Children's Treatment Network

WEBINAR – QUESTIONS & ANSWERS (APRIL 9, 2015)

1. Would definitely like to have the opportunity to see your updated policies and procedures surrounding consent. Also, would you be willing to provide examples of the partnership and information agreements?

   We will provide on request - happy to share! Information will be uploaded to the website under SNS section

2. What percentages of children have been eligible for "Single Plan of Care (SPOC) relative to overall children served by CTN?

   Because we wanted to ensure the use of the shared record and buy-in we set up strict criteria for the assignment of SPOC Coordinators. Given our criteria, we estimate approximately 21% of children who are eligible have a SPOC Coordinator (given current criteria which we recognize is not all the families and clients we are looking at in the SNS).

3. Can you share how you determine family eligibility for the coordinated care process?

   Eligibility into the single plan of care coordination service at CTN requires that a child is receiving two or more services from CTN. That criterion was implemented due to limited resources for this service.

4. Have there ever been situations where families have not given consent to the shared record and what was the outcome?

   Yes. Frontline providers will direct them to CTN's Privacy Officer/System Administrator (SA) to have a conversation about exactly what are they wanting. These cases have been very limited over time but often just securing the shared record to only the current team is all the family is looking for. They are re-assured that should someone else require access, the SA will only add them to the list of team members after speaking with the family. Initially we were fearful of this process as it could involve a lot of time but in reality we don't have to do this very often. The important thing is to let families know that there are options with regard to security.

5. Thanks for the answer regarding SPOC percentage. Now can you provide the number of SPOC Coordinators in place to meet needs of 350 children?

   There are seven FTEs across Simcoe and York spread across 12 individuals working part time. In York region we have a team of eight people in 3 partner agencies. In Simcoe we have four people in 3 partner agencies.

6. Could you please elaborate on the role of the SPOC Coordinator vis-a-vis the role of team members? Where does casework end and coordination begin? How do children move in and out of the SPOC Coordinator service?

   This has been the delicate balance we have been working towards in the development of the role of SPOC Coordinator. We have tried to be family centered in our approach. The coordinator works with a team facilitating them to developing an integrated plan. In addition families require support for some activities such as completing funding applications. If there is no one on the team whose role it is to complete funding applications then the SPOC coordinator would take on this activity to support the family rather than referring to another

service. If the SPOC coordinator lacked experience in a specific area; he/she would call on other SPOC Coordinators for assistance

7. Also, could you talk about how the SPOC Coordinator relates to complex medical care and the role of the CCAC Case Coordinator?

In York Region, the CCAC Care Coordinator supporting a child with complex medical needs would refer to a SPOC Coordinator if in addition to health services; community services were also involved. The CCAC care coordinator and SPOC coordinator work together to reach common goals and minimize duplication. The SPOC coordinator is responsible for ensuring that services are integrated and that a single plan is developed.
In Simcoe, the CCAC Care Coordinators providing care to medically complex children use the shared record and provide leadership to the team and lead the single plan of care process. They are not "obligated" to do this with the team however; they have found benefits to this process and will often choose to use this approach. Having access to the record has positively impacted their ability to coordinate (the community and developmental services). Both the team and the coordinators find value in using the record to communicate their activities with the client and family and track progress.

8. Are private services included in the CTN process?

Yes. It is a family's choice whether to include them in a meeting (may be an issue of payment). Some private providers do have access to the shared record so can view and record information that the SPOC coordinator can then share with the rest of the team if the private provider can't make the meeting.

9. How many Service Navigators do you have and how many SPOC Coordinators do you have?

CTN has a total of 4 .4 FTEs for Service Navigation, spread across a total of 5 full and part-time individuals. 1.2 of that FTE is dedicated to the ABA program. For ABA, the service navigator completes the intake including an assessment of needs and makes sure the families accessing ABA are linked to other services.
CTN has 7 FTEs for Single Plan of Care Coordination across Simcoe County and York Region.

10. Could you please share what the educational background of the service navigators is and what their caseload numbers are?

For Service navigation backgrounds range from Nurse, OT, Early Childhood Educator, Child and Youth Worker and Educational Assistant –all have several years of experience working in the children's service system either as a service coordinator, therapist or support to children and families with multiple needs. We receive approximately 30-35 new referrals a week so each service navigator has approx. 30-40 families on their caseload that they are dealing with at any given time.

11. How long does the SPOC Coordinator work with a child on average? Do they keep the same coordinator over years?

Usually, over several years, 20% of the caseload tends to require short term intervention while the remainder of families are involved for more than a year. Staffing changes tend to affect how long the same coordinator is involved with the family.

11. The Preschool Speech and Language Program (PSL) mentioned using the shared record for all clients. Can you share which PSL so we can connect?

    Markham Stouffville Hospital (York) and Royal Victoria Hospital (Simcoe) both use the shared record for clients.

