coordinates/leads/supports geographical or specialty team:
  - o to develop a cohesive working environment and effective team processes (planning, decision-making) that support the integrated working of multiple organizations in a family-centred approach to service delivery
  - o To guide the planning and collaborative participation of all stakeholders in development of child and family teams, single plans of care to meet practice standards for the team
- key informant re local team capacity and gaps
  - o monitors the local team waitlist and discusses challenges and needs with the clinical director
  - o identifies waitlist and caseload patterns, including the complexity of referrals and the intensity of the rehabilitation required
- primary communications, documentation and problem-solving link between CTN Clinical and Access Directors and local teams
- local team space oversight;
  - o monitors equipment utilization and sources out purchasing requirements
- tracks educational needs of the local team and arranges local continuing educational opportunities
  - o orient new local team members
  - o plays a role in training and support for the clinical guidelines/practice model
- represents local team at system level, working closely with the CTN Clinical Directors and other team leaders to facilitate access and reduce duplication across the network
- contact for specialty services

### ***The local or specialty team leader does not:***

- *manage or supervise staff*
- *assume accountability for local team*
- *assign responsibility or resources*

## **Skills and Characteristics:**

It is preferred for the local team leader to have a minimum of 5 years experience in a related role, with experience across the preschool and school age population.

- models the values and beliefs of the integrated model, including respect for all team members and families
- Professional human services background and experience with children with multiple disabilities
- is a skilled facilitator, negotiator and communicator
- has some experience with coordination between agencies and/or sectors
- has a broad knowledge base of the local stakeholders and some experience with self-directed teams
- comfortable with change management and conflict resolution

## **Key processes and tools**

The local team leaders are supported in their role, within this integrated model of service delivery, by the following:

- Coordinated access mechanism and service navigators
- common practices and guidelines for service coordination, child and family teams
- clinical software application that provides an electronic client record and supports the single plan of care
- CTN communication tools
- local team space equipped to support activities of the local team
- clinical directors
- CTN research and evaluation framework that assists the team in identifying its strengths and guides development

A process for selecting Local Team Facilitators has been undertaken as agreed by the Reference Implementation Group. The following candidates have been selected:

Local Team	Identified Local Team Facilitator
<b>Simcoe County</b>	
Barrie	Leanne Weeks
Orillia	Paul Leishman
Midland	Angela Paylor
Collingwood	Karen Vanderbrug
Alliston	Debbie Bushby
<b>York Region</b>	
Cross Border	Vicky Merrilees
Georgina	Kim Thorne
Markham	Kari Renahan
Oak Ridges	Jane McLellan
Vaughan	To Be Determined

### iii. Local Team Sites

**What is the geographical make up of the Local Teams?**

Local Teams	Towns/cities	Local Team Sites
<b>Simcoe County</b>		
<b>Barrie Area</b>	Barrie	Common Roof site in Barrie
	Essa	
	Innisfil	
	Oro-Medonte *	
	Springwater *	
<b>North Simcoe</b>	Christian Island	
	Midland	CLH building 12/06
	Penetanguishene	
	Tay	
	Tiny	
<b>Orillia Area</b>	Mnjikaning First Nation (Rama First Nation )	
	Orillia	In discussion with OSMH
	Ramara	
	Severn	
<b>Collingwood Area</b>	Clearview	
	Collingwood	In discussion with E3, CHC
	Wasaga Beach	
<b>South Simcoe</b>	Adjala-Tosorontio	
	New Tecumseth (Alliston)	In discussion with CLASS
<b>Cross-Border, Simcoe/York</b>		
<b>Cross-Border</b>	Bradford West Gwillimbury	
	Newmarket	TBD
	East Gwillimbury	
<b>Region of York</b>		
<b>Georgina</b>	Georgina	RL Graham PS, Keswick (Jan07)
	Georgina Island	
<b>Richmond Hill Area</b>	Aurora*	
	Richmond Hill	Oakridges – Resource Centre 02/07
<b>Markham Area</b>	Markham	TBD
	Whitchurch-Stouffville	
<b>Vaughan, King</b>	King	
	Vaughan	In discussion with CHC

- These areas may split halfway to another team
- Several areas will have cross-border connections with other areas

#### iv. Managing Relationships and Accountability

Working in a collaborative environment with partners requires clarity about who is accountable to whom for what. There needs to be a clear distinction between the employer-employee relationship between staff and their home organization, and the mutual accountability we share as members of the Network, and local teams.

This table sets out the parameters for these accountabilities:

	Agency Supervisors	Local Team Facilitators	Specialty Service Facilitators	CTN Clinical Directors
<b>Employee-Employer Contractual Relationship</b>	Hire/Supervise according to Employment contract: vacation, sick time, salary, benefits	N/A	N/A	N/A
<b>Supplies</b>	Office supplies and <ul style="list-style-type: none"> <li>• Desk, Phone</li> <li>• Travel</li> </ul>	Local Team site: <ul style="list-style-type: none"> <li>• Office supplies</li> <li>• Clinical supplies &amp; equipment</li> <li>• Drop down space</li> </ul>	Specialty Service Supplies	Purchase orders and budget for supplies and equipment
<b>Professional or College Requirements</b>	College certification	Clinical educational needs; both group and individual mentoring	Education requests – group and individual mentoring	Approve requests for funding for training
<b>Service Delivery Practice Standards</b>		CTN service delivery protocols; standards of practice; electronic documentation*		<ul style="list-style-type: none"> <li>• Clinical standards &amp; practice model</li> <li>• CTN policy and procedures</li> </ul>
<b>Workload Assignment</b>	Caseload composition and size	N/A	Criteria for specialty service eligibility and wait list	
<b>Team Functioning</b>	Team conflicts	Team building/ meetings/orientation		Hire team facilitators
<b>Program</b>		Parent, child and youth group development		
		Local community engagement		
		Interpretation services		
<b>Information System</b>	Computer, email, web access, software installation	Feedback: re clinical software		<ul style="list-style-type: none"> <li>• Goldcare System administrator</li> </ul>

## **4. Overview of Service Delivery**

### **i. Service Description for Service Coordination**

The goal of service coordination is to optimize family functioning and promote healthy child development by providing quality, integrated services in the most efficient, effective manner to families.

#### **Definition**

Service coordination is a family centered process that enables families, service providers and informal supports to plan, coordinate and monitor a comprehensive individualized Single Plan of Care. It facilitates the achievement and maintenance of a quality of life consistent with the family's values, priorities, strengths and preferences.

Service Coordination takes a lead role in establishing links among service providers and informal supports, across all systems: health, education, social services, financial resources, recreation, transportation, housing, etc. and guides the overall implementation of the individual Single Plan of Care, in consultation with the other team members. Families can be their own service coordinator, they can share that role with another team member, or they can request that a team member be the service coordinator.

#### **Principles of Service Coordination:**

1. Single point of contact, helping families to coordinate care and continuity across systems and time. If there is more than one coordinator, one will be designated lead.
2. Promotes and safeguards interest and well being of children and families.
3. Respects the family's dignity, rights, values, priorities and preferences.
4. Empowers families in determining their needs, vision, goals and the resources they require.
5. Supports effective, collaborative and respectful communication with all individuals involved.
6. Is sensitive to differences in culture, background, religion, and physical and cognitive development.
7. Supports a focus on existing community-based services, recognizing the least restrictive alternatives, minimal intervention, and the use of informal supports.
8. Supports a focus on a holistic approach that recognizes the uniqueness of each individual's needs and strengths.
9. Supports accessibility to a wide range of community supports, assuring children and families are offered the services they require.
10. Provides continuity, consistency and coordination of supports across all service sectors.
11. Ensures confidentiality and obtains repetitive informed consents from the family in accordance with respective agency policies.
12. Complies with the Duty to Report, in Section 72 of the *Child & Family Services Act*.
13. Minimizes duplication of assessments and services.
14. Embraces a practical, evidence-based approach to the delivery of health and social services that is responsive to changes, to ensure quality care and outcomes.

15. Ensures that the service coordinator is free of conflict of interest.

## **Service Coordination Processes**

Service Navigation occurs at CTN Access when service navigators complete the initial intake interview and ensure the family of children with multiple needs is connected appropriately to a service coordinator in the appropriate local team. Service Coordination begins when two or more service providers are or need to be involved with an individual or family to develop and coordinate a single plan of care. The first service coordinator receiving the family from Access will assume the temporary service coordination role, and will begin the Initial Plan for Assessments and Services (IPAS), until an ongoing service coordinator is selected. Roles for the temporary and ongoing service coordinator are contained within this document.

The role of Service Coordination is the planning and coordination of services. The intensity and type of service coordination varies based on the child and family's characteristics and changes with variable needs, within the context of their environment. Responsibility for service coordination may be shared with the family and other service partners, but a lead will always be determined. This responsibility may include any or all of the following elements:

1. **Identification in Access:** Identification and engagement takes place after the initial screening or referral in Access. When sufficient eligibility is determined, the client record will be opened. Information sharing, obtaining consent and establishing a relationship occur at the time of engagement, and during the bridging between service navigators in Access, and service coordination at the local teams.
2. **Assessment:** An overview of the family's physical and emotional health, values, cognitive status, functional status, coping abilities, resources and environmental conditions occurs for planning purposes. This overview provides information, from which the family's strengths, supports, resources, needs, limitations are determined. The Service Coordinator works with the family to identify and prioritize their visions for the future for their child and family. Assessment of risks and identification of crisis intervention and prevention strategies are key considerations in the assessment function. The initial assessment is documented in the Initial Plan of Assessment and Services (IPAS).
3. **Accessing Resources & Linking:** When the visions have been determined, professional and informal resources, including family, friends and community are considered. The service coordinator sets in motion the network of service providers who will work together with the family as a child and family team during the assessment process and for treatment where applicable. This network will also include CTN Specialty Services and Tertiary Resources. Families are helped to recognize their strengths and supports thus empowering them to be an active partner in the linking of resources.
4. **Goal Setting, Service Planning and Transitions:** The child and family team's assessments provide the framework for the determination of the Single Plan of Care

(SPOC). Service Coordination involves conferencing with the team to align all goals with the family's prioritized visions. As much as possible the service coordinator and team work together to develop common, multidisciplinary goals and activities to create a manageable plan for the family. The planning process will be iterative, to accommodate changes in needs, and particularly to prepare for successful transitions at key stages of development.

5. **Service Implementation & Coordination:** Implementation of the Single Plan of Care is facilitated by the service coordinator together with the family. Conferencing with service providers, implementing the Single Plan of Care, and mobilizing the family's supports are essential. Communication, coordination, and prevention of duplication are pivotal to the efficiency of the Plan implementation and achievement of outcomes. Maintenance of systematic records supports ongoing assessment and monitoring throughout. Families may wish to act as the service coordinator or they may choose the person from an agency most involved to be the service coordinator; however, responsibility for maintaining the electronic client record must be assigned. It is the primary responsibility of the service coordinator to ensure a smooth transition between service coordinators, particularly at transition times, or when a large number of team members are changing.
6. **Monitoring & Reassessment:** The service coordinator will monitor the Single Plan of Care with the family. The plan is reviewed and adjusted in response to changes in the child and/or family's needs and strengths. For active children, team meetings occur at a minimum of twice a year at predetermined times or at crisis or transition points depending on a family's needs.
7. **Advocacy:** Advocacy has two facets. It includes intervention on behalf of the client to obtain current resources in partnership with family and family's consent. Advocacy also may seek change in the system or add resources. Advocating for the client includes the responsibility to identify and communicate the gaps in the system. Encouraging community development, outcomes based on research, participation in social action for program refinement, and ongoing education may be involved.
8. **Supportive Counselling:** The service coordinator would provide support, encouragement, counselling and feedback to enable families to realize their visions and facilitate problem solving. Access of the Social Work specialty resource or other network counselling providers may be required as appropriate and would be facilitated by the service coordinator.
9. **Evaluation & Outcomes:** A planned evaluation of the process and follow-up in relation to the client's satisfaction, goal attainment and *Single Plan of Care* efficiency is done. The service coordinator should consider evaluation of the client service and the overall system to help identify and report any gaps or barriers.
10. **Discharge, Transition Planning & Disengagement:** Collaboration and negotiation occur among the families, the service providers, informal supports and service coordinator, to determine the needs for further services based on the priority needs/goals met. When service needs are expected to be lifelong, this includes

significant transition planning with other sectors, including adult systems, to be initiated when the child is 14 years old. Some families may require a separate discharge meeting to review progress, identify any unresolved issues, and make recommendations and closure.

When only one service provider is required for support, the family can be discharged from the service coordination process.

## **Procedures:**

### **1. Identification in Access:**

- Service Navigator determines if there is a service coordinator in place and makes contact with the service coordinator to highlight the family's concerns and requests
- ACCESS identifies the priority for Service Coordination, thru levels 1 – 4; level 5 = Case Coordination; this level of service coordination support would only be referred from child and family teams
- ACCESS will use the following guidelines to transfer the families for service coordination. It is recognized that all service coordination agencies should have the capability to assume any child, but that each agency has expertise with certain areas of need:
  - Early Intervention Programs -- preschoolers
  - CCAC -- medically fragile with instability
  - Developmental Services Agency – school aged children with cognitive concerns
  - School Boards -- access to school curriculum issues
  - Mental Health Agencies – mental health issues affecting the child and/or family; child protection issues
- ACCESS would identify if the family will require interpretation services for Service Coordination
- Service Coordination agency accepts referral and assigns Service Coordinator before Service Navigator transfers client
- All documentation collected at ACCESS is transferred to the Service Coordinator

### **2. Assessment:**

- The service coordinator is contact with the family either over the phone, in person, or with an Initial Service Planning Team to review the information collected at ACCESS
- The service coordinator explains the assessment process and the role of the service coordinator to the family
- Family is offered the choice of coordinating services on own or with the support of the service coordinator
- Initial vision statements are developed by the family with assistance from the service coordinator where required
- Through analysis of these visions, the family and service coordinator identify who else needs to be involved in the Child and Family's Single Plan of Care

- The service coordinator has the family sign consents to include the identified network provider agencies in to the circle of care; for sharing information and planning purposes
- The service coordinator conducts their own assessment around supports that may be required for social services, finances, recreation, etc. and aligns them with the family visions and makes recommendations. If these visions are deemed a priority for the family, the service coordinator may develop some short term goals to address these needs.
- If the service coordinator finds they are not the most appropriate service coordinator or does not have the capacity to take on the enhanced service coordinator role, they would negotiate and plan a transfer of care with another service coordinator/service coordinator agency
- Family is provided with a Canchild Family Kit
- All information is documented in the Initial Plan for Assessment and Services

### **3. Accessing Resources & Linking:**

- The service coordinator contacts the service provider agencies electronically (those that are linked to CTN) to inform them of a need for assessment and provides the family's Initial Single Plan of Care in which the family visions are documented
- The service coordinator will facilitate the transfer of information from Bloorview Kids Rehabilitation, Sick Kids and other tertiary/specialty medical services through parental consent
- The service coordinator will electronically alert Specialty Services and connect with the Specialty Team Facilitator of a child requiring service when deemed beyond the scope of the local team providers

### **4. Goal Setting & Service Planning:**

- Service Coordinator sets the date, time, location and agenda for the Single Plan of Care meeting and invites appropriate members of the child and family team
- Service Coordinator phones family before Single Plan of Care meetings to determine what family wants to achieve/communicate/learn/share at meeting
- Service Coordinator chairs the Single Plan of Care meeting. Gathers reports/update information from team members who will not be attending and makes that information available at meeting.
- Service Coordinator ensures that all recommendations identified by the providers align with the family visions
- Service Coordinator ensures that the families priorities are heard
- Service Coordinator may need to work with the family ahead of this meeting to discuss their visions and frame them in such a way that is meaningful to the family and the team
- Service Coordinator challenges the team to develop common activities to address multiple goals
- Service Coordinator is responsible for the documentation and dissemination of the Single Plan of Care

## **5. Service Implementation & Coordination:**

- The Service Coordinator updates the Single Plan of Care (visions, recommendations, follow-up assignments with who is responsible, SMART goals, timelines)
- Service Coordinator is responsible for engaging other network providers as identified and educating the entire child and family team on the Single Plan of Care
  - Service Coordinator contacts the family either face to face or by phone:
    - To ensure they understood what was said, done, decided,
- To ensure integration/follow through of plans (strategies/techniques) into the home.
- With family agreement, Service Coordinator carries out ongoing implementation of recommendations relative to SC role, e.g., complete funding applications, relay/review therapeutic intervention, equipment use, liaise between non home based service providers and home if required (e.g., school)
- The service coordinator may attend appointments with families when required, particularly when they are responsible for the communication or follow up from these appointments back to the team (e.g. of cases where this may be required may include ESL families, parents with mental health or developmental issues)
- See priority tool for service intensity guidelines

## **6. Monitoring, Reassessment & Transitions:**

- It is the responsibility of all child and family team members to adhere to the SPOC. As activities and goals change, the team must be aware of the impact on the overall plan and should take responsibility for calling a Planning Meeting when it is felt that too many changes have occurred and the plan is beginning to feel fragmented. The Service Coordinator is recognized as the lead in this process.
- Recommended frequency of Single Plan of Care meetings:
  - i. Inactive children = mail out/contact in anticipation of key transition points. Families would be directed to contact ACCESS to be re-interviewed, prioritized and directed to the most appropriate service coordination agency. The ideal would be if the previously assigned service coordinator could be utilized.
  - ii. Active children = dependent on number and frequency of changes to the SPOC. Level 4 children are likely to require a minimum of 2 SPOCs annually. SPOC changes are anticipated for the following and would, therefore, likely require a meeting:
    1. Transition Points
    2. Assessments/reassessments by Specialty or Tertiary Services.
- If the service coordinator finds they are not the most appropriate service coordinator as the child's needs and family visions change, they would negotiate

and plan a transfer of care with another service coordinator/service coordinator agency

#### **7. Advocacy:**

- Client gaps would be addressed with the child and family team; gaps in the child and family team would be identified and the service coordinator would assist the team to engage in new team members from the local team
- Gaps and/or barriers at the local team would be brought to the attention of the Local Team Facilitator to leverage services from another team if possible
- System gaps and/or barriers and possible solutions would be reported to Local Team Facilitators
- Facilitators will bring these issues to the CTN Clinical Directors during their regular team meetings
- CTN Clinical Directors would discuss with individual agencies or the Advisory Forum of York Region or the Simcoe County Coalition for solutions and support

#### **8. Supportive Counselling:**

- Service Coordinators can only offer counselling within their scope of practice.
- Clinical counselling should be arranged by the Service Coordinator thru the CTN Social Work services of a network partner.

#### **9. Evaluation & Outcomes:**

- Service Coordinators will be involved in CTN outcome initiatives, including the research study, parent satisfaction tools, etc.

#### **10. Discharge, Transition Planning & Disengagement:**

- To ensure a new service coordinator is assigned and a smooth transition planned when the current service coordinator involvement is ended and the family still requires further services.
- The service coordinator may need to go back to Service Navigation for guidance if their agency is no longer considered the appropriate provider or has the capacity at the given time

### **Identifying a Lead Service Coordinator**

#### **Rationale**

- evidence suggests that a lead professional is central to the effective delivery of integrated services to children who require support from a number of providers
- establishing a lead helps to overcome some of the frustrations in dealing with lack of coordination, numerous lengthy meetings, conflicting and confusing advice, not knowing who needs to talk to whom, not being able to identify the right support/right place/ right time

#### **Goal**

- All children who are receiving support from more than one practitioner receive a needed amount of service coordination.

- Children who are receiving service coordinator/case management from more than one person will have one practitioner who takes a lead role to ensure that services are coordinated, coherent and achieving intended outcomes.

**Core functions of the lead service coordinator:**

- to act as a single point of contact for the child or family
- to coordinate the delivery of actions agreed by the practitioners involved
- to reduce overlap and inconsistency in the services received

The lead is:

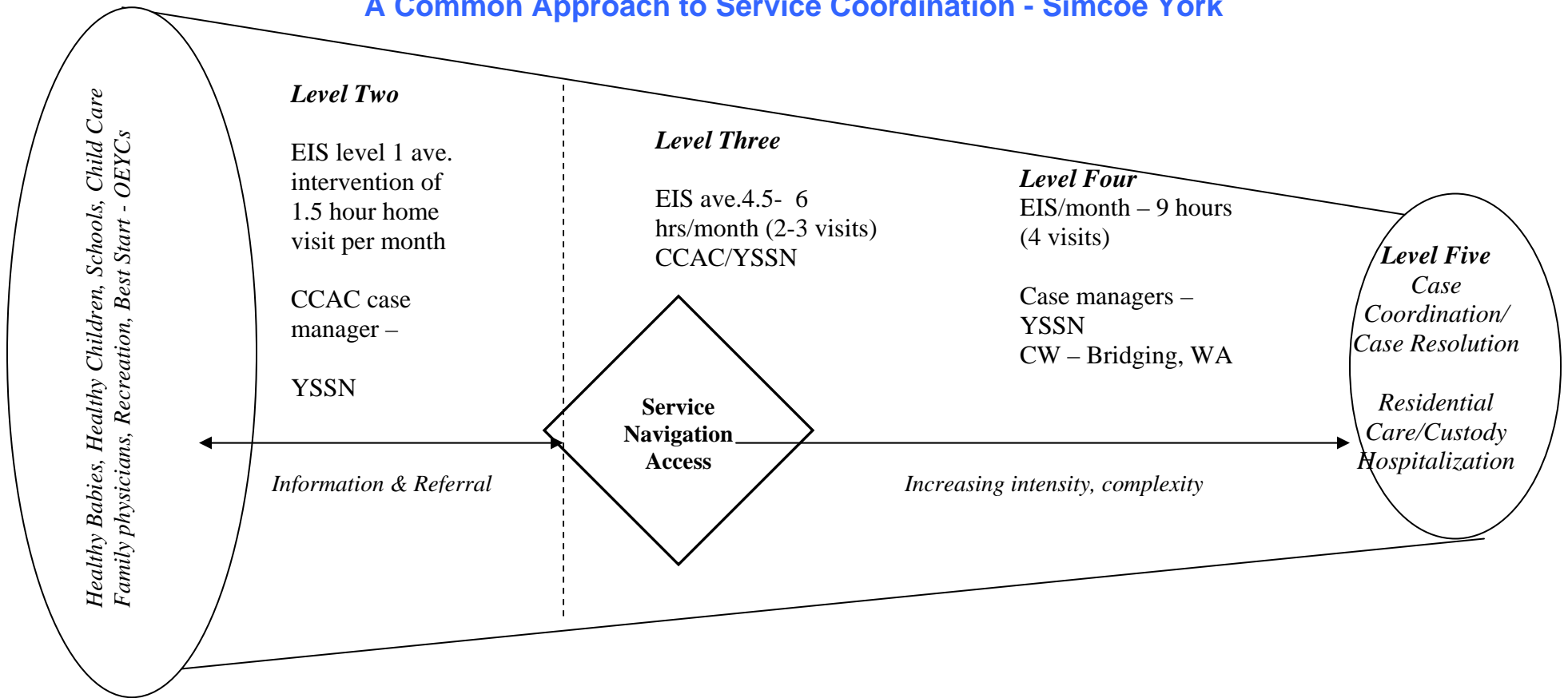
- selected from among any of the people currently involved
- should be the practitioner most relevant to the action plan, or who has the most appropriate skills
- not necessarily the first person to be involved
- determined as part of the assessment and planning process with the child & family team, and as trust and relationships are established
- based on criteria established in the local teams to avoid confusion in understanding the roles various members play.

**Criteria for determining the lead:**

- the predominant needs of the child/family
- level of trust established with the family
- the family's wishes
- primary or mandatory responsibility in the situation – e.g. CAS
- the skills/ capacity of the practitioners involved.

When a lead service coordinator is no longer needed (e.g. a 'regular' EI or CCAC case manager is sufficient to coordinate services), the lead SC role could be terminated/transferred to the regular EI, with flags in place to watch for needs that may intensify again.

## A Common Approach to Service Coordination - Simcoe York



Level One	Level Two	Level Three	Level Four	Level Five
Children appear to be developing typically; screening or monitoring may occur within universal service	Low level of concern that may require a brief engagement for a specific purpose, e.g. referral to educational groups	Medium level of concern for child, lower for family; increased level of individual intervention; ongoing SC required	High level of concern for child & family; highest level of intervention, consistent level of SC	Case Coordination, case resolution; Short term intensive or crisis intervention - specialized

<b>Level One</b>	<b>Level Two</b>	<b>Level Three</b>	<b>Level Four</b>	<b>Level Five</b>
<p>Typical Development</p> <ul style="list-style-type: none"> <li>- Mild concerns can be addressed through group education with parents, screening and monitoring by child care workers or teachers, dissemination of normal child development materials (Let's Grow)</li> <li>- Health Unit use of Nippissing and ASQ</li> <li>- Red Flags for 0-6;</li> <li>- In-school teams can problem-solve sufficiently</li> <li>- COMPASS teams</li> </ul>	<p>Child has Low Needs</p> <ul style="list-style-type: none"> <li>- Child and/or family at risk of poor outcomes</li> <li>- Family requires minimal support (although child may have higher needs) and is the primary service coordinator themselves</li> <li>- Barriers to accessing services</li> <li>- Mild delays in development</li> <li>- Non-entrenched problems with behaviour that require some direction and education</li> <li>- Concerns with diagnosis, attachment, transitions</li> <li>- Feeding and mobility issues</li> <li>- Family is isolated with lack of support</li> <li>- Services needed not available or long wait</li> </ul>	<p>Child has Moderate Needs</p> <ul style="list-style-type: none"> <li>- Developmental delays, atypical disorders or more significant physical challenges to functioning</li> <li>- ABI</li> <li>- Sensory impairments</li> <li>- Behavioural issues</li> <li>- Social emotional or CW stability issues</li> <li>- Abuse or FASD issues</li> <li>- Family may have low to moderate needs</li> <li>- Multiple providers on team requiring service coordination support and monitoring to establish and sustain single plan of care</li> <li>- Significant ESL issues</li> </ul>	<p>Child has High Needs</p> <ul style="list-style-type: none"> <li>- medically complex and/or tech dependent</li> <li>- ABI/illness/trauma</li> <li>- Deteriorating, unstable or rapidly changing conditions (child or family)</li> <li>- family unable to parent (housing, illness)</li> <li>- Sensory impairments</li> <li>- Behavioural issues</li> <li>- Developmental or Dual diagnosis</li> <li>- Family needs are moderate or high</li> <li>- Multiple providers on team need active, more intensive service coordination and facilitation to develop or sustain single plan of care</li> </ul>	<p>Very High Needs</p> <ul style="list-style-type: none"> <li>- both child and family have high needs and require highest level of intervention</li> <li>- safety issues</li> <li>- At risk of OPR or residential placement</li> <li>- In-hospital and requiring a plan for re-entry to community</li> <li>- Existing team and service coordinator works closely with Case Coordinator, Tertiary partners or CW to manage crisis or new plan or placement and to establish a transition plan</li> </ul>

## **Principles to Guide Decision Making for the Transfer of children between Network Therapists and or Organizations/Agencies**

**When deciding who should provide service to a child consider the following:**

- **Longevity of service need**--Are this child's and family's needs of a long term nature and would they be best served by CTN and a single plan of care
- **Presence of Physical Disability** – consider the transfer to a CTN caseload when the child has a physical disability and will have intermittent needs and will, or may, require periods of intense service beyond the mandate of most children's service agencies
- **Provide Continuity of service** would a transfer now cause undo stress to the child and family or cause a significant deterioration in function—attempt to maintain continuity of service for as long as is reasonable.
- **Least Disruption to Family**-- determine what else is going on in the child and family's life. Is this a natural time to transfer?
- **No Disruption of Service**--Child and family should not be without service during the transition when to do so would cause a significant deterioration in function.
- **Child and Family Team**--Who is already involved with the child and family? By transferring or not transferring are we unnecessarily expanding the team to include additional members/agencies?
- **Environmental Fit** –Who is the service provider best positioned to address needs in a specific environment, for example, home versus school.
- **Efficiency**—consider who is best able to provide service given distance, presence of other clients, relationship with existing team partners, processes in place
- **Expertise**—does this child require a specific level of expertise and/or skill? By transferring would we build skills in other providers or would the child be put at a significant disadvantage.

### **ii. Single Plan of Care (SPOC)**

#### **Implementing High-quality Collaborative Individualized Service/Support Planning: Necessary conditions**

Adapted from: Janet S. Walker, Ph.D., Nancy Koroloff, Ph.D., Kathryn Schutte, M.S.  
September 2003

Research and Training Center on Family  
Support and Children's Mental Health

In recent years, communities across the country have responded to the multifaceted needs of children with complex developmental disorders by using a variety of creative approaches for coordinating, designing, and delivering services. One popular approach is the use of collaborative Individualized Service/Support Planning teams (ISP teams). The ISP team members—the identified child/youth, parents/caregivers and other family and community members, mental health professionals, educators, and others—meet regularly to design and monitor a plan to meet the unique needs of the child and family. The planning process itself, as well as the services and supports provided, are intended to be individualized, family centered, culturally competent, and community and strengths based. In different communities, ISP teams are known by a variety of

different names, such as wraparound teams, family networking teams, child and family teams, and so on.

Among those who advocate and practice team-based ISP, there is a good deal of agreement about the definition of the team. There is also a consensus about the value base for ISP. Advocates and practitioners agree that the ISP process itself—as well as the plans produced through the process—should be individualized, family\* driven, community and strengths based, and culturally competent. This approach has been contrasted to traditional forms of service delivery, which have often been experienced by families as professional driven, family blaming, deficit based, and lacking in respect for the family's beliefs and values.

Achieving quality implementation of team based ISP has proven to be challenging. One set of challenges arises from the lack of a shared model of practice for ISP. Despite the consensus about the value base of ISP, there is little agreement regarding exactly how this value base should be translated into practice at the team level. As a result, there has been no formal definition of the techniques, behaviors, or procedures that make up the ISP process. This has led to a wide variety of practice models, many of which appear to be inconsistent with the original approach for ISP service delivery.

Other challenges to high quality implementation arise from the larger context within which ISP teams work. Practical experience has shown that achieving meaningful change at the service delivery level requires extensive support from the organizational level, as well as from the system level\*\* (or policy and funding context).

#### Team, organization, and system

A team is defined as the caregiver and youth and at least two or three other consistently attending core members from the list above who are charged with creating and implementing plans to meet the needs of the family and child. This core \* Service providers include human service professionals (e.g. care coordinator, child therapist, school psychologist, teacher, child welfare worker, probation officer) as well as professionals and volunteers who provide services to the community (judo teacher, scout leader, pastor). Team, organization, and system team may be supplemented as necessary by others who attend when their role in the plan is under consideration or when their input is invited.

At the organizational level, the picture becomes somewhat more complicated. We find it useful to distinguish between two roles that organizations or agencies can play relative to ISP teams. In the first role, an agency takes the lead in the ISP implementation, and is responsible for hiring, training, and supervising team facilitators. This agency may also provide training for other team members with specialized roles, such as family advocates or resource developers. In the second role, an agency acts as a partner to the team-based ISP process by contributing services, flexible funds and/or staff who serve as team members. Communities have developed a variety of strategies for distributing these roles across different agencies. In some systems, one agency may cover aspects of both functions (for example, when a therapist is also the team facilitator), whereas in other communities, the ISP model specifies that these roles should not merge. Furthermore, elements of the lead and partner roles may be divided up between different organizations or agencies in

different ways. Our conceptual framework stresses the importance of the lead agency's role because we see facilitation as a key to the team-based ISP process. We view the training and supervision of facilitators as requiring a level of understanding of, and support for the team-based ISP process that is substantially greater than that required of agencies that act primarily in the partner roles.

We use system level or policy and funding context to denote the larger service policy and economic context that surrounds the teams and team members' agencies. The system level is made up of multiple organizations that may focus on a specific set of services (e.g. mental health), a geographic area (e.g. county), population (e.g. children), or a combination of these. The policy and funding context may also include multiple governmental entities at the county, region, or province, as well as other organizations that set policy, monitor or enforce policy, or interpret state or national policies to local service providers. The system level also includes any body that has been constructed to oversee the development of the service system or to manage funds that have been pooled. The policy and funding context varies from community to community but at the very least will include those individuals and bodies that make decisions regarding policies and procedures and the allocation of resources that affect the functioning of the lead agency (or agencies) and by extension, the teams.

#### Configurations of support

At the level of least support from either organizations or systems, we have observed some teams that function for extended periods of time independently of any ISP program. These independent teams are unsupported by any formal arrangements at the organizational or system level. However, these independent teams tend to struggle, often unsuccessfully, to access and fund desired services and supports. Often they find they must either provide services/supports themselves or prevail upon sympathetic contacts in various agencies to make exceptions and bend rules. Team members on independent teams are often highly stressed by their continual efforts to work around existing policies and providers, as well as the need to negotiate multiple barriers to services and funds. Families also tend to be highly stressed due to continual uncertainty. Over time, these teams are not likely to have a significant impact on the agencies or systems with whom they interact, and so the stress experienced by team members does not decrease. Without any organizational or system support, independent teams have difficulty sustaining their work over time, and stimulating the creation of multiple independent teams does not seem like a viable means of systematically meeting the goals of children and families with high levels of need. We thus regard indifference on the part of organizations and systems—as is usually experienced by the independent teams—as insufficient to support high-quality ISP.

At the team level, there appears to be less stress on the families in the single-agency program model than in the independent team model; however, relatively greater stress generally falls on the care coordinators who are constantly negotiating exceptions with counterparts in other agencies and systems. What is more, single agency programs, while capable of having a significant positive impact on a small number of families, may be quite limited in terms of the number of teams they can support. For example, because there tends to be no restructuring of jobs in partner agencies to accommodate teamwork, team members from those agencies—or those in private practice—must donate their services to teams. As the number of teams in a community grows, it becomes

increasingly difficult for the lead agency to find people who are willing to assume—on top of existing job responsibilities—the considerable efforts that can come with participation on ISP teams. In the absence of a larger community effort to build capacity, increasing the number of teams at a given agency may quickly exhaust community capacity to provide desired support.

Most teams and programs appear to exist in a context of somewhat higher levels of system support, particularly in the context of newly developing systems of care. Often, these nascent systems of care have developed formal interagency agreements recognizing teams and providing pools of funds that can be used flexibly, as well as interagency committees which meet to problem solve or to create policies supportive of ISP teamwork. Ironically this situation can at times be even more stressful for team members, and particularly for care coordinators and families. This appears to be especially likely when the lead agency is also newly created and/or when the ISP program has been adopted as part of efforts at systems reform that have shaken up multiple agencies. In these cases, the care coordinators are subject to the same stresses as in the single-agency model, except that their power to elicit cooperation from partner agencies may be decreased (due to the agency's lack of well-established reputation and relationships with peer and system-level allies) while resistance to their efforts from partners may well increase (due to defensiveness on the part of peers in partner agencies which have also been swept up in the efforts to reform the system). Family members may experience high levels of stress due to uncertainties and difficulty in accessing services, supports, and funds to meet unique needs. Lead agencies in these circumstances may experience rapid turnover among care coordinators, and consequently the capacity for high quality ISP may never develop. On the other hand, strong, well-established agencies with clear models of ISP practice appear to be able to survive, and even thrive in conditions such as these. In general, however, ISP programs with tenuous, newly developing and/or only nominal system support appear to be quite vulnerable to turnover among system-level allies and to changes in funding arrangements.

High quality work in ISP cannot succeed where support is lacking from organizations and from the policy and funding context.

Overview of this report

#### TEAM LEVEL ORGANIZATIONAL LEVEL POLICY AND FUNDING CONTEXT (SYSTEM LEVEL)

i. Team adheres to a practice model that promotes effective planning and the value base of ISP.

Sub-conditions of practice model 1-7

i. Team members capably perform their roles on the team.

i. Team is aware of a wide array of services and supports and their effectiveness.

ii. Team identifies and develops family-specific natural supports.

iii. Team designs and tailor services based on families' expressed needs.

i. Team maintains documentation for continuous improvement and mutual accountability.

Accountability

Appropriate people, prepared to make decisions and commitments, attend meetings and participate collaboratively.

Capacity building/staffing

Acquiring services/supports

## Collaboration/partnerships

- i. Lead agency provides training, supervision and support for a clearly defined practice model.
  - ii. Lead agency demonstrates its commitment to the values of ISP.
  - iii. Partner agencies support the core values underlying the team ISP process.
- 
- i. Lead and partner agencies collaborate around the plan and the team.
  - ii. Lead agency supports team efforts to get necessary members to attend meetings and participate collaboratively.
  - iii. Partner agencies support their workers as team members and empower them to make decisions.
- 
- i. Lead and partner agencies provide working conditions that enable high quality work and reduce burnout.
- 
- i. Lead agency has clear policies and makes timely decisions regarding funding for costs required to meet families' unique needs.
  - ii. Lead agency encourages teams to develop plans based on child/family needs and strengths, rather than service fads or financial pressures.
  - iii. Lead agency demonstrates its commitment to developing culturally competent community and natural services and supports.
  - iv. Lead agency supports teams in effectively including community and natural supports.
  - v. Lead agency demonstrates its commitment to developing an array of effective providers.
- 
- i. Lead agency monitors adherence to the practice model, implementation of plans, and cost and effectiveness.
- 
- i. Leaders in the policy and funding context actively support the ISP practice model.
- 
- i. Policy and funding context encourages interagency cooperation around the team and the plan.
  - ii. Leaders in the policy and funding context play a problem-solving role across service boundaries.
- 
- i. Policy and funding context supports development of the special skills needed for key roles on ISP teams.
- 
- i. Policy and funding context grants autonomy and incentives to develop effective services and supports consistent with ISP practice model.
  - ii. Policy and funding context supports fiscal policies that allow the flexibility needed by ISP teams.
  - iii. Policy and funding context actively supports family and youth involvement in decision making.
- 
- i. Documentation requirements meet the needs of policy makers, funders, and other stakeholders.

## Team level

i. Team adheres to a practice model that promotes team cohesiveness and high quality planning in a manner consistent with the value base of ISP. Individualized Service/Support Planning teams face a variety of challenges in accomplishing their work. Like other teams involved in complex long-term planning, ISP teams need to overcome numerous challenges related to the “generic” tasks of teamwork. If any team is to be successful, its members must be able to select appropriate goals, devise high quality solutions to problems, avoid destructive conflict, maintain confidence in the team’s efforts, and so on.<sup>21,44</sup> In addition to these generic challenges of teamwork, ISP teams face a series of additional challenges that are more specific to the ISP process. These challenges arise because ISP specifies that team plans—as well as the planning process itself—should be individualized, family centered, and culturally competent. ISP teams are further required to create plans which build on the strengths and assets of the team, the family, and the community.

In this section, we describe the types of knowledge and skills that team members must possess if they are to overcome these challenges and work together effectively. The discussion throughout this section is based on the model of ISP team effectiveness.

## ISP Team Processes

### Planning

. The planning process prioritizes family/youth perspective and includes attention to

- Defining team mission\* and goals\* with associated strategies and performance criteria.\*
- Exchanging information,\* broadening perspectives,\* and generating multiple options before making decisions.\*
- Continually evaluating\* and revising\* goals and strategies.

### Building cohesiveness

. Team members build shared perceptions that

- Team members hold goals\* and values\* in common, including the values associated with ISP (cooperativeness)
- The team can be effective\* and ISP is an effective intervention (efficacy).
- The team follows fair procedures during discussion and decision making\* (equity).
- Team members are respected, even when they disagree or make mistakes\* (psychological safety).

ISP Outcomes Team achieves appropriately ambitious goals in a manner consistent with the ISP value base.

Increased coordination between services/supports and needs Supportive and adaptive relationships, increased family empowerment and quality of life.

\*These attributes of process have been linked to team effectiveness in studies across a variety of contexts.

The overall condition for high quality implementation of ISP at the team level is that a team adheres to a practice model that promotes team cohesiveness and high quality planning in a manner

consistent with the value base of ISP. This overall condition is quite complex, however, so we have organized the discussion around seven sub-conditions that provide more detail about the types of knowledge and skills that team members need to have in order to maximize the probability that their work will be effective. These sub-conditions are:

1. Team adheres to meeting structures, techniques, and procedures that support high quality planning,
2. Team considers multiple alternatives before making decisions,
3. Team adheres to procedures, techniques and/or structures that work to counteract power imbalances between and among providers and families,
4. Team uses structures and techniques that lead all members to feel that their input is valued,
5. Team builds agreement around plans despite differing priorities and diverging mandates,
6. Team builds an appreciation of strengths, and
7. Team planning reflects cultural competence.

Below, we describe each of these sub-conditions more fully. Ultimately, of course, it is up to the team to adhere to the practice model. As teams carry out their work, different people, with different roles, will take primary responsibility for ensuring that various sub-conditions are met. Facilitation may be the responsibility of a parent, a care-coordinator, or someone who has no other role on the team will take on a good deal of responsibility for ensuring that teamwork is family centered and strengths based.

1. Team adheres to meeting structures, techniques, and procedures that support high quality planning. At its heart, ISP is a planning process. Teams that are effective in complex, long-term planning use a structured process for creating and monitoring their plans. The process moves through successive cycles of setting goals, selecting and carrying out action.

