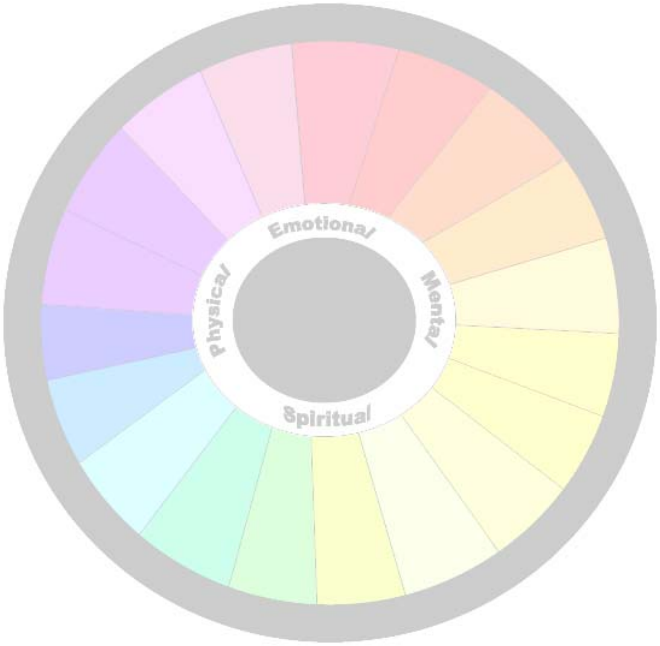
A Guide for Service Providers

Your Role in the Integrated Plan of Care Process



DRAFT: Initial Implementation
Ottawa Service Collaborative
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ABOUT THIS GUIDE

In the summer of 2011, the Ministry of Health and Long Term Care (MOHLTC) produced a report entitled, *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*, that commits to the creation of 18 Service Collaboratives to support coordinated services for youth and adults. The Centre for Addiction and Mental Health (CAMH) is the sponsor of the initiative and is implementing 14 geographically-based Service Collaboratives and four Justice Collaboratives through the System Improvement through Service Collaboratives (SISC) initiative. The announced Service Collaboratives are cross-sectoral in their representation, involving partners from education, mental health, addictions, client and family representatives, justice, Aboriginal and Francophone representatives, and other community organizations. The initiative is based in evidence and informed by implementation science, quality improvement and health equity. The overall initiative is attempting to address system fragmentation and to support local systems to improve coordination and enhance access to mental health and addiction services for children and youth with complex needs.

The SISC initiative began with the roll out of four developmental Service Collaborative sites, in London, Ottawa, Simcoe-Muskoka, and Thunder Bay. The first set of Service Collaboratives began initial engagement with community partners about the initiative in early 2012, and soon after formed initial memberships. The Ottawa Service Collaborative held an initial meeting in February 2012, and over the course of a few months, identified that *continuity of care for children and youth with complex needs and their families who are accessing multiple services from across sectors* was a system gap and a priority focus area.

To address this system gap the group analyzed key evidence and identified critical components to an intervention including;

- Meaningful child and youth involvement
- Meaningful family and supporter involvement
- Meaningful priority population involvement
- Interagency cross-sectoral collaboration
- Formalized care plans

These critical components were then used to guide the selection of the Ottawa Service Collaborative intervention, the *Integrated Plan of Care* process. A visual introduction of the Integrated Plan of Care process can be viewed at http://servicecollaboratives.ca/creating-opportunities-for-collaboration-in-ottawa/

What is the Integrated Plan of Care Process?

The Integrated Plan of Care process is based on taking a team approach to a shared vision that supports the health, well-being and function of children and youth with complex needs and their families. It involves clients, families and/or supporters, and service providers from different agencies, organizations and sectors collaborating together. The Integrated Plan of Care process is about connecting the child or youth, their family and/or supporters, and cross-sectoral service providers as equal partners to create a coordinated care plan that is focused on the needs of the child or youth and their families.

In considering the criteria for inclusion in the Integrated Plan of Care process, it is important to note the distinction between complexity and severity. A client could be severely impacted and even at high risk but if they can be effectively served by one agency, they may not have complex needs, for example a youth with schizophrenia who is actively psychotic and suicidal would have severe needs but not necessarily complex needs if they are being effectively served by one agency. On the other hand, a youth who is dealing with depression, has experienced trauma, and has a very difficult family environment, may have less severe needs but more complex needs in relation to care planning.

What are the Roles of Service Providers in the Integrated Plan of Care Process?

- **Referring Service Provider**
  The person identifying the potential benefit for the child/youth and family to participate in the IPC process is referred to as the Referring Service Provider.

- **Agency Implementation Lead**
  Each agency involved in the Integrated Plan of Care process has identified an Agency Implementation Lead. The Agency Implementation Lead supports the Referring Service Provider and the Integrated Care Team members in their agency to assess the benefit of the Integrated Care Plan process for the client and family. The Agency Implementation Lead also supports the Integrated Care Team to access the unique services needed by the client, through advocating internally to their agency and, if necessary, externally. Additionally, they foster communication and collaboration between agencies involved in the Integrated Plan of Care process.

- **Coordinated Access Mental Health Committee**
  The Mental Health Committee at Coordinated Access determines if the referred child or youth meets the criteria for the Integrated Plan of Care process. In order to ensure appropriate cross-sectoral representation, for children and youth being referred to Coordinated Access for the Integrated Plan of Care process, the Mental Health Committee may be augmented by other service providers based on the child or youth's identified needs. The Mental Health Committee is experienced in making recommendations and/or service plans for children and youth with complex mental health needs. They are also experienced in determining a client's eligibility to access the mental health flex funds and multiple complex special needs funds.

- **Integrated Plan of Care Lead**
  The Integrated Plan of Care Lead is the central point of contact for the Integrated Plan of Care process for the child/youth and their families and the other partnering service providers. The Integrated Plan of Care Lead assumes a leadership role for the implementation of the Integrated

Plan of Care process. They will be the individual who facilitates and coordinates the ongoing team meetings and who supports the client and their family and/or supporters in developing their Integrated Plan of Care.

- **Integrated Care Team**
  The Integrated Care Teams are composed of multi-disciplinary service providers, clients, families and/or supporters who develop and implement the Integrated Plan of Care.

- **Coordinated Access**
  Coordinated Access facilitates the work of the Mental Health Committee (scheduling meetings, ensuring records of meetings, supporting decisions taken at meetings, providing briefings and background information to support decision-making). They will also promote flexibility and exchange of services and facilitate the possible links to other services through Coordinated Access if the client does not meet inclusion criteria.