12. Could you please share the educational background of the SPOC Coordinators?

    The educational background of SPOC coordinators is also varied. We have SPOC coordinators with the following backgrounds: Educators with experience with children with special needs, Nurses (CCAC Care Coordinators), Social Workers and individuals with a developmental services background.

13. What type of devices do clinical staff use to access the SPOC when they are working in the community?

    Laptops mostly but some do have tablets. It's not the device so much as having internet access. Agencies provide specific devices for staff so it is very individual. We are finding that internet sticks work well. We are strongly encouraging providers not to print information from the record but rather to work on accessing the record for the information. Many partner agencies make internet access available to guests-enabling partners to access the internet while visiting clients (school boards, CTN sites).

14. Is there a policy regarding clinical staff printing and taking aspects of the record into a community setting?

    Yes, if you print you are responsible to protect that health information. Agencies agree to this when they sign the Information Sharing Agreement. Providers are cautioned that they are obligated to ensure the information is secure. We are trying to discourage printing from the record and carrying documents around from a privacy perspective.

15. How do you manage updating the contact information?

    CTN ACCESS at time of re-referral for additional services or an agency's intake point completes contact information when they open a shared record file. However once the file is open we spread the responsibility across all team members involved with the client to ensure that the record is accurate and up-to-date. We don't manage this centrally. We do have data issues whereby shared record information is not always complete. Every authorized user has the ability and accountability to update information.

16. Do the families have access to the electronic record?

    Families have access now (very recent) through our Family Portal Pilot Project. Together with KidsAbility, CTN is piloting family access to parts of the record (not clinical notes, Plan of Care or any assessment templates). Families can review documents in Document Manager, their child's demographic information, the members of their child's team and the calendar for appointments.
    In addition, clients and families can view the information in their shared record file upon request

17. I see that the activity lead on the vision is a role. Are the individuals indicated anywhere on the vision (for example, names)?

    No the vision is not attached to a provider. Visions are intended to be broad often with a function or participatory focus.

18. How does SPOC plan connect to school IEP?

    In many cases one informs the other. Understanding what the family wants leads everyone involved to develop ways they can develop or work on that goal. Sometimes the IEP will outline how the school staff will work to achieve the goal. Starting to align the two plans is one of the goals of a coordinated planning process (not trying to eliminate the IEP but making sure all are working to support the child across a number of environments). Often for school age children the goals do involve the school.

19. What component of the SPOC can the family see?

    Families are given a copy of the completed plan. Because the plan is a template AIM form in GoldCare –it cannot be viewed as part of the Family Portal at this time. If the plan is printed off, scanned and uploaded to Document Manager the family would have access through the Family Portal. As discussed in a previous question, the family can request to review the shared record file at any time.

20. Is the referral made by Service Navigator the only route to SPOC Coordinator?

    Yes. We did have an issue during the early years of the program - providers were referring directly to SPOC Coordinators = *"Hey I would love you to see this family they have a lot of needs",* however, what the providers and SPOC Coordinators didn't know is that there were a number of children waiting who also had many needs (some higher than the child and family they were asked to take on). We hold a central waitlist for all SPOC referrals and try, beyond extreme urgent needs, to triage by length of time waiting, location and expertise of the particular SPOC Coordinator, if that is required.

21. Who schedules the specific appointments with provider?

    The SPOC Coordinator works with the family to decide on a date and then consults with the other team members. Because most providers on the team use the shared record, team members can communicate using a client number by email (no identifiers are used so this makes things much faster to organize). Sometimes in order to make sure key people can attend there are compromises in terms of date/time and location of meeting. Only in very unusual circumstances would the family not be at a SPOC meeting.

22. Is there any reason we wouldn't want to have key partners (i.e. PSL) to use/open these records even if at the start they are a single service? Given that most of these children do end up with two or more services, does it make sense to use this for all?

    Yes in a way it does because we don't always know what services that child/family is going to need. Our advice would be if you need a starting point, these wouldn't be the children you would start with. A shared record is of most benefit to children/youth who are receiving services from multiple providers across multiple agencies

(these probably also are some of our most complex clients). As a Health Information Network Provider (HINP) there is also a resource and liability issue in terms of opening records for clients who may not need to have a shared record- need to also consider that resources are required to maintain the record (i.e. destroy when client reaches a certain age, release information upon request)

23. Does the Single Plan of Care document have sections that can be signed off by each discipline member, as per college's guidelines? We are struggling with this with CFARS and are not using it as a multidisciplinary document for that reason. *CFARS is the clinical assessment template contained in CRISP. It is completed by a number of disciplines*

    No it doesn't. It does name the role of the person taking the lead for the goal or activity (i.e. the "OT" but does not specifically name them). A name could be entered in the free text field. The way people do this is each of the team members will write an individual note stating they participated in the single plan of care meeting and they are in agreement with the plan.