A long-term goal or mission is agreed upon;

- Intermediate goals and observable indicators of progress towards goals are clearly defined;
- Tasks or action steps are linked to intermediate goals, and responsibility for performing each task is assigned;
- Progress on each action, goal and/or sub-goal is monitored and/or revisited in subsequent meetings, and strategies for achieving the goals are altered as needed. Adherence to these structures of good planning helps ISP teams access other avenues to increased effectiveness as well. Further along in this section, the discussion provides clarification of how adherence to these structures can lead to increased ISP team effectiveness by: helping teams turn conflict to constructive ends, providing opportunities to promote the family's perspective, and contributing to cultural competence and the individualization of plans. It is worth emphasizing that these benefits accrue only when the team is united behind a team plan.

2. Team considers multiple alternatives before making decisions. Teams are widely touted for their potential to reach creative solutions to complex problems. However, this potential is often unrealized, and teams may well be less creative and/or less productive than individuals working on the same task. This loss of creative potential appears to come about because team members are often over-eager to commit to the first goal, strategy, or solution that comes up, rather than generating multiple options and then choosing among them. Generating multiple options while

problem solving leads to superior solutions because first solutions tend to be of poorer quality than those generated later. Teams in general appear to be reluctant to adhere to procedures—such as brainstorming—that have been shown to stimulate creative, open-ended thinking.

Teams will need to develop a mindset that will keep them from committing too quickly to the first solution—often a service solution—that comes up. Discipline in generating multiple options also has great potential to increase the extent to which the plan will be family driven and culturally competent. When teams generate multiple options, family members have a greater opportunity to select the option that fits with their own preferences and their own cultural values.

3. Team adheres to procedures, techniques and/or structures that work to counteract power imbalances between and among providers and families. The value base of ISP specifies that the process is to be family centered, with the work of the team being driven by the family's own sense of its strengths, needs, and priorities. The family's choice should also guide decision making regarding the services and supports that will be accessed or developed to serve the team's goals. Plans devised with genuine family input are more likely to have realistic goals, to include creative and flexible strategies, and to engender a sense of family ownership. What is more, when the process is family centered, it is more likely that the plan will be truly individualized, and that it will reflect cultural competence.

Available research indicates that it is likely very difficult to realize this vision of family-driven teamwork. Mental health professionals often demonstrate a reluctance or inability to hear the family's perspective, or to respect the knowledge which families bring to collaboration. This may also reflect a more general dynamic that appears in teamwork. On any team, people of higher social status tend to talk more and have more influence over the decisions that are made. Thus, for example, team meetings are likely to be dominated by men rather than women, by bosses rather than subordinates, or by people with more rather than less formal education. It is very difficult for teams to overcome this sort of imbalance, even when team members are making conscious efforts to equalize participation and influence. On ISP teams, it is not uncommon for family members (particularly youth) to possess relatively few markers of high status. Even where family members have relatively high status outside of meetings, their status within meetings is likely to be deflated because of team members' tendency to see the family in terms of its needs and deficits.<sup>61</sup> As noted above, professionals also tend to have high opinions of their own expertise relative to those of families of children who are experiencing emotional and behavioral difficulties.

If the practice model does not provide teams with specific, concrete guidance about how to redress the imbalances of power between the family/youth and professionals, it is unlikely that the family's perspective(s) will be adequately represented in the planning process. Simple process interventions to increase the number of contributions to discussion and decision making may be effective, but it is likely that teams will need to employ a variety of strategies for increasing family input and decision making at various stages during the planning process. Strategies we have seen in use include providing opportunities for family members to speak first and last during discussions, checking back in with families after any decision, or using a family advocate to reinforce the family perspective as elicited in interviews outside of full team meetings. It is particularly important that the team goals reflect the family's perspective. When the family's strengths, needs, and priorities are codified in the

goals, the team's subsequent work by necessity builds from the family perspective. Obviously, this will not happen if the team has not selected goals, or if the goals are not clearly specified.

Beyond increasing family input into discussion and decision making, the planning process should also provide room for a qualitatively different sort of input from the family by providing opportunities for family members to "tell their stories." Potentially, providing such opportunities can be empowering for families by allowing them to provide a narrative explanation for how current situations have come to pass, and why.<sup>64</sup> The family's views of agency and causation thus become the frame for discussions of future steps. In addition to being inherently empowering, family storytelling can help the team access information that might otherwise be lost in more formal or abstract processes that are part of planning. A family's story can contain important information about hopes, goals, strategies, and resources. In some communities, the family is encouraged to add to their story at each ISP meeting by reflecting on how things are going, while in other communities the bulk of the story is elicited outside of meetings during interviews with a family advocate or care coordinator. Regardless of the specific techniques used, it appears that an ISP practice can be strengthened in important ways when opportunities are provided for family members to speak in an open-ended, narrative way about their experiences.

Beyond merely providing opportunities for the family to assert its perspective, our interviewees stressed the importance of creating a team atmosphere such that family members feel safe to speak openly and honestly about difficult topics, feel comfortable telling their stories, and feel engaged in the ISP process. Of course, it is desirable for all team members to feel psychologically safe and engaged in the ISP process. The discussion below—particularly that contained under the sub-conditions having to do with valuing input, building agreement, appreciating strengths, and reflecting cultural competence—

provides information about how the practice model should guide teams towards creating this sort of comfortable interpersonal environment. However, issues of psychological safety and engagement are of particular importance to the family, and the team needs to practice extra care to maintain the meeting as a safe and comfortable place where families feel valued and supported. Thus, for example, where team members might use techniques of active listening, such as reflecting and summarizing, to help demonstrate valuing of each team member's input, this might be done with greater frequency and deliberateness for input from the family.

4. Team uses structures and techniques that lead all members to feel that their input is valued. Teams are more effective when team members feel that discussion and decision making processes are equitable or fair. It is important to note that equity and equality are not the same. For example, teams may well feel that it is fair (equitable) for a mother to have more (unequal) opportunities than professional team members to speak and to make decisions. Team members are likely to feel that teamwork is equitable when they believe that they are respected, and that their input is valued. When team members' participation is not perceived as equitable, the team's effectiveness tends to suffer due to decreases in creativity and information sharing, and due to increases in destructive conflict. When team members feel that decisions are reached through processes that are not equitable, they are unlikely to feel committed to the decisions and to follow through on tasks.

As was noted previously, teams are often dominated by people with high status, and this can easily lead team members to feel that team process is not equitable. For example, a team's discussions

may be dominated by a psychiatrist or clinical supervisor, and valuable input from a behavioral skills specialist may be lost. Once again, it is likely that these tendencies will continue unless the practice model provides specific information about how to increase equity in participation, and how to make people feel that their input is respected and valued by the team. Teams need explicit guidance from the practice model about techniques to increase team perceptions of equity, not just through counteracting status differences, but through other methods as well. Some examples of team process or techniques that can increase perceptions of equity include: providing opportunities for each team member to give input into decisions; reflecting, summarizing, and/or recording team member ideas or suggestions; and having the team set its own rules or guidelines for how to demonstrate interpersonal respect.

The practice model should also provide specific guidance about how to help ensure that youth team members will feel respected and valued. Existing research offers little information about collaborative teamwork between adults and youth; however there was a strong consensus among team members who participated in our studies that including the youth could be quite difficult. On the other hand, we observed teams that were successful in engaging children as young as nine years old in the planning process. Teams that include the youth in the planning process may well also confront challenges when the youth and other family members disagree.

5. Team builds agreement around plans despite differing priorities and diverging mandates. On effective teams, members believe that their goals are cooperative. This means that team members believe that the actions of each team member serve to advance the goals of all. This does not mean that team members will never be in conflict or have disagreements; on the contrary, controversy is an essential source of creativity and learning on successful teams. Disagreement and controversy are particularly likely to occur on teams, like ISP teams, that have a high level of diversity in background and experience. What is more, on ISP teams, different team members may be responsible for carrying out specific mandates that appear to be contradictory. Our interviewees reported that this can be a source of great conflict on some teams.

In teams and groups, conflicts are less likely to arise, and more likely to be resolved when the team has a clear sense of shared goals. On ISP teams, conflict around the best ways to achieve goals may be decreased when the action steps are clearly linked to the goals. Furthermore, team members—especially those who may be skeptical about a particular goal or action step—need to be able to trust that the team will be pragmatic in evaluating the success of strategies or action steps, and discarding those which are not helping the team reach its goals.

A practice model must provide teams, particularly facilitators, with a variety of specific strategies for dealing productively with conflict and controversy. For example, facilitators should be able to recognize and intervene quickly in “negative process,” 9 cycles of blaming and attacking behaviors which are detrimental to group functioning. Many strategies for harnessing controversy depend on consistently reminding the team of shared goals, and building from there. Where skills in conflict management are lacking, there is a high probability that the team’s effectiveness will suffer.

6. Team builds an appreciation of strengths. The ISP value base stresses that the process should be strengths based. In particular, the strengths of the family and youth are to be built upon. Additionally, the assets of other team members, and of the community, are to be drawn on in the

plan. Research has little to say about whether a strengths orientation impacts team effectiveness; however, there is evidence that the affirmation of strengths can empower low status team members and increase their confidence and participation.<sup>7,19,20</sup> Furthermore, since acting in a strengths-based way is one of the requirements for ISP teamwork, it is important for team members to be able to recognize when they are being successful in practicing the value.

In our observations, we saw teams using several strategies to focus on strengths, especially those of the family. During interviews, a number of team members pointed out that child and family strengths are affirmed when the family is trusted and empowered to drive the ISP process. This is concrete evidence of a team's conviction that the family has a fundamental strength in knowing what to do to take care of itself. Research in other settings has shown that the participation of low status team members increases during teamwork when the team acknowledges specific contributions that the low status members have made to achieving team goals. Despite the strengths activities we observed, and the comments we heard, team members in our studies consistently expressed concern because they were unsure about how to build a strengths perspective into the ISP process. Team members pointed out that it is not easy to design a plan that simultaneously addresses needs and builds on strengths. They also expressed some confusion about the differences between "real" and "fake" or superficial strengths, a distinction that appears in many training materials. Clearly, a practice model for ISP should specify the procedures and techniques that teams can use to assist them in maintaining a strengths perspective.

7. Team planning reflects cultural competence. Each of the sub-conditions mentioned so far is potentially impacted by cultural values and norms. People from different cultural backgrounds may hold different values and make different judgments about, for example:

- what sorts of team procedures and rules will be acceptable,
- what sorts of interactions communicate respect,
- how strengths are defined and how they are talked about,
- how needs are defined and how they are talked about,
- how conflict is expressed and managed, and
- the most important types of goals for a child and family. Team members who hold different beliefs in these areas may have great difficulty working collaboratively together. What is more, cultural differences in values and norms can arise from many sources, and not just from differences in racial, ethnic, or religious background. For example, individual families have their own norms and values; and mental health, juvenile justice, and child welfare workers are imbedded in organizations and work-based interpersonal networks which reinforce their own norms and values. Indeed, the cultural gap between the perspective of professionals and the perspective of families is one that appears regularly in teams, regardless of the degree of the racial, ethnic or religious similarity among team members.

The practice model should provide some specific information about how to increase the cultural competence of teamwork. It is likely that this guidance will need to be formulated with the culture of specific communities in mind. Agencies will need to adjust and elaborate practice models to provide clearer support for cultural competence on teams. Other agency efforts to support cultural competence are discussed in sections on organizational supports for ISP.

Beyond this, it is clear that teams are likely to be more culturally competent when they adhere to the other elements of teamwork discussed above. For example, differences in norms and values often exacerbate the difficulty that teams encounter in hearing the family and following the family's lead in planning. This makes it even more important that the team adhere to structures, techniques, and procedures that support the family's values and the family's voice. Similarly, cultural competence is likely to be greater when the practice model specifies how the planning process can be structured to offer choices between options. This allows family members to review a variety of options, and select those that best reflect their values and priorities. A number of our interviewees believed that cultural competence would be increased when teams included larger numbers of community and natural supports. This is another area where the practice model could be expected to provide concrete guidance, by specifying what teams can do to recruit and retain community and natural supports.

### **Why a Single Plan of Care? = Continuity of Care**

Two common elements distinguish continuity. These elements are care of an individual child and family and care delivered over time. Both elements must be present for continuity to exist, but their presence alone is not sufficient to constitute continuity.

The first element, care of an individual child and family, distinguishes continuity from attributes such as integration of services and coordination, which are often used interchangeably with continuity. Continuity is not an attribute of providers or organizations. Continuity is how children and their families experience integration of services and coordination.

The second element, care over time, has been identified consistently as a longitudinal or chronological dimension of continuity. It is not a dimension but an intrinsic part of continuity. The time frame may be short, such as a single hospital admission, or long, such as the open ended relationships of primary or long term care. Time distinguishes continuity from other attributes such as the quality of the interpersonal communication during a single clinical encounter.

### **Three types of continuity**

There are three types of continuity in every discipline—informational, management, and relational.

#### **Three types of continuity**

*Informational continuity*—The use of information on past events and personal circumstances to make current care appropriate for each individual

*Management continuity*—A consistent and coherent approach to the management of a health condition that is responsive to a child and family's changing needs

*Relational continuity*—An ongoing therapeutic relationship between a child and family and one or more providers

The importance attached to each type differs according to the providers and the context of care, and each can be viewed from either a person focused or disease focused perspective.

*Informational continuity*—Information is the common thread linking care from one provider to another and from one healthcare event to another. Information can be disease or person focused. Documented information tends to focus on the medical condition, but knowledge about the child and family's preferences, values, and context is equally important for bridging separate care events and ensuring that services are responsive to needs.

*Management continuity* is especially important in chronic or complex clinical diseases that require management from several providers who could potentially work at cross purposes. Continuity is achieved when services are delivered in a complementary and timely manner. Shared management plans or care protocols facilitate management continuity, providing a sense of predictability and security in future care for the children/families and providers. Continuity of contact embodies the notion that regular contact is needed to ensure management goals are adapted and met and that providers must often facilitate access to a broad range of services. Flexibility in adapting care to changes in an individual's needs and circumstances is an important aspect of management continuity. When care is long term, both consistency and flexibility are critical for management continuity.

*Relational continuity* bridges not only past to current care but also provides a link to future care. A consistent core of staff provides families with a sense of predictability and coherence.

### **Summary points**

Continuity is the degree to which a series of discrete care events is experienced as coherent and connected and consistent with the child and family's needs and personal context.

Continuity of care is distinguished from other attributes of care by two core elements—care over time and the focus on the individual child and family.

Three types of continuity exist in all settings: informational, management, and relational

The emphasis on each type of continuity differs depending on the type and setting of care

### **Conclusion**

For the child and their families, the experience of continuity is the perception that providers know what has happened before, that different providers agree on a management plan, and that a provider who knows them will care for them in the future. For providers, the experience of continuity relates to their perception that they have sufficient knowledge and information about a child and family to best apply their professional competence and the confidence that their care inputs will be recognized and pursued by other providers.

Whatever the context, all types of continuity can contribute to better quality of care.

## **Initial Plan for Assessment and Services (IPAS)**

Upon receipt of a transfer from ACCESS, service coordination would initiate the IPAS. The IPAS requires a brief assessment by the service coordinator and/or team to determine the family's visions, areas of strengths and needs of the child and family and what resources are required to either further assess various developmental domains and/or to provide direct service to the family.

The IPAS meeting can be of various forms:

1. Service Coordinator telephone meeting with the family
2. Service Coordinator visit with the family
3. Team assessment – sometimes known as the ISPM (initial service plan meeting)
  - The team used for ISPM is not necessarily the team that would go on to do more indepth testing
  - ISPM assessments are generally arena assessments using a transdisciplinary team

Following the IPAS meeting, the family is provided with documentation that summarizes their visions and the assessments and services that will be put in place to further develop the child's Single Plan of Care (SPOC) to support these visions. The SPOC meeting is booked with the family within approximately 8 weeks of the IPAS meeting. The family is provided with some very general suggestions following the IPAS to support the enrichment of the child and family's environment.

### **Assessment Phase**

During the IPAS, it will be determined what assessments are required from which disciplines. The service coordinator will contact agencies with the local team that can provide these assessments. Where possible, transdisciplinary and intradisciplinary assessments are encouraged, thereby minimizing the number of visits for the child and family and decreasing the risk of potential repetition. When formal testing with individual therapists is required, an attempt will be made to coordinate appointments if being held at the local team sites.

Therapists are always encouraged to provide families with some individualized feedback and broad suggestions for development, but are cautioned against setting specific goals with families until the SPOC meeting.

A summary of the clinician's findings and their initial recommendations are placed in the SPOC in the Electronic Document.

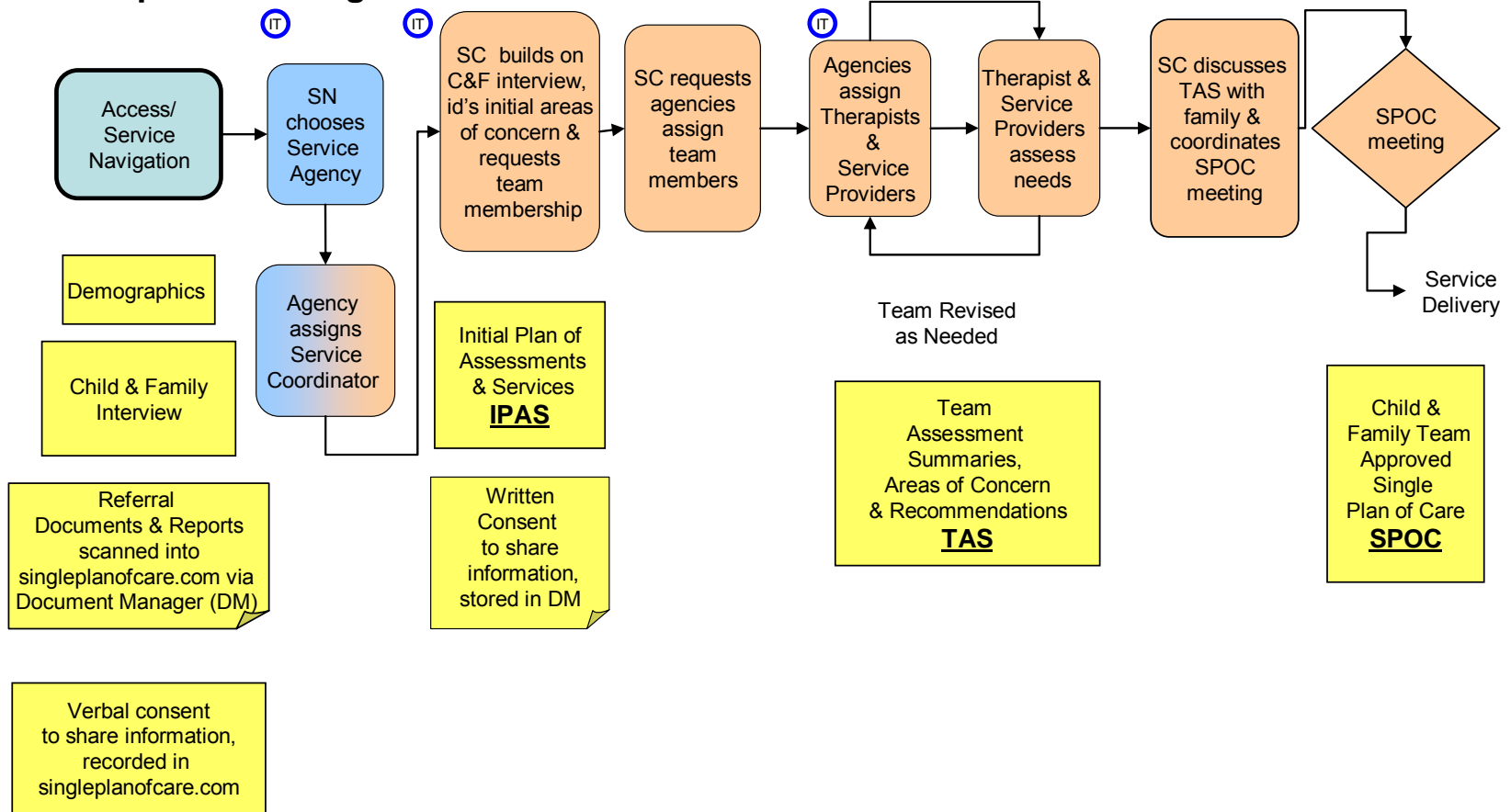
### **Single Plan of Care Meeting**

The SPOC meeting is not simply a case conference whereby individual team members and therapists take turns verbally summarizing their findings and goals to the family and team. What typically results from these meetings is a pot pourri of goals from which a multitude of activities are arrived. Families can often feel overwhelmed by the number of activities and their disconnect to each other, and to what the family finds meaningful. The result is that families frequently are unable to identify and articulate their child's goals.

The SPOC meeting is a planning meeting with the team and the family. It is preferred if team members are present for face to face discussion (this can be accomplished by videoconferencing), but teleconferencing is another alternative. The Service Coordinator chairs the meetings which last approximately one hour depending on the size of the team. The goal of the SPOC meeting is to develop a Single Plan of Care that addresses the family's visions, is comprehensive, but well coordinated. Team members are encouraged to brainstorm together goals and activities based on their assessments that will support the family's visions.

These goals and activities are placed in the SPOC in the electronic document for all team members to access. Modifications to the SPOC, particularly its activities, will occur over time and it is the team's responsibility to assess the timing of a review meeting (with likely team reevaluations) relative to the number of changes to the SPOC. Too many individual changes will result in the unravelling of the cohesiveness of a joint single plan.

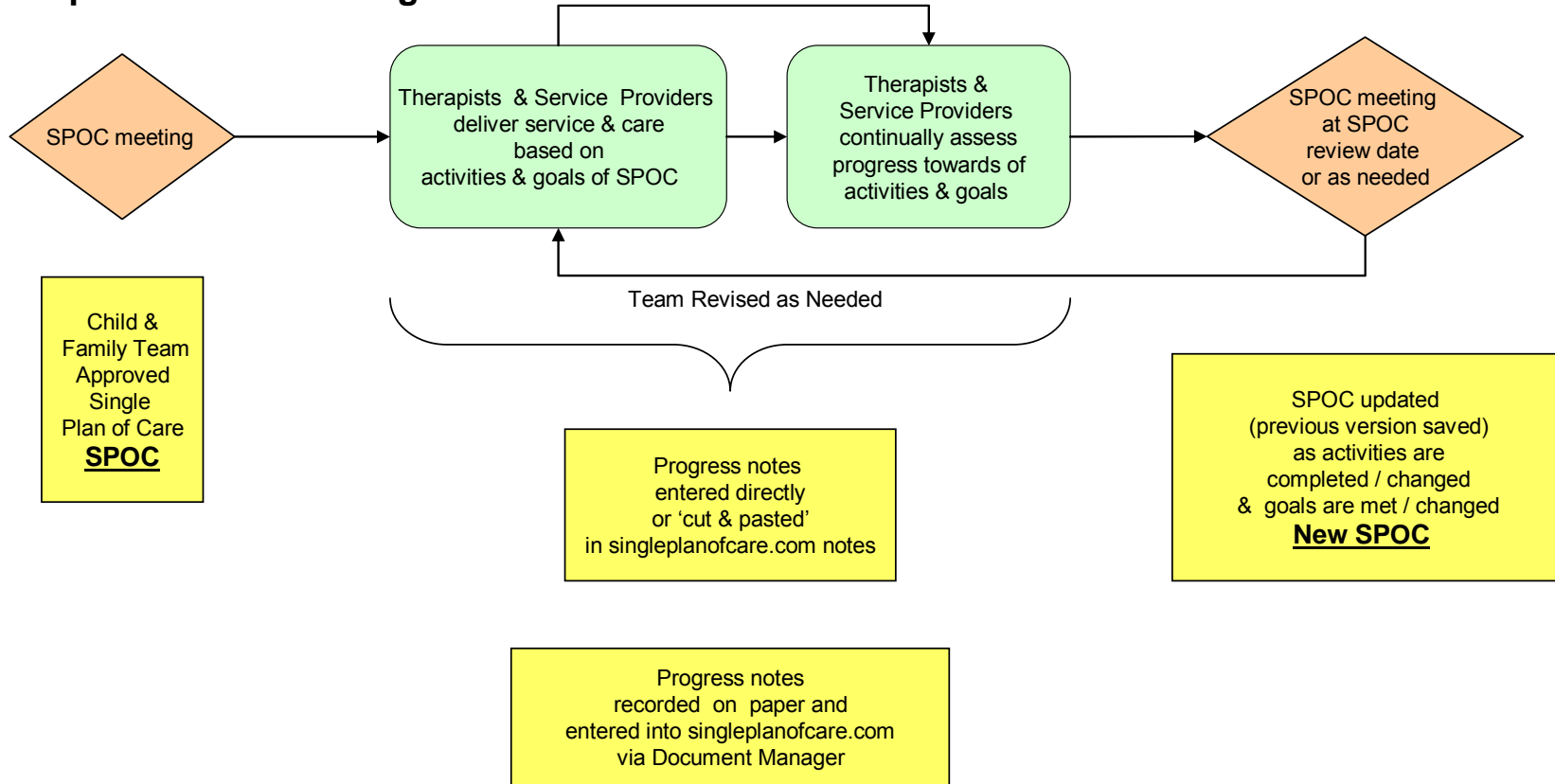
## Development of Single Plan of Care



Internal Transfer with External E-mail Notification



# Implementation of Single Plan of Care



	SPOC development step	Documentation	Documentation	Documentation	Documentation	Queries/Needs
1	SN contacts agency by phone to discuss transfer	SN documents in GC that agency has accepted transfer			GoldCare SN Transfer	
2	Agency rep receives transfer	Agency documents transfer received from SN			GoldCare SN Transfer	
3	Agency rep assigns SC or Service	Agency rep documents name of SC	Agency rep documents date that SC assigned		Add data field to demographic	
4	SC reviews Child and Family interview and determines what initial assessments / services are required					
5	SC visits or calls family, obtains consent to share information, discusses family's vision, and obtains agreement to proceed with assessment screening and /or services	SC documents initial areas of concern, initial service/assessment required, date service discussed with family, agreement by family (yes/no)	SC files written consent in DM	SC documents summary of assessment in Initial Assessment and Service Plan	SC documents planned date of SPOC meeting in IPAS	IPAS must be printable
6	SC sets tentative date for SPOC meeting	SC documents tentative date in IPAS				
7	SC notifies local team agencies of needed team composition for the IPAS assessment	SC documents agency notification				
8	Agencies assign team members	Agency rep documents name of assigned team member in IPAS				

9	Service provider reviews child information in GC file					
10	Service provider(s) see child for assessments	SP places Agency specific assessment report in DM or documents in notes	May chose to enter her entire assessment into Notes, and at a minimum should document that assessment occurred.	SP enters summary into team assessment summaries	SP documents areas of concern, date, id'd by, associated domain, commentd recommendations, recommendation priority, and the vision match of the recommendation priority	Assessment Summary needs cut and paste functionality and must be printable
11	SC reviews all assessment info and summaries					
12	SC calls family to arrange for SPOC meeting	documents call in SC notes and may review assessments with family as related to family vision				
13	SPOC meeting	SC documents meeting decisions, the Child and Family Vision, Child and Family Team Goals, Child and Family Activities	Goals support the vision and are derived from areas of concern and attached priorities. Activities are derived from recommendations			
14	SC prints off SPOC for family or team members					SPOC must be printable

15	SP(s) start to implement plan	each SP documents in their specific note area and DM if desired				
16	SC plans a SPOC review meeting				Alert of incomplete assessments and coomplete assessments due date	review date is alert in client file
17	SPOC review meeting	SC documents the revised vision, goals and activities			all previous data dumped in, SC deletes data that is not appropriate	
18	SP implements revised plan					

# Creating S.M.A.R.T. Goals

**S**pecific  
**M**easurable  
**A**ttainable  
**R**ealistic  
**T**angible

---

**Specific** - A specific goal has a much greater chance of being accomplished than a general goal. To set a specific goal you must answer the six "W" questions:

- \*Who: Who is involved?
- \*What: What do I want to accomplish?
- \*Where: Identify a location.
- \*When: Establish a time frame.
- \*Which: Identify requirements and constraints.
- \*Why: Specific reasons, purpose or benefits of accomplishing the goal.

**EXAMPLE:** A general goal would be, "Get in shape." But a specific goal would say, "Join a health club and workout 3 days a week."

---

**Measurable** - Establish concrete criteria for measuring progress toward the attainment of each goal you set. When you measure your progress, you stay on track, reach your target dates, and experience the exhilaration of achievement that spurs you on to continued effort required to reach your goal.

To determine if your goal is measurable, ask questions such as.....How much? How many? How will I know when it is accomplished?

---

**Attainable** - When you identify goals that are most important to you, you begin to figure out ways you can make them come true. You develop the attitudes, abilities, skills, and financial capacity to reach them. You begin seeing previously overlooked opportunities to bring yourself closer to the achievement of your goals.

You can attain most any goal you set when you plan your steps wisely and establish a time frame that allows you to carry out those steps. Goals that may have seemed far away and out of reach eventually move closer and become attainable, not because your goals shrink, but because you grow and expand to match them. When you list your

goals you build your self-image. You see yourself as worthy of these goals, and develop the traits and personality that allow you to possess them.

---

**Realistic** - To be realistic, a goal must represent an objective toward which you are both *willing* and *able* to work. A goal can be both high and realistic; you are the only one who can decide just how high your goal should be. But be sure that every goal represents substantial progress. A high goal is frequently easier to reach than a low one because a low goal exerts low motivational force. Some of the hardest jobs you ever accomplished actually seem easy simply because they were a labor of love.

Your goal is probably realistic if you truly *believe* that it can be accomplished. Additional ways to know if your goal is realistic is to determine if you have accomplished anything similar in the past or ask yourself what conditions would have to exist to accomplish this goal.

---

**Tangible** - A goal is tangible when you can experience it with one of the senses, that is, taste, touch, smell, sight or hearing. When your goal is tangible, or when you tie an tangible goal to a intangible goal, you have a better chance of making it specific and measurable and thus attainable.

Intangible goals are your goals for the internal changes required to reach more tangible goals. They are the personality characteristics and the behavior patterns you must develop to pave the way to success in your career or for reaching some other long-term goal. Since intangible goals are vital for improving your effectiveness, give close attention to *tangible* ways for measuring them.

## Initial Assessment and Service Plan

Jenny Lake , 4 years old, lives in Newmarket, 2 parent household, parents are Mary and Tom Lake

Initial Child and Family Visions	
Initial Child and Family Vision #1 <i>Jenny to attend nursery school 3 days per week</i>	Date <i>October 12, 2006</i>
Initial Child and Family Vision #2 <i>Jenny to be toilet trained</i>	Date <i>October 12, 2006</i>
Initial Child and Family Vision #3 <i>Jenny to join Y learn to swim program</i>	Date <i>October 12, 2006</i>

Service Coordinator's Initial Assessment and Service Planning Summary: *Jenny is a happy little girl who loves music and watching other children. Jenny will respond to cueing with regards to going to the bathroom but as yet not able to tell her parents when she must go to the bathroom. Jenny is starting to help with dressing, taking her pants and tops off. Her family are very active and interested in having Jenny join in more community activities in order to make new friends and be more comfortable with other adults. Parents are feeling uncomfortable taking Jenny to swimming lessons and are wondering if there are classes/instructors that are familiar with Jenny's difficulties. Jenny's family feels nursery school would be a way to prepare Jenny for school and also assist mom to work part time at home during the nursery school hours. In the past Jenny has had great difficulty separating from her parents. Parents have also been concerned about how Jenny will participate in the nursery school program without having someone at school to help her.*

Initial Area of Concern or Identified need	Initial Service Required	Date Service Discussed with Family	Family in Agreement		Date Agency Notified of need for Assessment	Team member assigned
			Yes	No		
<i>Jenny not able to communicate in some way her need to go to the bathroom</i>	<i>Service/Assessment #1 SLP services to assess readiness for Augmentative Communication strategies to help Jenny communicate her needs</i>	<i>Nov 2, 2006</i>	<i>Yes</i>		<i>Nov 5 2006</i>	
<i>Parent's comfort with community programs</i>	<i>Service/Assessment #2 Inclusive Recreation to introduce parents and Jenny to various programs</i>	<i>Nov 2, 2006</i>	<i>yes</i>		<i>Nov 6, 2006</i>	
<i>Enrolment in Nursery School Program</i>	<i>Service/Assessment #3 Early Interventionist to assist family with Nursery School choice and facilitate programming</i>	<i>Nov 2, 2006</i>	<i>Yes</i>		<i>Nov 6, 2006</i>	
<i>Dressing, Jenny starting to show interest. Want to encourage skill development</i>	<i>Service/Assessment #4 OT to assess abilities and provide family with suggestions, aids related dressing</i>	<i>Nov 2, 2006</i>	<i>No, Not at this time</i>		<i>NA</i>	

**Tentative Date for Single Plan of Care Meeting** *November 15, 2006*

## Team Assessment Summaries

*Jenny Lake , 4 years old, lives in Newmarket, 2 parent household, parents are Mary and Tom Lake*

<b>Initial Child and Family Vision</b>	
<i>Jenny to attend nursery school 3 days per week</i>	<i>October 12, 2006</i>
<i>Jenny to be toilet trained</i>	<i>October 12, 2006</i>
<i>Jenny to join Y learn to swim program</i>	<i>October 12, 2006</i>

### Summary of Assessment Findings

**Team Member #1 SLP Summary:** *Jenny is able to indicate yes no by moving her head and using facial expression. She is also able to recognize picture symbols of food items and can choose between two pictures indicating what she wants. She can make choices between fruit loops and crackers. She is not yet showing an understanding of items having to do with bathroom activities or objects or toileting.....*

**Team Member #2 Inclusive Recreation Summary:** *Jenny is shy with new people and prefers quiet environments. Jenny loves to be in the water however has difficulty with temperatures below 82 degrees. Parents are able to drive and attend sessions during the weekday.....*

**Team Member #3 Early Interventionist Summary:** *Jenny loves to watch other children and listen to music. She will engage when children approach her by smiling and laughing. Once engaged she is not as concerned as to where her parents are. She loves music, listening to stories, bubbles, playing in the sand and ripping paper. At this time no nursery school placements are available. Discussed possibility of attending a playgroup 3 mornings a week to help prepare for nursery school.....*

<b>Area of Concern</b>	<b>Date</b>	<b>Identified by : (role)</b>	<b>Domain</b>	<b>Comments</b>	<b>Recommendations</b>	<b>Priority</b>	<b>Vision Match</b>
<i>Jenny needs a way to communicate her wants and needs</i>	<i>Nov 7, 2006</i>	<i>SLP</i>	<i>COMM</i>	<i>Family will need access to Board maker</i>	<i>Implement PECS in a number of environments including bathroom and toileting activities</i>	<i>2</i>	<i>#2, #1, #3</i>
<i>Difficulty separating from parents</i>	<i>Nov 8, 2006</i>	<i>EI</i>	<i>BEH COG</i>		<i>Gradually have Jenny experience more and more time away from her parents in fun environments and activities</i>	<i>3</i>	<i>#2, #3</i>
<i>No Nursery School placements</i>	<i>Nov 8, 2006</i>	<i>SC</i>	<i>LEARN</i>	<i>No availability until jan07</i>	<i>Assist mom in finding play groups to attend, groups where mom can leave for short periods of time</i>	<i>3</i>	<i>#3</i>
<i>Jenny has been passive with regards to toileting activities</i>	<i>Nov 8, 2006</i>	<i>EI</i>	<i>ADL</i>	<i>Communication</i>	<i>Provide opportunities for initiation in various ways throughout day</i>	<i>3</i>	<i>#1, #2</i>
<i>Jenny can not tolerate cold water</i>	<i>Nov 10, 06</i>	<i>IRec</i>	<i>REC</i>	<i>No heated pools in area</i>	<i>Assist family to look for child's wetsuit</i>	<i>3</i>	<i>#3</i>

## Single Plan of Care

Jenny Lake , 4 years old, lives in Newmarket, 2 parent household, parents are Mary and Tom Lake

Initial Child and Family Vision	
<i>Jenny to attend nursery school 3 days per week</i>	<i>October 12, 2006</i>
<i>Jenny to be toilet trained</i>	<i>October 12, 2006</i>
<i>Jenny to join Y learn to swim program</i>	<i>October 12, 2006</i>

Are there any changes to the Child and Family Vision statements  Yes  No


If yes, Comments \_\_\_\_\_

Enter Revised Child and Family Vision Statements

Single Plan of Care Child and Family Visions	
Child and Family Vision #1	Date
Child and Family Vision #2	Date
Child and Family Vision #3	Date
Child and Family Vision #4	Date

## Single Plan of Care

Goal	Vision Match	Domain	Lead (role)	Date Set	How will we measure	Target Date	Review Date	Status	Comments
#1 Jenny to use PECS (level 4) to make choices from 5 pictures	#2, #1	COMM	SLP	Nov 15, 2006	Jenny will consistently use PECS to indicate food and activity choices	April 15, 2007	Feb 15, 2007	IP	Parents have access to Boardmaker
#2 Jenny to begin to show interest in toilet training	#1, 2	COG	EI	Nov 15, 2006	Jenny will initiate visits to the bathroom without prompting 1x/day	Jan 15, 2007	Dec 12, 2006	IP	The bathroom will have to become very enticing with books, music and bubbles
#3 Jenny to attend small group swimming class	#3	REC	I Rec	Nov 15, 2006	Jenny will attend class starting Dec 15 <sup>th</sup> without tears	Dec 15, 2006	Dec 15, 2006	IP	
#4 Jenny to assist with Dressing	#2	ADL	Famil y	Nov 15, 2006	Jenny able to pull pants down to upper thigh	Dec 25, 2006	Dec 1, 2006	IP	Parents to dress Jenny in loose pants
#5 Jenny to be comfortable at play group for 10 minutes without mom	#1	BEH COG	EI	Nov 15, 2006	Jenny will not cry while mom out of the room for 10 minutes	Dec 20, 2006	Dec 10, 2006	IP	Parents still need to decide on Playgroup.

Goal Match	Activity	Activity Lead (role)	Date Set	Target Date	Review Date	Status	Comments
#1 #4	<i>Use PECS at breakfast , snack and dressing times to indicate food and clothing choices</i>	<i>Family</i>	<i>Nov 15, 2006</i>	<i>Dec 20, 2006</i>	<i>Dec 1, 2006</i>	<i>IP</i>	
#2	<i>Provide toileting sequence strip. Read stories, blow bubbles , make music while Jenny is on the potty</i>	<i>Family</i>	<i>Nov 15, 2006</i>	<i>Nov 15, 2006</i>	<i>Dec 1, 2006</i>	<i>IP</i>	<i>EI/SLP to provide resources and activities</i>
#4	<i>Push-Pull games</i>	<i>EI</i>	<i>Nov 15, 2006</i>	<i>Dec 1, 2006</i>	<i>Nov 20, 2006</i>	<i>IP</i>	
#3	<i>Obtain wet suit</i>	<i>I rec</i>	<i>Nov 15, 2006</i>	<i>Nov 20, 2006</i>	<i>Nov 20, 2006</i>	<i>IP</i>	<i>All team members to ask other families if Jenny can borrow</i>
#5	<i>Mom and Dad to start leaving the room when Jenny working with Team members – SLP, EI</i>	<i>SLP</i>	<i>Nov 15, 2006</i>	<i>Nov 30, 2006</i>	<i>Nov 25, 2006</i>	<i>IP</i>	 <b>Children's Treatment Network</b> <small>OF SIMCOE YORK</small>

**Consent to Share Information has been updated and signed**  Yes  No  Yes

**Comments:** *Family would like Nursery School staff to receive a copy of the Single Plan of Care when Jenny starts to attend. SC will add to consent the appropriate time.*

**Next Child and Family Team Meeting Date:** *March 30, 2007 1pm at Jenny's House*

**Child and Family agrees with the Single Plan of Care and consents to the implementation of the Single Plan of Care as described.**  X Yes  No

if yes, refer to written consent filed and dated: *Nov 15, 2006*

DOMAIN	PRIORITY	GOAL STATUS	ACTIVITY STATUS
ADL	1 - immediate	IP – in progress	IP – in progress
Behavioural	2 - urgent	C - completed	C - completed
Cognition	3 - within 1 month	NA - no longer appropriate	NA - no longer appropriate
Communication	4 - within 3 months		
Community	5 - within 6 months		
Family			
Financial			
Health			
Housing			
Learning			
Physical Functioning			
Recreation			
Safety			
School			
Social/Emotional			
Spiritual			
Vocation			

### iii. Clinical Guidelines and Best Practises

#### Family Centred Care

by Deb Thomas

“Family-Centred Service is made up of a set of values, attitudes and approaches to services for children with special needs and their families. Family-centred service recognizes that:

- *each family is unique;*
- *the family is the constant in the child’s life; and*
- *family members are the experts in the child’s abilities and needs.*

In Family-centred services, the family works with service providers to make informed decisions about the services and supports the child and family receives. In Family-centred services, the strengths and needs of all family members are considered<sup>1</sup>.”

The Children’s Treatment Network of Simcoe York is committed to family-centred care, to ensuring that strengths and needs of the child and family are the considered during the assessment, intervention and supports that are provided. During the intake process, the identification and analysis of the strengths and needs determines which professionals will join the team. Together with family members, these professionals strive to enhance the optimal function of the child or youth and to improve the quality of life for family members. Family members decide their level of involvement in the decision making process and the other team members support and encourage that participation.