- **Steering Committee**
  The Steering Committee will provide strategic advice to the service providers involved in the IPC process on the implementation of the IPC process, including identified areas of needs and problem-solving solutions. They will also support the implementation of the IPC process locally by encouraging organizations within their sphere of influence to participate in the IPC process, the evaluation of the IPC process and the implementation of the IPC communication plan.

For a complete overview of Roles and Responsibilities, please refer to Appendix A.

Integrated Plan of Care: Guiding Principles

A commitment to continuity of care that reduces system fragmentation and contributes to better care experiences for children, youth and their families.

Meaningful client involvement that is client-centered and recognizes the client as a central decision maker in their care.

Meaningful family engagement that is considerate of supporting families and equipping them with the knowledge required to ensure a better care experience for clients.

Appropriate system improvements for priority populations, Aboriginal and Francophone, that are respectful of their needs, values their input and acknowledges the unique expertise required to provide culturally-competent support for their care.

Flexible and accessible care that is youth-friendly, offering a strength-based, non-judgmental environment for young people to feel supported, safe and free to be themselves.

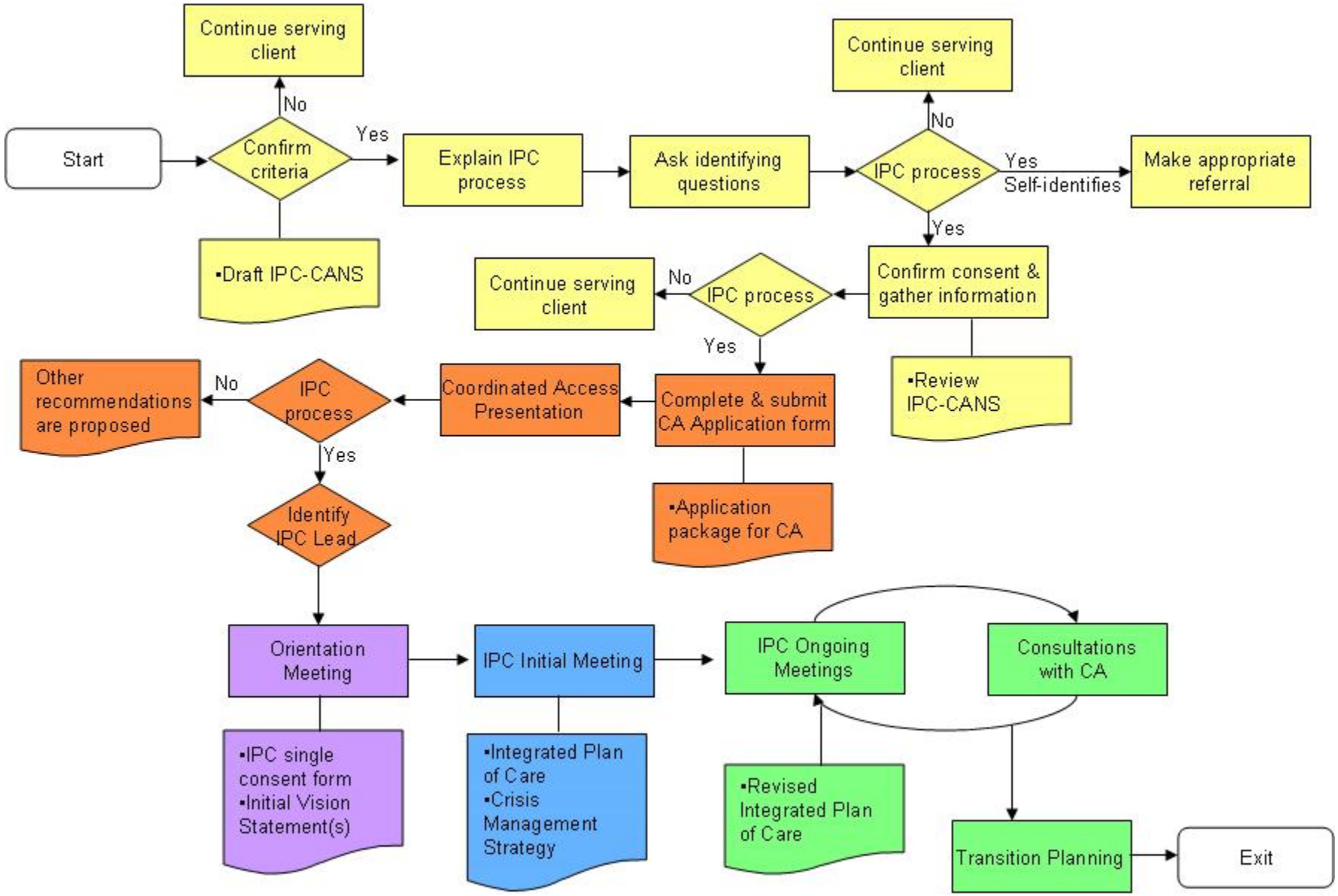
Holistic care that embraces the overall well-being of the client and focuses on a care experience that strives to look beyond clinical needs and operates with a multi-sectoral lens.

Effective inter-agency dialogue that facilitates open and transparent communication and fosters an environment of trust-building and collaboration.

Respect for client confidentiality and adherence to the clients' autonomy in decisions about their care and who has access to their information.