24. Follow up to SPOC and IEP overlay at transition. Would love to see this.

    This is the TIPP – Transitional Integrated Planning Process (please see the documents on the website.)

25. Can you share some more details regarding how the SPOC Coordinator "monitors" the plan?

    He/she meets with the family either by phone or in person, reviews the record, and connects with team members if there are questions or issues. Really he/she would take cue from the family if things weren't getting done or something was impeding progress. A provider may also go to the SPOC Coordinator and identify a barrier. The SPOC Coordinator may then meet with the family to discuss possible barriers.

26. How many children/youth are in the 0 - 21 range in Simcoe York?

    Simcoe's number is 4,195 and York's number is 10,923. Please note numbers were obtained by using Participation and Activity Study (PALS) prevalence rates and Statistics Canada population data, 2006.

27. What are you using to evaluate the process?

    We have done a number of evaluations using the MPOC (Measures of Processes of Care) embedded in a client satisfaction survey as well as completing a number of provider satisfaction surveys. We have also done some evaluations looking at goals and goal setting across a large number of SPOCs and a project looking at the use of the CANS (Child and Adolescent Needs and Strengths)—specifically, is the plan congruent with the needs identified on the CANS? Are the goals and activities lined up?
    Overall surveys indicate positive differences are seen with the families involved in a SPOC process.

28. Does a school staff (i.e. teacher, resource staff, principal, etc.) have access to the SPOC?

    They are involved in the single plan of care process but often do not have access to the information in the shared record. We are working with the school boards to increase the access they have. We had considerable success with the TIPP (transition to school process) and were able to train a number of Special Education Resource Teachers (SERTS) in the English school boards in Simcoe (>200 SERTS have been trained) to review the shared record in time for school entry and the writing of the first Individual Education Plan (IEP). The project team has

completed some really fulsome evaluations of the TIPP process and the document. The education members have found great value in having access to the shared record and find the transitional plan very helpful.
Across the 4 English school boards we have trained in total 457 school staff including therapists, SERTS, some teachers and psychology staff. Not all school staff access the shared record on a regular basis –often access is associated with a transition or, if they have a single plan of care coordinator, a scheduled planning meeting.

29. How long would you think another service delivery area should allow moving to this system?

    It's difficult to state definitely as much depends on the configuration of and number of different providers and how many service sectors are involved. It took us probably about two to three years to have a good number of agencies using the record consistently.

    If we were to start again, we would implement the use of the shared record incrementally, perhaps focusing on a concentrated group. Times are different then when we started, agencies are much more willing to work together and are seeing the value of a shared record for the family. The Special Needs Strategy has helped to bring agencies together and agencies and providers see the positive role technology can play. When CTN started most of the agency partners were still documenting in paper files so moving to a shared electronic file was a huge step.

30. If SPOC Coordinators are employed by different agencies how are salaries determined?

    Their salaries are aligned with salaries in their agency for a service coordination/case management position. In most cases they have come from this role or actually split the role part-time SPOC Coordinator and part time Case Manager (both with the same agency).

31. If you were starting over today, what would you do differently?

    Start with smaller pilots. Engage teams who support children with multiple service providers, grant them access, work with them on developing a single plan and then hope they take that out to the other teams they provide services with and gradually grow the skills. I think one can really appreciate the value of inter-professional practice when working with a child/family with many needs that may or may not cross sectors.

32. How does the shared electronic client record share wait lists? Can you track expected wait time to be picked up for treatment, or just how long the child has been waiting?

    We can only track just how long the child has been waiting. GoldCare tracks from date of admission so you can pull a report that lists all clients waiting for a specific program and how long they have waited.

33. Can you please describe the 35-45 caseloads? Is it a rolling case load?

    Approximately 20% of clients on a SPOC Coordinator's caseload are shorter term and require less intense support. SPOC Coordinators are starting to use the CANS to assist them in determining when a client may be discharged to the team who will then carry on and support the family in a coordinated way. For many clients, there is often someone on the team who can take on this role such as Family Support Worker or CCAC Care Coordinator. Over time it would be great to work on training all 'service coordinator' type roles to be able to lead a single plan of care process.

34. Just to be clear on the last point - the idea here would be if these partners wanted to use the GoldCare record as their sole record?

    They could; however, at this time CTN is not set up to provide reports to each of the individual partners should they require reports for their funders, MIS etc. We do not have the resources to do that.

35. So if I did understand correctly, the SLP from school cannot use the program?

    CTN welcomes school staff to participate in the shared record and some school therapists already do view and record in the shared record. It is sometimes up to the partner agency to determine which staff will participate in the record. Sometimes this is a caseload issue. The provider may not have enough clients with multiple special needs to warrant training. They won't access frequently so they would tend to forget how to use the record.