To be truly a family centred care agency, the Institute for Family–Centered Care<sup>2</sup> has listed the following guidelines for professionals to follow:

---

<sup>1</sup> The A Case for Family-Centred Service: A Best Practice Approach for Special Needs Children, Rehab & Community Care Medicine, Summer 2004, by Ian Corks

<sup>2</sup> Patient-and Family Centered Care, Institute for Family Centred Care, [www.familycenteredcare.org](http://www.familycenteredcare.org)  
Overview of Service Delivery

*Respect:* Respect and treat parents and family members with dignity; allow them time to talk; listen to what they say. Every family has a unique culture with different beliefs and values which shape their opinions and choices. These should be honoured with the understanding that parents and families want what is best for them and their children.

*Strength based:* Focus and build on child/youth and family strengths by offering opportunities that enhance control and independence

*Choice:* Explain and offer a full variety of choices and options

*Information:* Provide ample information that is helpful and encouraging so that families can make informed decisions. Families are also encouraged to learn skills and activities in order to become an active participant in their Child's Single Plan of Care.

*Support:* Provide the needed supports so that family members can grow and develop; offer opportunities for families to connect with other families

*Flexibility:* Ask families what they want and be responsive to that input by trying new things: work in a way that families and clients can contribute into the plan

*Collaboration:* Work together in setting goals, developing the care plan, service delivery approach, programs, and even the organizational policies

*Empowerment:* Help others to learn and develop new skills and abilities so that they can continue to improve their quality of life

Research<sup>3</sup>, into the outcomes of using a Family-centred service approach, has reported the following positive impacts for the child or youth, family and providers. Children and youth have made more improvement in learning and performing new skills, in adjusting psychologically to their disability and functioning, and generally in advancing their development and independence, that those without a Family-centred care model. Family members have learned more about their children's development and have become more involved in setting goals and doing therapy. Parents have reported feeling more competent as parents (specifically they indicate lowered stress levels and increased coping skills), feeling more in control, and having a better sense of well-being. Agencies have found that families expressed higher satisfaction with the care they receive.

Family-centred care has been described as a never ending process<sup>4</sup>. It provides a way for the agency to constantly improve service delivery and their relationships with families. For many members of the team, families and providers alike, Family-centred

---

<sup>3</sup> The A Case for Family-Centred Service: A Best Practice Approach for Special Needs Children, Rehab & Community Care Medicine, Summer 2004, by Ian Corks

<sup>4</sup> Implementing Family-Centred Service in Ontario Children's Rehabilitation Services, Law, M., Brown, S., Barnes, S, King, G, Rosenbaum, P., Kind, S, Jan 1997  
Overview of Service Delivery

care can be seen as both an exciting and intimidating opportunity. Family-centred care means that professionals and parents share control of decisions and interventions; thus creating equality and true partnership between families and service providers. Service providers must be confident and open to encouraging parents to make decisions and assume control. They must also feel comfortable discussing success and failure with families. For the families, Family-centred care means that they take on a proactive role, choosing how involved they wish to be and what outcomes they are seeking for their child/youth. Clear, open and honest communication with family members of what the Children's Treatment Network and its providers can and can not provide is crucial.

Agencies committed to Family-centred service demonstrate their commitment at many levels. They must ensure that all staff truly understand and practice the values and guiding principles of family-centred care. Agencies like Bloorview routinely ask families speak to new staff and medical interns on Family-centred care. Agencies must be willing to listen to family input and demonstrate their listening by modifying facilities and services. Some agencies show their commitment by making the agency more accessible, training the staff to be more responsive, and making the rules and processes easier for families.

For the CTN of Simcoe-York, parents and families have been involved in planning and advocating for the CTN for more than 6 years. The Board of Directors has a strong complement of family members. Soon, it will also have a Community Advisory Committee, comprised of family members and interested to community representatives, who will help guide the organization in Family-Centred Care. Currently, processes are underway to ensure that the local team facilities will be accessible, families will have access to information, and that staff hired through the CTN will be committed to FCC. The teams, which will be formed based upon the needs of each child and family, will cross the current service and age boundaries that often seem so arbitrary. Team staff will be committed to family-centred services, committed to providing clear and useful information, to sharing decision making, planning and services and to including families in the evaluation of child/youth outcomes and agency processes.

The CTN will use a number of approaches common to other Family-centred care agencies including:

- The assigning of one consistent person for the family to contact to ask questions, share information, and learn about resources or program planning for their child. This role, similar to that of the Early Interventionist or the old Easter Seals Nurse, is intended to give the families a live person to contact as needed. A person who will continue to provide support until the child transitions into adult programs.
- A single care plan, this is a team developed plan to ensure that all service providers are working towards the same goals, using the proven strategies and intervention approaches, and anticipating transitions so proper preventions and supports are put into place in a timely fashion.
- Developing an extensive network of support services and agencies so that the community resources that are needed for the child and family to be successful are invited and included in the assessment, problem solving, intervention, and ongoing support in an integrated fashion

- An integrated teamwork and communications structure to ensure that the collection of information is not duplicated , that providers collaborate, that information is shared, that the child/youth and family participate and that the agency engages in continuous improvement results in the enhancement of the family friendly CTN environment and the child/youth focused program.

The Children’s Treatment Network of Simcoe-York is committed to Family-centred care. Family-centred care is the foundation for all of the CTN programs, services and supports and will be demonstrated through our commitment to providing our clients and their families with the timely and appropriate supports, resources and information that they require as their needs and desires evolve.

For further information on Family Centred Care/Service please look to:

📌 Canchild Centre for Childhood Disability Research, McMaster University

[www.canchild.ca](http://www.canchild.ca)

📌 Institute for Family Centred Care: [www.familycenteredcare.org](http://www.familycenteredcare.org)

Coordinated Care Record (a comprehensive guide to collecting important information on your child’s special needs and supports): University of Illinois at Chicago, Division of Specialized Care for Children: <http://www.uic.edu/hsc/dscc/index.htm>: choose the “Families” button on the right and then the “Coordinated Care Record” from left column.

# Models for Team Interaction

<b>Component</b>	<b>Multidisciplinary</b>	<b>Interdisciplinary</b>	<b>Transdisciplinary</b>
Philosophy of Team Interaction	Team members recognize the importance of contributions from several disciplines.	Team members are willing and able to share responsibility for services among disciplines.	Team members commit to teach, learn, and work across disciplinary boundaries to plan and provide integrated services.
Family Role	Generally, families meet with team members separately by discipline.	The family may or may not be considered a team member. Families may work with the whole team or team representatives.	Families are always members of the team and determine their own team roles.
Lines of Communication	Lines of communication are typically informal. Members may not think of themselves as part of a team.	The team meets regularly for case conferences, consultations, etc.	The team meets regularly to share information and to teach and learn across disciplines (for consultations, team building, etc.).
Staff Development	Staff development generally is independent and within individual disciplines.	Staff development is frequently shared and held across disciplines.	Staff development across disciplines is critical to team development and role transition.
Assessment Process	Team members conduct separate assessments by disciplines.	Team members conduct assessments by discipline and share results.	The team participates in an arena assessment, observing and recording across disciplines.
SPOC Development	Team members develop separate plans for intervention within their own disciplines.	Goals are developed by discipline and shared with the rest of the team to form a single service plan.	Staff and family develop plan together based on family concerns, priorities, and resources.
SPOC Implementation	Team members implement their plan separately by discipline.	Team members implement parts of the plan for which their disciplines are responsible.	Team members share responsibility and are accountable for how the plan is implemented by one person, with the family.

From Garland, C.G., McGonigel, J.J., Frank, A., & Buck, D. (1989). The transdisciplinary model of service delivery. Lightfoot, VA: Child Development Resources; and Woodruff, G., & Hanson, C. (1987). Project KAI training packet. Unpublished manuscript. Funded by the U.S. Department of Education, Office of Special Education Programs, Handicapped Children's Early Education Program.

# Promoting Role Release on Transdisciplinary Teams

## **Role Extension**

Increasing one's own depth of understanding, theoretical knowledge, and clinical skills

- Read new articles and books within your discipline or about your child's condition.
- Attend conferences, seminars, and lectures.

Join a professional organization in your field or a family-to-family network.

- Explore resources at libraries or media centers.

---

## **Role Enrichment**

Developing a general awareness and understanding of other disciplines through defining terminology and sharing information about basic practices (can happen during team meetings and after clinical conferences)

- Listen to parents discuss their child's strengths and needs.
- Ask for explanations of unfamiliar technical language or jargon.
- Do an appraisal of what you wish you knew more about and what you could teach others.

---

## **Role Expansion**

Teaching others how to observe and make judgments and recommendations outside their own disciplines

- Watch someone from another discipline work with a child, and check your perception of what you observe.
- Attend a workshop in another field that includes some "hands-on" practicum experiences.
- Rotate the role of transdisciplinary arena assessment facilitator among all service providers on the team.

---

## **Role Exchange**

Team members have learned the theory, methods, and procedures of other disciplines and begin to implement techniques from these disciplines under direct supervision

- Allow yourself to be videotaped practicing a technique from another discipline; invite a team member from that discipline to review and critique the videotape with you.
- Work side by side in the center-based program, demonstrating interventions to families and staff.
- Suggest strategies for achieving an IFSP outcome outside your own discipline; check your accuracy with other team members.

<p><b>Role Release</b> Team members put newly acquired techniques into practice under the supervision of team members from the discipline that has accountability for those practices</p>	<ul style="list-style-type: none"> <li>• Do a self-appraisal—list new skills within your intervention repertoire that other team members have taught you. <ul style="list-style-type: none"> <li>• Monitor the performance of the service providers on your child’s IFSP team.</li> <li>• Present on the “whole” child at a clinical conference.</li> <li>• Accept responsibility for implementing, with the family, an entire IFSP.</li> </ul> </li> </ul>
<p><b>Role Support</b> Team member from one discipline provides direct services because needed intervention is too complicated or an intervention is required by law by a specific discipline</p>	<ul style="list-style-type: none"> <li>• Ask for help when you feel “stuck.”</li> <li>• Offer help when you see a team member struggling with a complex intervention.</li> <li>• Provide any intervention that only you can provide, but share the child’s progress and any related interventions with the primary service provider and the family.</li> </ul>

### Transdisciplinary Practice

Think about your staff who work with children and families. Consider the following questions regarding their work. There are no right or wrong answers.

In the last month, has a staff member:	Often*	Once	Never
Done a joint interview with another staff member on a new referral?			
Asked a parent to join in the observation of their child at the daycare/preschool/school setting?			
Used an assessment tool with another team member of a different discipline?			
Written a joint report regarding a child's assessment?			
Met with a team of 3 to 4 members, including a parent, to plan a child's SPOC/IFSP/IEP?			
Worked with another team to write joint, routines-based goals?			
Set up a communication system for other staff seeing a child in the home?			
Used a team data collection method and left notes about observations/ successes?			
Worked in a child's home/classroom/center site for a "block" of time?			
Discussed a suggestion with staff re. modifying a task after trying it his/herself with the child?			

Helped to set up a team data collection method regarding one of a child's daily routine activities?			
Shared discipline-specific information with other members of the team (e.g., recent research, intervention strategy)			
Participated in a team social activity (e.g., potluck, happy hour, outing)			

\*defined as three to four times per week

## Clinical Measurement Practical Guidelines for Service Providers

### Are you using a clinical measure?

A clinical measure is:

- a published measurement tool
- designed for a specific purpose and population
- with instructions for how to administer, score, and interpret the results

For examples of clinical measures used in physical, occupational, and speech-language therapy, see page 21.

### Are your assessments as useful as they can be?

Therapists feel a responsibility to ensure that measurements they use are clinically useful and not harmful to children and families. This includes considering the accuracy of assessments. Based on studies done at CanChild and on conversations with therapists, these guidelines were designed to provide therapists with practical ideas for dealing with two measurement problems clinicians commonly face:

- what to do if you feel you need to **modify** the measure to suit your clinical situation
- how to **interpret** a child's **change**.

Research suggests that therapists must deal with both these issues routinely, and that better guidelines about how to handle these problems could improve services to children. We suggest that you keep these guidelines handy when you conduct clinical assessments. They are intended to help you make assessment easier and more effective.

### Are you modifying the administration or scoring of a clinical measure?

Sarah: An Example from Occupational Therapy

Sarah is a 26-month old child with cerebral palsy (spastic diplegia, Gross Motor Function Classification System Level III) who has just moved to your area with her family. Her parents are concerned about her fine motor skills, and so you decide to do a baseline assessment using the Grasping and Visual Motor Integration subtests of the Peabody Developmental Motor Scales (PDMS-2).

The PDMS-2 is a standardized, norm-referenced instrument designed to assess the motor abilities of children from birth through 6 years of age using 6 subtests. The *Guide to Item Administration* contains detailed descriptions of every item in each of the subtests, including the child's position, the stimulus, and the procedure for testing, as well as the criteria for scoring. As recommended in the manual, you have read all of the item specifications, and have conducted assessments on three children outside your practice before using it clinically in your setting.

As you progress through your assessment, you note that Sarah does not stay in the position recommended in the manual, that she frequently seems to need more than the recommended 3 trials to be successful (or partly successful) with an individual item, and that she seems to need demonstration in addition to verbal instruction to understand what the item requires.

After 30 minutes of testing, you determine that Sarah's Grasping and her Visual Motor integrations subtest raw scores are 40 and 89, respectively. These raw scores place her at an age-equivalent of 14 and 22 months for grasping and visual motor integration, with corresponding ranking of 16th and 25th percentiles. ***Are these inferences correct?***

### **Modification**

Therapists often find that they want to use a clinical measure, but don't want to administer it in the way that the manual suggests. There are lots of reasons that therapists might do this, but therapists say they do it most often to accommodate the special needs of the children they work with.

### **Are you likely to do any of the following modifications?**

#### **ALTERING THE TEST CONTENT OR ITS ADMINISTRATION**

- Modifying the sequence of presenting items or materials
- Modifying the presentation of tasks or items by rewording them or by providing demonstrations or cues.
- Modifying starting positions.
- Modifying the test materials or equipment.
- Excluding some items or subscales.
- Modifying the administration or scoring of items to allow a child to do as well as possible.
- Modifying the administration to make the task more appealing to a reluctant child.
- Translating a measure or making other accommodations for language barrier.

- Allowing a child to use an adaptive device during testing.

## **TIMING**

- Allowing a child extra time for a timed test.
- Cutting short an assessment or conducting it over two sessions.

## **SCORING**

- Accepting parent reports of a child's function or behaviour when unable to observe it.
- Estimating or assuming the scoring of an item that was not tested.
- Scoring test items by observing the child's play or other activities, if the test normally requires administration using standard prompts.
- Looking up normed, age-equivalent, or scaled scores using an age comparison that doesn't apply to your child.

## **TEST USE OR APPLICATION**

- Using the measure outside the recommended chronological age range.
- Using the measure with a clinical population which is not discussed in the manual.
- Using a measure to assess change but you are not aware of any documentation that discusses the measurement of change using this instrument.

The manual for the measure may support some of these modifications, or you may know about some research in the published literature that supports them.

**If you don't know whether these modifications are supported by the manual or other documentation, they may cause problems for your assessment.**

It is understandable that you may try to adapt measures to work for your clients in specific situations. After all, meeting the needs of your clients is a part of your job.

The problem is that measures are developed and tested using standardized procedures. What may seem to you to be a small (and harmless!) modification can have unpredictable effects on the meaning of test scores (for more about what can happen, see page 8).

The people who develop clinical measures will not always give enough guidance for your testing situation. If you need to decide whether and how to modify a measure, go

to page 11 for some easy things you can do to get the best assessment results possible.

### **What problems are caused by modifying measures?**

We understand that modifying the administration or scoring of a clinical measure is sometimes necessary. However, it is important to be clear that there are trade-offs involved with this.

#### **Modification makes it harder to compare this child to other children**

If you modify the measure in different ways for different children, it makes it difficult to compare scores between children, or to compare your children to those assessed by other therapists. We cannot know how the comparison is affected by the differences in administration.

Many therapists believe that they can “adjust” their interpretation of scores for the likely effect of modifications they make, but it isn’t always clear how they can do this.

Many modifications, such as allowing a child extra time or providing extra prompts seem like they would increase the child’s score, but by how much?

For other modifications, such as accepting parent reports, it is not clear whether this would tend to increase or decrease a score, relative to the standard administration.

Modifications can present serious problems for the interpretations of normed scores, such as age equivalents and percentiles.

#### **Modification makes norms or scaled scores difficult to use**

The norms were established by administering the test in a standardized way to a large number of comparison children. If you didn’t administer the test the same way that it was given to the children in the normative sample, the meaning of the normed scores is unclear.

Some measures use scaled or criterion scores that are calculated using Rasch analysis or some other type of item response theory. Like normed scores, the meaning of scaled scores is established using a comparison to a large number of other children who were administered the test in a particular way, and so modifying a measure can cause similar problems.

## What about Sarah?

In the case of Sarah's assessment, the obtained percentile ranks of 16 and 25 are likely higher because of the modifications with respect to position, number of trials, and use of demonstration than they would be without such modifications. A consequence might be that Sarah be denied occupational therapy, if a policy of only working with children below the 10th percentile on a standardized test exists at your centre.

### **Modification alters the reliability and validity of the test**

The degree of reliability and validity which makes a test suitable for clinical use is established in studies that involve standardized administration, rather than adapted use.

It is possible that the reliability and validity of the modified test will no longer be adequate for clinical decision making.

### **Modification makes it difficult to evaluate change and treatment effectiveness**

Some modifications affect the responsiveness of measures to real clinical changes in children. For instance, you may choose an assessment tool that has not explicitly been shown to measure change, or use a test with a child outside the recommended age range. It is often the case that such modifications underestimate the degree to which the child actually changed, and may lead to an inappropriate conclusion about the usefulness of a treatment. Similarly, modifications that affect the reliability of a score may make it harder to see important changes in the child.

## What can you do if you think you need to modify a measure?

Some ways to deal with modified administration and scoring of clinical measures are listed below. They are approximately ordered from most to least preferred.

### **1. RE-CONSIDER IF YOU NEED TO MODIFY THE MEASURE.**

Therapists may often modify out of habit, or because they think it won't matter. It is always safer to "play by the book" (the test manual) if you can.

### **2. CONSULT THE MANUAL FOR GUIDANCE ABOUT NON-STANDARD SITUATIONS.**

For measures that are used widely in childhood disability, test developers may surprise you by providing guidance for special populations and circumstances that are similar to yours.

### **3. BE HONEST WITH YOURSELF ABOUT THE PURPOSE OF YOUR ASSESSMENT.**

Therapists often use clinical measures for purposes that don't depend on accurate and meaningful scores. For instance, using a measure may be a way to interact with a client, to observe how a child handles a novel task, or to get a rough idea of what the

child can do. If you don't need the scores, then how you administer the test might not matter. In these cases, don't interpret the number and don't record it in the chart.

#### **4. INVEST THE TIME REQUIRED TO COMPLETE THE MEASURE THE RIGHT WAY.**

Measurement is part of effective treatment. If time or costs are an obstacle, you may need to be clear with your supervisors and the child's family that accurate assessment is time well spent. It may be important to spend one or more whole sessions on assessment.

#### **5. AVOID USING NORMED, AGE-EQUIVALENT, OR SCALED SCORES WHEN INTERPRETING THE RESULTS OF A MEASURE YOU HAVE MODIFIED.**

If you must modify any aspect of the administration, **don't use normed, age-equivalent, or scaled scores** when interpreting the results.

Normative percentiles and other standardized scoring are obtained by using the standard administration, and you can't know whether your child's relative performance is the result of his or her ability or the way you administered the test. The **raw scores** may give you a rough idea of the kinds of tasks the child can do, without implying an accurate comparison to some standard.

#### **6. TRY TO BE CONSISTENT ON EACH ASSESSMENT.**

If you want to assess a child's change over time, and find that you must modify the administration of the measure, carefully record the modifications and try to be consistent on each assessment.

Doing this may mean that the evaluation of change over time might be valid for this child even if the comparison to other children is not.

#### **7. ENSURE YOU ARE USING THE RIGHT MEASURE FOR THE RIGHT REASON.**

Don't count on seeing developmental or treatment-related change using a measure unless you are aware of published documentation that validates the measure for this purpose.

#### **8. CAREFULLY RECORD ALL MODIFICATIONS YOU MAKE IN THE CHILD'S CHART.**

If you must make modifications, carefully record in the child's chart how your administration differs from the standard.

#### **9. DON'T PROVIDE SCORES OF MODIFIED MEASURES TO CHILDREN AND FAMILIES.**

If you must make modifications, don't provide the scores to children and families. Be clear that you have done the assessment in a non-standard way, and be honest about the way you are using the measurement. This may be an important ethical issue.

#### **Do you need to measure change?**

Often you will assess a child with a particular clinical measure on two or more occasions and you will want to interpret the difference between test scores. This may happen

because you want to know if a child is developing at an expected rate, given his clinical presentation, or because you want to evaluate the effectiveness of a program or treatment. There are some tricks to interpreting the difference between two scores that have to do with amount of uncertainty in scores.

### **The example of Sarah revisited**

Recall that Sarah is a 26-month old child with cerebral palsy (spastic diplegia, Gross Motor Function Classification System Level III). After determining Sarah's parents' goals for her, and conducting your baseline assessment of Sarah, you collaboratively decide to improve her fine motor function. You decide to conduct a trial period with motor learning strategies. You use the Grasping and Visual Motor Integration subtests of the Peabody Developmental Motor Scales (PDMS-2) to establish a baseline at your first assessment. You then provide a month of biweekly therapy with home programming and test her again after this period.

Sarah's raw score on the Grasping Subtest was 40 at baseline, and 43 at the end of the trial therapy period.

### **What do you need to consider when interpreting this apparent improvement?**

- **Is the PDMS suitable for evaluating change over time (see page 19)?**

If not, then you may be underestimating the effectiveness of your treatment.

- **If you modified the administration of the PDMS-2, did you do it the same way on both occasions (see page 11)?**

If not, then some of the observed change in scores may be due to the differences in administration.

- **The PDMS-2 scores on each occasion are estimates of Sarah's hand function.**

How good an **estimate** they are will depend in part on the **reliability** of the measure. You will need a way to measure the uncertainty in each score.

The last bullet here is really important when you are interpreting change. Any two scores for the same child are expected to be different to some degree, simply because of chance influences on the test scores that you don't care about. Unless you know how much of this chance variation to expect, you can't know whether the difference you observed was the result of your treatment.

### **How is the uncertainty in scores measured?**

The most common ways of expressing the uncertainty in scores are explained below. The people who designed the measure may use other methods and the manual should tell you how to interpret them.

## Standard Error of Measurement

This is a single number that is a function of the test's reliability and measures how much a child's observed score is expected to vary, even though the child's ability or status has not changed. Approximately 95% of test scores are expected to fall within plus or minus 2 standard errors.

## Confidence Intervals

A 95% confidence interval (CI) gives the range within which 95% of multiple test scores are expected to fall, if a child's ability or status has not changed. The 95% CI is calculated as the test score plus or minus 2 standard errors of measurement. Other coverage percentages could be reported, although 90% and 95% are most common.

## Minimum Detectable Change

Test designers may report the uncertainty in test scores as the smallest difference between two scores that would be greater than that expected by chance variations. This is normally calculated so that, if the subject was not really changing, the chance that you would observe a difference at least this large would be less than 5% or 10% (the manual should tell you this).

### How can you use these quantities to interpret change?

If the difference in scores that you observe is greater than you would expect by chance, as measured by one of the above methods, then there is a high probability that the child is really changing. To get better grasp of this, let's have another look at the example of Sarah.

### Did therapy help Sarah?

Sarah's Grasping Subtest score went from 40 to 43 during the 4 weeks of therapy, a difference of 3 points. According to the PDMS-2 manual, the standard error of measurement for the Grasping subtest is 1 point. This means, even though you observed a baseline score of 40, there is approximately a 95% chance that Sarah's typical baseline score could be anywhere in the range  $40 \pm 2$  (the score  $\pm 2$  standard errors of measurement).

In other words, the 95% confidence interval at baseline is 38 to 42. Similarly, the 95% interval after therapy would be 41 to 45 ( $43 \pm 2$ ).

The key point is that **these intervals overlap**, so that the upper limit of the baseline interval is greater than the lower limit of the post-therapy interval. The suggestion is that this observed difference could have plausibly occurred even if Sarah's hand function didn't really change, just because of the degree of variation naturally expected given the reliability of the test (i.e. due to measurement error).

This example should make it clear why you can't afford to treat any test score as if it were *the* exactly correct score. Without considering the uncertainty inherent in the two test scores, we may conclude incorrectly about the effectiveness of the treatment.

### **Why is accurate clinical measurement important?**

You may sometimes find it necessary to justify the time you spend on careful assessment. Here are some ideas that you can use.

#### **For therapists...**

Assessment is a fundamental part of planning and evaluating services, so does it make any sense to think of it as secondary to treatment? Does it make any sense to conduct an assessment that you feel is probably not accurate?

Because you care about whether the treatments you provide are effective, you will need to care about how you measure whether they are effective. The careful use of clinical measures offers a way of evaluating the services you provide.

Careful clinical assessments offer a reproducible and authoritative basis for explaining and supporting your clinical decisions to children, families, and managers.

#### **For children and families...**

Children and families are increasingly regarded as part of the rehabilitation team, rather than passive recipients of services. Accurate assessments of a child's status, prognosis, and treatment outcomes will help children and families participate in goal setting and treatment decisions in an informed and appropriate way. It will offer them a concrete way to understand their child's situation and to understand your approaches to offering services.

Families often ask questions like "how bad is it?", "is he very delayed?", "is she improving?", and "will my child ever walk?" The careful use of clinical measures can help you answer these difficult questions with confidence. Attention to the inherent uncertainty and difficulties in assessing a child can help highlight the times when you can't be confident answering these questions. This uncertainty is a reminder of the ethical responsibility not to be overconfident in measures when they are known to be imprecise.

#### **For administrators and managers...**

The routine and conscientious use of clinical measures at your service organization will provide a large body of reproducible, authoritative, and standardized data about the needs and outcomes among the children and families you serve.

This data can inform the difficult decisions you face everyday about how to manage services and allocate resources. Routine assessment results can help you communicate to funding agencies in concrete and credible ways regarding your organization's needs and the effectiveness of the services you provide. Increasingly, funding for services is contingent on having a clear mechanism for evaluating services in terms of client outcomes.

### **For your profession...**

Physical, occupational, and speech-language therapists offer services in a complex health service environment in which professionals from many disciplines compete for the resources to provide the services they think are most important. For better or worse, the status and credibility of your discipline depends in part on the perception that you can provide convincing evidence that what you do is effective.

### **What are the purposes of clinical measurement?**

One framework suggests that there are at least **four different purposes** for clinical measurement.

The purpose of assessment is important, because a measure that is suitable for one purpose may not necessarily be suitable for others.

Test manuals and other supporting documentation should indicate the appropriate purposes and provide explicit evidence to support these uses.

#### **Description**

These measures are used to describe the differences among individuals within groups, as when a measure of physical function may be used to identify a child's profile of impairments and identify treatment goals.

A descriptive instrument should measure all the aspects of the condition that are potentially relevant to the clinician.

#### **Discrimination**

These measures are designed to distinguish between people with and without a particular characteristic or functional problem. Examples might include speech-language tests designed to identify children who have clinically significant problems of speech or language. Evidence that a measure is suitable for discriminative purposes may include quantities that express the true-positive (sensitivity) and false positive (1 – specificity) rates for the test. In practice, the effectiveness of a test for discriminative purposes depends on the prevalence of the functional problem as well as the sensitivity and specificity. In general, it will be easier to identify clinically significant problems if they are more common.

#### **Prediction**

Predictive tests attempt to assess children in terms of their likely future outcomes. For instance, a measure of current function may be used to assess children who are at risk for later functional problems, or may try to predict the limit of later functional status.

To be effective for prediction, measures must have high test-retest reliability and there must be evidence that the measure can predict later outcomes of interest.

## Evaluation

Evaluative measures are designed to measure change over time within individuals, often in order to evaluate treatment effects.

To be effective, evaluative measures must be high in responsiveness. More responsive measures show more change in situations in which children are actually changing.

If a measure is to be used to evaluate treatment effects, the test manual or other supporting documents should explicitly report evidence of responsiveness. Sometimes this is established by examining the degree to which scores change in situations where we can safely assume that children really are changing. Frequently used quantitative measures of responsiveness include the standardized response mean and measures of clinically important change.

### **What clinical measures are most commonly used in pediatric disability practice in Ontario?**

#### **PHYSICAL THERAPISTS**

- Goniometer / Range of Motion
- Peabody Developmental Motor Scales (PDMS)
- Gross Motor Function Measure (GMFM)
- Alberta Infant Motor Scales (AIMS)

#### **OCCUPATIONAL THERAPISTS**

- Beery–Buktenica Developmental Test of Visual-Motor Integration (VMI)
- Test of Visual Perceptual Skills (Non-Motor) – Revised (TVPS)
- Peabody Developmental Motor Scales (PDMS)

#### **SPEECH LANGUAGE PATHOLOGISTS**

- Preschool Language Scale (PLS)
- Clinical Evaluation of Language Fundamentals (CELF)
- Goldman-Fristoe Test of Articulation
- Structured Photographic Articulation Test (SPAT)

### **How can you find the right measure?**

Therapists often choose their measures by relying on what is already available at their treatment centre and by what their colleagues tend to use. This is understandable since you are most comfortable with the measures you and your colleagues already know. However, it might help if you had a resource that could point you to some possible alternatives, particularly if you consistently find that you need to modify the measures you already use. Fortunately, help is at hand.

**All About Outcomes** is an interactive software package designed by a team from the *CanChild* Centre of Childhood Disability Research. It was designed to help clinicians to identify and select from among the available measures of clinical outcome measures those that are relevant to occupational, physical, and speech-language therapists. Measures are searchable by clinical domains of interest and the target of interventions. Best of all, you already have free access to All About Outcomes, because every Ontario Association of Children's Rehabilitation Services Centre already has a copy!

All About Outcomes is also available commercially from:  
Slack Incorporated, 6900 Grove Rd. Thorofare, NJ, USA 08086, phone: (609) 848-1000.  
More information about measures is also available from the *CanChild* website:  
[www.fhs.mcmaster.ca/canchild/](http://www.fhs.mcmaster.ca/canchild/)

**You may see these measurement terms often: What do they mean?**

### Reliability

The **reliability** of a clinical measure is the degree to which it can reproducibly or consistently detect differences among people. It is common to distinguish among different kinds of reliability.

**Test-retest reliability** is the degree to which the measured differences among people are consistent over time.

**Inter-rater reliability** is the degree to which multiple observers agree on the differences among people.

The technical definition of reliability focuses on the proportion of the differences among observed scores that is attributable to real differences among people, and studies of reliability are designed to estimate this.

High reliability is usually considered an important property of a clinical measure because you want to be sure that it measures the same thing each time you use it.

### Validity

A clinical measure is **valid** if it measures what you want and expect it to measure. Even when a measure is thought to be reliable, it may not be valid. For instance, a measure of physical function that is strongly influenced by a child's cognitive level may consistently show that children with cognitive deficits do more poorly than children without such deficits (i.e., the measure is reliable). However, since you want to measure physical function, this is not the difference you are interested in, and the measure is not valid for use in clinical samples with large variations in cognitive function.

## Responsiveness

A clinical measure is **responsive** if it can detect clinically meaningful changes in the characteristic, or function of interest. The responsiveness of a measure depends on its **sensitivity to change**. For instance, if it is known that children experience developmentally-related increases in some aspect of function, a more responsive measure of that function will show more change than a less responsive measure.

The responsiveness and sensitivity to change are important to consider when evaluating the effectiveness of a treatment or program for an individual person, because a measure of low responsiveness may show no effect of a treatment even if there is one.

## Standard Error of Measurement

Any score on a clinical measure is really an *estimate* of the characteristic or ability that you want to assess. Some estimates are better than others, and you will need a way to determine how much uncertainty there is in your estimate, given the measure you have chosen.

The **standard error of measurement** (SEM) is an index of the uncertainty in a score in terms of the degree to which multiple measurements of the same person are expected to vary even if the clinical attribute of interest has not changed. Conceptually, if a measure could be given many times to a person who is not changing, the SEM is the standard deviation of the scores that would be obtained, although it is not normally calculated this way. The SEM for a measure depends on its reliability and how much scores tend to vary among people generally.

The SEM is related to the probability of observing a score in a given interval. For instance, about 68% of scores will be within plus or minus 1 SEM of the average score, and about 95% will be within plus or minus 2 SEM's. As a consequence, the SEM can be used to construct **confidence intervals** for interpreting the accuracy of a test score.

## Confidence Intervals

**Confidence intervals** (CI) express the uncertainty or accuracy in a measurement in terms of the range of likely scores, given the score the person actually received and the SEM for the measure.

If you could give the same measure to a person many times, it is unlikely that all the scores would be exactly the same, even if the person is not really changing. So, how different would they be?

The CI answers this question. It is usually calculated from the measure's SEM, so that a 95% CI is calculated as the observed score plus or minus 2 standard errors. The usual interpretation of a 95% CI is that upon repeated testing, 95% of a person's scores would

fall within the lower and upper bounds of the interval, even assuming that the person had not changed.

The use of the CI emphasizes how the score you observed is actually an *estimate* of the person's characteristic or function, and that repeated testing under effectively the same conditions would give a range of scores, any one of which could be "correct."

More reliable tests will tend to have more narrow intervals, implying that the observed score is more closely representative of the person's function. The 95% CI on a score is sometimes much wider than you would be comfortable with for some clinical purposes, so it is important to consider this.

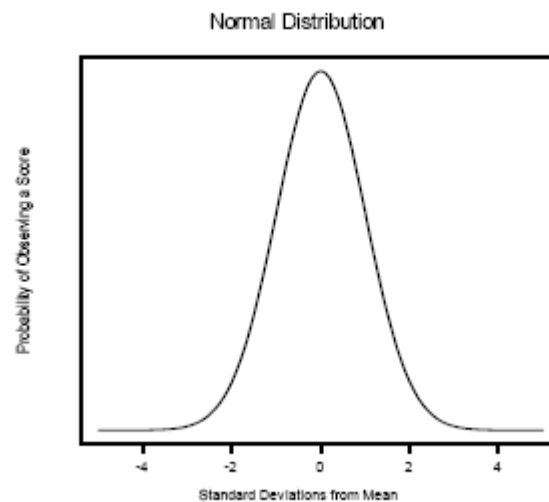
In a research context, confidence intervals can also be calculated for means or other quantities that describe the most likely score in a group of people. However, these confidence intervals are based on standard errors that are calculated in a different way than is the SEM for a single measurement.

### Normal Distribution

The **normal distribution** is one of several commonly used mathematical descriptions of the probability of getting any particular score. The normal distribution describes this probability in terms of the average and standard deviation of the scores in the population.

It is sometimes referred to as the "bell curve" because scores near the average are most common, with deviations from the average score becoming increasingly less likely, describing the shape of a bell.

The normal distribution is the usual basis for calculating the SEM and confidence intervals, and is also applied when calculating most types of standardized scores including percentiles, T-scores, Z-scores, and age-equivalent scores.



## Normative samples and norm-referenced measures

Measures are said to be **norm-referenced** if individual scores are interpreted by comparing them to the scores obtained for a large number of comparison children. This sample of comparison children constitutes the **normative sample**.

To interpret the measure, scores from the normative sample are used to transform the score for an individual child to a percentile, Z-score, or T-Score to measure how far above or below the child is from the average of the comparison sample.

To adjust interpretation for age- or sex-related differences, it is common to calculate norms within age-bands or genders. In practice, many measures used in pediatric rehabilitation use typically developing children as normative samples, although this is not always a clinically useful comparison.

## Z-Scores

By assuming that scores are consistent with the normal distribution and estimating the average and standard deviation for the relevant population, it is possible to transform any obtained score to a **Z-score** or **standard score**. This transformation re-calculates the score as if it came from a population with an average score of 0 and a standard deviation of 1.

Z-scores are therefore a way of expressing a person's score in units of standard deviation and relative to the average. For instance if a girl's score is 1.0, this means that she is 1 standard deviation above average, a score of 0 means she is perfectly average, and a score of -1.0 means that she is 1 standard deviation below average. Z-scores can be used to compare a child's performance on measures with different units that nonetheless can be standardized and compared as Z-scores.

More importantly, Z-scores are directly related to the probability of obtaining scores in a normal distribution, and so Z-scores can be used to calculate confidence intervals and percentiles. For instance, if a child receives a raw score of 25 on a clinical measure, it may not be clear whether this is high or low. However, if the average score in some large relevant comparison population is 20, and the standard deviation is 5, then the child's Z-score is 1. If scores in the comparison population really are normally distributed, then the child has obtained a score which is better than about 84% of similar children. In other words, this is one way of calculating percentiles based on norms.

Notice however, that the meaning of the score has changed in the process of transforming it. The original raw scores may have been based on what the child could actually do (e.g., the number of items correct), whereas the Z-scores and percentiles are only interpretable in terms of how far above or below average the child's performance is.

The usefulness of the Z-score therefore depends strongly on the appropriateness of the comparison sample.

### Percentile

A **percentile** is the percentage of people who score below a certain value. Percentiles must therefore range between 0 and near 100. If the scores of a measure approximately follow the normal distribution, a child at the 50th percentile has obtained the average score, and has a score better than 50% of children in the relevant population.

Percentiles are often calculated by administering the measure using standard procedures to a large sample of children who are representative of a reasonable comparison group. These children form the normative sample. Scores for these children can be rank-ordered and tabulated to identify the percentiles.

There are some difficulties with this method, and as an alternative it is common to assume that the scores in the normative sample are normally distributed and estimate the percentiles using Z-scores.

### Age-Equivalent Scores

For many measures it is possible to look-up **age-equivalent** or **grade-equivalent scores** from the raw scores.

Age-norms are found by calculating the average score obtained for children in each of several age-bands in the normative sample. The average score for each age-band defines its age equivalency. For example, if the average score for 6 year olds is 40, then any child who scores 40 has an age-equivalent score of 6 years.

There are some problems associated with the use of age-equivalent scores. One problem is that not all children within an age band in the normative sample have the same score. This source of uncertainty in the norms is not usually considered, for instance, by calculating the standard-error of the age-equivalent score.

### T-Scores

**T-scores** are like Z-scores except that they are scaled to have an average and standard deviation other than 0 and 1. The alternative average and standard deviation are usually somewhat arbitrary and often depend on convention. For instance, by long-standing convention, intelligence tests have a mean of 100 and a standard deviation of 15.

### Criterion referenced measures

As an alternative to norm-referenced measures, **criterion-referenced** measures do not use comparisons to a normative sample for interpreting scores.

Instead, criterion-referenced scores are interpreted by considering directly whether the child has met age-appropriate functional demands, as reflected in the content of the measure.

Scores are interpreted in terms of whether children can do specific tasks that are important for their age, grade, or clinical context, rather than how “normal”, “typical”, or “average” their performance is.

In other words, criterion-referenced measures are interpreted in terms of their content, rather than a population. Norms, percentiles, age-equivalent scores and other standardized scores should not be provided for criterion-referenced measures.

### **Rasch analysis and Item Response Theory**

**Item response theory (IRT)** is a set of related approaches to the reliability and validity of measures. **Rasch analysis** is a particular version of item response theory. In contrast to approaches that define reliability in terms of a measure’s ability to detect consistent variations among people, IRT methods use statistical methods to develop separate models of the difficulty of individual items and the functional abilities of children.

Although IRT methods can be more complex to use and interpret than traditional methods, there are some potential advantages. In particular, measures developed using IRT can generally be used for children having a wider variety of functional levels because children can be tested with the subset of items that is most relevant to their abilities. To use an IRT measure, you will be provided tables or a computer program that converts raw scores into IRT scaled scores. You may also be provided with aids such as item maps that describe the estimated difficulty of items by relating scaled scores to the probability of correctly performing the items.

#### **For more information**

The *CanChild* website has more information about measures and measurement issues: [www.fhs.mcmaster.ca/canchild/](http://www.fhs.mcmaster.ca/canchild/). Inquiries can also be directed to:

Steven Hanna  
CanChild Centre for Childhood Disability Research  
McMaster University, IAHS Room 408  
1400 Main St. West, Hamilton, Ontario, Canada L8S 1C7  
phone 905.525.9140 ext 27851  
fax 905.522.6095 email [hannas@mcmaster.ca](mailto:hannas@mcmaster.ca)

#### **Developed By:**

Steven Hanna, Dianne Russell, Doreen Bartlett, Marilyn Kertoy, Peter Rosenbaum, Marilyn Swinton

#### **Supported By:**

The Jack and Ina Pollock Charitable Foundation

#### **Research Version**

**Last Revised March 2005**

© Hanna, S., Russell, D., Bartlett, D., Kertoy, M., *CanChild* Centre for Childhood Disability Research, McMaster University  
Rosenbaum, P., & Swinton, M., 2005. *Clinical Measurement Guidelines for Service Providers*

## **Interpretation & Translation Services**

### **Policy**

CTN will provide a cultural/language informant/interpreter to all assessment and treatment sessions as deemed necessary by the family and clinician.