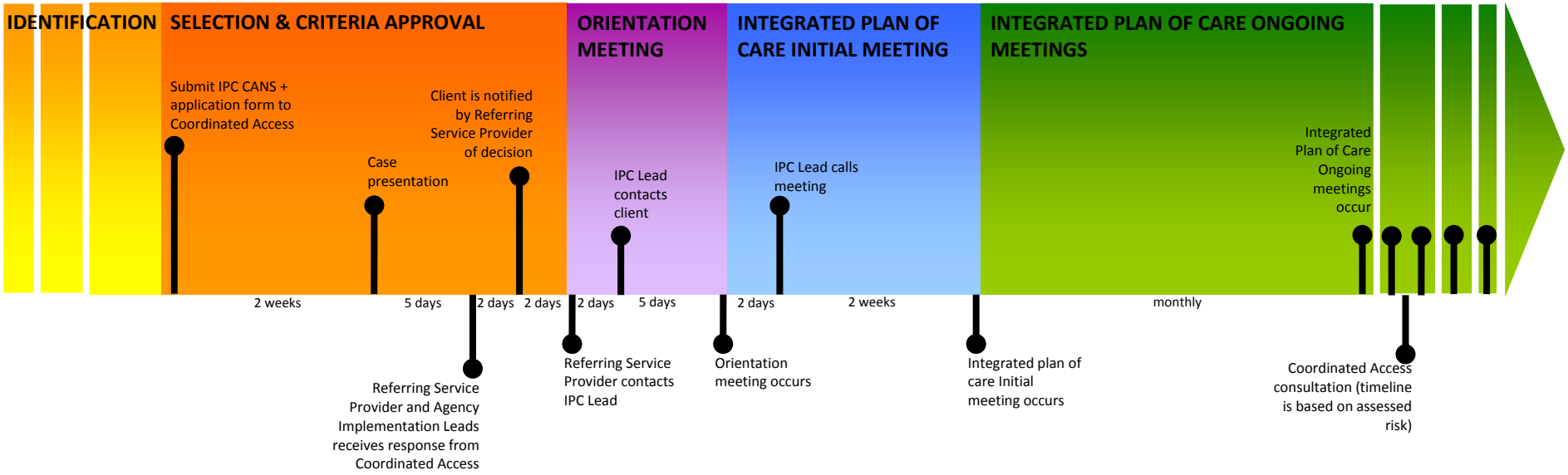
A commitment to use the best available practices and evidence-based approaches for appropriate, necessary system improvement and to implement them in keeping with their intended use.

The Integrated Plan of Care Process Map



The Integrated Plan of Care Process Timeline

Time spans represented are maximums.



Integrated Plan of Care process

Quick Reference Guide

Identification

Referring Service Provider to consider the following:

- Is the client between 6 and 18 years of age?
- Is the client currently accessing two or more services from across sectors or has the client in the past received services from multiple service providers?
- Is the client experiencing minimal success with current services and the rationale for lack of progress or improvement is unclear and worrisome?
- Is the client presenting behaviours that, if left unattended, place them, their family and/or community at serious risk?

If *yes* can be answered to all of these questions:

- Is the client at serious risk of harm to self and/or others, exhibiting behaviors such as cutting, suicidal ideation, serious physical assault of another, etc.
- Is the client experiencing multiple intersecting complex needs that are severe and broad that lead to major challenges for the client to participate meaningfully in society.
- Is a collaborative response required to respond to the needs of the client.

Draft IPC-CANS to determine strengths, level of risk and complexity of needs.

Connect with your **Agency Implementation Lead** to discuss potential client for IPC process.

Discuss IPC process with client and/or family.

Ask First Nations, Inuit & Métis and Francophone identifying questions.

If client and/or family are interested in the IPC process confirm signed consent forms, obtain any missing consents and discuss potential **Integrated Care Team members**. If the client self-identifies, make appropriate referrals.

Contact potential Integrated Care Team members **through AILs** to determine whether the client would benefit from the IPC process, inform the IPC-CANS and identify potential **Integrated Plan of Care Leads**.

Complete the IPC-CANS and review with the client and/or family for input.

Review information with AIL to determine whether or not to proceed with Coordinated Access application.

What are the Aboriginal identifying questions to ask?

Please indicate which cultural group best represents your identity, or portion of your identity:

Aboriginal (please select all that apply):

First Nations - Community:

- Cree
- Algonquin
- Mohawk
- Mi'kmaq
- Ojibway
- Other (please specify): _____

Métis - Community: _____

Inuit: Region/Community: _____

Other (please specify): _____

What are the Francophone identifying questions to ask?

1. Quelle est votre langue maternelle?
2. Si votre langue maternelle n'est ni le français, ni l'anglais, dans quelle langue officielle du Canada êtes-vous le plus à l'aise?

1.What is your mother tongue?
2. If your mother tongue is neither French nor English, in which of Canada's official languages are you more comfortable?

Identifying Potential IPC Leads:

An Integrated Care Team member who:

- Has a productive relationship with, and has ready access to the client, family and/or supporters
- Has the confidence of the client, family and/or supporters
- Can facilitate group collaboration and guide resolution of conflicting priorities

If the client is identified as First Nations, Inuit or Métis, the Lead should be decided in the following order, unless the client explicitly expresses this not be the case: Aboriginal agency, Aboriginal program, Aboriginal staff.

If the client is identified as Francophone, the Lead should be decided in the following order, unless the client explicitly expresses this not be the case: Francophone agency, Francophone program, Francophone staff.

COMPLETE FIDELITY CHECKLIST

Selection and Criteria Approval

- Complete and Submit IPC-CANS & Coordinated Access application form to Coordinated Access.
- Support and encourage client and/or family to actively participate and attend Coordinated Access presentation.
- Presentation is made by Referring Service provider and client and/or family (decision is made within **5 business days**).
- Inform client and/or family of recommendation within **2 business days** of decision.
- Discuss potential IPC Leads with youth and/or family and a decision is made by youth and/or family.
- Contact the IPC Lead within **2 business days** of decision by youth and inform Coordinated Access of the IPC Lead.

COMPLETE FIDELITY CHECKLIST

Orientation Meeting

IPC Lead to contact the client and their family and/or supporters within **2 business days** of being identified as the lead to schedule an orientation meeting within the **next 5 business days** to:

- Have client sign IPC process consent form.
- Have initial discussions with client about the strengths and needs of the client and their family/supporters.
- Support the client in developing and documenting an initial vision statement(s).
- Discuss potential dates for the first IPC Initial Planning Meeting.
- Discuss purpose of the IPC Initial Planning Meetings and the option of attending first portion of first one. Client and/or family/supporters decide whether or not they are going to attend.

COMPLETE FIDELITY CHECKLIST

Integrated Plan of Care Initial Planning Meetings

Within **2 business days** of the Orientation Meeting, the **IPC Lead** sets up the Integrated Plan of Care Initial Planning Meeting with the client and/or family and the Integrated Care Team to be held within **2 weeks**.

Request Service Summaries from each Integrated Care Team members and distribute to team, including client and/or family.

Facilitate the meeting to:

- Conduct introductions, discuss/clarify agency roles with client and family/supporters and review team roles
- Review recommendations from Coordinated Access
- Develop a comprehensive Integrated Plan of Care
- Develop a crisis management strategy
- Establish frequency of meetings (**once a month for the first six months**, at a minimum), regular communications and progress checks

COMPLETE FIDELITY CHECKLIST

Integrated Plan of Care Ongoing Meetings

IPC Lead facilitates the meeting to review the following and take necessary action as a team:

- Are the client's needs being met and their strengths being built through the actioning of the Integrated Plan of Care?
- Have the client needs, goals and/or vision changed?
- Are any changes to the Integrated Plan of Care needed?
- Is there a need to consider alterations or additions to the Integrated Care Team?
- Is there a need to find a new Integrated Plan of Care Lead?
- Is the Integrated Plan of Care still required?