36. Has the single plan of care been translated to other languages such as French for example? Is there an interest to have it translated?

    We have not translated the document into French. In the shared record the template is in English. Our language of documentation is English. We do have the Child and Family Interview paper copy translated into French so the family can follow and share information in French.

37. You mentioned the balance between service coordination and case management.

    This has been the delicate balance we have been working towards in the development of the role of SPOC Coordinator. What we have found to be the most family-centered approach is that the coordinator facilitates a team towards an integrated plan and any activities that need to be done (what I think you are referring to as "casework") that are outside of a therapist or other team member would be done by the coordinator when possible. If the coordinator feels like they don't have the skills they would approach another coordinator to learn/build capacity. For example, a single plan of care coordinator working with a team towards a vision of a fully accessible home would support the family with funding applications rather than referring to another agency to complete.

38. Can you please expand on criteria for access to SPOC Coordinator, beyond two or more agencies involved?

    Eligibility into the single plan of care coordination service at CTN requires that a child is receiving two or more services from CTN. This criterion was implemented due limited resources for the service.

39. What's the wait for a client to be assigned a SPOC?

    At this time the wait time for assignment is typically 2- 3 months from time of referral. The coordinators review caseloads regularly with their supervisors/managers. As a team, we review the waitlist. Often a child will be assigned as another family is moving into being discharged. Coordinators are very committed to keeping the waitlist to a minimum and they will often carry higher caseload numbers. This becomes manageable as the needs of families change and often fluctuate.

40. What is your process for managing a waitlist for SPOC Coordinator?

    We have a SPOC Coordinator who as part of her responsibilities manages the waitlist. The managers of the SPOC Coordinators developed a process and principles together about how we will manage, assign and communicate about families waiting for service. Once the intake is completed, the waitlist coordinator reviews the referral. Part of the waitlist management involves calling family and team members to provide some temporary support if possible and to help the team with any type of quick support they may require.

41. Would you be willing to share job description for SPOC Coordinators?

    Yes. We will include with documents on the website.

42. You mentioned the balance between service coordination and case management. Do the SPOC Coordinators provide assistance for funding applications, hospital and clinic visits, food and housing, transitions to school and adult services? If not, who does that?

    Yes they would provide this level of support if required by the family rather than involving another service on the team. If this is an ongoing need then the coordinator may work with the family/team to determine how best to meet this need over the long term.

43. What changes do you foresee making to your system to satisfy the Special Needs Strategy Coordinated Service Planning requirements?

    Expand the eligibility for SPOC and explore a "needs" based tool that considers family factors as well as child need, engage more partners to use the shared record, improve our Single Plan of Care template screen in the shared record.

44. Are there any legal implications for ensuring that the various agencies are properly trained in how to protect the privacy of the client / their Personal Health Information (PHI)? OR is the signing of the information sharing agreement enough (especially for agencies that are not Health Information Custodian (HIC)?

    Yes. The agency responsibility is outlined in the Information Sharing Agreement. Agencies that are not HIC's must ensure they are meeting the standards of PHIPA. CTN provides training on privacy and obtaining consent to share information as part of the shared record training. We also take opportunities to update providers about privacy when we can (i.e. our monthly newsletters).

45. Did you have someone playing a "planner" role in relation to this whole system? Someone whose role was shepherding this all into being?

    In terms of our senior leadership, this is a part of all our roles at CTN. We are all supporting the development of an integrated plan for the client and family and for teams to work collaboratively to develop and carry out that plan. Some of the questions that guide us are: How can we help providers work better together? How can we use the record/technology to support their work and communication with each other? How can we support families to be strong partners on the team? How can we ensure there is understanding of each other's roles? In addition to that, we do have a manager (Leanne Weeks) who is responsible for the SPOC Coordinators and working with the partners.

Children's Treatment Network

46. How long does a family have a SPOC Coordinator? Does the coordinator change depending on child's age and/or whether they are in school?

    Because Early Interventionists provide that coordinated role in the preschool years, our SPOC Coordinators work with school-aged clients up to transition to adult services. Depending on the complexity of the situation a family may be involved with SPOC coordination for several years. The individual SPOC Coordinator can change for various reasons - people leaving, caseload shifts, fit between family and SPOC Coordinator and sometimes expertise. Some of our SPOC Coordinators have extensive experience with transitional aged youth so it may serve the team and family well to switch to someone connected to that system for example.

47. Why would a client no longer require a SPOC? Under what circumstances?

    Examples are:

    - The team is working better together, able to identify goals and develop a single plan,
    - Team no longer as large maybe only one or two involved,
    - Needs have changed no longer the intensity, no longer involved with tertiary or medical services so less need to engage out of area team members, and
    - Family's skills have grown; they feel they can lead the plan together with other team members.