Clinicians will access their existing resources within their agency first, and then will investigate availability within their local team with the assistance of the Team Facilitator.

A professional interpreter is booked for all assessments when the family is not bilingual with English (i.e. the working language of the family is not English). Family members/friends are not acceptable interpreters, unless it is the wish of the family.

All recheck/reevaluation and goal setting appointments will be professionally interpreted when the family is not bilingual with English.

A professional interpreter is booked for the child's treatment sessions when the family is not bilingual with English. The number of treatment sessions that will require professional interpretation services will vary from family to family.

Some families may have a family member or friend that the family and clinician feel comfortable in using for translation.

It is anticipated that a minimum of half of the treatment sessions will require translation services, but that with increased knowledge of the treatment methodology, expectations and a good working relationship with the clinician, families might feel comfortable without this assistance.

Written documentation, where possible, should be provided to the family in the language that they can read. The Single Plan of Care contract with goals and brief home programming should be provided in the family's first language.

### **Expected Outcome**

All families in York Region will have access to CTN services regardless of their mother tongue.

### **Procedure/Guideline**

1. ACCESS will highlight that a referred child is learning a second language other than English and make note whether an interpreter is required to communicate with the parents.

2. If an interpreter is required to book an appointment, the service coordinator will determine if there is anyone in their local team that can make this initial contact call on their behalf. It is the Team Facilitator's role to keep this roster of languages at the local team up to date with current contact numbers.
3. Bridge Translations would be contacted for phone interpretation if there is no accessibility to this language at the local team. A Bridge Translation Interpretation Assignment form would need to be filled out to book this phone interpretation.
4. The clinician would explain to the interpreter the purpose of the conversation and would then place the interpreter on hold while the clinician in turn phones the family. Once the family has picked up the phone, the interpreter is brought back on line for three way teleconferencing.
5. An interpreter is booked for each appointment or series of appointments using the Bridge Translations Interpreter Assignment Form.
6. Bridge Translations will fax back the form with the confirmation information completed. A copy of this form is also faxed to CTN, Attn: Carolyn Cannon.
7. The interpreters can be asked to translate brief home programs at the end of a therapy session for the families to take home and apply the learned skills in their home language.
8. In event that the appointment with the interpreter needs to be cancelled, it is the clinician's responsibility to phone Bridge Translations at 1-888-243-9926 ext.0

## **Speech and Language**

### **Multiculturalism and Language Disorders**

#### Background and Definitions

Simultaneous bilingual children – children who learn two or more languages from birth or at least starting within the first year after birth. In effect, simultaneous bilingual children have two first languages. They can be exposed to languages in different ways, from their parents or siblings or from grandparents or relatives, to mention the most common patterns. We also sometime refer to these learners as bilingual children.

Second language learners/children – children who begin to learn an additional language after 3 years of age; that is, after the first language is established.

Dual language learners/children – both simultaneous bilingual children and second language learners. They may be preschool or school age.

Majority ethno-linguistic community – a community of individuals who speak the language spoken by most of the members of the community and/or are members of the ethnic/cultural group that most members of the community belong to. The community may be as large as a country, or it may be a state or province within a country or some smaller unit. The majority language and culture usually have special recognition as the official language and culture of the community. In other cases, they are regarded unofficially as the high-status language and culture in the community. Their majority language is the language used by most newspapers and other media and in the courts and by political bodies in the community. Examples are Anglo Americans in the United States, English Canadians in Canada, and native German speakers in Germany. We also use the term majority group synonymously.

Minority ethno-linguistic community – a community made up of individuals who speak a minority language and who belong to a minority culture. The language and culture may be in the demographic minority or have relatively low social, economic, and political power. Examples are Spanish speakers or individuals of Hispanic background in the United States, speakers of Inuktitut or Chinese in Canada, speakers of Navajo or Hopi in the United States, and Turkish speakers in Holland and Germany. We also use the term minority group synonymously.

Therefore four types of dual language learners:

	Majority Group	Minority Group
Simultaneous bilinguals	Children from a majority group learning two languages from birth	Children from a minority group learning two languages from birth
Second language learners	Children from a majority group learning a second language after their first is established	Children from a minority group learning a second language after their first is established

Specific Language Impairment (SLI) – a developmental disorder in which children have delayed or deviant language development; however, children with SLI have typical intelligence, hearing, and social-emotional behaviour as well as not frank neurological impairment.

Subtractive bilingual environments –the acquisition of the majority language comes at the cost of loss of the native language i.e. parents of immigrant children are often encouraged to use only the majority language in the home during the preschool years as a way of facilitating the child’s integration into the majority language schools

Additive bilingual environments – substantial support for children to maintain their native language as they acquire an additional language. Dual language children from majority ethno-linguistic groups often enjoy the benefits of living in additive bilingual environments. They are not made to feel that they have to be a member of only one cultural group.

Dominance – the condition in which bilingual people have greater grammatical proficiency in, more vocabulary for, or greater fluency in one language or simply use one language (The dominant language) more often. The dominant language can change throughout the life span; a bilingual person can be just slightly dominant or highly dominant in one language. In bilingual children, dominance potentially has effects for language choice and for how closely bilingual children can be compared with monolingual children with respect to rate of development.

## **Key Points and Clinical Implications For Simultaneous Bilinguals**

1. Research on infants with monolingual and dual language exposure indicates that infants have the innate capacity to acquire two languages without significant costs to the development of either language. Simultaneous dual language children generally experience the same milestones at approximately the same age as monolingual children, in both the early months and later on with respect to grammatical development.

### **Implications**

- Do not assume that any delays or difficulties a dual language child is experiencing in language development are due to dual language exposure. Dual language exposure is not a risk factor in language development.
- In order to ensure full dual language development, it is important that children be given consistent, continuous and rich exposure to both languages on a regular basis. What appear to be delays in the development of one or both languages could be due to inadequate exposure. Input is important.
- Clinicians should use the same developmental variation that characterizes monolingual children as a benchmark for judging SLI in dual language learners; in other words, some time-related variation is typical, but extreme cases are cause for concern and call for further examination.

2. Children exposed to two languages from birth have two separate but interconnected linguistic systems from the outset. Developmental language patterns and rates are the same overall for monolingual and bilingual children for phonology and grammar. When bilingual children occasionally produce rather unique errors in their language, it is most likely the result of cross-linguistic influence.

### **Implications**

- Do not assume that bilingual children will be delayed in language development or that they will display unique stages or patterns in their languages because dual language input might confuse them. Bilingual children can be expected to appear as “two monolingual children in one,” for the most part, and can differentiate between their two languages.

- Do not be concerned if bilingual children sometime produce sentences in one language that follow the grammatical rules of their other language; this kind of cross linguistic influence is typical and temporary and is not a sign of confusion or impairment. E.g. code mixing

3. Dominance or unbalanced development of the two languages is expected and typical in bilingual acquisition. Bilingual children may appear more advanced in one other two languages. It is important to keep in mind that when speaking their non-dominant language, bilingual children may use words from their dominant language because they do not know them yet in their non-dominant language. This style of language use is typical and does not indicate the presence of language or pragmatic impairment.

**Dominant language will have:**

1. longer MLU and more advanced grammatical structures
2. larger number of different word types, or verb types in particular, used in a stretch of discourse of fixed length
3. Fewer pauses or hesitations
4. Greater volubility

**Implications**

- Determine which of the bilingual child's two languages is the dominant language before assessing the child's language development. This can be achieved by asking the parents about the child's language environment in order to ascertain which language the child is exposed to and uses more often. The language of greatest exposure is typically the dominant language. This can be determined by asking the parents a series of questions about language use around the child. More precise measures of language dominance would include examining vocabulary size, sentence length and complexity, and volubility in each language.
- When assessing a bilingual child, the dominant language is the one to examine for the upper limits of that child's development. This can be problematic for cases where the societal or majority language is the language of the clinician, but the child's more proficient language is a minority language, because the clinician lacks competence in the appropriate language of assessment.
- Testing bilingual children in their non-dominant language could result in substantial underestimation of the child's linguistic abilities overall and for vocabulary size in particular.

3. Bilingual children usually exhibit the same rates and stages of development with respect to phonology and grammar. In contrast, they typically have smaller vocabularies in each language than monolingual children of the same age who are learning the same language. When their two vocabularies are added together with translation equivalents counted only once, however, bilingual children typically have vocabularies of an age-appropriate size.

## **Implications**

- Do not use vocabulary tests as a central measure.
- Expect vocabulary size in each language of a bilingual child to be smaller than that of a monolingual child

5. Bilingual children with SLI display characteristics of SLI in both of their languages. They do not experience more severe impairments than same-age monolingual children with SLI. Children with SLI have the capacity to become bilingual.

- Be careful not to confuse SLI with bilingual-specific developmental patterns, such as cross-linguistic influence or code-mixing
- It is not always possible to conduct an assessment in both languages; if the child shows an SLI profile in one language, one can assume that she also shows an SLI profile in her other language. Distinguish between delay and impairment; it is possible that the child has been assessed in her non-dominant language and that this is the reason for the appearance of developmental delay.
- One should not assume that the dual language acquisition is causing the problem; a more severe SLI in a bilingual child could be that the child is tested in their non-dominant language or that the child is simply more severely affected
- Intervention in both languages would be ideal, but if for example, English is the only language that can be used, it will still be useful for diagnostics and treatment.
- It is not appropriate or recommended to suggest that a bilingual child with SLI be encouraged to use only one language. There is no reason to assume that dual language knowledge is a burden for children with SLI; in fact, children with SLI are able to learn two languages.

## **Key Points and Clinical Implications For Second Language Learners**

1. Children acquire grammatical proficiency and build their vocabularies slowly in their L2. They may even go through a silent period when they first come in to contact with the new language. When they start producing their second language, their first utterances are usually short and formulaic. L2 children may become good communicators with their peers and with adults within a few months of exposure to English, but this does not mean that their accuracy with grammar, their vocabulary size and diversity, and their pronunciation is in the range of the native-speaking peers. Even after 2 years of full-time English exposure at school, L2 children may not sound like native speakers, and it could take them 5-7 years to master those aspects of the target language that are relevant to schooling.

### **Implications**

- It is important to determine how long the child has had consistent exposure to the L2 before considering whether the child appears to have a language delay or disorder. Consistent = full time exposure at school or preschool. Exposure less than a year, cultural differences, or emotional trauma could also be reasons for uncommunicative behaviour.

- Do not use standardized tests of language development for ESL children. Most likely not appropriate for L2 children within the first 2 years of exposure.
- Translations of language tests are not useful because 1) cultural differences make what is considered age-appropriate vocabulary different between languages; 2) typological differences between languages mean that certain target grammatical structures that are typical of children at a certain level of development in one language are not the same in other languages; and 3) above all, a translation is not nor med.

2. There is a great deal of individual variation between children in how quickly they learn a second language. Exposure, personality/social style and language aptitude can be factors.

### **Implications**

- Another reason to exercise caution using standardized tests with L2 children
- Acquiring an L2 under difficult personal circumstances can affect the children's interpersonal style with teacher and other children; can affect their ability to get input in the L2

3. The inter-language of L2 children is characterized by some phonological, lexical and grammatical differences from the target language. L2 children can take more than 2 years to accurately produce grammatical morphemes on a consistent basis.

### **Implications**

- If an L2 child seems to vacillate between using correct and incorrect sounding sentences, realize that his behaviour is a typical part of L2 acquisition and should not be considered as a sign of impairment when it is the only sign
- WE expect that L2 child is suspected of having language impairment, it is essential to find out whether she shows evidence for impairment in the L1 as ell; interview the parents

4. L1 attrition (shift in dominance, erosion, or complete loss of the L1) is a common phenomenon in minority language children; however, maintain proficiency in the L2 is beneficial for both psychosocial and cognitive/educational reasons, in particular for L2 children in subtractive bilingual environments. Maintenance of the L1 is more difficult if the child is being educated entirely through the medium of the L2.

### **Implications**

- If parents are worried about how their child speaks the L1, that he sounds funny or doesn't speak it well, this may not be a sing of impairment, but instead, a sign of L1 attrition.
- Dual language children should be given full support to learn both languages fully

## **Policy**

CTN will provide full support to families and care providers to allow for dual language development for children with language impairments. It is recognized that knowing two languages and being able to use them appropriately and effectively is a personal, social, professional and societal asset and is every child's right.

CTN will not provide English as a Second Language Instruction (ESL) without evidence of language impairment.

Competent treatment of impaired language development in dual language children requires an understanding of the typical course of bilingual and second language acquisition.

### **Expected Outcome:**

CTN clinicians will be able to distinguish between a speech and language impairment versus delayed acquisition of English as a result of non dominant exposure. Children will be able to develop receptive, expressive and articulation skills in the languages that they are exposed to within the constraints of the amount of exposure of these languages and the inherent language disorder the child presents with.

### **Procedure:**

#### **Assessment**

1. ACCESS will highlight that a referred child is learning a second language other than English and make note whether an interpreter is required to communicate with the parents.
2. If the parents can communicate well in English, a phone call is made by the assessing SLP prior to the assessment to determine the child's dominant language.
3. Ideally, the assessment will be conducted in the child's dominant language using standardized tests where appropriate.
4. If the dominant language is NOT English, a speech language pathologist in the network that speaks L1 may be accessed via Team Facilitator rosters.
5. For those languages for which there is no SLP access, CTN will arrange for a cultural/language informant/interpreter. In some cases, it may be determined that the parents English is proficient and knowledge of developmental milestones in L1 would be sufficient for the assessment.
6. Assessment of dominant L1 that is not English will be primarily through observation and interviewing the parent via checklists.

## Treatment

1. Ideally, treatment should be conducted in the child's dominant language or in both languages as in the case for those children who are balanced in their simultaneous acquisition.
2. Treatment of L1 for those under the age of 3 years would mirror what is offered to monolingual children enrolled in YRPSLP. Parents will be coached on how to interact with their children to facilitate language development. The format of this instruction will vary depending on the parent's knowledge of English. If their English is strong, they will be invited to a parent workshop; otherwise instruction will be given in small ELS groups with an interpreter if required.
3. Treatment of L1 over the age of 3 years is not really possible except for those languages spoken by SLPs in the network and again with limited capacity. Treatment can be conducted in English if the child's English exposure outside the therapeutic session is dominant. Parents should be given a home program that they can practice in L1. Home programming in English should be reserved for those parents that are fluent in English.
4. If the child does not have English exposure outside of the therapeutic session, it is recommended that treatment continue with coaching the family with language facilitation techniques in their first language. Families should be encouraged to enroll their child in English library, nursery school and day care programs to begin English exposure.
5. Parents should not be encouraged to communicate with their children only in English, but rather to continue to enrich their child's language development in their L1.

## REFERENCES:

Dual Language Development & Disorders. A Handbook on Bilingualism and Second Language Learning. Genesee, Paradis, Crago. Baltimore: Paul Brooks Publishing Company, 2004.

## Physical Therapist

Functions/Roles	Skill set	Baseline knowledge
Basic Positioning, seating, equipment, lifting, sleep positioning (with and without equipment)	Physiotherapy pediatric experience	College
Propulsion (wheelchair self propulsion and power wheelchair driving)	ADP authorizer (mobility and communications?)(preferred)	3-5 years pediatric experience Neurodevelopmental Treatment-Introductory level
Cardiorespiratory assessment and analysis	Ability to determine needs and implement appropriate intervention for acute and chronic conditions	Local services Tertiary services Familiar with issues related to Cystic Fibrosis, asthma, thoracic surgery
Assessment and analysis regarding muscle tone, range of motion, strength, coordination, balance, proprioception, quality of movement and motor planning Gait assessment and analysis Splinting and serial casting	Ability to screen to determine needs, complete assessments using a range of assessment tools tailored to fit child/family needs and interpret tests and determine functional, achievable goals and recommendations	Knowledge of typical and atypical development Familiar with developmental aspects of motor control in skill acquisition Knowledge of motor learning theories and strategies Familiar with musculoskeletal development and adaptation
Development of activity and exercise programs  Recommendations and training regarding necessary equipment and its use	Ability to implement the appropriate amount and type of intervention (proper modality, intensity, duration, evaluation) and reassess for progress/ difficulties, modify interventions and approach and implement  Consideration of cardiovascular and muscular endurance	Understanding physical fitness during childhood and adolescence Disability expertise: cerebral palsy, seizure disorder, acquired brain injury*, developmental disability, Autism Spectrum Disorder, muscular dystrophy, spina bifida, developmental coordination disorder, Down Syndrome, Arthritis and orthopedic surgical intervention related to these populations Knowledge concerning limb deficiencies and amputations
Sensory motor, sensory diet and protocols	Ability to negotiate with family and team co-workers to set goals, treatment approach, modifications, accommodations, instructions, training, and resources needed...)	World Health Organization – ICF/participation model
Play/adapted toys, games, recreation equipment	Able to carry out consultation, direct treatment, mediator model, monitoring roles effectively Educate families, children and youth regarding recreational adaptation and inclusion in school, community and leisure settings	Behaviour management
Back care, lifting: training families and staff in back care, transfers and lifting techniques		
Environmental adaptations/ accessibility: home and building accessibility, equipment adaptations, environmental safety and hygiene, equipment to support care,	Able to interact and communicate with children and youth (with varying cognitive and special needs) Able to help develop and/or utilize Care Plans (developed for client needs)	
Disability management/staff and peer sensitivity /awareness training		
Self advocacy		

## Occupational Therapist

Functions/Roles	Skill set	Baseline knowledge
* Basic Positioning, seating, equipment, lifting, sleep positioning (with and without equipment)	OT Pediatric experience	College
* Propulsion (wheelchair self propulsion and power wheelchair driving)	ADP authorizer (mobility and communications?)	3-5 years pediatric experience
Self feeding, swallowing, adapted equipment	Normal and abnormal development	Local services
ADL dressing adaptive clothing and equipment, domestic chores, self care, independent living- financial management, shopping, care provider direction adapted lifting, toileting,	Ability to screen to determine needs, complete assessments using a range of assessment tools tailored to fit child/family needs and interpret tests and determine functional, achievable goals and recommendations	Disability expertise: cerebral palsy, seizure disorder, acquired brain injury*, developmental disability, Autism Spectrum Disorder, muscular dystrophy, spina bifida, developmental coordination disorder, pre and post surgery kids, Down Syndrome, arthritis & amputations
Fine motor: Printing and writing, adapted equipment and techniques: eye hand coordination, visual perception, motor control, normal development, accommodations, compensations and equipment	Ability to implement the appropriate amount and type of intervention (proper modality, intensity, duration, evaluation) and reassess for progress/ difficulties, modify interventions and approach and implement	Knowledge of normal and abnormal development (gm, fm play, cognitive, communization, social, self help)
* SI, sensory motor, sensory diet & protocols	Ability to negotiate with family and team co-workers to set goals, treatment approach, modifications, accommodations, instructions, training, and resources needed...	World Health Organization – ICF/participation model
* Play/adapted toys	Able to carry out consultation, direct treatment, mediator model, monitoring roles effectively	Behaviour management
Alternative access for tech, cause effect (switch use/turn taking, technology adapted access, mounting, training in access and modifications (hardware and software), keyboarding Environmental control (toys, living devices) Communication support: especially with non verbal clients	Able to interact and communicate with children and youth (with varying cognitive and special needs)  Able to help develop and/or utilize Care Plans (developed for client needs)	
Toileting		
Task skills, orientation (ABI), task completion, reality orientation		
* Motor plan (kinesthetics, Proprioception, muscle tone), Range of motion, exercise program, strength, coordination, exercise and activity programs and equipment Splinting, serial casting		
* Developmental Coordination Disorder		
* Self advocacy		
* Disability management/staff and peer sensitivity /awareness training		
*Backcare, lifting: training families and staff in back-care, transfers and lifting		

Functions/Roles	Skill set	Baseline knowledge
*Environmental adaptations/accessibility: home and building accessibility, equipment adaptations, environmental safety and hygiene, equipment to support care,		
*Transition planning adult services and supports (prevocational)		

\* indicates roles that can be carried out by PT or OT

## Rehab Assistant

Functions/Roles	Skill set	Baseline knowledge
Provide assistance and follow treatment programs for children, youth and families, as delegated by the supervising health professional	Exchange information freely, build on others' ideas, support groups decisions.	Degree from a recognized University in Kinesiology, Physical Education, or Diploma in Physical Therapy / Occupational Assistant from a recognized community college. To be aware of and practice safety standards.
Complete assigned tasks to maintain the optimum functioning of the rehabilitation department and treatment area	Detect existence of problems or opportunities, identify underlying issues or problems, organize information, identify cause and effect relationships and report to supervising body	2 years pediatric experience  Local services
Assist with tidying up and cleaning equipment as necessary	The ability to carry out treatment programs as delegated by the supervising health professional  Able to interact and communicate with children and youth (with varying cognitive and special needs)	Demonstrated ability to work with children and youth who are challenged by physical, developmental and emotional difficulties (e.g. cerebral palsy, acquired brain injury, developmental disability, Autism Spectrum Disorder, muscular dystrophy, spina bifida, developmental coordination disorder, Down Syndrome, arthritis and amputations)
Monitor crutches, splints, etc ... and request ordering as necessary	The ability to complete assigned tasks to maintain the optimum functioning of the rehabilitation department and treatment area	Knowledge of typical and atypical development
Assist with clinics (e.g. seating, mobility, serial casting)	To provide accurate and concise documentation with regard to interventions with clients and families	World Health Organization – ICF/participation model
Assistance during group or individual based therapeutic intervention	A commitment to developing an individuals optimum level of independence, restoring function, and maintaining ability	Behaviour management

OT or PT assistants: must be physically within the building under supervision of a registered therapist

## Speech Language Pathologist

Function/Roles	Skill Set	Baseline Knowledge
Assessment of nonverbal infants/toddlers and children	Informal assessment skills without reliance on formal measures	Knowledge of prelinguistic development Strong knowledge in normal language development
Assessment of social communication disorders and play	Informal assessment skills without reliance on formal measures	Knowledge of pragmatic skills and normal development of play
Assessment of physically handicapped children's comprehension of language	Able to modify assessment procedures to allow for demonstration of comprehension of language without physical movement	
Differential diagnosis between motor speech disorders and expressive language disorders	Experience PROMPT or similar systematic approach to assessment	Understanding of the motor systems of speech and their coordination
Differential diagnosis between motor speech disorders, phonology and dysarthria	Able to identify where the level of disorder is occurring	Understanding of neurological involvement and accompanying dysarthria's of speech
Augmentative Communication Assessment	ADP individual authorizer Ability to encode language in to a variety of symbol sets and be able to substep and superstep between them	Strong knowledge of symbol set continuum Familiarity with augmentative systems
Assessment of Parent Child Interaction	Hanen Training in: ➤ It Takes Two to Talk ➤ More than Words	Cultural Differences in parenting and expectations of the child
Assessment of Feeding/Swallowing	Able to make observations about oral and pharyngeal stages of swallow Able to evaluate a child's oral intake as normal or abnormal	Normal Development
Parent Education	Hanen Training Strong Parent Coaching and Counselling skills	Adult Learning Cultural Differences in parenting and expectations of the child
SLP - Treatment of Motor Speech or Dysarthric Speech Disorders	PROMPT Experience	
Augmentative Communication	As above Ability to expand communication system to meet child's growing needs in various environments	Strong knowledge in Picture Exchange Communication System (PECS); PCS, Boardmaker ADP individual authorizer level devices and general clinic level devices
Treatment of Feeding and Swallowing	Able to work with various food textures in a systematic fashion	

## Communicative Disorders Assistant

Function/Roles	Skill Set	Baseline Knowledge
Observation of nonverbal infants/toddlers and children		Knowledge of prelinguistic development Strong knowledge in normal language development, pragmatics and play
Treatment with physically handicapped children's comprehension of language	Able to modify treatment procedures to allow for active participation by the child	
Treatment/Coaching of Parent Child Interaction	Hanen Training	Cultural Differences in parenting and expectations of the child
Parent Education/Caregiver Education	Presentation Skills	Adult Learning Cultural Differences in parenting and expectations of the child Knowledge of preschool settings/curriculum and expectations Knowledge of school settings/curriculum and expectations
Treatment of Motor Speech or Dysarthric Speech Disorders	Experience	Understanding of the motor systems of speech and their coordination
Augmentative Communication	Ability to encode language in to a variety of symbol sets and be able to substep and superstep between them Ability to adapt high and low tech devices to the child's physical needs Equipment trouble shooting skills Strong computer skills Able to program devices and set up low tech systems Able to maintain AAC equipment	Strong knowledge in PECs; Picture Communication Symbols, Boardmaker Familiarity with high and low technology devices

## Social Worker

The role of the CTN social worker is to work with families and children with special needs to promote optimal family and individual functioning, recognizing unique family goals, values and needs. The social worker works as a part of the larger team, and, for the most part, in a short term capacity. While it is often the role of a social worker to provide case management and future planning support to families, in most cases this will be the role of the CTN service coordinator. The CTN social worker will assume this responsibility when the issues are more complex and require a counselling as opposed to a supportive approach. The social worker may participate in the team assessment process, as needed. The social worker will work closely with the service coordinator to ensure a clear delineation of roles and smooth transition of service.

Functions/Roles	Skill set	Baseline knowledge
Reporting guideline	Professional affiliation: college or equivalent	Eligible for college membership
Assessment: Family (behaviour based) Individual and family coping skills Family dynamics Potential risk factors Strengths and supports	Demonstrated skill in assessment of children and families Experience with children with special needs Understanding of behaviour as communication Multidisciplinary approach	BSW: Counselling stream 2+ years experience in related service Knowledge of assessment protocols and practice Broad knowledge base of health and social services.
Counselling: individual and family counselling grief counselling, adjustment to disability/illness attachment caregiver distress intergenerational or family conflict parenting difficulties social isolation	Specific training in brief focussed therapy Skill in play and/or activity based therapy Knowledge of developmental and physical disabilities and impact on family dynamics Conflict management skills	Demonstrated skill in individual and family counselling Multidisciplinary treatment approach
Counselling groups: focused treatment therapy group for parents, youth with disabilities and their siblings (possibly in conjunction with other team members) Parenting, Sibling support Self esteem	Demonstrated skill in working with therapeutic and educational small groups with a variety of age groups	Detailed knowledge of education, health and social services Theory of group practice Understanding of the difference between educational and therapeutic groups Understanding of grief as it pertains to families with a member with a disability Cultural sensitivity and respect for diversity

<b>Functions/Roles</b>	<b>Skill set</b>	<b>Baseline knowledge</b>
Grief and loss Coping skills Psychosocial and psychoeducational groups		
Individual counselling with children/youth (see individual and family counselling above)	Play/activity based therapy Demonstrated skill in working with individuals with alternative communication styles	Experience working with children and youth
Group work with children and youth: social skills counselling assertiveness, self advocacy relationships	Demonstrated skill in running groups for youth with disabilities	Training in group work with youth
Work in team multidisciplinary assessment clinic support work closely with service coordinator as needed	Experience in multidisciplinary work setting	Understanding of multidisciplinary approach to service delivery
Staff and team member training: interplay between family dynamics and the child with special needs therapeutic process group facilitation individual and team consultation (all above) Co-lead groups	Adult learning styles Demonstrated skill in teaching and training adults Demonstrated skills in mentoring	Excellent communication skills
Liaison with existing SW/professional workforce	Participation in local chapter of OASW	

## Psychologist

<b>Function/Roles</b>	<b>Skill Set</b>	<b>Baseline Knowledge</b>
Assessment of cognitive abilities in babies, toddlers and preschoolers	Able to administer tests, such as the Bayley Scales of Infant and Toddler Development (Third Edition), Wechsler Preschool and Primary Scale of Intelligence: Third Edition (WPPSI-III) and interpret the results	Knowledge of cognitive development in typically developing children
Assessment of cognitive development in school age children	Able to administer tests such as the Wechsler Intelligence Scale for Children: Fourth Edition (WISC-IV) and interpret the results	Same as the above

<b>Function/Roles</b>	<b>Skill Set</b>	<b>Baseline Knowledge</b>
Assessment of emotional functioning in children of all ages	Informal assessment skills and use of appropriate questionnaires such as the Children's Depression Inventory (CDI) and interpret the results	Knowledge of emotional development in typically developing children
Assessment of nature and severity of behavioural difficulties in children of all ages	Informal assessment skills and use of appropriate questionnaires such as the Achenbach Child Behaviour Checklist and interpret the results	Knowledge of behavioural development in typically developing children as well as of abnormal child development
Assessment of adaptive behaviour in children of all ages	Able to administer questionnaires such as the Vineland Adaptive Behaviour Scales and interpret the results	Knowledge of the development of communication daily living skills, socialization and motor skills in typically developing children
Assessment of learning disabilities	Able to administer tests such as the Wechsler Individual Achievement Test: Second Edition (WIAT-II), Wide Range Assessment of Memory and Learning (WRAML), Children's Memory Scale as well as the tests of cognitive abilities already mentioned above and interpret the results	Knowledge of normal learning and learning disabilities in children
Assessment of Autistic Spectrum Disorders	Informal assessment skills and use of measures such as the Childhood Autism Rating Scale (CARS), Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), Autistic Diagnostic Observation Schedule- Generic (ADOS-G)	Knowledge of child psychiatry and abnormal development in children
Parent counselling re behavioural concerns, school placement issues, for children in general and children on the autistic spectrum in particular	Experience in parent counselling	Knowledge of behaviour modification and educational options in both York Region School Boards

## **Specialty Service Team Facilitators**

### **Reporting Relationships**

- Reports directly to supervisor of hosting agency that hired the Specialty Team Facilitator
- Develops clinical, budgetary, educational and workload guidelines with the CTN Clinical Director
- Communicates and liaises with CTN Clinical Director, CTN Specialty Team, Peer Specialty Team Facilitator from the other region, Local Team Facilitators, ACCESS Service Navigators, Child and Family team Service Coordinators, other hosting agency supervisors, Bloorview Kids Rehab mentors

## **Job Responsibilities**

### **Clinical**

- Participates in providing a developmental assessment to CTN clients with a complex diagnostic query
- Collaborates with staff in designing and implementing an integrated approach to care

### **Team**

- Leads the Specialty Team to provide a collaborative team approach with clients, families and school/preschool partners in order to provide a comprehensive developmental assessment
- Ensures that team members receive appropriate professional development and supports as identified– in coordination with the CTN Clinical Director.
- Ensures there is sufficient time and support to form trans-disciplinary teams and share information and clinical experiences on a regular basis – including clinical discussions, prescription reviews, etc.
- Monitors equity of service delivery across teams – provides feedback to teams and CTN Clinical Director
- May provide hosting agency supervisors with appropriate feedback regarding Specialty Team staff performance if requested

### **Administrative**

- Leads staff in designing, documenting and implementing an efficient, effective, client-focused Service Delivery Model for CTN clients with complex developmental needs across all hosting agencies
- Works collaboratively with the CTN ACCESS service navigators in designing, documenting and monitoring clear, efficient and effective Referral and Intake policies and procedures
- Leads staff, along with the CTN ACCESS Director and Clinical Director, in designing, documenting, implementing, and monitoring clear, efficient and effective documentation policies and procedures that meet all professional Colleges, hosting agencies and can be integrated into the CTN's electronic document and single plan of care
- Leads staff, along with the CTN Director of Evaluation and Planning and Clinical Director, in designing, documenting, implementing, and monitoring standard ways of measuring and documenting outcomes – of direct client services, as well as indirect services needed to support and train local teams
- Leads staff, along with the CTN Director of Evaluation and Planning and Clinical Director, in designing, documenting, implementing, and monitoring Quality Improvement activities to ensure the delivery of efficient and effective service

- Liaises with CTN Clinical Director to provide feedback on workload measurement systems from Specialty Team and provides functional guidance to the Specialty Team with respect to coding
- Liaises with hosting agency supervisors to assist with Specialty Team staff recruitment as requested

### **Education**

- Coordinates and plans appropriate professional development activities to meet the identified needs of Specialty Team staff – incorporating a variety of formal and informal workshops, small group trainings, individual coaching and mentoring
- Collaborates with local team facilitators in identifying, designing and implementing appropriate supports, resources and trainings for clients, their local school or preschool teams, families and other partners

### **Equipment**

- Leads staff in identifying materials and equipment required by the Specialty Team in supporting CTN clients with complex communication needs within their educational or home environments
- Liaise with local team facilitators in setting up and implementing appropriate materials and equipment for a centralized Community Resource Centre and loan library for local teams as well as for use by the Specialty Team for demonstration, assessment, short term loan, and training.
- Liaise with local team staff (i.e., Resource Centre admin support staff) around equipment that is on loan or in need of repair, using an automated equipment tracking system. CTN will set up a database, bar code system and/or library/loan system for items that would be loaned – books, materials and equipment for all staff.

### **Goals**

1. To establish an ongoing mechanism to facilitate local teams in the region in supporting CTN clients with complex developmental needs:
  - a) Where the client is in the initial stages of assessment and intervention & where the client's needs do not require a dedicated, trans-disciplinary team  
and/or
  - b) Where the client (or local team) requires more support - by preparing an appropriate referral to the Specialty Team to ensure effective, efficient, seamless assessment  
and/or
  - c) Where the client is waiting for services from the Specialty Team

## **Augmentative and Alternative Communication Specialty Service (AACSS)**

Augmentative and Alternative Communication (AAC) refers to methods (other than speech or handwriting) that are used to send a message from one person to another. We all use face-to-face augmentative communication techniques, such as facial expressions, gestures and body language and written communication techniques such as handwriting/typing. In difficult listening situations (i.e. noisy rooms), we tend to augment our words with even more gestures and exaggerated facial expressions. People with severe speech and language problems must rely quite heavily on these standard techniques as well as on special augmentative techniques that have been specifically developed for them. Some of these special face-to-face communication techniques include sign language, picture/word communication boards and voice output devices. Some written communication techniques include adapted/alternative keyboards for computer access. Special AAC is used when speech is not possible or is very difficult to understand and when manual handwriting is not functional, due to a physical disability.

### **Service Description**

- The Augmentative and Alternative Communication Specialty Service (AACSS) of the Children's Treatment Network strives to enable children and youth with physical and communication needs to develop functional face-to-face or written communication.
- The services of AACSS are oriented to the needs of the child and their team and includes assessment, consultation, intervention and training in specialized communication techniques and/or systems.
- AACSS provides in-services and workshops to build on the knowledge of the local team. Coaching and mentoring are also available to local team members around specific children, and can be supportive in low technology and individual authorizer (IA) prescriptions.
- Low and high technology communication devices may be prescribed through AACSS\* to enhance an individual's face-to-face or written communication. Because AACSS has been integrated with the York and Simcoe Boards of Education, AACSS is able to prescribe computers and educational software for general learning purposes for the physically disabled for both home and school.

### **Criteria for Access to AACSS**

- Children and youth under the age of 19 years (or until graduation from high school) who reside or attend school in York Region or Simcoe County
- Children and youth who are not able to write due to a physical disability and/or those who are functionally non-speaking.

## **Access to AACSS**

- 1) As part of the child's Single Plan of Care (SPOC) the child and family team will identify the goal of having the child use an augmentative device/writing aid for communication.
- 2) The child's local child and family team will initiate the assessment for AAC and will refer to the AACSS when necessary (i.e. for assistance in assessment, prescription needs, training use to both the child and parents/caregivers/and teachers).
- 3) Referrals to the AACSS are facilitated by the child and family's Service Coordinator.
- 4) Priority will be given to individuals without a means of communication or if they have had a sudden change in their communication status.

## **The Assessment Process:**

- 1) Assessments are conducted over two or three sessions. Observations occur both in home and (pre)school. Other primary facilitators (therapists, teachers, assistants) will be asked for information to clarify the child's communication needs and to participate in the assessment.
- 2) Assessments are conducted by a speech language pathologist, occupational therapist or both depending on the needs of the client. The assistive devices technician may also be involved toward the end of the assessment process if customization or mounting of a device is required.
- 3) If clients require equipment that will have an impact on their seating/mobility systems, the child's local team occupational therapist will be consulted and specialty seating and mobility services may be arranged.
- 4) An assessment with a variety of communication strategies and systems will be conducted, to determine which components will best help the client meet his/her communication needs.
- 6) An eight-week trial (approximate) with equipment may be provided in some cases to help determine whether the system is appropriate and useful in your environment.
- 7) Clients, parents and their local team will be asked to help determine the final augmentative communication system and to prioritize goals and make modifications to the Single Plan of Care.

What's involved in ordering a communication device, if one is prescribed?

Once a decision has been reached regarding the communication system and if equipment needs to be ordered, your AACSS clinician(s) will prescribe the equipment and arrange for the appropriate paperwork to be completed by our program assistant. If you are eligible for ADP funding and if prior authorization from ADP for the equipment is required, this will also be done.

## **ACS and the Assistant Devices Program (ADP)**

As our service is accredited as an Expanded Level Clinic by ADP, our clinicians are able to prescribe both high and low technology devices for individuals who meet ADP's eligibility criteria for funding assistance. ACS clinicians will help you determine if you/your child meet the eligibility criteria. (Note: Individuals with a primary diagnosis of Learning Disability are not eligible for ADP funding for written communication equipment). Funding assistance from ADP may be toward the purchase or lease of a specific communication device.

Is there funding available for the portion not funded by ADP?

The portion of the cost not funded by ADP is most often the responsibility of the client/family. However, if you receive benefits from:

- Ontario Disability Support Program (ODSP);
- Ontario Works Program (OW); or
- Assistance to Children with Severe Disabilities (ACSD)

The Ontario Ministry of Health will provide assistance up to 100% of the maximum allowable costs toward the purchase price of any authorized equipment. Note that this additional assistance applies to qualified clients only and is solely applicable toward purchased equipment. Once you are on the ACS caseload, your therapist(s) will discuss the advantages and disadvantages of purchasing versus leasing (if applicable to you). He/she will also assist you in applying for all ADP funding available to you.

In addition to government funding sources, insurance benefits may provide coverage, depending on the individual plan. On request, if a physician's letter of prescription is required, one will be provided. Financial assistance for purchase or lease or lease may also be available from such agencies as the Easter Seals Society, March of Dimes or local service clubs.

In all cases, the client/family must make the application for financial assistance to these agencies. You may contact our service coordinators if you need assistance with the process. You will need confirmation of funding before proceeding with the ordering of your equipment from the vendor of your choice.

What happens next?

An appointment will be arranged once the prescribed device arrives. This can take up to eight weeks after the paperwork, funding and ordering of the equipment has been completed. Equipment that needs extensive programming will take longer as will equipment that requires customization by our rehabilitation technologist or technician.

AACSS team members will provide instruction and support to the client, parents and facilitators on the programming of devices and/or implementation of systems or techniques to help meet the identified goals. They also will remain active and provide further consultation, to help you move toward accomplishing the identified goals. If you run into problems with your equipment or need assistance with problem solving or establishing new goals, contact your AACSS clinicians.

Will I need regular follow-up?

A review of a client's communication system generally occurs annually for those clients who are establishing their communication strategies or for those whose needs are changing. An earlier review can also be requested at any time. For our clients who turn 19 years of age, we will continue to follow them if they have ongoing communication needs that can best be met by our service. Once any of our client's communication needs have been satisfactorily addressed, their file will be made inactive in AACSS. However, should needs change, the file can be reactivated upon request. In the child's final year of school, the transitioning of the child's AAC needs would be incorporated in to his Single Plan of Transition and adult AAC services would be contacted by the child and family team's service coordinator. For clients who lease a system from ADP, an annual review is required.

Written Communication Instruction

The Written Communication Instructor provides keyboarding and word processing instruction programs for ACS clients who use some type of a keyboard access method (ranging from one handed typing through to specialized keyboard access). Voice recognition instruction is also provided to help clients become familiar with the features of their voice recognition system.

### **Feeding Specialty Services (FSS)**

***Feeding Specialty Services (FSS) provides assessment and treatment for children ages birth to 19 with feeding and swallowing difficulties in Simcoe County and York Region. These difficulties may include weakness in the muscles of the mouth, difficulty nursing or bottle feeding, difficulty with certain textures, poor chewing skills, poor weight gain/weight loss, coughing or choking while eating/drinking, significant reflux, children on tube feedings, surgery in the face or neck, and a history of upper respiratory infections. The team may consist of a Speech Language Pathologist, Occupational Therapist, Registered Dietitian, Psychologist and Paediatrician as required based upon the specified areas of concerns.***

### **Service Description**

- The services of FSS are oriented to the needs of the child and their team and include assessment, consultation, intervention and training in strategies to assist the child and family with feeding and swallowing difficulties.

- FSS provides in-services and workshops to build on the knowledge of the local team. Coaching and mentoring are also available to local team members regarding specific children.

### **Criteria for Access to FSS**

- Children and youth under the age of 19 years (or until graduation from High School) and who reside or attend school in York Region or Simcoe County.
- Children and youth who are not swallowing safely or not eating as expected for their age, and who may have a physical disability.

### **Access to FSS**

1. The child's local team and family will initiate the assessment for feeding and swallowing difficulties and will refer to the FSS when necessary.
2. Referrals to the FSS are facilitated by the child and family's Service Coordinator.
3. Priority will be given to individuals whose health may be significantly affected (e.g., suspected aspiration, failure to thrive).
4. A physician referral may be required if the consulting paediatrician to the team or a videofluoroscopy study is required. The FSS will contact the family's physician office directly.