Attend progress check meetings at Coordinated Access. If the IPC process is no longer required, develop a transition plan.

Identification

This stage requires **making an informed decision** about whether the Integrated Plan of Care process could meet the needs of the client.

Individuals Involved

Referring Service Provider
Agency Implementation Lead
Potential Integrated Care Team

Paperwork to be Completed

Integrated Plan of Care Child and Adolescent Needs and Strengths (IPC – CANS) tool (see Appendix C)
Identification Fidelity Checklist (see Appendix Q)

Key Steps

- ➔ Identify a need for Integrated Plan of Care process
- ➔ Review Integrated Plan of Care Criteria
- ➔ Ask the First Nations, Inuit and Métis identifying questions
- ➔ Ask the Francophone identifying questions
- ➔ Confirm consent
- ➔ Connect with potential Integrated Plan of Care Team Members
- ➔ Identify potential Integrated Plan of Care Lead(s)
- ➔ Complete IPC – CANS
- ➔ Consult with Agency Implementation Lead

What Is Your Role?

Referring Service Provider

Step One: To identify a need for the Integrated Plan of Care, the Referring Service Provider will consider the following:

- Is the client between 6 and 18 years of age*?
- Is the client currently accessing two or more services from across sectors or has the client in the past received services from multiple service providers?
- Is the client experiencing minimal success with current services and the rationale for lack of progress or improvement is unclear and worrisome?
- Is the client presenting behaviours that, if left unattended, place them, their family and/or community at serious risk?

* It is understood that a youth who becomes 18 years of age while engaged in the formalized care plan process will continue to be served until an appropriate transition can be made – transition plan would become part of the care plan process.

Step Two: If *yes* can be answered to all of these questions, consider the inclusion criteria for the Integrated Plan of Care process. Review the following inclusion criteria:

- The client is at serious risk of harm to self and/or others, exhibiting behaviors such as cutting, suicidal ideation, serious physical assault of another, etc.
- The client is experiencing multiple intersecting complex needs that are severe and broad that lead to major challenges for the client to participate meaningfully in society. For more information about complex needs, refer to Appendix B.
- Organization or service provider assesses that child, youth and/or their family needs exceed any one organization's scope and a collaborative response is required to respond to the needs of the child/youth.

Step Three: To allow for a common base of information, the **Referring Service Provider** will complete a draft of the IPC – CANS to determine strengths, level of risk and complexity of need based on their knowledge and experience with the client(refer to Appendix C).

Step Four: The **Referring Service Provider** will check in with **Agency Implementation Lead** to discuss potential client for the IPC process, including the draft IPC-CANS**.**

- If the **Agency Implementation Lead** agrees that the client meets the inclusion criteria and would benefit from the Integrated Plan of Care, the Integrated Plan of Care process is discussed with the client and their family and/or supporters.
- If the Agency Implementation Lead does not agree that the client meets the inclusion criteria or would not benefit from the Integrated Plan of care, continue serving the client

Step Five: Discuss the IPC process with the client and/or family and/or supporters.

- If the client is interested, continue to step Six
- If the client is not interested, continue serving the client

Step Six: If the client would like to consider the IPC process, ask the First Nations, Inuit and Métis identifying questions to determine if the client self identifies as an Aboriginal client.

- If the client self identifies as Aboriginal indicate that they may choose to participate in the Aboriginal Integrated Plan of Care process.
- If the client indicates they would like to be involved in the Aboriginal Integrated Plan of Care process, the **Referring Service Provider** communicates with their own **Agency Implementation Lead** to discuss the plan and to designate someone to connect the child/youth to the System Navigator at the Wabano Centre for Aboriginal Health.
    - The designated person communicates with the System Navigator at the Wabano Centre for Aboriginal Health to discuss making a potential referral into the Aboriginal Integrated Plan of Care process.
- If the client self-identifies and indicates they would prefer not to be involved in the Aboriginal Integrated Plan of Care process, the option of involving an Aboriginal service in the Integrated Plan of Care process is offered. If the client agrees, the **Referring Service Provider** connects with the System Navigator at the Wabano Centre for Aboriginal Health and includes the request to have a Wabano representative on the Coordinated Access Mental Health Committee in their application to Coordinated Access.
- If the client does not self identify as Aboriginal continue to step Seven.

What are the Aboriginal identifying questions to ask?

Please indicate which cultural group best represents your identity, or portion of your identity (please select all that apply):

- ❑ First Nations - Community: _____
    - o Cree
    - o Algonquin
    - o Mohawk
    - o Mi'kmaq
    - o Ojibway
    - o Other (please specify): _____
- ❑ Métis - Community: _____
- ❑ Inuit: Region/Community: _____
- ❑ Other (please specify): _____

Step Seven: Ask the Francophone identifying questions to determine if the client self-identifies as Francophone.

- If the client identifies as Francophone make the active offer (refer to Appendix D & E) to continue with the process in the cultural and linguistic services of their choice.
- If the Francophone client wishes to receive French services and your agency offers bilingual services, then connect with your **Agency Implementation Lead** to develop a French cultural and linguistic plan.
- If the Francophone client wishes to receive French services and your agency does not provide bilingual services, connect with your **Agency Implementation Lead** to discuss a referral plan for cultural and linguistic services while you continue to serve the client.
- If the client does not identify as Francophone continue to step Eight.

What are the Francophone identifying questions to ask?

1. Quelle est votre langue maternelle?
2. Si votre langue maternelle n'est ni le français, ni l'anglais, dans quelle langue officielle du Canada êtes-vous le plus à l'aise?

1.What is your mother tongue?
2. If your mother tongue is neither French nor English, in which of Canada's official languages are you more comfortable?

Step Eight: Discuss potential Integrated Plan of Care Team members with client and/or family/supporters.

- Confirm that information sharing consent was obtained during intake with potential Integrated Care Team members. If this was not done during intake, obtain consent to share information with potential Integrated Plan of Care Team members.
- Provide the *Integrated Plan of Care Process Information Pamphlet* to parents and supporters (refer to Appendix F).