### **The Assessment Process:**

1. Assessments are conducted by a Speech-Language Pathologist, Occupational Therapist, Registered Dietitian, or by a team of professionals that may also include a Psychologist and Paediatrician as required based upon the specified areas of concerns
2. Family and local team members will be asked to help determine appropriate feeding goals for the child.
3. When necessary, it may be recommended that the child have further assessment of their ability to swallow safely through x-ray evaluation (e.g., Videofluoroscopic Swallow Study).
4. When appropriate, referrals to and collaboration with other professionals or services may be recommended to further assist the child in their overall health and development (e.g., Gastrointestinal Specialist (GI), Ear, Nose and Throat Specialist (ENT)).

### **What Happens Next?**

- Members of the local team will be encouraged to attend the assessment in order to support the family and to help them with the strategies in their daily environment.

- Ongoing support and mentoring will be available as needed for the local team.
- When the child requires ongoing monitoring of their swallowing safety, the FSS team will assess as needed.

## **DEVELOPMENTAL ASSESSMENT SPECIALTY SERVICE**

The developmental team is comprised of members from various disciplines including a developmental paediatrician, a psychologist, a speech language pathologist, an occupational therapist and a social worker. Assessments are conducted on children presenting with either primary or secondary features of an Autism Spectrum Disorder or a Global Developmental Disability. Observations, interviews, standardized tests and other data are used by the team to aid in this process.

### **Service Description**

- The Developmental Assessment Service of the Children's Treatment Network strives to assess children and youth with complex developmental needs to determine a diagnosis and appropriate treatment.
- The Developmental Assessment Service provides in-services and workshops to build on the knowledge of the local team. Coaching and mentoring are also available to local team members around specific children.

### **Criteria for Access to Developmental Assessment Specialty Service**

- Children and youth under the age of 19 years (or until graduation from high school) who reside in Simcoe County or York Region with a complex developmental profile requiring a trans-disciplinary assessment for the purpose of diagnosis.

### **Access to Developmental Assessment Specialty Service**

- 5) As part of the child's Single Plan of Care (SPOC) the child and family team will identify the goal of having the child participate in a full developmental assessment.
- 6) The local child and family team will initiate diagnostic testing to their capability and then make a referral to the Diagnostic Assessment Service.
- 7) Referrals to the Diagnostic Assessment Service are facilitated by the child and family's Service Coordinator and/or the local paediatrician.

### **The Assessment Process:**

- 1) Assessments are conducted over two or three sessions. Other primary facilitators (therapists, teachers, assistants) will be asked for information to clarify the child's needs and to participate in the assessment.

- 2) Assessments are conducted by members of the team which may include a developmental paediatrician, psychologist, speech language pathologist, occupational therapist and social worker depending on the needs of the client.
- 3) Following the completion of the assessment, team members will meet with the family and their team to provide a copy of the final report, discuss the recommended action plan and build on the single plan of care.
- 4) Follow-up assessment or a developmental review may be required at the discretion of the local child and family team.

Medical monitoring may be required by the developmental paediatrician in consult with the local paediatrician.

### **Seating and Mobility Specialty Service (SMSS)**

***Seating and Mobility Specialty Services (SMSS) provides assessment and treatment for children ages birth to 19 in Simcoe County and York Region. The seating and mobility team may be comprised of members from various disciplines including a physiotherapist (PT), an occupational therapist (OT) and a vendor consultant(s).***

#### **Service Description**

- The services of SMSS are oriented to the needs of the child and their team and include assessment, consultation, intervention and training in strategies to assist the team to fit custom wheelchairs, walkers, scooters, etc.
- SMSS provides in-services and workshops to build on the knowledge of the local team.

#### **Criteria for Access to SMSS**

- The child and family's team therapist would access the Specialty Service when assistance with an ADP prescription was required and/or if the C&F therapist felt they needed additional assistance to assess the needs of the child.

#### **Access to SMSS**

5. The child's local team and family will initiate the assessment for seating and mobility equipment and will refer to the SMSS when necessary.
6. Referrals to the SMSS are facilitated by the child and family's OT or PT.

### **The Assessment and Fitting Process:**

- The local team PT or OT will attend the assessment/fitting appointments in order to build their learning for future needs and to support the family
- Ongoing support and mentoring will be available as needed for the local team.

### **Orthotics Specialty Service (OSS)**

***Orthotics Specialty Services (OSS) provides assessment and treatment for children ages birth to 19 requiring casting/splinting/orthotics for hands or feet in Simcoe County and York Region. The orthotics team may be comprised of members from various disciplines including a physiotherapist (PT), an occupational therapist (OT) and an orthotist.***

### **Service Description**

- The services of OSS are oriented to the needs of the child and their team and include assessment, consultation, intervention and training in strategies to assist the team to fit custom orthotics.
- FSS provides in-services and workshops to build on the knowledge of the local team.

### **Criteria for Access to OSS**

- The child and family's team therapist would access the Specialty Service if the C&F therapist felt they needed additional assistance to assess the needs of the child

### **Access to OSS**

7. The child's local team and family will initiate the assessment for orthotics and will refer to the OSS when necessary.
8. Referrals to the OSS are facilitated by the child and family's OT or PT.

### **The Assessment and Fitting Process:**

- The local team PT or OT will attend the assessment/fitting appointments as required in order to build their learning for future needs and to support the family
- Ongoing support and mentoring will be available as needed for the local team.

## **5. Information Management (Draft Policy)**

**The Children’s Treatment Network of Simcoe York is committed to protecting the privacy and security of its participants. Any personally identifiable information CTN collects will be used solely by and for CTN and will not be sold or otherwise distributed to third parties. We recognize a special obligation to protect personal information obtained from children and families.**

### **i. General Guidelines**

Children, youth and their families are best served by the Network when:

- staff in the Network have access to the data they require to support their work together as an efficient team with the child and family
- families can be assured that only authorized staff in the Network have access to their personal information , and the confidentiality of their personal information is protected by appropriate operational practices according to the appropriate legislation
- there are clear guidelines and communication regarding processes and procedures for sharing information, ensuring that it is shared only with informed consent, and that no harm is caused

### **Scope**

This framework for privacy and security may include in its scope all children, youth and families served by any staff whose organization is a member of the Network. By virtue of the CTN model, the privacy guidelines will of necessity spill over into the day-to-day operational practice of the CTN partners. These guidelines are intended to guide the Network as a health information custodian, its agents and partners, and specifically, the Network’s use of an electronic client record and single plan of care.

This guideline includes requirements under the following legislation:

Personal Health Information Protection Act (PHIPA)

Freedom of Information and Protection of Privacy Act (FIPPA and MFIPPA)

Child & Family Services Act (CFSA)

Education Act

### **ii. Basic Rights of Individuals with respect to Privacy**

- Individuals have the right of access to their own health information
- Individuals have the right to privacy and protection of confidential information, including the right to consent, withhold or withdraw consent

- Individuals have the right to require the correction or amendment of personal health information about themselves.

## **Definitions**

### **Confidentiality**

Information of some sensitivity not already in the public domain or not readily available from another public source, and which has been shared in a relationship where the person giving it understood that it would not be shared with others without their express consent.

### **Express Consent**

The client provides informed, explicit, verbal or written consent based on their understanding of what will occur and why. Express consent is required if a health information custodian discloses information to a person who is not a health information custodian or to a health custodian but not for purposes of providing or assisting in providing health care.

### **Implied Consent**

If personal health information is received for the purpose of providing health care, or assisting in the provision of health care, the client is assumed to have implied consent to collect, use or disclose the information for the purposes of providing health care or assisting in providing health care, unless the custodian becomes aware that the individual has expressly withheld or withdrawn consent.

### **Health Information Custodian**

A health information custodian (HIC) is a person or organization who has custody or control of personal health information as a result of or in connection with performing the person's or organization's powers or duties. The Network and some of its members are HICs.

**Agent**, in relation to a health information custodian, is a person who with the authorization of the custodian, acts for or on behalf of the custodian, and not the agent's own purposes.

### **Health Care and Health Care Practitioners**

PHIPA defines health care as any observation, examination, assessment, care, service, procedure that is conducted for a health-related purpose, and is carried out or provided to:

- diagnose, treat or maintain an individual's physical or mental condition
- prevent disease or injury or to promote health

### **Circle of Care**

*PHIPA* does not define "circle of care". The term refers to those in the health care team who are involved in the care or treatment of a particular person. The Network would identify the circle of care as including the members of the child and youth/family's team as identified on the Single Plan of Care.

### **Lockbox**

The term "lock box" applies to situations where the individual has expressly restricted disclosure of specific personal health information to others -- even to others involved in the circle of care. This decision and related discussions should be well documented in the patient's record. It is to be noted that individuals may not prevent the custodian from disclosing personal health information permitted or required by law.

### **Documentation Guidelines**

*-Under Development*

### **iii. Information Sharing**

#### **Electronic Record**

Information about children and youth being served by the Network will be recorded in an electronic record. Only authorized staff with the consent of the young person or child's parent or guardian will access the electronic record. In some situations, access to some information will be restricted to a particular category of practitioner or user. Details about the clinical software application, the electronic record and the single plan of care are in a separate module.

Authorized users will access the electronic record and single plan of care either through a secure web interface, through their agency's secure network, or through another designated user. They will be trained to access and use the software application appropriately, and to ensure that the information is accurate and secure. A system administrator will oversee the access control process.

#### **Guidance for Sharing Information**

To enable the development and delivery of an integrated plan of care, Network members need to understand when, why and how to share information with each other, so they can do so confidently and appropriately in daily practice.

This will require ongoing learning and collaboration among Network members to develop and practice new processes for integrated assessments, planning and intervention. Privacy policy, procedures and training will be updated as practices to support integrated working evolve.

Staff will continue to be sensitive to the need to protect confidential information, and adhere to their professional codes of conduct. The relationship between providers and client is based on the assumption that the appropriate sharing of information within the relationship is beneficial to the child and family.

#### **Principles for Information Sharing**

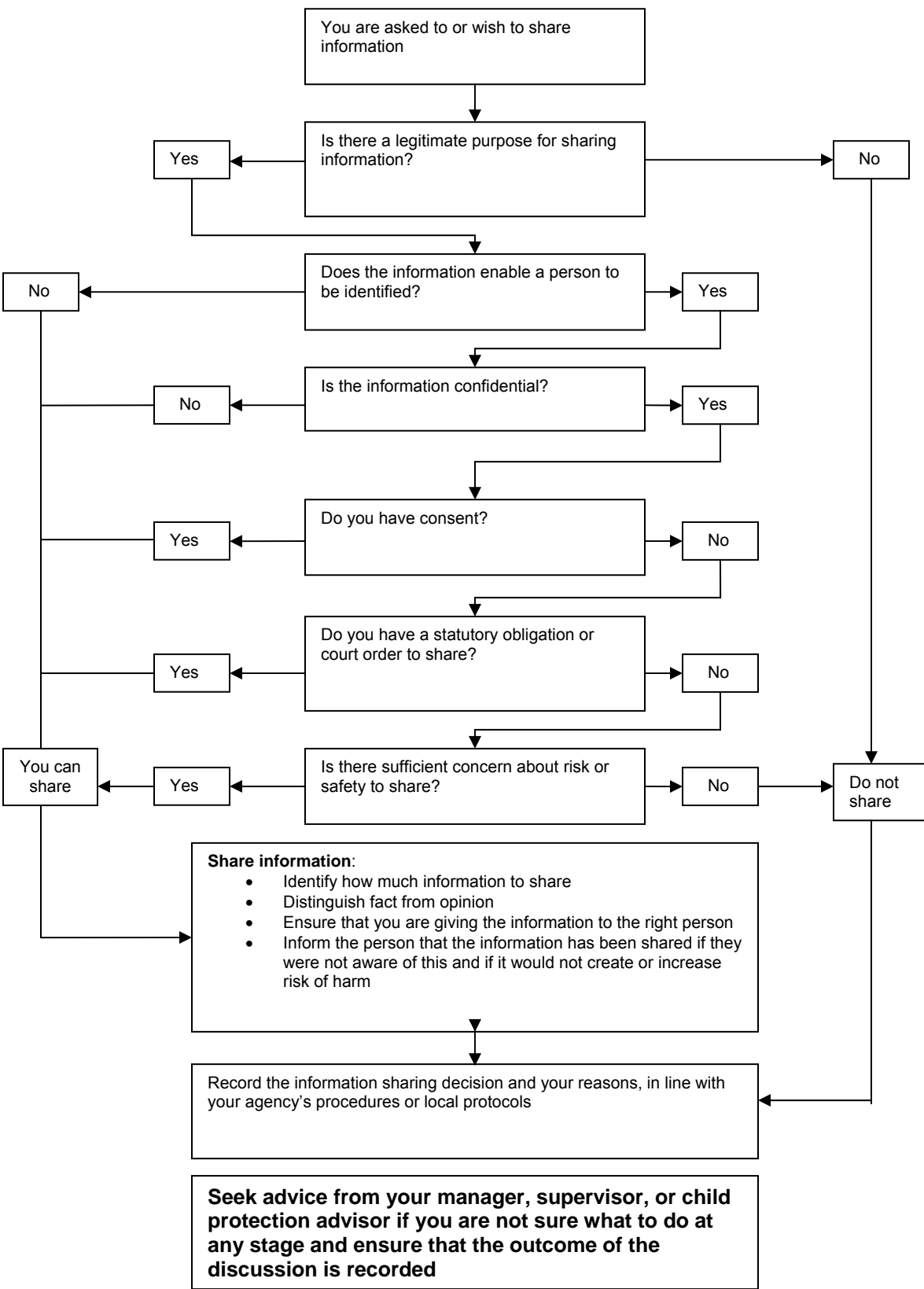
- 1) Day to day operations are conducted so that personal identifiable information is used in a fair and lawful manner that places the client at the centre of the process
- 2) There must be a defined and justifiable purpose for sharing information, and it is explained openly and transparently as early in the engagement as possible
- 3) Every request for disclosure and reason for decision must be recorded
- 4) Sharing personal identifiable information should be the minimum information required for the stated purpose
- 5) Personal identifiable information should not be kept for longer than necessary in accordance with the purpose, and be kept accurate and up to date
- 6) Access to personal identifiable information should be restricted to a 'need to know' basis; when in doubt, seek advice

- 7) Those with access to personal identifiable information should be trained in their responsibilities to protect it
- 8) Responsibility regarding personal information may extend beyond the death of the person
- 9) All personal identifiable information must be held in a safe and secure environment, including the means by which it is transmitted or received

## **Governance for Information Sharing**

- **Information sharing agreement** will be developed with each of the Network partners that will detail the governance and practice for the privacy and security of personal information through **common network approach to privacy** and information sharing. It will cover issues related to:
  - Designated contact, Staff confidentiality agreements
  - Operational policies and procedures
  - Security Audit procedures and accountabilities for security
  - Training
  - Data retention, destruction of records
  - Communication to families
  - Problem-solving and conflict resolution
  - Terms of Reference for a **Network Privacy Working Group** to oversee issues related to privacy and information sharing, including the initial, and ongoing review of the Privacy Impact Assessment (PIA)
- Each member will identify **one contact person** to ensure compliance with the legislation, be the point person in the organization for the Goldcare system administrator to ensure the right people have access to the electronic record, and to deal with enquiries about information and privacy issues
- **Communications/Short Notices:** Notices and Materials will be available – eventually in multiple languages, to inform children, youth and families about their rights with respect to privacy, and what to expect regarding Network practices. These will take the form of pamphlets, posters, disclaimers on email, website, etc.
- The information sharing agreement will provide a foundation for other CTN data-sharing partnerships, such as membership in the Electronic Child Health Network (**eCHN**), Ontario Telemedicine Network (**OTN**) or Smart Systems for Health (**SSHA**) that support integrated service delivery to children and families

**Flowchart of key principles for information sharing**  
**Source: Every Child Matters, UK**



#### iv. Collection, Use and Disclosure

- Generally, personal information can be collected, used and disclosed if the individual consents, or the collection, use or disclosure is permitted or required by legislation
  - Information should not be collected, used or disclosed if other information will serve the purpose
  - Only the information necessary to meet the purpose can be collected, used or disclosed
- Express consent is required to collect, use or disclose personal information for marketing purposes, including vendors
- Express consent is required for participation in a research project. Individuals have the right to expect that the research project has been evaluated for ethics approval, and that the researcher has signed a confidentiality agreement with CTN.
- Personal information should generally be collected directly from individuals, but can be collected indirectly if:
  - The individual consents
  - The information is necessary for the provision of health care and direct collection is not reasonably possible
  - The custodian collects the information from a person who is not a custodian for research purposes
- Custodians can use information without consent or provide to an agent..:
  - For the purpose for which it was collected
  - For purpose for which it is permitted or required by law to disclose
  - For planning or delivering programs or services that the custodian provides or funds
  - For risk management, error management or quality improvement of care
  - For educating agents who provide health care
  - For disposing of information or modifying information to conceal identity
  - To seek consent of the individual
  - For purpose of a proceeding
- Disclosure without consent: As a general rule, personal information should only be disclosed with the consent of the individual, except where
  - Required by law to disclose – e.g. CFSA Duty to Report, court order
  - Emergency/Urgent circumstances - there are reasonable grounds to believe that the disclosure is necessary to eliminate or reduce a significant risk (good judgement) of serious bodily harm to a person or group of persons
- The recipient of personal information from a custodian must not use or disclose information for any purpose other than the purpose for which it was disclosed.

- The health information custodian must have a process in place to revise inaccurate records

### **General guidelines for Consent**

- The child, youth and family are at the centre of what happens to their information – they are the owners of the information
- The approach to requesting consent to share information must be open, transparent and respectful, with the outcome of making the individual knowledgeable about why data is being collected and how it may be used.
- Providing individuals with all the information they need to make a decision is the basis of informed consent
- Informed Consent (See definitions) can be:
  - Explicit/ express
  - Implicit/ implied (HICs to HICs; Circle of Care, except when withheld or withdrawn)
  - verbal or written
  - Withheld or Withdrawn
  - Conditional
- CTN will proactively inform users when they first engage with service as to circumstances by which their information may be gathered, recorded and shared
- The governance framework of network partners must be respected

### **Who can Consent**

- An individual who is able to understand the relevant information and the consequences of withholding consent. Capacity to consent may be presumed unless there are reasonable grounds to believe that the individual is incapable of consenting.
- A parent or guardian, or someone authorized or required by law may consent on behalf of a child who is less than 16 years of age. In general, a parent with only right of access cannot consent on behalf of a child less than 16 years of age.
- A substitute decision maker can be determined if an individual authorizes another person to act on their behalf, or if incapable, the parent, guardian, attorney, spouse, parent, parent with right of access only, or another relative or the Public Guardian and Trustee may consent if no one else is available to consent.
- The wishes of the child and young person will always be taken into account, and in some cases where there is a conflict and they are capable of informed consent, may override those of the parent.

## **v. Security of Personal Information**

### **Security/Privacy Policy**

1. A comprehensive security/privacy policy will be in place, including
  - a. Network and access security; firewalls
  - b. Hardware and software operation
  - c. Physical security
  - d. Annual risk assessment and Privacy audit activity
  - e. Procedures for dealing with security and privacy incidents or breaches
  - f. Training
2. A process will be set out in the Information Sharing Agreement (see governance) for situations where Network partners do not comply with these guidelines (once approved). For example, inappropriate refusal to disclose information, disregard for policies and procedures or the rights of clients would be discussed initially with the designated person for the agency, and if unresolved, discussed with the senior manager, in accordance with procedures identified in the Information Sharing Agreement.
3. Complaints may be directed to the CTN Privacy Officer (sandy.thurston@ctn-simcoeyork.ca), and if unresolved, can be directed to the Information and Privacy Commissioner (IPC) of Ontario. See [www.ipc.on.ca](http://www.ipc.on.ca)
4. Audit Policy  
CTN's capacity to audit privacy and security compliance resides in the Goldcare application's data trail functions. An audit will be conducted on a regular basis to monitor adherence to the privacy guideline, and address issues identified in the process.

### **System Security and Access**

At all times, information will be held in a safe, secure environment, including the means by which it is transmitted or received between partner organizations, and, in so far as it is reasonably practicable, to be free from unauthorized or unlawful access or interception, accidental loss or damage. The level of security will be commensurate with the sensitivity and classification of the information to be stored, shared, transmitted or received.

### **Physical Security**

- All computers and other electronic devices should be password protected
- Workstations and meeting places must provide sufficient privacy for the protection of confidential information during normal working. Access to locked filing cabinets to be provided where necessary
- Fax machines used for personal health information must be in a secure location, with a routine that ensures that they are directed to the right person immediately
- When absent from the computer, personal identifying information must not be on the screen, and the program should be locked from inadvertent access

- Access to a shredder for secure destruction of paper records

### **Goldcare – Clinical Software Application for the Electronic Record**

- Access Security: the Designated Contact for each Network member will provide to the CTN System Administrator (michelle.biehler@ctn-simcoeyork.ca), the names of their employees who require access to the electronic record and for what purpose
- The CTN system administrator confirms eligibility and assigns each individual to a user group, identifies any restrictions to access, then notifies the data user of their login ID and password for authenticated access to the system. The system administrator maintains a current database of all system users.
- Each data user will be oriented and trained to the use of Goldcare
- Restricted Access: The System Administrator can restrict access for a specific user at the record level. However, the default is set to allow all users to *view* all information in the client records in the local teams in which they are involved, with *write* access restricted to the user's own user group's permissions in Goldcare
- LockBox: Any user can restrict access to confidential information that an individual client does not consent to be disclosed. There is provision to 'lock' information from view by inserting it into a 'locked file' or folder in the Document Manager section of the clinical application. The information is encrypted and password protected and can only be accessed by the person who has entered it.
- Password: A password policy is outlined for the use of Goldcare to reinforce the care that must be taken to protect the personal information stored within it.

### **Acceptable Use Policy – CTN Networks, Software, Hardware**

#### **Appropriate use:**

- a. Users will employ only those accounts for which they are authorized, and shall take necessary precautions to prevent others from obtaining access to their computer accounts or passwords
- b. Users will be guided by their professional practice standards
- c. Minimal personal use is acceptable
- d. Data is to be treated as confidential, shared with informed consent
- e. While away from the office, keep all electronic devices with you, secure from theft, loss and unauthorized access. Avoid removing personal information from the office unless necessary and safeguard privacy in all conversations

#### **Inappropriate use**

- a. Activity for personal gain, or that is in contravention of the Criminal Code or Ontario Human Rights Code is prohibited
- b. Accumulation of unnecessary, outdated or non-work related files is discouraged

- c. activity that jeopardizes the integrity of the network, application or computer, such as installing unauthorized software is prohibited
- d. Intentional breach of privacy or confidentiality

## vi. Procedures

### Consent: Roles and Responsibilities

	Service Navigators	Service Coordinators	Clinicians/Practitioners
<b>Consent to collect, use, disclose personal information to HICs &amp; non-HICs</b>	Express verbal consent to do the CFI, and refer to service coordinator and initial team		
<b>Consent for assessment and planning; and to proceed with the single plan of care when consensus is reached</b>		<ul style="list-style-type: none"> <li>• Add information to initial consent to gather, share information with additional members, to develop plan</li> <li>• a single plan of care is consented to as treatment plan and circle of care</li> </ul>	<ul style="list-style-type: none"> <li>• May need written consent for a specific procedure or assessment</li> </ul>
<b>Consent to treat</b>			Regularly, ongoing

### Consent Form

The way consent is collected may vary depending on the purpose or stage of care. The form for consent allows for all the individual information and wishes to be inserted electronically in either a verbal conversation, or in written form prior to printing and signing. If there is a necessity to disclose your personal information beyond the parameters of the original consent, especially where express consent is required, individuals will be notified with a request to update the consent.

### Recording Consent

All requests for consent and consents received – including any conditions or changes, are logged in the individual’s electronic record, in the consent tracking log. Written consents are scanned into the Document manager consent folder.

If there are restrictions to access, the System Administrator and Privacy Officer must be notified immediately, to enable the appropriate restrictions to user ID. In such cases, an alternate process will grant access to only those members who have consent.

### **Consent is refused or withheld**

Children/young people and their parents/guardians can refuse to give consent, and refuse to receive treatment and intervention services. In these circumstances, their views must be respected, once they have a clear idea of the consequences of withholding consent.

If this occurs, service navigators or coordinators or the Privacy Officer will explore opportunities for supporting the child/or and family in universal settings (e.g. child care, school), perhaps as a stepping stone to encouraging them to take up the more targeted support available. There may be opportunities for parents to participate through drop-in programs (Ontario Early Years Centres, Best Start hubs), parenting support (Hanan Programs, Triple P programs), etc.

### **Process for Managing a Privacy Breach**

- a. Identify the scope of the breach and contain it.
- b. Report to the agency designated contact person, and the privacy officer, who will investigate as the type of breach warrants; breaches may be categorized as:
  - i. not serious, e.g. inadvertent access that is unintentional and has no negative consequences, and may require additional training
  - ii. serious but unintentional, e.g. confidential information was inappropriately disclosed, but without negative intent, and may require a review of practices
  - iii. serious and malicious intent that requires significant investigation, and potentially involvement of the police
- c. Notify the individual whose information was breached that a breach has taken place along with the steps taken to resolve the breach. A HIC must notify the individual at the first *reasonable* opportunity if the information is stolen, lost or accessed by unauthorized persons.
- d. Review and revision of organizational policies or procedures as necessary, and/or Network policies

### **Request to Access/Review Record**

- a) Confirm the type of information sought, and the scope of the request, e.g. any particular part of the record, involving a specific incident as well as the individual's identity
- b) Direct the requester to the request form, and submit to the Privacy Officer, who will evaluate and respond to the request within 30 days, with a possible 30 day extension

### **How to Correct Records**

- a) Strike out the incorrect information in a manner that does not obliterate it or
- b) Label the information as incorrect and sever from the record, while maintaining a link to the record
- c) If the correction cannot be recorded in the record, every effort must be made to inform persons accessing the record that the information is incorrect and where to obtain the correct information.

## **Complaints Process**

- a) Encourage the individual to discuss the nature of their complaint, including other members of the team as needed, clarifying the specifics of the complaint
- b) If further process required, ask the individual to submit complaint in writing to the Privacy Officer who will gather information and make findings
- c) If the complaint is substantiated, immediate action will be undertaken to rectify the situation, responding to the individual with the explanation
- d) If the complaint cannot be substantiated, review the findings with the individual, and indicate the opportunity to make complaint to the IPC

## **vii. Forms**

The following draft forms are attached below, and will be posted to the website when finalized:

- Consent
- Request to access individual record (attached as separate PDF file)
- Complaint (in development)
- Fact Sheet for families

For more information on ***CTN's Privacy and Security Policy***  
Please contact the Privacy Officer at **877-719-4795**  
Or e-mail **sandy.thurston@ctn-simcoeyork.ca**



Children's Treatment Network  
OF SIMCOE YORK

### CONSENT FOR INFORMATION SHARING and STORAGE

I understand that information will be collected, recorded, stored and used for the purpose of planning and providing services for me } or for my child and family } or for the child for whom I am a guardian }. This information may include: telephone referral forms, histories, assessments, treatment plans, progress reports or notes, videotapes, etc.

Child or Youth's Name	Date of Birth
Contact Information:	

I have had the reasons for information sharing between agencies explained to me, and I understand those reasons. I agree to the sharing of information, as agreed, between the services listed below.     Yes     No

### A service navigator/coordinator to specify with you, the information that may be seen by the agencies listed below, noting any exceptions.

*List all services with contact information: telephone, email*

Signed\* \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

\* Confirmed from custody documentation, if application regarding parent's right to information, and to give consent

Network staff signature \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

This consent is effective for one year from the date when it was given.

It replaces a verbal consent given on \_\_\_\_\_.

For more information, contact the Children's Treatment Network at 1-866-377-0286.



# Privacy & Consent

Children's Treatment Network of Simcoe York  
ACCESS: 866-377-0286 ADMINISTRATION: 877-719-4795

## What Families Need to Know

### CTN MUST:

- 1 Collect only the information we need to do our job
- 2 Take steps to safeguard your personal information
- 3 Take reasonable steps to ensure that the records are accurate and complete
- 4 Comply with privacy legislation

To provide your family with services that best meet the needs of you and your child(ren), agencies and organizations that make up the Children's Treatment Network, including service navigators, service coordinators, therapists and specialized services staff, will ask for information about your child and family.

Each time you or your child receives care or services, information will be recorded in a personal record.

All the members of the Network are required by law to protect the information you share in strict confidence, and to ensure that you provide **informed consent** for the purpose discussed with you before any confidential information is disclosed or used.

## Your Right to Privacy

Privacy legislation protects your right to:

- Consent to how your information will be collected, used and shared, except in specific circumstances. Consent can be **implied**, based on the assumption that you have sought treatment so your information can be shared with other practitioners for the purposes of receiving the care you seek.
- In other circumstances, **express consent** is required - either verbal, written or electronic, where you might be required to give consent to specific individuals or purposes. For either type of consent to be valid, you must be given sufficient information for your consent to be **informed**. You have the right to withhold or withdraw consent
- Request access to your personal record and the information in it
- Request that a correction be made to your record

---

*"Families want to tell their story once, and be certain that their confidential information is used and shared appropriately."*

*"We have a special obligation to protect the privacy and security of children, young people and families"*

---

## Key points on privacy

---

*“CTN is committed to improving information sharing practice for those who need to know and work together... to better meet the needs of your child and your family, while protecting the privacy of personal information in accordance with all the relevant legislation*

---

1. Network staff will explain to children, young people and families at the outset, openly and honestly, what and how information will, or could be shared and why, and seek their agreement. **Take time to ask all the questions you need.** Each individual has the right to withhold consent. The exception is where to do so would put that child, young person or others at increased risk of significant harm.
2. Network staff must always consider the safety and welfare of a child or young person when making decisions on whether to share information about them. Where there is concern that the child may be suffering or is at risk of suffering significant harm, the child’s safety and welfare must be the overriding concern; everyone has a duty to report under the Child and Family Services Act.
3. Network staff will wherever possible, respect the wishes of children, young people or families who do not consent to share confidential information. When in doubt, network staff will seek expert advice.
4. Network staff will ensure that any information shared is as accurate and up-to-date as possible, necessary for the purpose for which it is shared, shared only with those people who need to see it, and shared in a secure manner.
5. Consents and reasons for sharing information will always be recorded, and individuals have the right to access their health record.

*Information is collected pursuant to the Child and Family Services Act, R.S.O.1990, c.C11 and the Personal Health Information Protection Act, 2004, and will be retained, used, disclosed and disposed of in accordance with the legislation (including the Freedom of Information and Protection of Privacy Act, and the Municipal Freedom of Information and Protection of Privacy Act) and the nature of the information collected.*



*For further information about the collection or use of personal information, or to share a concern, please contact Children's Treatment Network of Simcoe York at 1-877-719-4795, and ask for the Privacy Officer.*

# Request to Access Personal Health Information

*Under the Personal Health Information Protection Act, 2004*



## Children's Treatment Network OF SIMCOE YORK

### Your Information:

Mr.     Mrs.     Ms.     Miss

Surname \_\_\_\_\_ Given Name \_\_\_\_\_ Initials \_\_\_\_\_

Address \_\_\_\_\_ Unit \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone \_\_\_\_\_ Evening \_\_\_\_\_

### Substitute Decision – Maker Information:\*

Surname \_\_\_\_\_ Given Name \_\_\_\_\_ Initials \_\_\_\_\_

Address \_\_\_\_\_ Unit \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone \_\_\_\_\_ Evening \_\_\_\_\_

\*Please provide documentation to satisfy the health information custodian that you are an authorized substitute decision-maker, if available.

**Please provide a detailed description of the personal health information you are requesting and details that will assist in locating this information (e.g. dates, names of health care provider, etc.).**

**Preferred Method of Access to Records:**     Examine Original     Receive a Copy

Signature \_\_\_\_\_ Date \_\_\_\_\_

### For Health Information Custodian Use Only

Date Received \_\_\_\_\_ Request Number \_\_\_\_\_ Comments \_\_\_\_\_

The personal Health Information contained on this form is collected pursuant to the *Personal Health Information Protection Act, 2004* (the Act) and will be used for the purpose of responding to your request for access pursuant to section 54 of the Act. Questions about this collection should be directed to the privacy Contact Person at CTN – 877-719-4795.

## **6. Electronic Record/Single Plan of Care Software**

### **i. Electronic Information System A Tool to Support Integration**

A common electronic client record used by all partners across the Network is an essential tool to support the development and delivery of an integrated, single plan of care for each child and family.

Goldcare, a product of Campana Systems Inc., was chosen by the Children's Treatment Network after a lengthy and thorough process, as the software application of choice. Campana Systems Inc. has been working together with Children's Treatment Network to ensure that the software application will meet the needs of our multi-agency Network for collecting, storing and sharing client information.

Once totally implemented, multi-disciplinary teams from partner organizations will be able to

- record information from a team assessment,
- develop an integrated single plan of care,
- share confidential information and clinical notes across multiple organizations securely,
- prioritize efforts,
- monitor progress and
- communicate scheduling information easily

Shared use of this electronic record will also help eliminate duplication of services and allow Network partners to maximize resources to help meet the needs and goals of children and families.

The software development and implementation will occur in three phases.

#### **Phase I Pilot Program (late November to end of 2006) -**

Service navigators, service coordinators, therapists and clinicians from over 20 Network Partners will pilot the software application. During this first phase, Network Partners will identify, assess and develop integrated care plans for 30-50 high needs children and their families. Training for the pilot group will begin in mid-November and will focus on processes for developing a single plan of care as well as use of the software application.

#### **Phase II (January to May 2007) –**

Input from the Phase I pilot will be used to refine and streamline the software for rollout to more Network Partners. During Phase II, the software will be fine-tuned in order to increase functionality, streamline connectivity, and begin to build some critical interfaces with network partner systems. Training will be expanded to include more Network Partner staff.

### **Phase III (June to end of 2007) –**

The balance of 2007 will focus on continued expansion of clinical tools and operational features of the Electronic Client Record system. We will also continue to implement the application with more Network Partners and expand staff training. Throughout the process, we will continue to work with all Partners to identify and transition all children requiring integrated Network services onto the Electronic Client Record system.

### **Elements of the Software**

#### **Workspace**

The Workspace is a unique feature to the software. The workspace is individualized to each service coordinator and service provider. The workspace lists client names specific to the clinician and helps in the identification of work elements. It provides information such as name, local team, phone number and contact names to assist with scheduling and work load management. The Workspace also has links to reference material such as the CTN website and local team information.

Four work spaces will be available:

- Service Navigation-- provides a list of all new client referred to CTN, sorts them by service navigator and details what elements of work have been completed
- Service Coordination--provides the Service Coordinator with a list of all clients on his/her caseload, the phase of care the client is in, contact information and details related to the client's progress
- Service Provider--provides the service provider with a list of all clients on his/her caseload, contact information and details related to the client's progress.
- Management—this workspace is designed to provide managers of specific organizations and agencies with system wide information as well as general caseload information related to the clients assigned to their agency personnel.

#### **Demographics**

The demographics section of the electronic client record records information specific to the client and relevant to network partner agencies. Information captured in the demographic fields is able to auto-populate other sections of Goldcare minimizing duplication of data entry. Although some fields will be locked once information is entered and saved, changes to most fields can be made easily by all members of the child and family team as families move, schools change and contacts increase.

#### **Child and Family Interview (CFI)**

The Child and Family Interview (CFI) is a data entry tool used to capture the information the service navigator (SN) collects from the family at the time of Intake. It is comprehensive and reviews information from the perspective of what issues or concerns can the entire children's service system address, rather than from the perspective of a single agency. It is intended to be directed by the family and the questions asked are based on the concerns raised by the family. The software allows for many free text entries in order to capture the family's story. Where possible and practical drop down menus have been added to facilitate data entry.

Through the process of conducting the Child and Family Interview the Service Navigator determines together with the family the priority of needs and decides whether service Electronic Record/Single Plan of Care Software

coordination is required or whether the child requires a single service. Once identified the service navigator contacts the appropriate agency or organization and forwards the demographic and CFI to the agency. In the initial phases of the software implementation this may involve printing off the electronic client record and faxing it to the agency. As more agencies are integrated with the system, an email message will trigger the agency to review the client's file. Once completed the Child and Family Interview can be reviewed by all team members and can be printed off for the family or for team members who do not yet have access to the electronic client system.

### **Initial Plan of Assessments and Services (IPAS)**

The Initial Plan of Assessments and Services is completed by the service coordinator (SC) and records the initial visions of the family. Completing the IPAS is one of the steps in the development of the Single Plan of Care. The IPAS builds on the information gathered through the Child and Family Interview and includes additional information gathered by the service coordinator. The service coordinator uses the tool to document the child and family's visions and to summarize critical information for the child and family team. In order to develop the single plan of care and assist the child and family to meet their visions, the service coordinator summarizes the initial plan for the child and family by entering his/her initial concerns, the immediate service needs and the specific clinical assessments required. As service providers become involved with the child, viewing the IPAS will facilitate the scheduling of joint or transdisciplinary assessments and inform the team as to the range of services and supports the child and family will be accessing.

### **The Team Assessment Summary (TAS)**

The Team Assessment Summary re-states the child and family's visions (auto-populated from the IPAS) and provides free text space for each discipline to record their assessment summaries.

As all assessment summaries are entered and stored within the same section, the TAS facilitates easy review of the summaries of the other disciplines, by every team member. Full assessment reports can either be entered directly into Goldcare notes or saved as a report in the discipline specific Document Manager folder (see below). As the software becomes available to increasing numbers of Network partners the need for printing and faxing reports will be eliminated. Child and family team members will have easy access to assessment information.

### **The Single Plan of Care (SPOC)**

The Single Plan of Care module within GoldCare provides a framework to record the visions, goals and activities agreed upon by the team members at the Child and Family Team meeting. The Single Plan of Care module provides a mix of drop downs and free text fields for entry by the Service Coordinator and/or members of the Child and family Team. Goals and activities listed within the Single Plan of Care can be modified by any one of the team members. The date for the next meeting to review the Single Plan of Care is entered and appears on the workspace of the service coordinator to assist in with scheduling and work load management. The Single Plan of Care can be printed for family and team members not linked to GoldCare. When a new Single Plan of Care is required, the former can be closed and saved.

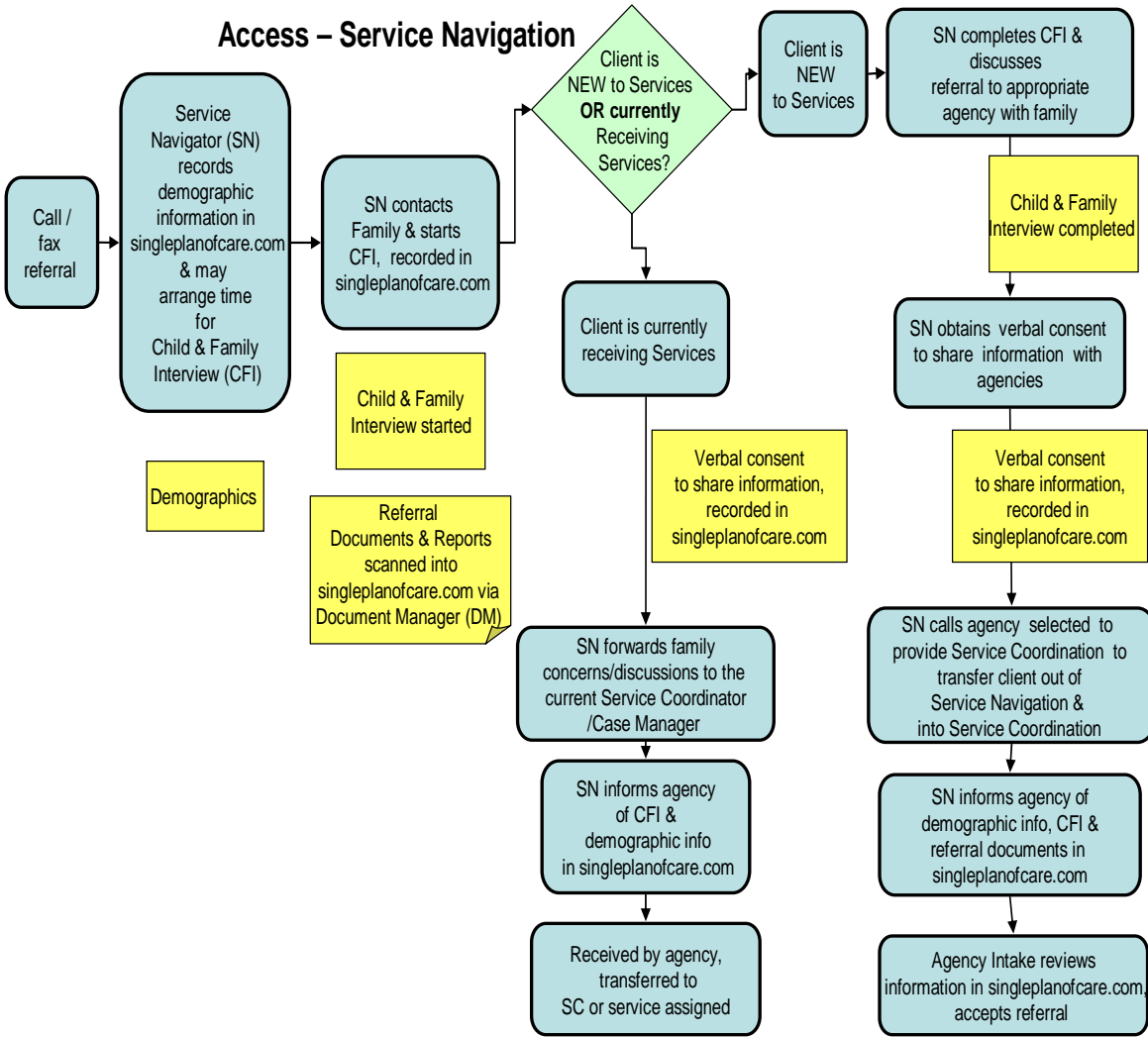
## **Document Manager**

Document Manager is a filing system for discipline specific reports, summaries, and clinical notes. Because not everyone will be able to enter directly into the electronic record immediately, Document Manager allows for printed and hand written materials to be scanned and filed. In addition to folders that are viewable by the whole team, Document Manager also provides some disciplines with the option of filing items in a locked folder that is password protected. Locking should only occur if the family has explicitly placed restrictions on who can view the information.

## **Clinical Notes**

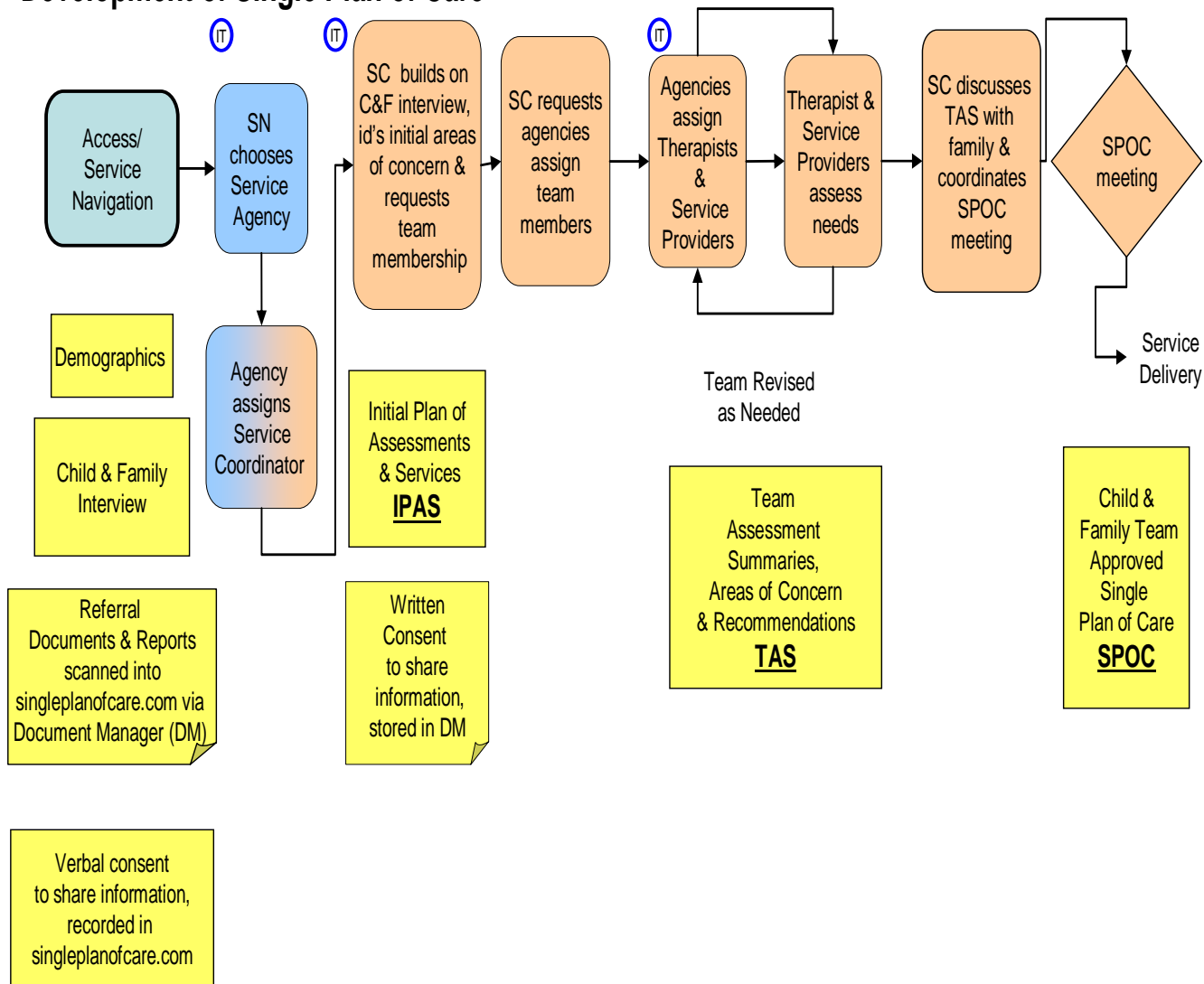
The software facilitates the sharing of information by having most team members document in the same place, providing a chronological listing of the latest notes entered by date and by whom. Some disciplines have a separate clinical notes section to facilitate securing sensitive information that families may not want shared with the entire team, for example, children's mental health and child protection services. A special function within the software allows Clinical Notes to be sorted by discipline should a clinician need a record of all his/her entries.

## Access – Service Navigation



## Access / Service Navigation

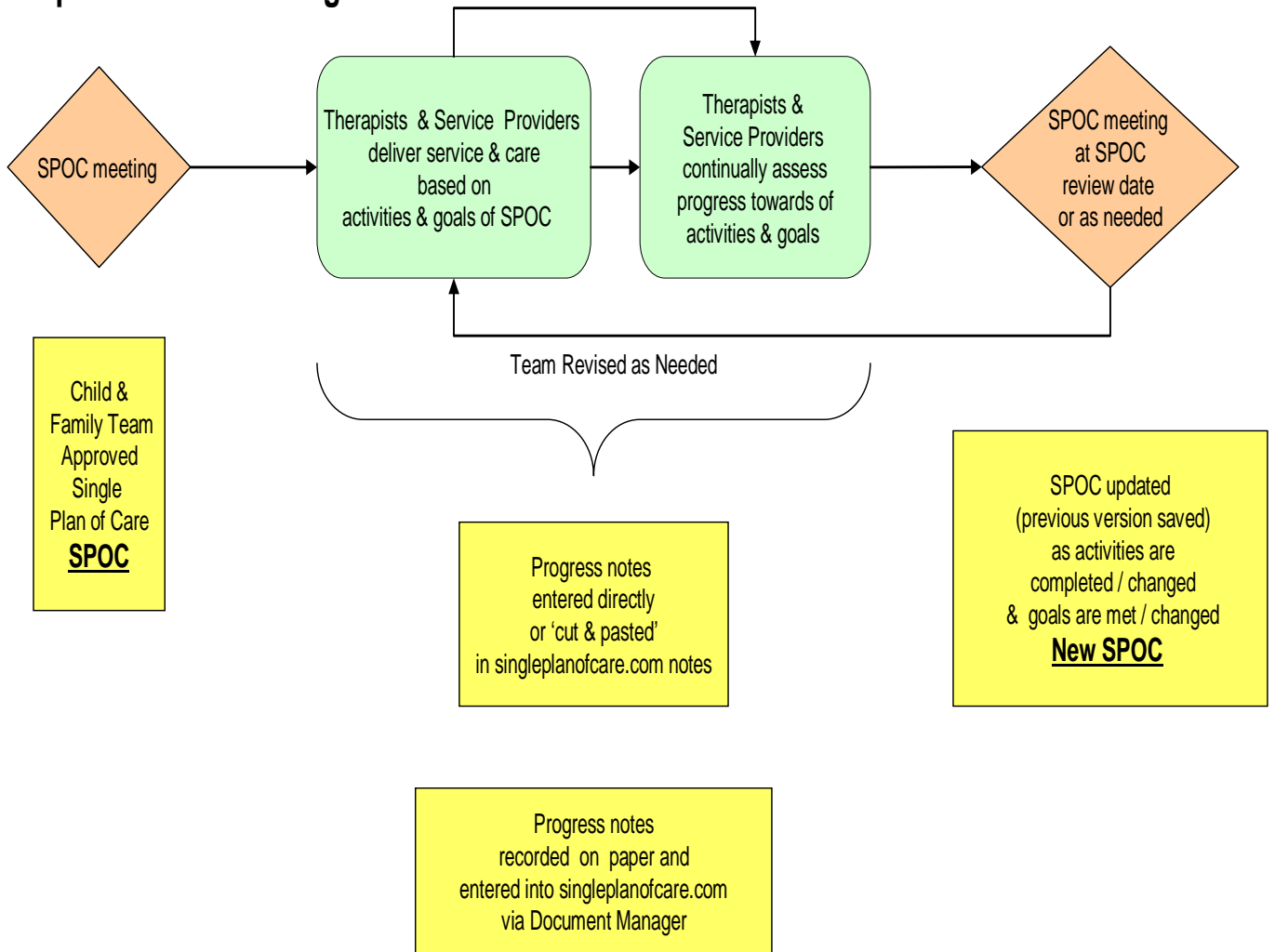
## Development of Single Plan of Care



Internal Transfer with External E-mail Notification



# Implementation of Single Plan of Care



## **Templates for The Initial Plan of Assessments and Services, The Team Assessment Summaries and The Single Plan of Care**

The following templates show the data fields that make up the 3 key modules that support the development and implementation of the Single Plan of Care. The templates provide the reader with a view to what information is being collected. The view will be different from that which appears in the software.

### **The Initial Plan of Assessments and Services (IPAS)**

The Service Coordinator will complete the Initial Plan of Assessments and Services (IPAS) entering a brief summary of information gathered from the Child and Family Interview and from any additional information obtained from contact with the family or the review of reports. The Service Coordinator will outline concerns and/or needs and what initial actions are required. The Service Coordinator will contact the appropriate agency/agencies. The agency will assign a service provider who will enter their name into the IPAS. Once complete, the module will be closed and information from the IPAS such as the Child and Family's vision(s) will auto-populate to the Team Assessment Summary (TAS) thus reducing the amount of keying.

### **The Team Assessment Summaries (TAS)**

Once all team members have completed their assessments, information is entered into the TAS. Team members enter the concerns identified through the assessment process, the domain impacted by the concern, their recommendations related to that concern and the optimum timeline for that concern to be addressed (priority). Once all service providers have entered their summaries the TAS is closed and the Single Plan of Care module can be opened.

### **The Single Plan of Care (SPOC)**

The Single Plan of Care module encourages the child and family to confirm the original vision statements and provides a framework for team agreed upon goals and activities. Goals are meant to be stated in a "SMART" (*specific, measurable, achievable, realistic and time limited*) while team activities should be meaningful and whenever possible integrated across disciplines, intervention programs, and environments in order to maximize practice and progress. The Single Plan of Care can be modified by individual team members as progress is made and new activities are implemented. Single Plan of Care modules can be saved in order to provide the team with a history of the child and family's progress.

## Initial Plan for Assessment and Services (IPAS)

**Demographics** *auto populated from demographic information*

### Initial Child and Family Visions

Initial Child and Family Vision # 1 <i>free text</i>	Date <i>ddmmyy</i>
Initial Child and Family Vision # 2	Date
Initial Child and Family Vision # 3	Date
<i>more</i>	

**Service Coordinator Summary:** *free text*

Initial Area of Concern or Identified Need	Initial Actions Recommended	Date service discussed with family	Family in Agreement	Agency Name	Date Agency notified of need for Assessment / Service	Team member assigned
<i>free text</i>	<i>free text</i>	<i>ddmmyy</i>	<i>yes/ no</i>	<i>name</i>	<i>ddmmyy</i>	<i>Name</i>

**Tentative Date for Single Plan of Care Meeting:** \_\_\_\_\_ *ddmmyy*

## Team Assessment Summaries (TAS)

**Demographics** *auto populated from demographic information*

**Initial Child and Family Visions** *auto-populated from IPAS*

Initial Child and Family Vision # 1 <i>auto populated</i>	Date <i>auto populated</i>
Initial Child and Family Vision # 2 <i>auto populated</i>	Date <i>auto populated</i>
Initial Child and Family Vision # 3 <i>auto populated</i>	Date <i>auto populated</i>

**Summary of Assessment Findings:**  
 Team Member #1 - *free text with auto stamp, date, time, user name, role*

**Summary of Assessment Findings:**  
 Team Member #2

**Summary of Assessment Findings:**  
 Team Member #3

**Summary of Assessment Findings:**  
*more...*

Area of Concern	Date	Identified by Who (role)	Domain	Comments	Recommendations	Priority	Vision Match
<i>free text</i>	<i>ddmmyy</i>	<i>free text</i>	<i>drop down</i>	<i>free text</i>	<i>free text</i>	<i>drop down</i>	<i>numeric</i>

## Single Plan of Care

<b>Demographics</b> <i>auto populated from demographic information</i>
--

<b>Initial Child and Family Visions</b> <i>auto-populated from IPAS</i>	
Initial Child and Family Vision # 1 <i>auto populated</i>	Date <i>auto populated</i>
Initial Child and Family Vision # 2 <i>auto populated</i>	Date <i>auto populated</i>
Initial Child and Family Vision # 3 <i>auto populated</i>	Date <i>auto populated</i>

**Are there any changes to the Initial Child and Family Vision Statements?** Yes No

If Yes, Comments	<i>free text</i>
---------------------	------------------

**Enter revised Child and Family Vision Statements**

<b>Initial Child and Family Visions</b> <i>auto-populated from IPAS</i>	
Initial Child and Family Vision # 1 <i>auto populated</i>	Date <i>auto populated</i>
Initial Child and Family Vision # 2 <i>auto populated</i>	Date <i>auto populated</i>
Initial Child and Family Vision # 3 <i>auto populated</i>	Date <i>auto populated</i>

**Child and Family Team Shared Goals**

Goal	Vision Match	Domain	Goal Lead (Role)	Date Goal Set	How will we measure	Goal Target date	Goal Review date	Goal Status	Comments
<i>free text</i>	<i>vision #</i>	<i>drop down</i>	<i>free text</i>	<i>ddmmyy</i>	<i>free text</i>	<i>ddmmyy</i>	<i>ddmmyy</i>	<i>drop down</i>	<i>free text</i>
1:									
2:									
3:									
More...									

**Child and Family Team Shared Activities**

Goal Match	Activity	Activity Lead (role)	Date Activity Set	Activity Target Date	Activity Review Date	Activity Status	Comments
goal #	Freertext	free text	ddmmyy	ddmmyy	ddmmyy	Drop down	free text
	Activity 1:						
	Activity 2:						
	Activity 3:						
	Activity 4:						
	More...						

Consent to share information has been updated and signed? Yes No

If yes, refer to written consent filed in Document Manager, dated: \_\_\_\_\_ (ddmmyy)

Comments:

Next Child and Family Team Meeting date: \_\_\_\_\_ (ddmmyy)

Child and Family agree with the Single Plan of Care and consent to the implementation of the Single Plan of Care as described: Yes No Dated:

\_\_\_\_\_ (ddmmyy)

## **IPAS, TAS and SPOC Drop down Menus**

The following is a list of drop down choices available when developing and completing the Single Plan of Care

<b>LIFE DOMAIN</b>	<b>PRIORITY</b>	<b>GOAL STATUS</b>	<b>ACTIVITY STATUS</b>
ADL	1 - immediate	IP – in progress	IP – in progress
Behavioural	2 – urgent	C - completed	C - completed
Cognition	3 – within 1 month	NA – no longer appropriate	NA – no longer appropriate
Communication	4 – within 3 months		
Community	5 - within 6 months		
Family			
Financial			
Health			
Housing			
Learning			
Physical Functioning			
Recreation			
Safety			
School			
Social/Emotional			
Spiritual			
Vocation			

## ii. Stage of Care Codes for CTN and Relationship to Workspaces

The following codes identify the Stage of Care the child and family is experiencing and the work associated with that Stage of Care. Service Coordinators and providers will be asked to enter a specific code in the Stage of Care Module within Goldcare in order to inform the team of their progress. Information relating to a Stage of Care may be triggered by the completion of a specific task such as the completion of the Child and Family Interview. This information will be reflected in the work space and will assist the practitioner in determining client progress and work flow.

Stage of Care Code	Stage of Care Status	Description	Trigger/Information	Applicable workspace
<b>DI</b>	Demographic Intake	File received Demographics completed	Pulls from a field on Demographics Page that SN checks when completed at time of Initial Demo Intake	Service Navigator
<b>CFIC</b>	Child and Family Interview	Child and Family Interview completed	Pulls from a field on the Demographics that SN checks when Child and Family Interview Completed	Service Navigator
<b>SC</b>	Transfer to Agency for Service Coordination or Service	Agency has accepted the Transfer	Triggered when Agency receiving transfer adds name into Service Coordinator field /Service Provider Assigned Field on demographic/Intake field	Service Coordinator Service Navigator
<b>AP</b>	Initial Plan for Assessments and Services (IPAS)	Initial Plan for Assessments and Services Completed	Triggered when IPAS is closed. (when Team Member Assessment Summaries or Single Plan of Care is Opened )	Service Coordinator Service Provider
<b>SP</b>	Single Plan of Care	Single Plan of Care Completed	Triggered when Current version of Single Plan of Care is closed	Service Coordinator Service Provider
<b>SD-O</b>	Service Delivery	Single Plan of Care demonstrates Goals that remain in progress ( IP)	Triggered when Single Plan of Care fields for Goal status reflect IP status (minimum 1 goal still being worked on)	Service Coordinator Service Provider Management
<b>SD-I</b>	Service Delivery Inactive	Per Discipline/Service – Single Plan of Care demonstrates all activities for that discipline are completed or no longer appropriate. (C or NA)	Triggered when Single Plan of Care field for Activities Status for the specific discipline reflect either a NA or C  Triggered by demographic stage of care field	Service Provider Service Coordinator
<b>SDC</b>	Service Discharge	Per Discipline/service Single Plan of Care demonstrates all Active, Inactive and Discharged Services	Triggered from service discharge entry in demographic Stage of Care Status Field. Service Provider enters at time Client is discharged from the service due to: service plan complete, age limit reached, death, client preference, community services.	Management Service Coordinator Service Provider
<b>CDC</b>	Client Record discharged	Client no longer receiving children's services through the Network due to a move out of area, age >19, death, youth and/or family choice	Triggered from Client File Closed and date fields in Demographics. Service Coordinator or Service Provider enters when all services are discharged. Records discharge as being due to due to service plan complete, age limit reached, death, client preference, community services, or other.	Management Service Coordinator Service Provider

### iii. Singleplanofcare.com - Glossary of Terms

Active Client	<ul style="list-style-type: none"> <li>• Client who is receiving services from CTN or from network partners</li> <li>• Client has multiple needs</li> <li>• Client will have a Service Coordinator and a Single Plan of Care</li> <li>• Documentation will occur in the client's electronic file</li> </ul>
Activity	<ul style="list-style-type: none"> <li>• The strategy that will be used to achieve a specific goal or a number of goals</li> </ul>
Area of Concern	<ul style="list-style-type: none"> <li>• The need as identified by the service provider</li> </ul>
Assessment Information Manager (AIM)	<ul style="list-style-type: none"> <li>• GoldCare database in which assessments are stored – included CFI, IPAS, TAS, SPOC</li> </ul>
Child and Family Interview (CFI)	<ul style="list-style-type: none"> <li>• Interview Tool used by Service Navigation to gather preliminary information about the child and family and assists in determining initial service needs</li> </ul>
Child and Family Team	<ul style="list-style-type: none"> <li>• The team of individuals including the family who come together to develop the Single Plan of Care</li> <li>• Members work in an integrative way to ensure goals are met</li> <li>• Members decide together if additional services are required and whether specialty services and/or CTN rehab services are required in order to meet the goals as set out in the Single Plan of Care.</li> </ul>
Child and Family Visions	<ul style="list-style-type: none"> <li>• Statements from the family explaining their needs, hopes for their child and family</li> <li>• What the family identifies as needing help with</li> <li>• May initially be stated as the child and family's area of most concern</li> </ul>
Clinical Assessment	<ul style="list-style-type: none"> <li>• Assessment completed by a professional team member</li> <li>• May be standardized</li> <li>• Provides information related to child's strength's and as well as areas of concern</li> <li>• Foundation for the development of the single plan of care</li> </ul>
CTN hosted Staff	<ul style="list-style-type: none"> <li>• Staff employed by a partner agency which receives funding for the position from CTN</li> <li>• Partner agency has agreed to provide services according to the CTN model</li> </ul>
Demographic Intake	<ul style="list-style-type: none"> <li>• Demographic and contact information collected in Access and entered into GoldCare.</li> </ul>
Discharge	<ul style="list-style-type: none"> <li>• Client is discharged from CTN. The following Reasons for discharge must be documented: client choice including move, death, goals met, hospitalization, and inc</li> </ul>

Document Manager	<ul style="list-style-type: none"> <li>• GoldCare tool used for electronic storage of paper records. Multiple file formats are supported.</li> <li>• It attaches scanned forms and reports to the client record. The original file name is retained.</li> <li>• For easy access to information for all CTN members, it is important to use standard naming conventions for documents which will be associated with the electronic client record (see Naming Conventions)</li> </ul>
Domain	<ul style="list-style-type: none"> <li>• Refers to the focus within one's life area</li> <li>• Includes the following: ADL, Behavioural, Cognition, Communication, Community, Family, Financial, Health, Housing, Learning, Physical Functioning, Recreation, Safety, School , Social/Emotional, Spiritual, Vocation</li> </ul>
Electronic Referral (e-Referral)	<ul style="list-style-type: none"> <li>• Method by which information about a new client referral is communicated to agencies from either the SN, SC or team members</li> <li>• Alerts recipient to open GoldCare and view client information</li> </ul>
Enterprise Web Service Manager (EWSM)	<ul style="list-style-type: none"> <li>• An Internet-browser application that enables users to access portions of GoldCare that is relevant to their work.</li> <li>• Secured with User ID and Passwords, users can access and update information from a remote PC</li> </ul>
Goal	<ul style="list-style-type: none"> <li>• What the child and family team are trying to achieve</li> <li>• Relates to the Child and Family's Vision(s)</li> <li>• is stated in such a way as to be specific, measurable, achievable, realistic, and time specific,</li> <li>• May be long term or short term in nature</li> </ul>
Inactive Client	<ul style="list-style-type: none"> <li>• Client is registered in the Goldcare but Client may or may not be receiving services from network partners</li> <li>• Client does not have multiple needs and the need for a Single Plan of Care has not been demonstrated</li> <li>• Client is not accessing CTN specialty services and/or rehabilitation services</li> </ul>
Initial Plan of Assessment and Services (IPAS)	<ul style="list-style-type: none"> <li>• Has been referred to as the Provisional Plan of Care in earlier documents</li> <li>• Plan developed by the Service Coordinator prior to the Child and Family Team Meeting to determine what services and assessments are required to initiate a comprehensive plan that responds to the child and family's needs and vision</li> </ul>

Local Team	<ul style="list-style-type: none"> <li>• A group of personnel who are associated with a number of agencies and organizations in a given geographical area</li> <li>• The pool of skills and expertise from which the SC draws to assemble the Child and Family Team.</li> <li>• CTN will have 10 Local Teams</li> </ul>
Local Team Facilitator	<ul style="list-style-type: none"> <li>• Person funded by CTN to facilitate local team processes, identify training and service needs</li> <li>• Assists with implementation of the CTN model at the local team level</li> </ul>
Measure-Analyze-Plan-Improve with Technology (MAPIT)	<ul style="list-style-type: none"> <li>• GoldCare tool for managing quality indicators.</li> <li>• Users can define, measure, review and report on quality and performance indicators.</li> <li>• Information is collected from GoldCare, third party applications or can be entered manually. MAPIT can be used alone or with other GoldCare applications.</li> <li>• The MAPIT Dashboard is configurable, enabling you to have different views for management and staff so users can see the indicators that are pertinent to their responsibility.</li> </ul>
Priority	<ul style="list-style-type: none"> <li>• The degree of urgency required to address the need or area of concern without causing further deterioration to the child and/or family</li> </ul>
Review Date	<ul style="list-style-type: none"> <li>• Date the team will review the progress related to the goal or activity</li> </ul>
Service Coordinator (SC)	<ul style="list-style-type: none"> <li>• Person who assembles the child and family team based on the information provided by SN and their assessment of the child and family</li> <li>• Engages appropriate members of the Local Team to complete assessments in order to start building the Single Plan of Care</li> <li>• Gathers and summarizes team assessment information</li> <li>• Assembles team members, including family, to develop the Single Plan of Care</li> <li>• Monitors the implementation of the plan and informs team when changes in the plan are required</li> <li>• Anticipates transitions in child and family's life and the implications this may have on the single plan of care and the mix of services and providers</li> <li>• Assists the child and family to access appropriate services and supports</li> <li>• Assists the child and family to transition to the adult service system</li> <li>• Facilitates child and family team planning meetings on a regular basis as determined by the Single Plan of Care</li> </ul>

Service Discharge	<ul style="list-style-type: none"> <li>• Discharge specific to one service. Client can be service discharged from several services and remain active for Service Coordination</li> </ul>
Service Navigator (SN)	<ul style="list-style-type: none"> <li>• First service contact person for the client</li> <li>• Person who initiates the electronic file</li> <li>• Collects demographic data</li> <li>• Completes multi-domain interview to determine child and family needs</li> <li>• Determines and selects most appropriate service agency and provides referral to that agency</li> <li>• Determines if Service Coordination is needed</li> <li>• SN determines most appropriate agency for service coordination, contacts selected agency and provides referral and interview information</li> <li>• SN is responsible for client until service agency accepts referral of client</li> <li>• Once referral is accepted and deemed appropriate then service navigation phase is complete.</li> </ul>
Single Plan of Care (SPOC)	<ul style="list-style-type: none"> <li>• The outcome of the Child and Family Team Meeting.</li> <li>• The Single Plan of Care outlines the family's vision, the areas of concern, the child and family team goals and the activities required to meet the goals</li> <li>• The goals within the Single Plan of Care link back to the child and Family's vision</li> </ul>
Specialty Service	<ul style="list-style-type: none"> <li>• A Specific CTN Rehabilitation service</li> <li>• Provide training and mentoring to Local team therapists</li> <li>• Provide specialized assessments when there is no local capacity to do so</li> </ul>
Status	<ul style="list-style-type: none"> <li>• Describes how action related to a goal or activity is progressing</li> <li>• Can be stated as: In progress (IP), Achieved (A), No longer Appropriate (NA)</li> </ul>
Target Date	<ul style="list-style-type: none"> <li>• Date the team expects to achieve the goal or complete the activity</li> </ul>
Transfer	<ul style="list-style-type: none"> <li>• The transfer of responsibility for the client from service navigation to the agency providing a specific service or, to the service coordinator for more complex clients. For development of the Initial Plan of Care and the facilitation of the Child and Family Team Meeting and the Development of the Single Plan of Care</li> </ul>
Workspace	<ul style="list-style-type: none"> <li>• In GoldCare, the initial screen that is seen and that lists clients and relevant information</li> <li>• Workspaces are designed specific for roles: Service Navigation, Service Coordination, Service Provider and Management</li> </ul>

#### **iv. Training Plan for Practice Phase for Child and Family Team Members**

The following training plan is being proposed as a way to assist the current complement of CTN hosted service providers as well as the providers already providing service, to become familiar and start to apply the CTN model. This initial, or practice, phase will allow us to try out the elements of the model, such as the development of the single plan of care, while at the same time becoming familiar with the CTN software application.

In order to ensure that individuals will find the learning relevant to their practice we will be providing the training to members of already established teams in order that they might then as a team learn together, support each other and immediately apply the information to a current client situation.

In order to determine who will participate in this practice phase we are asking service Coordinators to review their caseloads and recommend specific clients who have multi-needs and who are receiving services from at least 2 other professionals/agencies within the Children's Service System. Clients who are new to service and/or who may not have all services completely established may provide the greatest learning opportunity as we work to developing local team processes and protocols.

Once Child and Family teams members have been identified, CTN will inform the service provider agency managers that their staff have been named as team members. With approval from the agency, CTN will then confirm the participant list and provide team members with training session dates.

Specific Child and Family Team members will be invited to attend 2 CTN Training Days, the first day to review CTN processes, and the 2<sup>nd</sup> day to learn the software application. The CTN overview and Process Training Day will accommodate a group of 40 people. The software training Day will be offered to a smaller group of 20 people.

##### **Steps in Process**

1. Agency providing Service Coordination (hosted and non-hosted) to review clients, and identify children with a multi partner team in place. If possible, agency to assign Service Coordinators from different geographies in order to ensure that we have participants from each local team.
2. Service Coordination Agency to complete Excel sheet, listing how long the client has been receiving services, the most involved team members, their agency and role within the team. Team membership can include both hosted and non-hosted staff.
3. CTN to review submitted client team participants and determine training configuration
4. CTN to discuss selection of participants with the supervisors of Service Coordination and Service Provider agencies.
5. Supervisors of Agencies to inform selected team participants of training dates
6. CTN to contact participants to discuss/obtain password for software and confirm training date

7. Service Coordinators to contact families, obtain consent for sharing name information with CTN and to discuss and set up the Single Plan of Care Meeting (Team meeting) for a date following the software training.
8. Service Coordinator to set up the Single Plan of Care Meeting the other team members for sometime soon after the training in order to apply the learning.

Agencies will be asked to provide the following number of clients in order to provide a wide representation for practicing

<b>Simcoe Preschool ( 10)</b>	<b>Simcoe School Age (9)</b> (3 each from various parts of the County)
SCS -Infant Development (2) (1 in North, 1 in South)	SCS- Family Support Program (3)
Catulpa- Early Intervention (1) Orillia	Catulpa Family Support Program (3)
SCS-Resource Teacher Program (3) (1 in Barrie, 1 in Bradford, 1 in Angus)	CCACSC (3)
CCACSC Medically Fragile Program (1)	
E3 Resource Teacher Program (1)	
CLASS Resource Teacher Program (1)	
CLH Resource Teacher Program (1)	

<b>York Region Preschool (10)</b>	<b>York Region School Age (11)</b>
EIS (5 from various parts of Region)	CCAC YR (4 from various parts of the region including Georgina)
CCACYR (5 from various parts of Region)	YSSN (4 from various parts of the region)
	YRDSB (* 2 new if possible)
	Kinark/Bluehills (1 if possible)

\*\*In addition, **10** new clients will be identified from Access in order to practice the entire process from Intake and initial data entry, to the building of the Child and Family Team and the development of the Single Plan of Care

## Training Calendar

		<b>1 November</b> -Inform Reference Group -Send out email – inform agencies of training dates	2	3
6	<b>7</b> Agencies to have list back to CTN	<b>8</b> Supervisor and Team Facilitator Training	<b>9</b> CTN finalizes team members and confirms training dates	<b>10</b> Once teams confirmed, SC to obtain consent from families to participate and establish a possible date for the Child & Family Team to meet and develop the Single Plan of Care
<b>13</b> Michelle to contact all team members for passwords	14	<b>15</b> Training/testing of SPOC, notes, workspaces	<b>16</b> Passwords to Campana	17
20	21	22	23	24
<b>27</b> Training Super User Group* (20+) Team Facilitators, Project team, CTN, Others.	<b>28</b> Send out notification for Group 3 training in January	<b>29</b>	30 CTN Process Training for Group 1 and 2 (40)	<b>1 December</b>
<b>4</b> Group 1 Software training (20)	5	<b>6</b> Group 2 Software Training (20)	7	8
11 The following weeks may provide opportunity to meet as a team and develop the SPOC	12	13	14	15
18	19	20	21	22
25	26	27	28	29
1 January	2	3	4	5
8	9	<b>10</b> CTN Process Training Day For Group 3 and 4 (40)	11	<b>12</b> CTN Software Training Day for Group 3 (20)
15	<b>16</b> CTN Software Training Day for Group 4 (20)	17	18	19
22	23	24	25	26

## v. Accessing singleplanofcare.com

Singleplanofcare.com, CTN's software application will be available to Network partners to load onto their computers and Laptops as Information Sharing Agreements and Connectivity Plans are finalized with Network partners during 2006 and into 2007.

The Full singleplanofcare.com Application will be available to those staff working from stationary sites such as Service Navigators, some Service Coordinators and agency managers. Full singleplanofcare.com users will have access to all modules and will have the ability to make customized reports.

Service Providers who will be accessing singleplanofcare.com from a variety of sites and home offices will be able to access the modules in the software relevant to their work over a secure web connection. Most of the software's functionality will be available over the web. Practitioners will access via a secure connection, using personal Passwords and User Id's. Some functionality such as creating reports will not be available over the web.

CTN has purchased a number of concurrent user licenses for the use of the Full singleplanofcare.com Application. Usage will be monitored over Phase II and III to determine if delays occur and if so whether they are due to an insufficient number of licenses or a higher than expected number of users at any given time.

Software for loading will be available prior to training sessions and will be discussed at the time of Password assignment. Prior to staff loading singleplanofcare.com they must ensure that their agency's information technology system can support singleplanofcare.com. Web users will require access to the Internet and the software to be loaded onto their laptop or home office computer.

### Password Assignment

Passwords to access singleplanofcare.com must be kept confidential and must be different than the Password used to access the agency electronic record system. Prior to training, staff will be contacted to provide the following information:

First Name	Initial	Last Name	Agency	Role	Email Address	Local Team	10 Character Password	Challenge Question	Answer to Challenge Question

**Role:** refers to the discipline or function one would bring to the Child and Family Team, for example, SN, SC, PT

**Local Team:** list the Local Team(s), geographical area where you provide service

**Password:** must include upper and lower case letters and numbers

**Challenge Question:** A question only you would know the answer to such as father's birthplace, first car, first pet's name. Do not use mother's maiden name (too common).

**Challenge Question Answer:** provide the answer to your challenge question.

## **vi. Trouble Shooting singleplanofcare.com**

### **Hardware**

*-Under Development*

### **Problems Logging On**

Occasionally, you may enter an incorrect ID or password while logging on to singleplanofcare.com.

If you receive an error message, write down the message and show it to your System Administrator. Listed below are some common problems.

### **Typing Errors**

If your ID or password is typed incorrectly, a message box appears telling you what was entered incorrectly (password, for example). Once you acknowledge the message, singleplanofcare.com will allow you to try 5 times before restricting your access.

Remember: User IDs and passwords are case-sensitive. Make sure you do not have Caps Lock on while typing your password.

### **User ID or Password Unknown**

If you do not know your user ID or you have forgotten your password, ask your System Administrator for assistance. In order to ensure your identity you will be asked your challenge question. You must answer your challenge question correctly in order for your password to be released to you.

## 7. Resources for Use by the Network

### i. Communications

CTN, with the assistance of the Communications Advisory Group, and project management from Extraordinary Conversations, has a Communications Plan focusing on building awareness about CTN. The plan includes:

- Development and dissemination of print materials, including the brochure and poster.
- Monthly e-Bulletins to build awareness about CTN and keep stakeholders abreast of Network development
  - For access to brochures or to receive the e-Bulletin, please contact [Carolyn.cannon@ctn-simcoeyork.ca](mailto:Carolyn.cannon@ctn-simcoeyork.ca) or call 877-719-4795 (252).
- Website [www.ctn-simcoeyork.ca](http://www.ctn-simcoeyork.ca)
  - The website contains sections for families and providers, and is updated regularly. When the reference guide is complete, it will be posted in modules on the website, along with forms of all kinds for families and providers. It is intended to be the primary source of information about CTN, supported by the two resource centres.
  - The clinical software application will eventually be accessible through the website, as will training and orientation modules
  - The website contains links to all Network partners, and to other links of interest to families and professionals. Please watch the website for upcoming events or training sessions, news releases, etc.
  - For projects and working teams, there will shortly be a secure communication tool called **Sharepoint**, at [team@singleplanofcare.com](mailto:team@singleplanofcare.com). This tool will allow working groups to communicate online and manage multiple versions of working documents. The site is password protected.
- **Presentations:** CTN CEO and staff are happy to make presentations about CTN to groups of any size.
- **Use of Logo Policy:** Network members are encouraged to use the CTN Logo. To access the logo, please contact the CEO [Robert.morton@ctn-simcoeyork.ca](mailto:Robert.morton@ctn-simcoeyork.ca) and indicate the planned use for the logo. CTN will provide an e-file that contains several variations of the logo, and instructions for the appropriate technical use of the logo.
- **Launches and Events:** As CTN's implementation proceeds, each local team site launch will provide an opportunity to bring children, families and providers together and share information about what the network can provide.

## ii. Capacity – Building

### Continuing Education

#### **POLICY:**

The system wide Children’s Treatment Network is responsible for ensuring that staff education needs are addressed through program wide and individual continuing education opportunities. Each staff member is responsible for tracking their educational activities for their organizations and colleges.

- CTN hosted workshops will be made available to all appropriate clinicians across the network
- Team Facilitators and Specialty Service staff are entitled to attend additional conferences/workshops to support the capacity at the local team
- Travel expenses including mileage (and hotel if outside GTA) for the duration of the workshop can be submitted (shared travel and accommodation is recommended).

#### **EXPECTED OUTCOME:**

CTN members will be able to update their clinical and non-clinical skills through continuing education opportunities.

#### **PROCEDURE/GUIDELINE:**

1. Members are requested to submit a Training Fund Application form to CTN’s Administrative Assistant and keep a copy for their own records.
2. CTN director will designate a close date for submissions of the Training Fund form approximately one month before the educational event or by the registration deadline date of the course if earlier.
3. CTN will review all submissions and determine eligibility to the Training Fund. Eligibility will be based on clinician’s written submission, agency and geographic disbursement.
4. CTN director will inform successful candidates within one week of submission close date.
5. The member is required to present the course/workshop content at a local team meeting and/or a system wide educational forum and make course material accessible.



**Children's Treatment Network**  
OF SIMCOE YORK

## Training Fund Application

Name: \_\_\_\_\_ Professional Designation: \_\_\_\_\_

Position: \_\_\_\_\_ Organization: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

How long have you worked in your home organization? \_\_\_\_\_

Title of Workshop, Conference or training event you will be attending: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Objective of attending this training: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Other experience related to this training: \_\_\_\_\_

\_\_\_\_\_

Anticipated Expenses – Registration fee: \_\_\_\_\_

Other Costs: \_\_\_\_\_ Total Cost: \_\_\_\_\_

Funding from other sources? \_\_\_\_\_

Funding Requested (specify CAN or US \$): \_\_\_\_\_

### **Attachment Checklist** – Please enclose the following documentation:

- a copy of the course outline and cost breakdown
- Indication of how the knowledge gained could be transferred to other parts of the Network (See checklist)

**Training Fund Application**

***On the basis of the information supplied, I hereby apply for the amount of \$\_\_\_\_\_. In the event that I resign from my current position or organization, I understand that I may be required to reimburse CTN on a pro-rata basis.***

***I have highlighted the following activity(ies) I will undertake to share the knowledge gained at the workshop or conference, to help increase the overall capacity of the Network:***

- Make a presentation at a workshop or meeting
- Provide in-servicing or mentoring to local or specialty teams
- Develop a summary or report for sharing across the Network
- Other – please describe below

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Email address

\_\_\_\_\_  
Telephone

**Manager’s Support:**

**We agree to support this request for funding, including the commitment to participate in knowledge transfer activities after the training opportunity.**

\_\_\_\_\_  
Manager’s Signature

\_\_\_\_\_  
Contact Information

**SEND THE COMPLETED APPLICATION FORM AND SUPPORTING INFORMATION TO Carolyn Cannon, Executive ASSISTANT [Carolyn.cannon@ctn-simcoeyork.ca](mailto:Carolyn.cannon@ctn-simcoeyork.ca) .**

Decision:  Approved  Not approved Final: Y\_\_\_

Info Needed \_\_\_\_\_

Date \_\_\_\_\_

## Criteria for accessing Training Fund

Children's Treatment Network is committed to being a learning organization. It is committed to building capacity in individuals, teams and the system as a whole.

As CTN evolves, training opportunities will be tailored to the strengths and gaps across the network in a proactive Training Plan, based on a skill inventory across the network. Until then, the network will take advantage of training opportunities as they arise, based on the following criteria:

1. Do we need this skill or knowledge?
  - Does the training focus on the needed core knowledge base identified by the CTN Intensive Working Group?
  - How does it fit with the CTN population
  - Is this a specialized skill set that is required but to a limited extent?
  - Is this a non-core knowledge or skill that it would be useful for the network to have for consultative, but not regular use? Why?
  - Can this training contribute to system improvement? How?
  - Is the training based on an evidence-based practice, or is it considered to be a best practice? If it is a promising practice only, what is the value in investing in it?
2. Is this the best way to build necessary capacity?
  - Is the need for this training reflected in the CTN Operating Plan?
  - How much capacity does the network need? Should the training be organized locally for broader network participation?
  - Does the network have existing capacity that might be able to in-service or mentor?
  - Is this the right person to train?
  - Is this the most affordable way to build capacity?
3. Is there an achievable, realistic way of transferring the knowledge?
  - Is the home organization willing to share in the cost, and/or support the employee in attending, then sharing the knowledge with the network?
  - How could this knowledge be transferred for capacity-building?
4. Are there other more urgent training priorities and is funding available?