Identifying the Integrated Plan of Care Lead:

Considerations when identifying an Integrated Plan of Care Lead include any Service Team member who:

- Has established a positive client relationship and has ready access to the client and family and/or supporters
- Has the confidence of the client, family and/or supporters
- Can facilitate group collaboration and guide resolution of conflicting priorities/goals

If the client is identified as First Nations, Inuit or Métis, the Integrated Plan of Care Lead should be decided in the following order, unless the client and/or the family and/or supporters explicitly express this not be the case:

- Aboriginal agency
- Aboriginal focused program
- Aboriginal staff (linked to Aboriginal network)

If the client is identified as Francophone, the Integrated Plan of Care Lead should be decided in the following order, unless the client and/or the family and/or supporters explicitly express this not be the case:

- Francophone and /or agency with bilingual designation
- Francophone or bilingual program
- Francophone staff (linked to Francophone network)

Step Nine: Connect with potential **Integrated Care Team** members through Agency Implementation Leads to discuss the benefit of IPC process for the client and gather information to inform the IPC-CANS and Coordinated Access application. Request agreement to participate in the Integrated Care Team and discuss capacity to take on Integrated Plan of Care Lead role for potential IPC process.

Step Ten: Based on the information gathered from potential Integrated Care Team members, the **Referring Service Provider** reviews the draft IPC-CANS (Appendix C) completed in Step three and makes any necessary additions or changes. Once completed, the **Referring Service Provider** will discuss the completed IPC – CANS with the client and their family and/or supporters in order to receive feedback and make changes. Once finalized, a copy is given to the client and/or family and/or supporters.

Step Eleven: The **Referring Service Provider** connects with the **Agency Implementation Lead** to decide whether or not to proceed with the Coordinated Access application for this client.

- Once the decision has been made, the **Referring Service Provider** connects with the client and/or family and/or supporters to inform them whether or not you will be proceeding with the application.

What Is Your Role?

Agency Implementation Lead

Step One: Discuss with Agency Implementation Leads which agency staff member are **potential Integrated Care Team** members.

Step Two: Discuss and review with the **Referring Service Provider**:

- The strengths and needs of the client and family and/or supporters.
- The completed IPC – CANS.
- If the client is a strong potential candidate for the Integrated Plan of Care process. If yes, support the Referring Service Provider to complete all necessary steps to make the application to Coordinated Access
- If it is determined that the client is not a strong candidate for the Integrated Plan of Care process, discuss with the Referring Service Provider other options to improve services for the client.

What is Your Role?

Potential Integrated Care Team Member

Step One: Respond to the **Referring Service Provider** and participate by:

- Discussing benefit of IPC process
- Contributing information for the IPC-CANS
- Identifying candidates for Integrated Plan of Care Leads

Selection and Criteria Approval

This stage involves ensuring fidelity to the Integrated Plan of Care inclusion criteria and providing appropriate recommendations for the client.

Individuals Involved

Referring Service Provider
Agency Implementation Lead
Mental Health Committee at Coordinated Access

Paperwork to be Completed

Coordinated Access Application Form
Selection and Criteria Fidelity Checklist (see Appendix Q)

Key Steps

- ➔ Complete Coordinated Access application form
- ➔ Submit Coordinated Access application form and IPC-CANS to the Mental Health Committee
- ➔ Support and encourage client and/or family to actively participate in the case presentation to the Mental Health Committee
- ➔ Mental Health Committee makes recommendations
- ➔ Inform client and/or family of decision made
- ➔ Client and/or family decides on Integrated Plan of Care Lead (if applicable)

What is Your Role?

Referring Service Provider

Step One: Have client and/or family sign the Coordinated Access consent form and complete the Coordinated Access application form (found at http://coordinatedaccess.ca/en/?page_id=18)

- If the client indicated in the identification stage that they would like to involve Aboriginal Services at the Mental Health Committee meeting, clearly indicate on the Coordinated Access application form a request to have an Aboriginal representative attend the Mental Health Committee presentation
- If client identifies as Francophone, clearly indicate on the Coordinated Access application form a request for presentation to the French Mental Health Committee and complete the French application form

Step Two: The Referring Service Provider submits the following documentation to the Mental Health Committee at Coordinated Access:

- Coordinated Access application and consent forms (found at http://coordinatedaccess.ca/en/?page_id=18)
- IPC – CANS (refer to Appendix C)

The Referring Service Provider will receive a date for the case presentation within **two weeks** of the completed application being submitted for an English presentation and within **one month** for a French presentation.

Step Three: The Referring Service Provider supports and encourages the client and family to actively participate in the case presentation to the Mental Health Committee to the degree that they are comfortable with. The Referring Service Provider and the client and family (if available) prepare and make a 15 minute case presentation, in the official language of their choice, to the Mental Health Committee at Coordinated Access and are available to answer questions following the presentation. For

more information on what to include in the case presentation, see http://coordinatedaccess.ca/en/?page_id=173.

- **Within five business days** of the case review, the Mental Health Committee at Coordinated Access will inform the Referring Service Provider in writing of their decision, copying all respective Agency Implementation Leads of potential Integrated Care Team members identified for this Integrated Plan of Care process. The letter sent outlines the decision made as well as suggestions of service providers to include in the Integrated Plan of Care process, potential services to explore, treatment recommendations and a review presentation date within three months, or sooner as necessitated by level of risk.

Step Four: The Referring Service Provider informs the client **within two business days** of the Mental Health Committee's decision:

- If the client **does not meet the criteria** for the Integrated Plan of Care process, the Mental Health Committee at Coordinated Access will make recommendations and suggestions to support the Referring Service Provider in meeting the needs of the client, including possible access to other services through Coordinated Access.
- If client **does meets the criteria** for the IPC process, the Referring Service Provider:
  - Discusses IPC Leads candidates with the client and/or family and/or supporters and a decision is made by the client and/or family and/or supporters.
  - Connects with Case Coordinator (see IPC process Contact List) at Coordinated Access to inform them of who the IPC Lead is for this client.
  - Connects with identified IPC Lead.

What is Your Role?

Agency Implementation Lead

Step One: Support the Referring Service Provider in the completion of the Coordinated Access application form for submission to the Mental Health Committee at Coordinated Access. This form can be found at: http://coordinatedaccess.ca/en/?page_id=18

Step Two: Support the Referring Service Provider in the preparation of the Coordinated Access presentation.

What is Your Role?

Mental Health Committee at Coordinated Access

Step One: Review and process the referrals for the Integrated Plan of Care process by:

- Reviewing the completed IPC – CANS and Coordinated Access application form submitted.
- Attending the case presentation by the Referring Service Provider and potentially the client and family. Ask any relevant questions to clarify information needed to assess the potential impact of the Integrated Plan of Care process on the needs of the client and family.
- Ensuring Francophone and/or First Nations, Inuit or Métis representation on Mental Health Committee at Coordinated Access as needed.
- Determining if the client meets the inclusion criteria of the Integrated Plan of Care Process.