## Reimbursement Guidelines

### Rationale

CTN is committed to increasing community capacity to support children and youth with special needs, and their families. To that end, CTN will invest in opportunities to develop the knowledge and expertise across the Network that will improve outcomes for kids and families.

### Decision-making

CTN will use the criteria identified in the application to make determinations about funding as quickly as possible after the deadline. The priority for funding will be areas of knowledge in which the Network requires additional capacity. Every effort will be made to maximize the use of training funds so as much capacity can be built as possible. Until a Network training plan is in place, decisions will be made by the CTN Management Team, based on the application submitted. Decisions will be marked 'Final' or 'Can be appealed if more information is available'.

### Funding

Subject to the availability of funding and the application of the criteria, CTN may be able to provide full or partial support for fees and related expenses.

Expenses, including travel, accommodation and meals, will be paid based on the actual cost incurred and receipts submitted, in accordance with the expense policy of the home organization.

Advance payment of course/conference fees, once approved, may be arranged with reasonable notice. Reimbursement may be requested by CTN if, within a year of the training opportunity, the funded person leaves their organization and their newly developed capacity is unavailable to the Network.

Requests must be pre-approved. *Unless otherwise arranged*, they will be paid when expenses and receipts have been submitted to Carolyn Cannon at:

[Carolyn.cannon@ctn-simcoeyork.ca](mailto:Carolyn.cannon@ctn-simcoeyork.ca)

Fax: 705 – 726-2870

Tel : 877-719-4795 (252)

Mail to : 165 Ferris Lane, Barrie, L4M 2Y1

October 31, 2006

### **iii. Resource Centers**

The Resource Centre is an information service, and provides opportunities for local visibility for CTN SY. Composed of a visible store front which is user friendly and offers accessible materials to families, teachers, therapists and consumers, it also will have a “virtual” library that contains current and relevant information and research findings with linkages to other appropriate portals.

### **Guiding Principles and Operating Practices**

- A community-based, family-centred, visible face of CTN SY;
- One-stop, easy access for families, children, youth, CTN SY staff, and other service provider staff to obtain information and access CTN SY tools, client files, and service plans;
- Linked to central management/administrative/decision support/logistical functions of CTN SY to access resources (e.g. staff, supplies, equipment, space), systems, tools, protocols, standards, and operational norms;
- Resource function is part of each local team function — each team member needs to be knowledgeable about CTN SY services, local children’s services including recreation, education, mental health, developmental services, acute paediatric care, advocacy;

- At one central location in each of Simcoe County and York Region, a larger resource area will be located — computer terminal for use of families, “virtual library”, information on local and Simcoe/York children’s services resources, and access to support groups will be established;
- Although the CTN is a ‘virtual’ network, not a ‘centre’, it is important to have physical locations where staff, children and families can go. As well, where possible, the locations will have a visible presence to the public in terms of signage and possible street level or storefront presence.

**Simcoe County Resource Centre** will include space to allow for:

- Office space for the Clinical Director;
- Therapy space including paediatric therapy gym, activity room (including sensory integration capacity), small treatment areas, and medical/clinic room with video/audio recording capability;
- Specialty clinic space;
- Observation rooms;
- Equipment storage area;
- Access to shared meeting and group space;
- Touch-down space for Local Team members and CTN administrative staff.

**York Resource Centre** will include the same types of space as the Simcoe County Resource Centre, as well as space for:

- Chief Executive Officer;
- Executive Assistant;
- Clinical Director and Access Director.

Please refer to the Functional Program following the resource centre floor plans.

# Simcoe Resource Centre

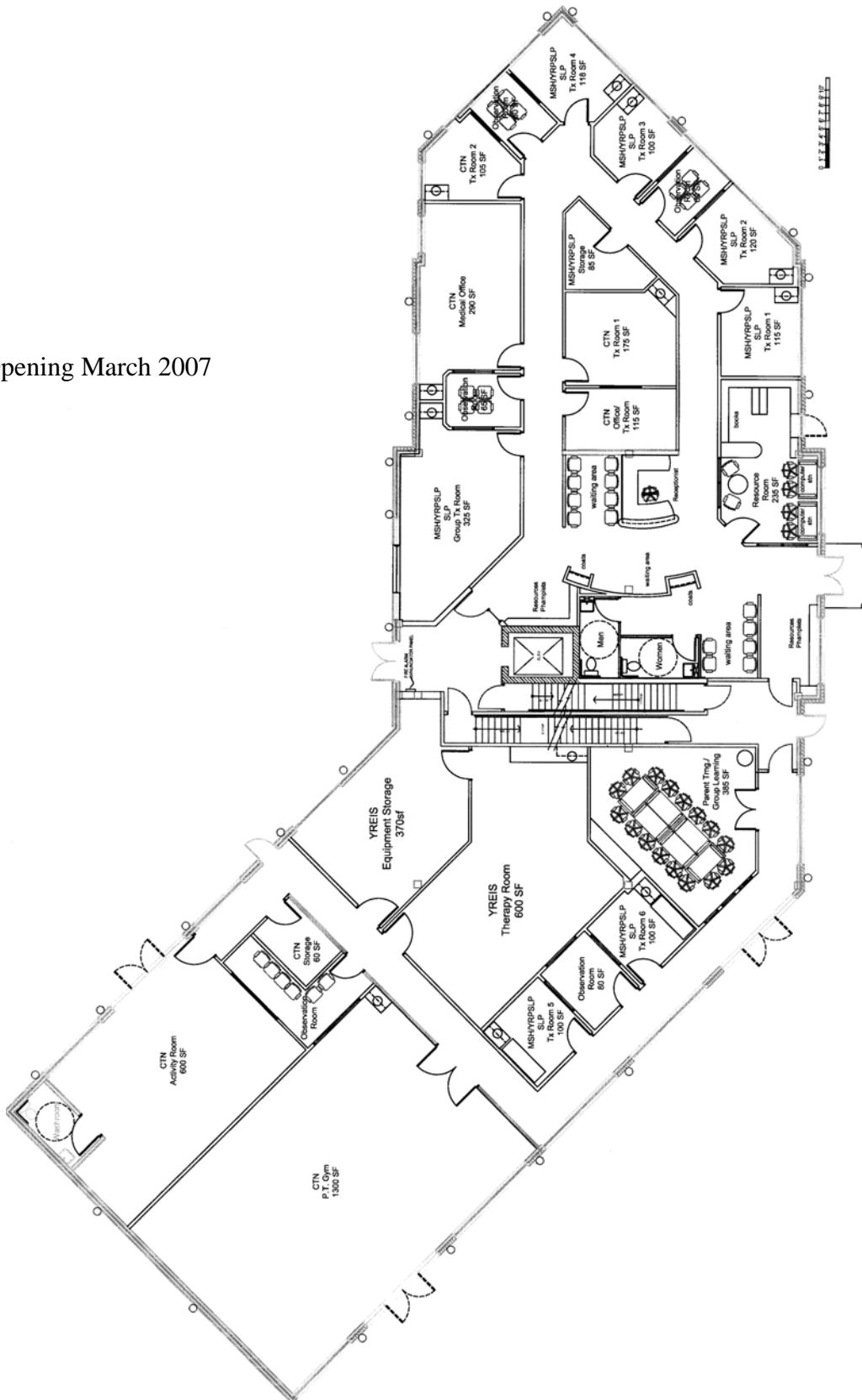
## LEGEND

- █ NEW PATH FOUNDATION
- █ NEW PATH YOUTH AND FAMILY COUNSELLING SERVICES OF SIMCOE COUNTY
- █ CATULPA COMMUNITY SUPPORT SERVICES INC.
- █ SIMCOE OUTREACH SERVICES
- █ A CENTRE FOR ADDICTIONS INC.
- █ CANADIAN MENTAL HEALTH ASSOCIATION BARRIE SIMCOE BRANCH
- █ CHILDREN'S TREATMENT NETWORK SIMCOE YORK
- █ COMMON AREAS
- CORRIDORS



# York Resource Centre

Opening March 2007



## **Functional Program**

### **Introduction**

The Children's Treatment Network of Simcoe York (CTNSY), established in 2005, is one of 20 Children's Treatment Centres (CTC's) in Ontario. It will provide a fully integrated range of new and existing professional rehabilitation and other support services to meet the needs of children and youth and their families, living in Simcoe and York regions.

Most clients served by CTNSY will have complex physical needs with associated developmental, behavioural, communication and/or educational needs.

The CTNSY will encompass:

- individualized and integrated therapy and care delivered in the clients local community, to the extent possible;
- family centred service;
- streamlined access, coordination and continuity of therapy and care;
- shared responsibility and accountability with other providers of service.

The CTNSY will be organized in a unique and distinctly different manner than other CTC's; it will reflect a fully integrated system approach to service delivery. It will build on the capacity of existing service providers and address existing gaps in service by augmenting service delivery and infrastructure supports. The result will be a fully coordinated system of therapy and care enabling children, youth and their families to achieve optimal outcomes.

While the CTNSY will directly employ staff, many staff will be employees of existing community organizations contracted to provide various levels of service. The CTNSY will have 10 local teams situated throughout Simcoe and York regions.

All CTNSY facilities will be located within existing community (host) organizations. The teams to be located in Barrie and Newmarket will be considered CTNSY "resource centres"; they will have additional resources and space to provide more specialized and resource intense services to the regions.

Further, most administrative (e.g., finance, human resources support, etc.) and all support services (e.g., housekeeping) will be provided by the host organizations. CTNSY administrative staff will be located within the resource centre in Barrie.

The CTNSY is in its very early stages of development and implementation. In parallel with defining the range of services and optimal size and location of each team, it must also begin to negotiate agreements with host organizations for the provision of space and other supports.

The document which follows is a modified functional program. It outlines three levels of space requirements, depending on the size and type of team to be located in the local communities. The primary purpose of this document is to assist CTNSY in discussions with potential host organizations regarding

- the designated space required by CTNSY at a host organization;
- services and space the CTNSY is wishing to share with the host organization;
- administrative and other supports that CTNSY requires the host organization to provide.

## **Functions**

Core services provided by each local CTNSY team will include:

- physiotherapy
- occupational therapy
- speech language pathology
- case management

Depending on need in the local community, services may also include

- recreation therapy
- EI/school personnel
- local information resource

In addition to the above, each resource centre will provide specialized services which may include

- subspecialty assessments and follow-ups
- assessment of needs for, prescription of, modification of, and teaching to use, adaptive seating and power mobility equipment
- augmentative communication including assessment and fitting of customized technical devices
- assessment and customizing of special adaptive devices for toys for recreation and socialization
- assessment and treatment of feeding and swallowing disorders
- psychological assessments and counselling
- assessment and fitting of orthotics

## **Operational Assumptions**

### Hours of Operation

Hours of operation will be dependent on the number of staff assigned to each team. For the most part, teams will operate over an eight hour period, five days a week, with extended evening and weekend hours, as required.

### Referral, Registration and Arrival

Families who are new to the system and have a child with multiple needs, will be

referred to the System Access Team. It will be a collaborative access mechanism allowing children and youth to access the most appropriate service in a streamlined and coordinated manner. Families who are knowledgeable and have a child with a single need will typically access the organization to which they know/are known.

The access team will screen and assess the client's needs and then refer them to the most appropriate organization(s). A case manager will follow the client and his/her family to assist in coordinating and accessing services across the system.

Scheduling of first time and follow-up appointments for CTNSY services will be provided by the host organization.

On arrival at each site, clients and their families will register at the host organization's reception area. They will wait in the waiting area until the time of their appointment. Within each resource centre there will be a family resource area, close to the waiting area, for families to access information.

Many clients will also be seen in their own homes and in community locations such as preschools, schools, community centres, etc.

### Service Delivery

#### Physiotherapy, Occupational Therapy and Speech Language Pathology

Therapists will provide assessment and therapy services in designated therapy areas. They will also meet with children, parents and community service providers in meeting rooms to provide education, consultation and information regarding a child's progress.

Speech language pathology visits will occur individually or in small groups in multi-use training rooms. Parents and community service providers will observe therapy within the training rooms or in adjacent observation rooms.

Feeding assessments will occur in one of the training rooms, and will involve the therapist, child, one to two parents and possibly one to two other staff. Observation of the assessment may occur in an adjacent observation room.

Therapists will each have an assigned workstation to complete indirect care functions, such as coordinating referrals, documenting assessment and treatment findings, ordering of equipment and making confidential telephone calls. Workstations will be located close to the areas where staff provide therapy. Generally, not more than four workstations will be in one room.

## **Clinics**

Most clinics will occur at the resource centres. A multipurpose therapy/treatment room will be used for clinics that require access to specialized equipment (e.g., seating clinics). Clinics that include physical examinations and discussion with the client and family will occur in an examination room, for the most part. Meetings between clients, parents and staff will also occur in conference/group rooms.

## **Information and Communications**

A family resource area will be located in each resource centre, adjacent to the waiting area, and will accommodate resource information including the internet, for clients and parents to access.

Staff will access common databases and information networks to obtain clinical (with parents' consent), financial and utilization information. This information will be accessed by staff in their own work areas.

Client records will be stored in a separate filing cabinet at each site.

Support services such as housekeeping and maintenance will be provided by the host organization.

## **Workload**

The workload of each team has not been established. It will be based on the client needs and the existing gaps in services that exist within each local community.

## **Staffing**

Staffing for each team has not been developed. It is anticipated that, in total, there will be about 90 FTE, across the 10 teams, in the future.

For the purposes of identifying space, four levels of space requirements will be used:

- Small Local Team: The local team will have a physiotherapist, occupational therapist and speech language pathologist; up to 3 FTE in total.
- Large Local Team: The local team will have 10 to 12 FTE in total comprised of physiotherapy, occupational therapy, speech language pathology, case managers, recreation therapists, EI/school personnel local information resource persons and visiting specialists.
- Simcoe County (Barrie) Resource Centre: The resource centre will include the staffing of a large local team option two as well as staffing and clinics for  
-augmentative communication  
-seating and mobility  
-feeding and swallowing  
-additional specialist clinics.

- York Region Resource Centre: The resource centre will include the space of the Simcoe County (Barrie) Resource Centre, as well as space for –chief executive officer –administrative assistant –clinical coordinator.

## **Considerations for Space and Design**

### Location

All CTNSY spaces should be located together, on one level, preferably ground level. Should the ground floor not be available, CTNSY space must be directly accessible to an elevator. The entrance to the building must be close to parking, and have a protected drop off area.

### Overall Requirements

CTNSY space should be located within an organization that emulates a non-institutional environment with an emphasis on wellness. Spaces should be bright and open, with wide corridors, entrances and doorways and significant natural light. CTNSY spaces must be highly functional and supportive for children, youth and their families. This entails convenient access to multiple areas used by children and families, adequate space for parents to be involved in therapy and education, and age appropriate decor and facilities.

All areas must be easily accessible by children with motor, cognitive and perceptual impairments. However, there must also be opportunities for children and youth to experience some challenges within a safe environment. Spaces should also be fully accessible by staff and families, some of whom may also have physical disabilities.

Clients and their families must be able to move easily throughout the facility where CTNSY is housed. A physical layout reinforced by good orientation cues is essential. The milieu of the host organization must support self confidence and enable children to find their way easily and begin to master their environment.

Easily accessible outside play areas that incorporate therapy areas into the design are also highly desirable.

Within the host organization, circulation spaces may be used for both therapy and circulation, particularly those adjacent to therapy and training areas. Hallways leading to the therapy areas such as the gym should be able to be considered therapeutic hallways. The purpose will be to create a teaching environment in a relatively protected area that exposes clients to common obstacles that can limit mobility and that they may experience in community settings. Ideally, they should vary in width and length and possess some challenges for clients to master. They should not be a main thoroughfare.

The facilities must provide flexibility for future changes and shifts among programs and services over time. As much as possible, areas should be adaptable to accommodate different functions.

The design and finishes of the host organization must be durable and sensory friendly. For example, flooring must be easy to keep clean and dry, and walls, particularly those in main thoroughfares, must have bumpers to protect clients learning how to manoeuvre mobility devices.

## **Specific CTNSY Requirements**

The following are essential for the designated CTNSY spaces

- Each SLP therapy room should accommodate the client, a parent and the therapist and contain a counter and sink.
- An observation room should be adjacent to the SLP treatment room(s).
- The OT activity room should accommodate up to eight clients, space for table activities and a kitchenette, including a sink.
- Each PT gym must have space for various pieces of equipment (the amount of equipment will vary according to the size of the team), a play area for up to six children and a walking area. The PT gym in the resource centres should also be able to accommodate sensory integration equipment.
- The PT gym and OT activity room should be adjacent.
- Therapy rooms require natural light yet should not have direct views to the outside which tend to be distracting for children.
- The resource areas, to be located in the resource centres, should be adjacent to the waiting rooms of the host organization. They will be sized to accommodate reading materials, a computer workstation and a workstation for parent use.
- Each team requires access to the following spaces which can be shared with the host organization. While included in the CTNSY space requirements, they will not have to be included if the host organization has them within its space and can accommodate the activity of the CTNSY team
  - a group room sized to accommodate up to 6 persons
  - an interview room sized to accommodate up to 4 persons
  - a parent training room sized to accommodate up to 20 persons.

## **Host Organization Spaces**

The following spaces must be available within the host organization and sufficiently sized to accommodate the activity associated with CTNSY

- reception and waiting areas
- photocopy/mail room
- file storage area
- wheelchair accessible client and staff washrooms; one washroom must also include an adult sized change table
- staff lunch room
- housekeeping rooms
- conference/classroom able to accommodate 30 to 40 seats

## Space Allocation

				NSF	No.	Total
<b>Resource Centre, Simcoe County (Barrie)</b>						
Departmental Gross Area (square feet)						7,665
Gross to Net Ratio						1.50
Net Square Feet (NSF)						5,110
<b>CTN Designated Spaces</b>						
1	.	1	Treatment room, SLP	140	2	280
1	.	2	Observation room	80	1	80
1	.	3	Physiotherapy gym	1,280	1	1,280
			• height table	1 @ 80		
			• double plinth	3 @ 100		
			• floor mats	2 @ 80		
			• parallel bars	2 @ 50		
			• steps	2 @ 20		
			• play area	1 @ 200		
			• walking area	1 @ 100		
			• sensory integration area	1 @ 300		
1	.	4	Team room	240	3	720
			• workstations	4 @ 60		
1	.	5	ADL washroom, OT	120	1	120
			• 2 pc.	1 @ 80		
			• change table	1 @ 40		
1	.	6	Activity room, OT, seats 8	400	1	400
1	.	7	Storage, PT, OT, SLP	150	1	150
1	.	8	Snoezelen room	350	1	350
1	.	9	Exam room	120	2	240
1	.	10	Clinic room	450	1	450
1	.	11	Storage	150	1	150
1	.	12	Resource room	100	1	100
1	.	13	Office, multipurpose	120	1	120
			Subtotal			4,440
<b>Shared Spaces</b>						
1	.	14	Group room, seats 6	150	1	150
1	.	15	Parent training room, seats 20	400	1	400
1	.	16	Interview room, seats 4	120	1	120
			Subtotal			670
<b>Resource Centre, York Region</b>						
Departmental Gross Area (square feet)						6,960
Gross to Net Ratio						1.50
Net Square Feet (NSF)						4,640

CTN Designated Spaces

1	.	1	Treatment room, SLP		140	2	280
1	.	2	Observation room		80	1	80
1	.	3	Physiotherapy gym		1,280	1	1,280
			• height table	1 @	80		
			• double plinth	3 @	100		
			• floor mats	2 @	80		
			• parallel bars	2 @	50		
			• steps	2 @	20		
			• play area	1 @	200		
			• walking area	1 @	100		
			• sensory integration area	1 @	300		
1	.	4	Storage		180	1	180
1	.	5	Team room		240	3	720
			• workstations	4 @	60		
1	.	6	ADL washroom, OT		120	1	120
			• 2 pc.	1 @	80		
			• change table	1 @	40		
1	.	7	Activity room OT, seats 8		400	1	400
1	.	8	Resource room		100	1	100
1	.	9	Snoezelen room		350	1	350
1	.	10	Office, multipurpose		120	1	120
			Subtotal				3,630
			Shared spaces				
1	.	11	Group room, seats 6		150	1	150
1	.	12	Parent training room, seats 20		400	1	400
1	.	13	Interview room, seats 4		120	1	120
			Subtotal				670
			Administrative Areas				
1	.	14	Office, clinical coordinator		120	1	120
1	.	15	Office, chief executive officer		120	1	120
1	.	16	Office, admin assistant		100	1	100
			Subtotal				340

**Large Local Team**

NSF No. Total

Departmental Gross Area (square feet) Gross to  
Net Ratio Net Square Feet (NSF)

5,085  
1.50  
3,390

CTN Designated Spaces

1	.	1	Treatment room, SLP		140	2	280
1	.	2	Observation room		80	1	80
1	.	3	Physiotherapy gym		860	1	860
			• Height table	1 @	80		
			• double plinth	2 @	100		
			• floor mats	2 @	80		
			• parallel bars	2 @	50		
			• steps	1 @	20		
			• play area	1 @	200		
			• walking area	1 @	100		
1	.	4	Storage		140	1	140
1	.	5	Team room		240	3	720
			• workstations	4 @	60		
1	.	6	ADL washroom, OT		120	1	120
			• 2 pc.	1 @	80		
			• change table	1 @	40		
1	.	7	Activity room OT, seats 8		400	1	400
1	.	8	Office, multipurpose		120	1	120
			Subtotal				2,720
			Shared spaces				
1	.	9	Group room, seats 6		150	1	150
1	.	10	Parent training room, seats 20		400	1	400
1	.	11	Interview room, seats 4		120	1	120
			Subtotal				670

**Small Local Team**

NSF No. Total

Departmental Gross Area (square feet) Gross to  
Net Ratio Net Square Feet (NSF)

3,300  
1.50  
2,200

CTN Designated Spaces

1	.	1	Treatment room, SLP		140	1	140
1	.	2	Observation room		80	1	80
1	.	3	Physiotherapy gym		630	1	630
			• height table	1 @	80		
			• double plinth	1 @	100		
			• Floor mats	1 @	80		
			• parallel bars	1 @	50		
			• steps	1 @	20		
			• play area	1 @	200		
			• walking area	1 @	100		
1	.	4	Storage		80	1	80
1	.	5	Team room		180	1	180
			• workstations	3 @	60		
1	.	6	ADL washroom, OT		120	1	120
			• 2 pc.	1 @	80		
			• change table	1 @	40		
1	.	7	Activity room OT, seats 8		300	1	300
			Subtotal				1,530
			Shared Spaces				
1	.	8	Group room, seats 6		150	1	150
1	.	9	Parent training room, seats 20		400	1	400
1	.	10	Interview room, seats 4		120	1	120
			Subtotal				670

#### **iv. How to Access:**

##### **Space**

Therapeutic space will be available at all local team sites for therapists within the network to use for work with children and youth. Included within this space will be a physiotherapy gym, OT activity room, SLP/Psychology treatment/assessment spaces, and observation rooms. Within the resource centres medical/clinic rooms and specialty services space will be available. Each site will share meeting room, group room, training space and staff space with other community partners. Additionally, team touch-down space with computer workstations will be available.

A mechanism will be created for accessing this therapeutic space that will be specific to each local team site. Currently only the Barrie local team space is available for use within the network. To access this space simply contact Carolyn Cannon at 877-719-4785 ext. 252 to book the required space. As each site becomes established, a specific process will be developed for accessing the appropriate therapeutic space.

##### **Equipment**

Basic therapeutic equipment will be available at each local team site. In addition, access to loaner or trial equipment through third party vendors will be established.

The following equipment will be available at each local team site:

- Double Plinths
- Mat Tables
- Wall Mirrors
- Rolling Mirrors
- Parallel Bars
- Steps (convertible)
- Playcentre
- Therapy Balls 18"
- Therapy Balls 25"
- Therapy Balls 33"
- Floor Mats 4'X8"
- Positioning Wedges 10"
- Positioning Wedges 8"
- Rolls 10"X36"
- Rolls 12"X48"
- Rolls 8"X24"
- Rolling Stools
- Feeding seats and universal corner seats
- Scooter boards
- Nesting furniture
- Trip Trapp chairs
- Balance Boards
- Weighted balls, foam balls, small rubber balls
- Weighted vests, weighted lap pads, wrist/leg weights
- Core disks
- Children's tables and chairs
- First Class Chair – small and large

Resource Centres include all of the above plus the following:  
Ultra-low speed treadmill with LiteGait gait trainer  
Climbing wall  
Platform Swing  
Airwalker Swing  
Deluxe Bolster Swing  
Steamroller Deluxe

## **Assessment Instruments/Tests**

The following assessment instruments/tests will be available at each local team site:

ADOS Kits  
Peabody Developmental Motor Scales with software kit  
Movement ABC  
BEERY Test of Visual Motor Integration  
Infant/Toddler Sensory Profile  
Sensory Profile  
Adolescent/Adult Sensory Profile  
Alberta Infant Motor Scales (not yet acquired)  
Bruininks Test of Motor Proficiency  
TVPS(n-m)-R  
TVPS(n-m)UL-R  
TVMS-R  
TVMS-UL  
PLS-4  
SPAT-D  
SPELT-P2  
SPELT-3  
PPVT-III A&B/EVT Kits with Assists  
Vineland Adaptive Behaviour Scales  
DSM-IV Manual (not yet acquired)  
Piers-Harris 2  
MDI-C  
GFTA-2 Test  
GMFM  
CELF-Preschool-2  
EOWPVT  
CELF-4  
PAT with computerized scoring  
The Listening Test 2  
The WORD Test-2 Adolescent  
Test of Problem Solving - Revised Elementary  
TOPS – Adolescent  
Functional Communication Profile  
CTOPP  
PLAI-2  
OWLS  
Elementary-Word-2  
Board Maker with addendums

Resource Centres have all the above plus:  
Wechsler Presch & Pri Scale of Intelligence with Scoring Assistant  
Wechsler Intelligence Scale for Children  
Wechsler Individual Achievement Test  
Bayley Scales Infant & Toddler Development

The above equipment or instruments/tests will be available for use by December 2006. A process will be established for direct access at each site through the local team facilitators as each site is established and local team facilitators are in place.

## **Interpreter Services**

CTN will provide a cultural/language informant/interpreter to all assessment and treatment sessions as deemed necessary by the family and clinician.

Clinicians will access their existing resources within their agency first, and then will investigate availability within their local team with the assistance of the Team Facilitator.

A professional interpreter is booked for all assessments when the family is not bilingual with English (i.e. the working language of the family is not English). Family members/friends are not acceptable interpreters, unless it is the wish of the family.

All recheck/reevaluation and goal setting appointments will be professionally interpreted when the family is not bilingual with English.

A professional interpreter is booked for the child's treatment sessions when the family is not bilingual with English. The number of treatment sessions that will require professional interpretation services will vary from family to family.

Some families may have a family member or friend that the family and clinician feel comfortable in using for translation.

It is anticipated that a minimum of half of the treatment sessions will require translation services, but that with increased knowledge of the treatment methodology, expectations and a good working relationship with the clinician, families might feel comfortable without this assistance.

Written documentation, where possible, should be provided to the family in the language that they can read. The Single Plan of Care contract with goals and brief home programming should be provided in the family's first language.

## **Expected Outcome**

All families in York Region will have access to CTN services regardless of their mother tongue.

## Procedure/Guideline

1. ACCESS will highlight that a referred child is learning a second language other than English and make note whether an interpreter is required to communicate with the parents.
2. If an interpreter is required to book an appointment, the service coordinator will determine if there is anyone in their local team that can make this initial contact call on their behalf. It is the Team Facilitator's role to keep this roster of languages at the local team up to date with current contact numbers.
3. Bridge Translations would be contacted for phone interpretation if there is no accessibility to this language at the local team. A Bridge Translation Interpretation Assignment form would need to be filled out to book this phone interpretation.
4. The clinician would explain to the interpreter the purpose of the conversation and would then place the interpreter on hold while the clinician in turn phones the family. Once the family has picked up the phone, the interpreter is brought back on line for three way teleconferencing.
5. An interpreter is booked for each appointment or series of appointments using the Bridge Translations Interpreter Assignment Form.
6. Bridge Translations will fax back the form with the confirmation information completed. A copy of this form is also faxed to CTN, Attn: Carolyn Cannon.
7. The interpreters can be asked to translate brief home programs at the end of a therapy session for the families to take home and apply the learned skills in their home language.
8. In event that the appointment with the interpreter needs to be cancelled, it is the clinician's responsibility to phone Bridge Translations at 1-888-243-9926 ext.0

## **8. For Host Agencies and Hosted Staff**

### **i. Setting Service Targets**

Service targets will be negotiated with each host agency based on the services hosted. It is recognized that we have insufficient data to accurately predict what would be the most appropriate service targets at this point in time and will refine as data becomes available through our electronic client record software. The following data elements will be tracked as part of this process:

- # individuals (by age, service recipient type) waiting for assessment
- # individuals waiting for service initiation
- # days waiting for assessment
- # days waiting for service initiation
- # visits, face-to face, or telephone, by discipline and service recipient
- # unique individuals served
- # days available for service (operating days)
- # new referrals
- # active carryovers April 1
- # group sessions, if applicable
- # files closed, by category
- # staff by employment status (FT,PT, PT –temp, casual) by discipline
- Workload activity (hour, visit, by discipline and service recipient)

In this regard, the process for refining and solidifying the service targets will be based on the following assumptions:

### **Caseload Weighting**

*-Under Development*

### **Monitoring Recruitment**

CTN SY will be funding over 80 Full Time Equivalents (FTEs) of new professional staff during implementation. All of these positions will be recruited through contracted host agencies with the assistance of CTN SY.

CTN SY has initiated this recruitment process through a coordinated initiative where a single announcement and request for candidates was distributed extensively across Canada. It was a marketing/recruiting piece that explained what CTN SY is all about and briefly describes the positions being sought. The piece focused initially on the PT, OT, SLP and Rehab Assistant, SW, and Psychology roles. Candidates were asked to send their resumes to a central point and to express their preferred location of work (number of options for preference to be determined). The resumes were then reviewed by the CTN SY management team with a follow up call to those who were screened in. These resumes have then been distributed to the appropriate Host organization. There will be a common approach to recruiting practices, CTN SY messaging etc.

The attached recruitment monitoring sheet has been developed and is updated monthly (updated November 2006) and reported to the Board of Directors for CTN SY.

<b>Physiotherapist</b>			
Agency	Contract FTE	Recruited FTE	% Complete
OSMH	1.30	0.20	15%
PRO	2.26	2.26	100%
EIS YR	3.00		0%
Southlake	0.80	0.80	100%
YRDSB	2.50		0%
YCDSB	1.50	1.50	100%
<b>Total</b>	<b>11.36</b>	<b>4.76</b>	<b>42%</b>

<b>Occupational Therapist</b>			
Agency	Contract FTE	Recruited FTE	% Complete
RVH	1.00		0%
OSMH	1.60	1.00	63%
PRO	2.54	2.54	100%
EIS YR	3.50		0%
MSH	0.60	0.60	100%
YRDSB	4.00		0%
YCDSB	2.50	2.50	100%
<b>Total</b>	<b>15.74</b>	<b>6.64</b>	<b>42%</b>

<b>Communication Disorders Assistant</b>			
Agency	Contract FTE	Recruited FTE	% Complete
MSH	1.00	1.00	100%
YRDSB	1.00		0%
YCDSB	1.00	1.00	100%
BKR	1.00	1.00	100%
<b>Total</b>	<b>4.00</b>	<b>3.00</b>	<b>75%</b>

<b>Rehabilitation Assistant</b>			
Agency	Contract FTE	Recruited FTE	% Complete
OSMH	0.80		0%
<b>Total</b>	<b>0.80</b>	<b>0.00</b>	<b>0%</b>

<b>Speech Language Pathologist</b>			
Agency	Contract FTE	Recruited FTE	% Complete
RVH	1.50		0%
Speech Clinic	2.00	2.00	100%
SCDSB	1.00		0%
SMCDSB	1.00		0%
MSH	2.60	3.60	138%
Southlake	0.20	0.20	100%
YRDSB	3.50		0%
YCDSB	2.50	2.00	80%
<b>Total</b>	<b>14.30</b>	<b>7.80</b>	<b>55%</b>

<b>Social Worker</b>			
Agency	Contract FTE	Recruited FTE	% Complete
MSH	0.50	0.50	100%
Kinark	0.50		0%
Undistributed	1.80		0%
<b>Total</b>	<b>2.80</b>	<b>0.50</b>	<b>18%</b>

<b>Service Coordinators</b>			
Agency	Contract FTE	Recruited FTE	% Complete
SCS	1.20		0%
Catulpa	0.80	0.80	100%
CCAC SC	1.50		0%
CCAC YR	1.50	1.50	100%
EIS YR	1.00		0%
YRDSB	2.00		0%
YSSN	2.00	2.00	100%
Kinark	0.50		0%
<b>Total</b>	<b>10.50</b>	<b>4.30</b>	<b>41%</b>

<b>Registered Dietitian</b>			
Agency	Contract FTE	Recruited FTE	% Complete
RVH	0.20		0%
Southlake	0.20		0%
<b>Total</b>	<b>0.40</b>	<b>0.00</b>	<b>0%</b>

<b>AAC Technician</b>			
Agency	Contract FTE	Recruited FTE	% Complete
Undistributed	1.00		#DIV/0!
<b>Total</b>	<b>1.00</b>	<b>0.00</b>	<b>0%</b>

<b>Inclusive Recreation</b>			
Agency	Contract FTE	Recruited FTE	% Complete
Catulpa	2.00	1.00	50%
YSSN	1.00		0%
<b>Total</b>	<b>3.00</b>	<b>1.00</b>	<b>33%</b>

**Developmental Paediatrician**

Agency	Contract FTE	Recruited FTE	% Complete
Simcoe	1.00	0.80	80%
York	1.00	1.10	110%
Totals	2.00	1.90	95%

**Psychologists**

Agency	Contract FTE	Recruited FTE	% Complete
YCH	2.00		0%
MSH	0.60	0.60	100%
Totals	2.60	0.60	23%

**Team Leaders**

Agency	Contract FTE	Recruited FTE	% Complete
<b>Specialty Services</b>			
RVH	0.50	0.50	100%
MSH	1.00	1.00	100%
SouthLake	0.20	0.20	100%
Undistributed	1.50		0%
<b>Local Team</b>			
OSMH	0.60	0.60	100%
PRO	0.40	0.40	100%
CCAC SC	0.60	0.60	100%
YCDSB	0.60	0.60	100%
YSSN	0.70	0.70	100%
MSH	0.60	0.60	100%
Undistributed	0.60		0%
Totals	7.30	5.20	71%

**Non-Clinical Staff**

Agency	Contract FTE	Recruited FTE	% Complete
CCACYR	4.00	4.00	100%
SOS	0.50	0.50	100%
Undistributed	2.00		0%
Totals	6.50	4.50	69%

Please Note: The non-clinical positions include the Access staff (service navigators, I/R specialist), team support positions, and resource centre facilitators.