Step Two: Once a decision has been made, the Chair of the Mental Health Committee informs those involved:

- If the client does not meet the inclusion criteria, make recommendations and suggestions to support the Referring Service Provider to meet the needs of the client.
- If the client does meet the inclusion criteria, contact the Referring Service Provider to start the Integrated Plan of Care process. A letter is sent outlining the decision made as well as suggestions of service providers to include in the Integrated Plan of Care process, potential services to explore, treatment recommendations and a review presentation date within three months, or sooner as necessitated by level of risk.
- Agency Implementation Leads of all agencies to be involved in IPC process are copied on letter from Coordinated Access informing them of the decision made.

Orientation Meeting

This stage involves discussing the strengths, needs and vision of the client and/or family and/or supporters.

Individuals Involved
Integrated Plan of Care Lead

Paperwork to be Completed
IPC process consent form
(see Appendix G)
Initial vision statement
(see Appendix H)
Orientation Meeting Fidelity Checklist
(see Appendix Q)

Key Steps
- ➔ Establish an Orientation Meeting
- ➔ Sign IPC process consent form
- ➔ Develop and document vision statement
- ➔ Establish dates for Integrated Plan of Care Initial Planning meeting

What is Your Role?

The Integrated Plan of Care Lead

Step One: Within **two business days** of being identified as the Integrated Plan of Care Lead, the Integrated Plan of Care Lead will contact the client and/or their family and/or supporters to schedule an orientation meeting within the **next five business days**. This meeting can be done in person or by phone.

Step Two: The Integrated Plan of Care Lead will connect with the client and their family and/or supporters to:

- Have client/family member sign IPC process consent form (refer to Appendix G)
- Have initial discussions about the strengths and needs of the client and their family and/or supporters.
- Support the client in developing and documenting an initial vision statement(s) (refer to Appendix H) in either official language.
- Discuss potential dates for the Integrated Plan of Care Initial Planning Meeting
- Discuss purpose of the IPC Initial Planning meeting and offer the client and/or family and/or supporters the option of attending the first part of the meeting. The first part is optional to the client and/or family given that it is agency focused, given the different service providers a chance to introduce themselves, their roles and build an awareness of each other. The client and/or family and/or supporters decide whether or not they will attend the first part of the meeting. See below description of both parts of the meeting:

PART ONE (attendance is OPTIONAL for client and/or family and/or supporters):

- Introductions
- Discussion/clarification of agency roles with the client and family and/or supporters
- Review of team roles for meetings

PART TWO (Mandatory for everyone):

- Brief overview of Service Summaries (refer to Appendix I)
- Review recommendations from the Mental Health Committee at Coordinated Access
- Discuss Team Commitment (refer to Appendix J)
- Review Tips for an Effective Meeting (refer to Appendix K)
- Develop a comprehensive Integrated Plan of Care (refer to Appendix L)
- Develop a Crisis Management Strategy (refer to Appendix M)
- Establish frequency of meetings (**once a month for the first six months**, at a minimum), regular communications and progress checks
- Review Conflict Resolution Pathway for Integrated Care Teams (refer to Appendix N)

Integrated Plan of Care Initial Planning Meetings

This stage provides an opportunity for the Integrated Care Team to develop the Integrated Plan of Care with the support of their Integrated Care Team. The Integrated Care Team is comprised of service providers, client, family members and/or supporters and is led by the client. Depending on the complexity of the situation, this stage may take one to three meetings to complete.

Individuals Involved

Integrated Plan of Care Lead
Integrated Care Team

Paperwork to be Completed

Service Summaries (see Appendix I)
Integrated Plan of Care Template (see Appendix L)
Crisis Management Strategy (see Appendix M)
Integrated Plan of Care Initial Meeting Fidelity Checklist (see Appendix Q)

Key Steps

- ➔ Complete Service Summaries
- ➔ Complete Integrated Plan of Care template
- ➔ Develop Crisis Management strategy
- ➔ Review Team Commitment (see Appendix J)
- ➔ Review Tips for an Effective Meeting (see Appendix K)
- ➔ Establish ongoing meeting and communication frequency
- ➔ Review Conflict Resolution Pathway for Integrated Care Teams

What is Your Role?

Integrated Plan of Care Lead

Step One: Within **two business days** of the Orientation Meeting, schedule an Integrated Plan of Care Initial Planning Meeting with the client and/or their family and/or supporters and the Integrated Care Team members to be held **within two weeks**.

Step Two: Request Service Summaries from each Integrated Care Team members (refer to Appendix I) and distribute to team, including client and/or family and/or supporters.

Step Three: Facilitate the Integrated Plan of Care Initial Meeting and support the client, their family and/or supporters and the Integrated Care Team throughout. The meeting should cover:
PART TWO (Mandatory for everyone):

- Brief overview of Service Summaries
- Review recommendations from the Mental Health Committee at Coordinated Access
- Discuss Team Commitment (refer to Appendix J)
- Review Tips for an Effective Meeting (refer to Appendix K)
- Develop a comprehensive Integrated Plan of Care (refer to Appendix L)
- Develop a Crisis Management Strategy (refer to Appendix M)
- Establish frequency of meetings (**once a month for the first six months**, at a minimum), regular communications and progress checks

- Review Conflict Resolution Pathway for Integrated Care Teams (refer to Appendix N)

It is important to ensure that when developing the Integrated Plan of Care that each goal has a designated Integrated Care Team member who will take primary responsibility for that goal with other members involved in supporting activities.

Step Four: Once the initial Integrated Plan of Care template is complete, begin implementation of the Integrated Plan of Care.

- Set meeting date (within one month) for first Integrated Plan of Care Ongoing Meeting to review progress.

What is Your Role?

Integrated Care Team

Step One: Prepare for the Integrated Plan of Care Initial Planning Meeting:

- Prepare a Service Summary and submit to the Referring Service Provider (refer to Appendix I) ahead of the meeting.
- Review Service Summaries provided by other Integrated Care Team members.