Total Contract Clinical FTE's	75.80
Total Recruited Clinical FTE's	35.70
% Complete	47%
Total Contract Non-clin FTE's	6.50
Total Recruited Non-clin FTE's	4.50
% Complete	69%
<b>Total All Contract FTE's</b>	<b>82.30</b>
<b>Total All Recruited FTE's</b>	<b>40.20</b>
<b>% Complete</b>	<b>49%</b>

- ii. **Confirming Specific Roles – ‘Core’ and/or Specialty Services**
  - Orientation of New Staff – *Under Development*
  - Priorities for Training – *Under Development*
- iii. **Performance Management Plan – *Under Development***
- iv. **Information Management – Connectivity to singleplanofcare.com and expectations for use – *Under Development***
- v. **Relationship with Clinical Directors – *Under Development***
- vi. **How and When are the Service Contracts Reviewed – *Under Development***

## 9. Appendices

### i. Appendix 1 – Inventory of Children’s Services Available For York Region and Simcoe County

York Region						
Preschool and School age						
Agency	Target population	Services Offered	Geography/ Hours	Eligibility criteria / Fee	Contact information	Who/When to refer?
Childrens Mental Health						
<u>Blue Hills Child and Family Centre</u>	0-18 years	<ul style="list-style-type: none"> <li>Services focus on social and emotional well being, primarily for children youth and families, and include residential and non-residential programs, programs for the support and education of staff of other child serving systems.</li> <li>Provides range of mental health services</li> <li>Provides family mediation &amp; information service, family law information centre</li> </ul>	York Region Mon-Thursday: 8:30-8:00 Friday : 8:30-4:30	No charge  (*User fees for summer program)	905-773-4323  Fax: 905-773-8133  bluehillsschildandfamily.ca (June 2006)	Childrens Mental Health Services
<u>Kinark Child and Family Services</u>	0-19 years	<ul style="list-style-type: none"> <li>Group counseling, professional assessments, youth crisis intervention, respite relief, residential treatment, childcare</li> <li>Individual and family therapy, residential</li> </ul>	Offices in Markham, Newmarket, Keswick  Mon-Thursday: 8:30-8:00 Friday : 8:30-5:00	No charge	888-454-6275 905-773-0375 905-898-4572 After hours: 905-898-4572  Fax: 905- 836-2890  Website:www.kinark.on.ca  no mention of mobile crisis	Youth and families with Mental Health concerns  Childcare (preschool and School age) in Keswick & Sutton (905-476-9395)  Families seeking IBI

		<p>treatment, therapeutic, foster care, day treatment, zero to 6</p> <ul style="list-style-type: none"> <li>• Preschool Autism Program (IBI)</li> <li>• ASD School Support (not direct therapy)</li> </ul>				(preschool) intervention for Autism
<p><u>Behaviour Management Services of York and Simcoe</u> (York Central Hospital)</p>	<p>ABI: 16 years and up IBI: 0-6 years</p>	<ul style="list-style-type: none"> <li>• Behaviour management intervention</li> <li>• Sexuality Clinic to address issues with sexual behaviour</li> <li>• ABI (rehab assessment, treatment , support)</li> <li>• Preschool Autism Services (IBI) for mod-severe autism (assessed and Referred by Kinark)</li> </ul>	<p>York Region Mon-Friday: 9:00-5:00</p>	<p>Developmental delay of 2 years or more with a significant cognitive delay</p>	<p>905-773-2362 Fax: 905-773-5176 Behaviour.mgmt@bellnet.ca</p>	<p>Behaviour intervention, sexual behaviours, ABI, Preschool IBI for mod-severe autism (assessed and Referred by Kinark)</p>
<p><u>Southlake Regional Health Centre</u></p>	<p>up to 18 years of age</p>	<p><u>Child and Adolescent Crisis Program</u></p> <ul style="list-style-type: none"> <li>• Urgent assessment and short-term treatment for children</li> <li>• Support to parents during crisis periods</li> <li>• Brief individual and</li> </ul>		<p>The program, available to the residents of the hospital's service area</p> <p>Does not require a physician's referral</p>	<p>905-853-2227 Fax 905-830-5970</p>	<p>Urgent mental health</p>

		family therapy.				
	up to 16 years of age	<p><u>Child and Family Clinic</u></p> <ul style="list-style-type: none"> <li>• Assessment and treatment services for the more severe mental health problems of childhood and adolescence.</li> <li>• psychiatric team consultation - a diagnostic assessment including treatment recommendations</li> <li>• family therapy</li> <li>• parent counseling</li> <li>• individual therapy, including play therapy, cognitive-behavioural therapy, psychodynamic psychotherapy, interpersonal psychotherapy</li> <li>• psychiatric/medication consultation</li> <li>• psychological assessment</li> <li>• Group therapy, including peer socialization/anger management</li> </ul>		<p>Reside in the hospital's service area.</p> <p>A referral from a staff physician is required.</p>	<p>905-895-4521</p> <ul style="list-style-type: none"> <li>• Reception: extension 2215</li> <li>• Intake Worker: extension 2759</li> </ul> <p>Fax 905-830-5977</p>	<p>Outpatient child and adolescent mental health clinic</p> <p>Severe mental health problems e.g. anxiety disorders, including obsessive compulsive disorder , depression and other mood disorders , childhood trauma and abuse, child and adolescent sexual offending, gender identity disorder , childhood psychosis , pervasive development disorder, eating disorders for children under 13 years of age</p>

		groups, child and adolescent groups for mood, self-esteem, anxiety issues, etc.				
	under 18 years of age	<u>Child &amp; Adolescent In-Patient Unit</u> <ul style="list-style-type: none"> <li>• in-patient unit</li> <li>• Short-term assessment, crisis stabilization.</li> </ul>		Reside in York Region.		<p>The regional in-patient unit consists of 5 interim beds</p> <p>short-term assessment, crisis stabilization</p> <p>crisis presentations</p>
	13 to 18 years of age	<u>Eating Disorder Program</u> <ul style="list-style-type: none"> <li>• Assessment</li> <li>• Outpatient includes individual therapy, family therapy, nutritional counseling, psycho-education classes, parent support group and/or therapeutic groups for adolescents.</li> <li>• Day Treatment Program is more intensive support with half-day of schooling in the morning and a half-</li> </ul>		<p>live in York Region or Simcoe County</p> <p>A medical assessment by the referring physician will be required in advance.</p>	<p>905-895-4521 extension 2322</p> <p>Fax 905-830-5970</p>	Eating disorders

		day of therapy in the afternoon				
<u>York Centre for Children, Youth and Families</u>	0-18 years	<ul style="list-style-type: none"> <li>day treatment and family counseling</li> <li>May provide services in school, community, home.</li> </ul>	York Region Mon-Friday: 8:30-4:30		905-887-5896	Different age appropriate programs for children and youth with emotional/behavioural problems
<u>Community Crisis Response Service (310-COPE)</u> <u>York Support Services Network</u>	Children and youth (and adults) in mental health crisis	<ul style="list-style-type: none"> <li>telephone mental health crisis support</li> <li>mobile outreach response (when required) with Kinark</li> <li>enhanced mobile response in partnership with police (as needed)</li> </ul>	York Region: telephone 7 days / week 24 hours/ day Mobile: as required		905-310-2673 (COPE) 1-800-848-6838  Fax: 905 -898-1171  <a href="mailto:crisis@yssn.ca">crisis@yssn.ca</a>	Parents who believe their child is in crisis and may be of harm to themselves or to others
Autism						
<u>Kerry's Place Autism Services</u>	children and adolescents with autism	<ul style="list-style-type: none"> <li>Address individual social, educational, vocational and developmental needs.</li> <li>Specialized residential services and community outreach for adolescents.</li> <li>Provides parent/mediator training, program planning and case management.</li> </ul>	York Region Mon- Friday: 9:00 -4:30	Proof of diagnosis of Autism, PDD, Asperger's Syndrome	905-713-6808 Fax: 905-841-1461 <a href="http://www.kerrysplace.org">www.kerrysplace.org</a>	Autism services
		•				Autism

<u>Geneva Centre for Autism</u>	Preschool, School age and Teens with Autism	<ul style="list-style-type: none"> <li>• Respite</li> <li>• social skills groups</li> <li>• early intervention</li> <li>• parent education and support</li> <li>• behaviour and communication consultation</li> <li>• school to work supports</li> </ul>	York Region  Mon-Friday: 9:00-5:00	Diagnosis of Autism	1-888-436-3829 Fax: 416-322-5894 <a href="http://www.autism.net">www.autism.net</a>	
**See Children's Mental Health: Behaviour Management Services of York and Simcoe and Kinark						
<u>Health Connection</u>	All ages Referral to Public Health programs and services	<ul style="list-style-type: none"> <li>• Access to registered dietitian and sexual PHN by phone or email for health related questions</li> <li>• Health education or individual counseling.</li> <li>• Interpreter services for over 150 languages and TTY line for deaf?? and hard of hearing</li> </ul>	York Region  Mon-Friday: 8:30-4:30  24/7 pre-recorded health info  24/7 ability to leave VM and call will be returned next business day	free	1-800-361-5653  Fax: 905-762-2955 <a href="http://www.york.ca">www.york.ca</a>	Family with a health concern that does not require immediate attention
<u>York Region Health Services Dental Screening and Preventative Clinics</u>	Children 0-13 years	<ul style="list-style-type: none"> <li>• Screening and prevention</li> </ul>	Newmarket, Richmond Hill, Markham. Screening in area elementary schools, child care centres, and Ontario Early Years Centres	No charge for screening and some services	905-895-4512	Dental concerns
<u>York Region</u>	0-6 years.	<ul style="list-style-type: none"> <li>• Support for parenting</li> </ul>	York	No charge	1-800-361-5653	Families with generally healthy



<u>Paediatric Developmental Assessment Clinic</u>	18 months – 5 years	<ul style="list-style-type: none"> <li>Team assessment for children experiencing difficulty with their development.</li> </ul>	Located in MSH	MD referral required	905-472-7534 Fax: 905-472-7535	Diagnostic for children experiencing difficulty with their development.
Developmental Services / Special Needs						
<u>York Support Services Network (YSSN)</u>	children ages 6-21 with a developmental disability	<u>Developmental Services Program</u> <ul style="list-style-type: none"> <li>Case management for children with developmental disability or dual diagnosis</li> <li>Children's case Coordination</li> <li>Integrated recreation</li> </ul>	York Region	Developmental disability	905-898-3721 1-888-695-0070 ext. 574  Fax: 905-898-1171 aporretta@yssn.ca	child who has a developmental disability  Addresses needs related to crisis, accommodation services, day supports and respite, financial resources
		<u>CHAP Program York Region</u> <ul style="list-style-type: none"> <li>Matches need for respite worker to a pool of potential workers</li> </ul>		Apply through respite registry (www.respiteservices.com)	kdelong@yssn.ca	Respite for families of children with developmental disabilities including autism and/or physical disabilities
<u>Early Intervention Services (EIS), Regional Municipality of York</u>	birth to school-entry	<ul style="list-style-type: none"> <li>Screen &amp; assess growth and development</li> <li>intervention</li> <li>OT and/or PT consultation</li> <li>play groups for children with special needs</li> <li>Promote and support participation in a community child care program</li> </ul>	York Region		1-888-703-KIDS (5437)  www.york.ca	Infants & preschoolers with special needs  At risk due to prematurely, low-birth weight or multiple births, Have delayed development  Have a disability such as Cerebral Palsy, Autism or Down Syndrome

		<ul style="list-style-type: none"> <li>• Consult with and support child care providers</li> <li>• workshops for parents and caregivers of children with special needs</li> <li>• transition to kindergarten</li> </ul>				
<u>Community Living York South</u>		<ul style="list-style-type: none"> <li>• outreach services to families with people living at home or independently</li> <li>• assist families to create support systems</li> <li>• connects to available resources</li> </ul>		Markham, Stouffville, Richmond Hill and Vaughan.	905-884-9110 Fax: 905-737-3284 <a href="mailto:info@ysacl.on.ca">info@ysacl.on.ca</a>	Supports individuals with intellectual disability.
<u>Community Living Newmarket /Aurora District</u>		<ul style="list-style-type: none"> <li>• residential support</li> <li>• employment support</li> <li>• day supports</li> <li>• parental relief</li> <li>• Leisure opportunities.</li> </ul>	Mon-Friday: 8:30-4:30	Aurora, East Gwillimbury, Newmarket, parts of King, Whitchurch-Stouffville	905-898-3000 905-773-6346 Fax:905-898-6441 <a href="http://www.clnad.com">www.clnad.com</a>	Supports individuals with intellectual disability.
<u>Community Living Georgina</u>		<ul style="list-style-type: none"> <li>• daily activity programs</li> <li>• 24 hour support in a residential setting.</li> <li>• Skills programs</li> <li>• Housing supports</li> <li>• Transition from schools</li> </ul>		Southern shore of Lake Simcoe	(905) 722-8947 Fax: (905) 722-9591 Email: <a href="mailto:gacl@ils.net">gacl@ils.net</a>	Support and services for individuals with developmental disabilities.

Child Protection / Family Services						
<u>York Region Children's Aid Society (CAS)</u>	0-16 yrs	<ul style="list-style-type: none"> <li>• protect children</li> <li>• promote safe, healthy , caring environment</li> </ul>	York Region  Mon-Friday: 9:00-5:00 plus 24 hour emergency services		905-895-2318 1-800-718-3850 Fax: 905- 895-8379 www.yorkcas.on.ca	Legal responsibility to protect children from abuse, abandonment and neglect. Investigation of child welfare concerns or risk of concerns. Protection
<u>Catholic Community Services of York Region</u>		<ul style="list-style-type: none"> <li>• Counseling child management issues, family breakdown, stress.</li> <li>• Immigrant Services</li> <li>• Focus on Fathers</li> </ul>	York Region  Mon-Friday: 8:30-4:30	Fees geared to income	905-770-7040 1-800-263-2075 Fax: 905-770-7064 ccsyrr@ccsyrr.org	Catholic social justice tradition
<u>Family Services York Region</u>		<ul style="list-style-type: none"> <li>• Counseling</li> <li>• Group therapy</li> <li>• Anger management</li> <li>• Psychologists.</li> <li>• day treatment</li> </ul>	Newmarket-Bradford, Richmond Hill, Markham, Georgina	Fees geared to income  (free under 19 years of age)	Markham 1-866-415-9723 Richmond Hill, 1-888-820-9986 Newmarket 1-888-223-3999  Fax:905-415-9706 www.fsyrr.ca	
<u>Jewish family &amp; child Services</u>	No age restriction.	<ul style="list-style-type: none"> <li>• Counseling</li> <li>• Education</li> <li>• Prevention</li> <li>• Individual, family &amp; group therapy.</li> <li>• Life skills</li> <li>• workshops</li> </ul>	Thornhill ; York Region Mon-Thurs 9:00 - 5; Fri 9:00 - 4pm; Evenings by Appointment	Fees assistance available	905-882-2331 Fax: 905 882-2355  <a href="http://www.toronto.com/jfcs">www.toronto.com/jfcs</a>	Jewish family & child Services
<u>York Region Abuse Program (YRAP)</u>		<ul style="list-style-type: none"> <li>• treatment for childhood sexual abuse</li> </ul>	York Region	no charge to the residents of York Region and surrounding northern areas without like services	905-853-3040 1-800-263-2240  Fax: (905) 853-1023 yrap@yrap2.org	child abuse

Childcare						
<u>Ontario Early Years Centres</u>	0-6 years	<ul style="list-style-type: none"> <li>• programs and activities</li> <li>• answers to questions</li> <li>• information about programs and services for young children</li> <li>• early years professionals</li> </ul>	York North, Aurora/King, Oak Ridges, Thornhill, Markham	No charge	<a href="http://www.ontarioearlyyears.ca">www.ontarioearlyyears.ca</a>	Resource for parents
Shelters						
<u>Leeder Place Family Shelter</u>  Transitional and Supportive Housing Services of York Region		<ul style="list-style-type: none"> <li>• Short term emergency housing for homeless families</li> </ul>	24 hours/day	No fees  Duration of service 2-4 weeks	905-898-1658 Fax: 905-898-6414 tshsyr@allstream.net	Families who need emergency temporary shelter.
<u>Sandgate Women's Shelter</u>		<ul style="list-style-type: none"> <li>• Emergency crisis shelter</li> <li>• 24 hour crisis telephone support</li> <li>• a group for children who have experienced violence against women</li> <li>• Transitional Support and Housing</li> </ul>	York Region	No charge	1-800-661-8294 905-722-3220	shelter for abused women and children

<u>Yellow Brick House</u>		<ul style="list-style-type: none"> <li>• Emergency housing shelter (short term) for women and their children</li> <li>• Referrals</li> <li>• Programs &amp; assistance for children who may witness abuse in the home and family.</li> <li>• RETA'S PLACE is a second- stage apartment building. For ex- residents of Yellow Brick House. (LOS 6 months).</li> </ul>	York Region 24 hours a day/ 7 days a week	for a period of 6 weeks crisis eviction	Admin:1 800 263-2231 Emergency Shelter: 1 800 263-3247  Fax: 905 727-7316  <a href="http://www.yellowbrickhouse.org/">www.yellowbrickhouse.org/</a>	must be in crisis Emergency shelter to women and children
<u>Pathways for Children, Youth and Families of York Region</u>	Residential support 16-19 years.  Drop in centre for youth 14-20 years	<ul style="list-style-type: none"> <li>• Residential support for youth 16-19 years.</li> <li>• Drop in centre for youth 14-20 years</li> <li>• Family Resource Centre</li> </ul>	Mon-Friday: 9:00-5:00	Residential (does not admit youth with major substance abuse or known significant criminal record)	905-471-7877 Fax: 905-471-7949 <a href="http://www.pathwaysyorkregion.org">www.pathwaysyorkregion.org</a>	Youth in housing crisis and homeless youth.

**Simcoe County**

Infant and Preschool Services						
Agency	Target Population	Services Offered	Geography	Eligibility criteria	Contact information	Who/When to refer?
Children's Mental Health						
Children's Mental Health Crisis Line	0-18 years	Children and parents, immediate telephone response to deescalate crisis, may visit site of crisis and/or provide short term intervention	Across Simcoe County		705 728-5044 1-888-893-8333	Child or youth experiencing a crisis that is not imminently life threatening but would benefit from an immediate response. Usually for out of control of behaviour
New Path Youth and Family Services  Early Years Service	Children 0-18 years of age with social-emotional and/or behavioural concerns and their families	Intensive in home work with parents and child Parenting Programs, Triple P and Social Skills programs Service Coordination (COMPASS) Day treatment Residential Multidisciplinary approach including SW, psychiatry, psychology	All Simcoe county		Central Intake Number 705 725-7656 Mobile Crisis Line = 728-5044 1-800-893-8333 Mon-Friday 8:30-8:30	Child or youth requiring counseling due to truancy, anxiety, aggression, mental health diagnosis. Families who require education, support and counseling to cope and assist their child.
Kinark	Children 0-18 years of age with social-emotional and/or behavioural concerns and their families	Family and individual counseling Crisis response service through Markham Office  Services for youth and families with Mental Health concerns Family and individual counseling services (office based) Triple P Parenting Programs Day Treatment Residential Services	All Simcoe County offices in Barrie and Midland		1-888-4-KINARK 1-888-454-6275  www.kinark.on.ca	Families seeking IBI intervention for Autism through Markham Office Children with mental health concerns who require individual or family counseling Parents who require parent education such as Triple P Families can self refer when a child is experiencing difficulty at home, school or in the community

		Home Based Services Crisis Response Services				
Catholic Family Life	Families	Offers counseling for individuals, families, couples for child management issues, family breakdown, and stress. Fees geared to income	Simcoe County Multiple offices	No restrictions No religious affiliation	705 726-2503 ext 101 www.catholicfamilylife.ca	Families requiring counseling and support, Marital counseling Fee for service geared to income
Health Services, Parent Education, Screening and Referral						
Health Connection		Access to public health professional by phone or email for health related questions	All Simcoe County		721-7520, or 1-877-721-7520	Family with a health concern that does not require immediate attention
Healthy Babies Healthy Children	Children and families 0-6 years. Self referral to be encouraged	Support for parenting, service coordination and linkage to community resources. Home visits from PHN for ages 0-6yrs. Lay home visitors for 0-3 yrs	Across Simcoe County		721-7520, or 1-877-721-7520	Families with infants and children who may be at risk and who may require support to access community services, or who need more information re child development, behaviour, breastfeeding, feeding issues. Child and families deemed to be at risk for developmental concerns and parenting issues.
Preschool Rehabilitation Services						
Preschool Speech and Language – Royal Victoria Hospital	Birth to school entry	Assessment and Treatment of communication disorders Provide individual and group education	Across Simcoe County	5 years and under (not yet in school)	705-739-5696 1-800-675-1979	Child with a speech and/or language concern. Offer Hanen Program for Younger children <2yrs Service may be provided through a mediator in various settings, i.e. nursery school/day care or at the RVH Hospital
Audiology Hearing Health Services - Royal Victoria Hospital	All ages	Hearing Assessments Infant Hearing	Simcoe County Muskoka Parry Sound	Physician Referral Required IHP does not require referral, automatically referred at birth	705-739-5696 FAX 705-739-5674	Infants who did not receive infant hearing test in hospital may access through RVH Parent concerned re infant (IHP) and child's over 2 yrs or discharged from IHP and adults hearing in Simcoe County
Children's Rehabilitation Services - Royal Victoria Hospital	Birth to school entry	OT Assessment and treatment Feeding Clinic	Barrie, Bradford, Borden, Angus  Simcoe County	4 years and under Requires medical referral	705-739-5696 FAX 705-739-5674	Preschool child with OT needs. Preschool child with feeding, swallowing, weight gain, concerns who would benefit from a comprehensive approach

		(includes dietician and SLP) and access to video fluoroscopy	for Feeding Clinic 6 yrs less a day – Doctor referral			(Feeding Clinic) Screening for specific eligibility at intake
Children's Therapy Services Orillia Soldier's Memorial Hospital CTS	Infants and children 0-6 yrs or until school entry	OT, PT, Psychology Social Work Provide Assessment and treatment services	Orillia, Bradford, Alliston, Collingwood, Midland, Barrie	0-6 years Valid Health Card Number	705 326-2214 FAX 705-326-0667	OT and/or PT for Infants or Preschool children whose development is at risk. Service is provided in the home, hospital setting and or in daycare and nursery school. Social work service offers brief intervention
Community Care Access Centre Simcoe County CCACSC	Infants and children who are medically fragile	Service Coordination OT, PT, SLP, Dietician, Social work, nursing	Across Simcoe County	0-18 years, up to age 21 if still attending school Valid Health Card Number	705 721-8010 1 888-721-2222	Infant or preschooler with significant medical concerns requiring therapy services, and/or nursing services for health care teaching and/or respite Case management
Child Protection Services						
Children's Aid Society CAS	Children 0-16 yrs	Investigation of child protection concerns or risk of concerns. Protection Prevention programs, family support and adoption	Across Simcoe County	Less than 16 years of age Living in Simcoe County	705 726-6587 Crisis phone = 1 800 461-4236  Fax 705-726-9788	Child protection concerns
Early Intervention and Developmental Services						
Catulpa Community Support Services  Resource Teacher Program (Early Intervention Program) Inclusive Recreation	18 months to school entry	Service Coordination Children at risk for developmental or behavioural delays. , support to children in Inclusive day care setting Individual work with child and family Triple P group and individual	Orillia  Across Simcoe County	Developmental or physical disability	705 326-2214 ext 239 Fax 705 735-6826 <a href="http://www.catulpa.on.ca">www.catulpa.on.ca</a>  Inclusive Recreation= 705 733-3227 ext 245	Preschooler with developmental concerns who requires assistance to access day care/nursery school, family requires assistance with service coordination, funding applications, respite funding, mediator training (any barrier to typical development including behaviour)
Simcoe Community Services Resource Teacher	Preschoolers under age 6 years	Service Coordination Home visiting, developmental assessment, parent education, individual	Barrie, Bradford, Angus	2 years of age up to school entry Resident of Simcoe County	705 726-9082 FAX 705-720-1083  www	Preschooler with developmental concerns who requires assistance to access day care/nursery school, family requires assistance with service coordination, funding applications, respite funding,

Program		work with child & family. Assist with implementing therapy & developmental programming Assist with transition to school. Support to children & inclusive daycare settings Triple P, group & individual Nursery school			.simcoecommunityservices.ca	mediator training
Simcoe Community Services  Infant Development Program	0-3 years with limited service for 3-6 year olds	Service Coordination Home visiting, parent education, developmental assessment, parent education, assist with implementing therapy & developmental programming	Across Simcoe County	Age 3 and under Resident of Simcoe County *note brief service from 3-6 years	705 726-9082 Central office FAX 705-720-1083  Satellite offices 705 326-2214 ext 235 Orillia, Collingwood, Midland, Bradford Worker in Alliston	Infant or toddler with or at risk for developmental concerns. Assistance to families to develop plan and access appropriate therapies.
E3 Community Services	Preschoolers age 18m until school entry	Service Coordination Home visiting, developmental assessment, parent education, Assist with implementing therapy & developmental programming Assist with transition to school	Collingwood and Stayner	Ages 1.5 to 5 years, experiencing barriers to development	<a href="http://www.e3.ca">www.e3.ca</a>  705 446-0816 Fax 705 445-6313	Preschooler with developmental concerns who requires assistance to access day care/nursery school, family requires assistance with service coordination, funding applications, respite funding, mediator training
Community Living Association of South Simcoe (CLASS)  Resource	Preschoolers age 3+ until school entry	Service Coordination Home visiting, developmental assessment, parent education, Assist with implementing therapy	Alliston/Adjala area	Developmental Disability	705 435-4792 Fax 705 435-2766  <a href="http://www.class.on.ca">www.class.on.ca</a>	Preschooler with developmental concerns who requires assistance to access day care/nursery school, family requires assistance with service coordination, funding applications, respite funding, mediator training

Teacher Program		& developmental programming Assist with transition to school				
Community Living Huronia  Resource Teacher Program	Preschoolers age 3+ until school entry	Service Coordination Home visiting, parent education, developmental assessment. Assist with implementing therapy & developmental program. Assist with transition to school	Midland Penetanguishene Elmvale	Preschooler with delay in development or at risk of delay	705 527-6744 Fax 705 527-6744	Preschooler with developmental concerns who requires assistance to access day care/nursery school, family requires assistance with service coordination, funding applications, respite funding, mediator training
Domestic Violence/Shelters						
Green Haven Shelter	Women and Children requiring emergency shelter and/or counseling	Counseling for women affected by emotional and/or physical violence	Orillia	Women Ages 16 years and up with or without children	24 hour Crisis line  705 327-7319  1-888-285-6958	Women and their families who require support to deal with physical and/or emotional violence in the Orillia and surrounding area
Barrie Women and Children's Shelter	Women and Children requiring emergency shelter and/or counseling	Counseling for women affected by emotional and/or physical violence	Barrie	Women experiencing abuse	1-800-461-1716  Crisis Line 705 728-6300 Fax 705 728-1364	Women and their families who require support to deal with physical and/or emotional violence in the Barrie and surrounding area

## ii. Appendix 2 - Where to Go for Help?

The following contacts may be helpful when searching for Information about available Services and Contact information for both York Region and Simcoe County:

[www.ctn-simcoeyork.ca](http://www.ctn-simcoeyork.ca) Children's Treatment Network (CTN) website which features CTN contact information as well as providing direct links to Network partner websites. You can also call the Children's Treatment Network at **1-866- 377-0286**. For

general information please ask for Information and Referral. To make a referral for services please ask to speak with a Service Navigator.

### For York Region

[www.region.york.on.ca](http://www.region.york.on.ca) York Links, an information directory of services available in York Region. Provides description and contact information. The number to call is

**905-830-4444 ext. 2151** or toll free **1-877 464-9675**

### For Simcoe County

[www.211SimcoeCounty.ca](http://www.211SimcoeCounty.ca) 211 Simcoe County is an information Directory for the Simcoe County area. Callers from York Region can Access Information about Simcoe County Services by calling **1-866-743-7818**. Callers from Simcoe County can dial 211.

## iii. Appendix 3 – Definitions and Glossary Of Terms

Item	Definition
Access	Access is a coordinated intake and information service for all children and their families. It will coordinate intake for the agencies that sign-on as partners. Those agencies/sectors signing on will provide their own caseload definitions/priority/screening tools for navigation into the larger (system) access.
Accessibility	The degree to which a program or service can be reached and obtained by a consumer, regardless of age, gender, place of residence, language spoken, or multicultural background.
ABA/IBI	Applied Behavioural Analysis/Intensive Behavioural Intervention. Preschool Autism Program serves children with autism from birth to age six.
ABI	Acquired Brain Injury
Assistance to Children with Severe Disabilities (ACSD)	Financial assistance program to directly support families of children and youth with special needs; administered by the MCYS, helping offset some of the extraordinary expenses borne by families whose children need specialized equipment, services, etc.
Assistive Devices Program (ADP)	Financial assistance program administered by MOHLTC, to Ontario residents with long-term physical disabilities to obtain basic, competitively priced, personalized assistive devices appropriate for the individual's needs and essential for independent living.
Autism/PDD	The common term for a range of disabilities medically classified as pervasive developmental disorders (PDD). Symptoms are present from infancy, but not often recognized until age two or three, when the child fails to develop appropriate language and social skills.
Care	Primary needs of the individual are for care, support and "enabling", rather than cure (to distinguish from medical care).
Catchment	The geographic area in which all or a majority of an agency's clientele reside.
Care plan coordination	An organized system of service delivery to coordinate all important, pertinent information about a child with a disability or chronic illness and his/her family. Care coordinators can be parents, professionals, or paid or unpaid lay advocates who initiate, facilitate, orchestrate and organize access to and use of community services and resources. Care plan coordination permits enhanced coordination and supervision of care that may be carried out by a variety of service providers in several different locations. Case managers can be a part of the service provider agency, or independent of it. Case managers may also determine eligibility for service.
Coordination	Formal or clearly recognized informal, linkages between two or more entities. These entities can be components of an integrated system or can be component parts of two components or systems.

Item	Definition
Child and Family Team	<p>The Child and Family Team is the specific team of providers assigned to work with the child and family.</p> <p>Includes a Service Co-ordinator role.</p> <p>May include professionals from outside the region e.g. if brings specialty expertise).</p> <p>(This is the unique team that is composed specifically to meet the child and family's needs. It may have professionals from a single Partner agency or a mix of professionals from a variety of agencies or outside of the Simcoe and York. Each team is comprised of all the providers that "touch" the child and family)</p>
Child Care Special Needs Resourcing	Funded by Consolidated Municipal Service Managers and cost-shared with MCYS, funding provides for staff (resource teachers, early interventionists), equipment, supplies or services to support children with special needs in integrated childcare.
Child Care Enhancement	(Child Care) funding to support child care centers in ensuring access to child care for children with special needs
Child Welfare	Child protection services funded by MCYS under the Child & Family Services Act (CFSA).
Children's Treatment Centre (CTC)	CTCs are community-based organizations that provide service to children with physical disabilities and special needs. They vary in size and scope, but each provides physiotherapy and occupational therapy and speech language therapy as "core" services.
Community based	Services provided out of hospital, or by non-hospital providers.
CCAC	Community Care Access Centre
Community Development	The process of supporting community groups in: identifying their (health) issues, planning and acting upon their strategies for social action/social change, and gaining increased self reliance and decision-making power as a result of their activities.
Continuum of Care	A full range of flexible, effectively linked services from institutional care to home-based, community based care, including direct treatment, mediator and consultation models.
"Core" Services	14 rehabilitation services defined in the Long Term Care Act – Services commonly required to meet the specific needs of children with special needs and their families.
CTN Resource Leader (formerly Team Leader)	<p>The Resource Leader is a member of the local team who has the role of providing (CTN funded) resource and process leadership to the team. Activities and responsibilities of this role may include:</p> <ul style="list-style-type: none"> <li>➤ Meeting with host agencies to give and receive feedback on protocols and best practices.</li> <li>➤ Identifying gaps within the teams and making recommendations to the Clinical Director</li> <li>➤ Being the primary contact with host agency regarding facility and material support for service group of the members</li> <li>➤ Linking with other Local Teams related to identifying need and sharing resources</li> </ul> <p>The CTN resource leader provides system level organization (tracks CTN spending stats) at making sure that the geographic group is connected and communicating</p>
CTN Service Co-ordinator	<p>The CTN Service Co-ordinator is the primary contact for the family and acts within a guide role with families. He/she acts as a single point of contact for a family, helping the family to co-ordinate their care across all systems. It is expected that the Service Co-ordinator will have a broad knowledge of the service system, and in particular services for children with complex needs.</p> <p>Host agencies or families themselves may perform this role.</p>
CTN Service - Principles	<p>All CTN funded services must be:</p> <ul style="list-style-type: none"> <li>➤ <b>Accessible</b> across the factors of: location, language, hours, mandate for eligibility, and seamlessness (all providers work together)</li> <li>➤ <b>Comprehensive:</b> provide the full range of service that child might need, for the appropriate length of time (as a system, cooperating agencies ensure access to the full range of services from the universal to the most complex –G Brown Funnel)</li> <li>➤ <b>Integrated:</b> offer seamless, coordinated services that provide all the pieces that the family wants/needs, without contradiction/duplication. Provide services in a single work-plan with a unified strategy around the plan</li> <li>➤ <b>Community based, strengths based, mutual aid based and normalized settings:</b> (community based) as much as possible. (Avoid professional based system) (Consider: mutual aid/self help groups for parents by parents, recreation, etc.)</li> </ul>

Item	Definition
CTN Services – Definitions (based 2002 Report)	<p>Services to clients may be provided on an individual or group basis and are planned for in collaboration with clients and families. Consultation and/or training may be made available to parents and other caregivers. These services can be provided in various locations including: at the centre, satellites, in the client are home and nursery/preschool/school.</p> <p><b>Occupational Therapy</b> - The practice of occupational therapy is the assessment of function and adaptive behaviour, and the treatment and prevention of disorders that affect function or adaptive behaviour to develop, maintain, rehabilitate or augment function in the areas of self care, productivity and leisure. It also includes training others to address a child's needs and/or achieve service goals and providing and/or assisting in the acquisition of prescribed/specialized equipment, supplies or goods.</p> <p><b>Physiotherapy</b> - The practice of physiotherapy is the assessment of physical function and the treatment, rehabilitation, and prevention of physical dysfunction, injury or pain to develop, maintain, rehabilitate or augment function or to relieve pain. It also includes training others to address a child's needs and/or achieve service goals and, providing and/or assisting in the acquisition of prescribed/specialized equipment, supplies or goods.</p> <p><b>Speech — Language Pathology Services</b> - The practice of speech — language pathology is the assessment of speech and language functions and the treatment and prevention of speech and language dysfunctions or disorders to develop, maintain, rehabilitate or augment oral motor or communication function. It also includes training others to address a child's needs and/or achieve service goals and, providing and/or assisting in the acquisition of prescribed/specialized equipment, supplies or goods.</p> <p><b>Social Work</b> - The discipline of enabling children and families to develop the skills and abilities necessary to optimize their functioning and thus reduce the risk of psycho-social breakdown.</p> <p>Services may include any of the following (this is not a comprehensive list):</p> <ul style="list-style-type: none"> <li>➤ counselling for parents and children;</li> <li>➤ accessing appropriate community resources;</li> <li>➤ training parents/siblings/child in skills geared to managing ongoing care plan coordination needs; and</li> </ul> <p>community consultation and liaison.</p> <p><b>Psychology &amp; Psychometry</b> - The practice of psychology and psychometry includes the assessment of the cognitive, behavioural, educational and/or emotional status of children. Psychological assessment, individual or group psychotherapy, as well as consultation and training services may also be available.</p> <p><b>Audiology</b> - Audiology services include testing a child's hearing, monitoring of middle ear problems and prescribing hearing aids and other listening devices.</p> <p><b>Nursing</b> - The practice of nursing is the promotion of health, assessment, provision of care and treatment of health conditions by supportive, preventive, therapeutic rehabilitative means to attain or maintain optimal function.</p> <p><b>Seating</b> - Seating services include the assessment and prescription of seating devices and wheelchairs and other mobility devices to provide comfort, facilitate function and mobility for those with long-term physical disabilities. These devices may be manual, powered or adapted.</p> <p><b>Orthotics/Prosthetics</b> - Orthotic and prosthetic services provide children with custom made splints and braces which prevent deformity and in some cases enable the client to walk independently. Prostheses (artificial limbs) are also provided to the amputee population.</p> <p><b>Augmentative Communications</b> - Augmentative communication services include the provision of electronic and non-electronic communication aids for those children whose physical disabilities preclude functional spoken or written communication.</p> <p><b>Recreation Therapy</b> - Recreation therapy services provide assessment and treatment services for children experiencing difficulty participating in leisure and recreation activities. The objective is to provide the children and their families with the skills, resources and opportunities necessary to pursue a healthy and independent lifestyle.</p> <p><b>Medical Services</b> - Medical specialists offer diagnosis, assessment, consultation, counselling and appropriate medical management to clients and families.</p> <p><b>Technical Services</b> - Technical services promote the use of computers and other adaptive devices for children with physical disabilities.</p> <p><b>Cleft Lip/Palate Dental Treatment Service</b> - To help families of children and young adults with expenses related to correcting cleft lip/palate problems the Ministry of Health and Long-Term Care established the Cleft Lip and Palate Program. Through this program, the MOHLTC provides 75 per cent of the dental treatment by a certified specialist who is associated with correcting the cleft lip and/or palate. The service also covers 75 per cent of treatment costs of severe acquired (non-genetic) dental dysfunction for patients up to 22 years of age.</p> <p>The service covers the following dental services: prosthetics, orthodontics, dental orthopedics, dental consultations, infant orthopedics, feeding and swallowing therapy supervision, preventive dentistry — including endodontics (root canal) and periodontics</p>

Item	Definition
CTN Services – What the new funding supports	<p>Children who are supported by the CTN infusion of funds:</p> <ul style="list-style-type: none"> <li>➤ Children and youth who “need treatment” since they have “special needs that extend beyond those provided by single agency provider (e.g., those that provide a single discipline or function and those that provide multiple/integrated discipline and functions –EIS) and have special needs that require a level of intervention beyond the mandate of the service provider (agency).</li> <li>➤ When the child’s needs are beyond scope of existing service provider and child is determined to be a CTN (level 4 or 5) client, the host (provider) is permitted access to the CTN envelop of funds to ensure that the front line staff provides treatment, receives mentoring or the support of specialty resources. (CTN funds are infused into the host funding, allowing the host the freedom to assign staff to provide the type and level of response that family needs).</li> <li>➤ Certain host agencies may receive an envelop of CTN funds to self direct so as to not need to check with the CTN Resource Leader to access the money in a timely fashion. These host agencies would be expected to responsibly use funds to provide care plan and appropriate resources.</li> </ul>
Developmental Disability	General term for a wide range of conditions resulting from many different causes. People with developmental disability seem to have limited ability to learn, or learn more slowly than the typical person, and have difficulty in meeting the social, educational, and vocational expectations of family and society.
Disability	Any restriction or lack of ability to perform an activity in the manner, or within the range, considered normal for a human being. A loss or reduction of functional ability and activity.
Dual Diagnosis	A term that refers to an individual with a developmental disability and mental health needs.
Early intervention service – Preschool	Early intervention services include: Infant Development, Resource Teachers or early interventionists, Therapy Programs (PT, OT, SLP) and other disciplines involved with children 0-6.
Early Years Centres, Ontario	Serving children from birth to age six. Services include early learning and literacy programs for parents and their children, programs to support parents and caregivers in all aspects of early child development, programs for new parents on pregnancy and parenting, links to other Early Years programs, outreach activities.
Enhanced Respite Program (MF)	Program administered with Special Services at Home, to assist families who have a medically fragile and/or technologically dependent child to purchase respite services. Eligibility is determined by CCAC.
Family	A self-identified group of two or more individuals whose association may or may not be through blood lines or law, but who function in a way that they consider themselves to be a family.
Family-Centered Care	A philosophy of care that recognizes and respects the pivotal and primary role of the family in the lives of children with special needs. It promotes normal patterns of living at home and in the community, and ensures that parents are partners in decision-making.
Family Support	Programs delivering a range of services such as parent peer contact and mutual support, education, counseling and mediation, care coordination and referrals to other resources.
Governance	The structure, power and composition of agency boards of directors – either individually or as a joint venture, which are ultimately accountable to funders and consumers for the operation of the agency or system of services.
Habilitation	The act or process of developing a skill to be able to function within a given environment.
Handicap	A disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfillment of a role that is normal, depending on age, sex, social and cultural factors, for that individual.
Healthy Babies, Healthy Children Program	Funded by MOHLTC, Serving children from prenatal to age six, a risk screening and assessment program during pregnancy and postpartum to identify children who are at risk of poor social, emotional, cognitive and physical health outcomes; links those identified as “at risk” with appropriate services and supports and provides home visiting and care plan coordination.
Impairment	Any loss or abnormality of psychological, physiological, or anatomical structure or function.
Inclusion	The act or process of integrating individuals as equals into a group or activity.

Item	Definition
Infrastructure	The organizational arrangements and processes that together provide a basic foundation for the system.
Interface	Ways and means that components of related services (health, education, social, support) come together or interact with one another; the point of contact between two components or systems. There may be a gap between the components or systems, or an overlap, or their boundaries may just touch each other.
Infant Development	The Infant Development Program is an in-home early intervention program generally for families of children between the ages of 0 to 3 years of age, who are at risk of developmental delays.
Integration (Service or system)	"Integrated" refers to the concept that a given service is part of a larger whole. For example, a number of types of service could come under one administrative entity or be part of a coalition of services. The fact that the parts are components of a larger entity means that they are integrated within that entity, e.g. a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held accountable for outcomes.
Key Informant	A Key Informant is someone from the local team (e.g., the Service Coordinator) or perhaps the CTN Resource Leader who liaises with the Children's Mental Health (CM) sector. Key informants link the child and family team to CMH system for the few CHM/CTN dual sector kids. (The intention is to support parents struggling with children who have both a physical disability, and behavioural and/or Mental Health concerns at the Triple P 4 &5 levels. (It is believed that currently CTN dual diagnosis or multiple complex type children and youth have existing case managers who liaise with the Mental Health agencies.)
Local Team	The Local Team is the group of all potential providers in the geographic area. (alias the <b>Existing Partner Group</b> : describes the professionals that work in agencies like CCAC and its provider agencies, PSLP, EIS/ID/ED, IH, Children's mental health providers, developmental services (YSSN, Catulpa), children's case coordinator, school boards, and hospitals. These professionals represent agencies within York /Simcoe that currently support the CTN kids and we anticipate may be/become partners.
Levels of Care:	<b>Primary Care:</b> Provided by health care worker on client's first contact with the health care system – nurse, doctor, to restore or maintain functioning. <b>Secondary Care:</b> provided by a specialist health care professional, on referral from primary care, for specialized services. <b>Tertiary Care:</b> Care that provides highly specialized skills, technology and support services; usually provided in facilities serving a large region.
Long Term Care	A set of health, personal care and social services delivered over a sustained period of time to persons who have lost, or who never acquired, some degree of functional capacity, to assist them to manage as independently as possible.
MCYS	Ministry of Children and Youth Services
Medically Complex/Fragile	Children whose medical and/or physiological conditions combine to render them in need of ongoing medical intervention and monitoring, experience periods of exacerbation, and are at higher than average risk for health problems.
Multiply Handicapped	Individuals who have more than one illness or disability. The combination of disabilities renders their needs more acute and their care more complex.
Ontario Works	Social assistance programs
ODSP	Ontario Disability Support Program
Outreach	Services that are provided to individuals in non-traditional or isolated settings at home or in the community.
Palliative Care	The combination of active and compassionate therapies intended to comfort and support the person and family who are living with a life-threatening illness, at any time during the illness and bereavement periods.
Parent	A natural or foster parent, another member of the family (a primary care giver for the child with health condition(s), or a legal guardian
Personal Care	Care provided to fulfill the basic needs of the individual; e.g. assistance with activities of daily living – dressing, bathing, eating, toileting, etc

Item	Definition
Professional Services	Services provided by trained professionals, such as nursing, physiotherapy, occupational therapy, speech and language pathology, nutrition, social work, behaviour management. Services may be provided at home, in school, in the community or in the hospital.
Psychological Associate	Psychological Associate: has psychological training at a Masters level with specialized training to perform assessments and is registered with the College of Psychologists
Psychologist	Psychologists can make a diagnosis and is registered with the College of Psychology
Psychometrist	Psychometrist: has a BA in psychology and is trained to carry out psychological testing in a centre/hospital based environment under the direction of a psychologist.
Rehabilitation	Professionally directed, time-limited, services provided to improve physical and psychological conditions and to elevate, maintain or restore functional abilities to an optimal level.
Respite Care	A service whose main function is to relieve the family caregiver(s) for a specific period of time, while facilitating a positive and rewarding experience for the child.
Special Services At Home Funding (SSAH)	Financial assistance program administered by MCYS that provides individualized funding to help families support the developmental needs of children/youth with special needs.
Specialty Service Leader	Specialty Service Leaders are the key people within each team of specialty services, who will be responsible for: <ul style="list-style-type: none"> <li>➤ Receiving referrals for the specialty service</li> <li>➤ Triaging the waiting list within their own Specialty Services Team</li> <li>➤ Guiding decisions about service provision within the Specialty Service Team</li> <li>➤ Being the primary contact for the child and family Service Coordinator regarding individual case issues</li> </ul>
Specialty Service Teams	These services require a team of individuals with specific expertise that are provided as needed to enhance services currently available at the Local Team level. Specialty resources and services include: <ul style="list-style-type: none"> <li>➤ Augmentative Communication</li> <li>➤ Diagnostic assessment</li> <li>➤ Seating, mobility and equipment</li> <li>➤ Feeding and swallowing</li> <li>➤ Orthotics and prosthetics</li> </ul> <p>These specialized resources are organized in a rational fashion (e.g. as team/clinic or sole consultant) and are available to support professional development (education/mentoring/modeling), to carry out direct specialized functions (assessment, prescription or consultation). When possible Child and Family Team members and partner agency providers will be trained and supported to develop expertise across the full range of specialty resources – however, it is expected that clients with complex needs will continue to need specialized expertise or credentials that are beyond the scope of practice/knowledge of some/many providers. (The role to provide specialty services, train/mentor and consult with providers with the goal of building capacity within the community within the area of specialized resources to the extent that it is possible)</p>
Technologically Dependent	An individual who requires the routine use of a medical device to compensate for the loss of a life sustaining body function, and requires daily, ongoing care and/or monitoring by trained personnel. (e.g. ventilator, oxygen, tube feeding etc).
Tertiary Services	These are agencies with recognized expertise that are usually located outside of York or Simcoe. Tertiary providers offer a level of assessment, consultation, multi-disciplinary or specialty services that CTN-SY and providers from within the local team are not able to provide. Tertiary providers may include: Bloorview Kids Rehab, Hospital for Sick Children, Geneva Centre.
Transdisciplinary	A philosophy of collective responsibility and accountability for service planning, care, management, training and delivery, across all involved in providing care for an individual.
Transitions	Services to support transfer of children and youth from acute care to home or community; preschool to school; school to adult services or independence.