Step Two: Participate in the Integrated Plan of Care Initial Meeting by supporting the client and their family and/or supporters to:

- Discuss and complete Team Commitment (refer to Appendix J)
- Review Tips for an Effective Meeting (refer to Appendix K)
- Develop a comprehensive Integrated Plan of Care (refer to Appendix L)
- Develop a Crisis Management Strategy (refer to Appendix M)
- Establish frequency of meetings (**once a month for the first six months**, at a minimum), regular communications and progress checks
- Review Conflict Resolution Pathway for Integrated Care Teams (refer to Appendix N)

Integrated Plan of Care Ongoing Meetings

This stage ensures progress checks review and monitor progress towards the vision and goals outlines in the Integrated Plan of Care and remain responsive to the needs of the client. Not all Integrated Care Team members need to attend all meetings. Frequency and who should attend is determined by the present priority being addressed in the integrated plan of care and the needs of the client and/or family and/or supporters.

Individuals Involved

Integrated Plan of Care Lead
Integrated Care Team

Paperwork to be Completed

Perception of Care measure (see Appendix O/P)
IPC-CANS (see Appendix C)
Integrated Plan of Care Template (see Appendix L)
Integrated Plan of Care Ongoing Meetings Fidelity Checklist (see Appendix Q)

Key Steps

- ➔ Repeat this step multiple times as determined by the needs of the client, at a minimum monthly for the first six months
- ➔ Have client and/or family complete the Perception of Care measure at the first meeting and repeat every 6 months
- ➔ Review IPC-CANS, 6 months after initial completion
- ➔ Review and monitor progress toward the vision and the goals outlined in the Integrated Plan of Care and identify if the Integrated Plan of Care needs to be revised
- ➔ Assess if changes in the Integrated Care Team are necessary
- ➔ Attend progress check meetings at Coordinated Access

What is Your Role?

Integrated Plan of Care Lead

Step One: Have the client and/or family complete the Perception of Care measure at first ongoing meeting and repeat every 6 months (see appendix O/P)

Step Two: Review and update IPC-CANS every 6 months.

Step Three: Facilitate the Integrated Plan of Care Ongoing Meetings to review the Integrated Plan of Care in order to determine progress. Consider the following:

- Are the client's needs being met and their strengths being built through the actioning of the Integrated Plan of Care?
- Have the client needs, goals and/or vision changed?
- Are any changes to the Integrated Plan of Care needed?
- Is there a need to consider alterations or additions to the Integrated Care Team?
- Is there a need to find a new Integrated Plan of Care Lead?
- Is the Integrated Plan of Care still required?

Step Four: Attend progress check meetings at Coordinated Access based on Mental Health Committee recommendations.

What is Your Role?

Integrated Care Team

Step One: Attend the meeting, review the Integrated Plan of Care and make changes as needed:

- Review needs met and strengths built through the actioning of the Integrated Plan of Care.
- Discuss and review progress towards the goals and shared vision.
- Make any necessary changes to the Integrated Plan of Care.
- Review team membership (both to bring into the team and to phase out).
- Identify a new Integrated Plan of Care Lead.
- Determine if the Integrated Plan of Care process is still required.

Step Two: Attend progress check meetings at Coordinated Access based on Mental Health Committee recommendations.

APPENDIX A: Roles and Responsibilities of Key Positions

The IPC process uses a team approach to develop and implement the integrated plan of care. The implementation of the IPC process necessitates the creation of new roles and responsibilities for service providers, including the following:

Partner Agencies

1. Agency Implementation Lead

Each agency/organization involved in the Integrated Plan of Care process will identify an Agency Implementation Lead. The roles and responsibilities of the Agency Implementation Lead include:

1. Supports Referring Service Provider in their agency to assess the child/youth and family's strengths and needs using the IPC-CANS.
2. Supports the Referring Service Provider to complete the "Ottawa Children's Coordinated Access and Referral to Services" package.
3. Fosters communication and collaboration between agencies involved in the Integrated Plan of Care process.
4. Supports the IPC Lead to plan and facilitate the Integrated Plan of Care meetings.
5. Considers, evaluates and makes a determination for "flexing agency mandate" when indicated to best serve a child/youth in IPC process.
6. Advocates with partner AILs to ensure "the right services at the right time" for children/youth in the IPC process.
7. Supports Integrated Care team to access the unique services needed by the youth, through advocating internally to their agency and, if necessary, externally.
8. Works with the Steering Committee and Regional Implementation Coach to identify and resolve process situations that impede agencies from working together in the interests of children and youth with complex needs and their families.
9. Collects evaluation data from IPC Leads within agency in order to review and discuss Integrated Plan of Care process at baseline and every six months following baseline. Removes identifying information before referring data to Regional Evaluation Coordinator or Steering Committee.
10. Works with the Regional Evaluation Coordinator or Steering Committee to ensure that all measures are collected, and assists in coordinating any necessary additional data collection from IPC Leads within their organizations.
11. Participates in evaluation activities (e.g. AIL World Café) aimed at improving the IPC process.
12. Participates in Ad Hoc meetings of the AILs to problem-solve and to develop capacity to sustain the implementation of the IPC process.

2. Referring Service Provider

The Referring Service Provider is the person who identifies the potential benefit for the child/youth and family to participate in the Integrated Plan of Care process and begins the IPC process. The roles and responsibilities of the Referring Service Provider include:

1. Identify clients that would benefit from the Integrated Plan of Care process by considering IPC criteria, completing the IPC-CANS, in consultation with the Agency Implementation Lead (AIL), potential Integrated Care Team members and the client and family.
2. Obtain informed consent.
3. Complete and submit the "Ottawa Children's Coordinated Access and Referral to Service" package for the IPC process and prepare presentation to the Mental Health Case Resolution Committee.
4. Liaise with Coordinated Access to review referral, files and information as required
5. Support and encourage the client and family to actively participate in the presentation to the Mental Health Case Resolution Committee to the degree they are comfortable with.
6. Link the client and family with the IPC Lead.
7. Foster communication and collaboration between agencies involved in the Integrated Plan of Care process.
8. Identify cultural and linguistic preferences of clients and assurance of appropriate service link.
9. Make the active offer and appropriate referral if applicable for all Aboriginal and Francophone clients.
10. Identify and seek support to access the unique services needed by the youth, through advocating internally to their agency and, if necessary, externally.
11. Participate in available IPC skills training (e.g. CANS, youth engagement)

3. Integrated Plan of Care (IPC) Lead

The IPC Lead is the central point of contact for the Integrated Plan of Care process for the child/youth and their families and the other partnering service providers. The IPC Lead assumes a leadership role for the implementation of the Integrated Plan of Care process. The IPC Lead is selected by the child/youth and their family/supporters. If the child/youth is identified as First Nations, Métis or Inuit, the IPC Lead should be a First Nations, Métis or Inuit service provider, unless the child/youth/family explicitly expresses that this not be the case. If the child/youth is identified as Francophone, the IPC Lead should be from a Francophone agency, unless the child/youth/family explicitly expresses this not be the case. The roles and responsibilities of the IPC Lead include:

1. Establish and maintain a supportive and trusting professional strength-based relationship with the child/youth/family.
2. Support and represent the needs of the child/youth/family.
3. Facilitate the work of the teams (scheduling meetings, ensuring records of meetings, supporting decisions taken at meetings, providing briefings and background information to support decision-making) and the overall Integrated Plan of Care process.
4. Champions the vision of the Integrated Plan of Care that was created to all team members and child/youth and family.
5. Foster communication and collaboration between agencies involved in the Integrated Care Team.
6. Works with Integrated Care Team to resolve conflict issues as they arise and assists the team to problem-solve challenges that impede the Team from working together.
7. Understand and adhere to the collection and sharing of information obligations required by law and consented to by the client and/or family and is able to explain the concept of informed consent to the client and/or family.
8. Maintain the accuracy and integrity of information contained in case files.
9. Ensure follow through and monitoring of Integrated Plan of Care through regular meetings.
10. Identify and seek support to access the unique services needed by the youth, through advocating internally to their agency and, if necessary, externally.
11. Collect necessary evaluation information according to a predetermined schedule and submits this information to the Agency Implementation Lead.
12. Coordinates with Coordinated Access quarterly (or as needed) presentations and reviews of the IPC progress.

4. Integrated Care Team

The Integrated Plan of Care process is about connecting cross-sectoral service providers, parents and children/youth as partners to create a coordinated care plan that remains focused on the understood strengths and needs of the child/youth and their family. Together, this group of cross-sectoral service providers, parents and children/youth is known as the Integrated Care Team. The roles and responsibilities of the Integrated Care team include:

1. Strive to fulfill, to the best of their abilities, the guidelines listed in the "Team Commitment" resource (Appendix J)
2. Provide other Team Members with Name, Program, Agency, Role and Services being provided to the child/youth and family.
3. Actively participate in Integrated Plan of Care meetings.
4. Review relevant documentation, including IPC-CANS and team assessment summaries, to prepare for IPC meetings.

5. Engage with service providers from partner agencies to develop Integrated Plan of Care and follow through on the goals and activities outlined in the Integrated Plan of Care.
6. Engage client and/or family members to participate in the scope of services agreed upon the integrated plan of care.
7. Foster communication and collaboration between agencies involved in the Integrated Plan of Care process.
8. Works with Integrated Care Team to identify and resolve problems that impede the Team from working together.
9. Ensure representation on Integrated Care Team from Aboriginal and Francophone agencies if applicable.
10. Understand and adhere to the collection and sharing of information obligations required by law and consented to by the client and/or family.
11. Assist and complete all necessary documentation for the IPC process and for the evaluation of the IPC.

Supporting Organizational Bodies – Roles and Responsibilities

1. Mental Health Case Resolution Committee

The Mental Health Case Resolution Committee at Coordinated Access is experienced in making recommendations and/or service plans for children and youth already in service with complex mental health needs. There is both an English and a French Committee. The roles and responsibilities of the Mental Health Case Resolution Committee include:

1. Ensure fidelity to the IPC inclusion criteria for initial implementation.
2. Review the referral documentation submitted.
3. Attend the case presentation by the Referring Service Provider and potentially the client and family. Ask any relevant questions to clarify information needed. Assess the potential impact of the Integrated Plan of Care process on the needs of the client and family.
4. Determine if the client meets the inclusion criteria of the Integrated Plan of Care process.
5. If child/youth does not meet the inclusion criteria, make recommendations and suggestions to support the Referring Service Provider in meeting the needs of the client, including possible access to other services through Coordinated Access.
6. Support the access to unique services needed by the youth.
7. If child/youth meets the inclusion criteria, make recommendations regarding potential members of the Integrated Care team, integrated plan of care goals, treatment/service needs.
8. Participate in quarterly (or as needed) case review meetings of IPC process clients.

2. Steering Committee

The IPC Steering Committee will provide leadership, monitoring and advice on the overall implementation and sustainability of the Integrated Plan of Care process and reflect on the evaluation of the Integrated Plan of Care process. The roles and responsibilities of the Steering Committee include:

1. Provide strategic advice to the service providers involved in the IPC process on the implementation of the IPC process, including identified areas of needs and problem-solving solution.
2. Support the implementation of the IPC process locally by encouraging organizations within their sphere of influence to participate in the IPC process.
3. Support the evaluation of the IPC process.
4. Support the implementation of the IPC communication plan.
5. Act as a resolution mechanism if Coordinated Access or the Integrated Care Team is running into major roadblocks.

3. Coordinated Access

The roles and responsibilities of Coordinated Access include:

1. Facilitate the work of the Mental Health Case Resolution Committee (scheduling meetings, ensuring records of meetings, supporting decisions taken at meetings, providing briefings and background information to support decision-making).
2. Promote flexibility and exchange of services.
3. Facilitate possible access and/or links to other services through Coordinated Access if client does not meet inclusion criteria.
4. Facilitate possible access and/or links to other services through Coordinated Access if part of the Integrated Plan of Care.
5. Assign unique identifiers to children and youth involved in the IPC process and maintain a master list to be shared with CAMH on a bi-monthly basis.
6. Schedule IPC Lead to attend and present progress update at quarterly case review meetings.

APPENDIX B: Definition of Complex Needs

Complex Needs are understood to mean:

Multiple intersecting needs that span health, mental health and social issues, leading to major challenges participating in society. Categories of complex needs and contributing social factors include concurrent disorders, complex trauma, suicide and self-harm, inter-generational trauma, residential school trauma, homelessness. There is no generic complex needs case. Each individual with complex needs has a unique interaction between their health and social care needs and requires a personalised response from services.

- Rather than use the term 'complex needs' to describe an individual's characteristics, it is defined in terms of an active framework for response.
- Fits with the tiered framework[1]
- Essence of complex needs implies both
    - **breadth of need –** multiple needs (more than one) that are interrelated or interconnected across multiple domains of health, mental health and social circumstances.
    - **Depth of need –** reflects the overall severity of the person's situation and ability to manage

[1] Rush, B. (2010) Tiered frameworks for planning substance use service delivery systems: Origins and key principles. *Nordic Studies on Alcohol and Drugs*, *27*(6), 617-636.

APPENDIX C: Integrated Plan of Care Child and Adolescent Needs and Skills (IPC-CANS)

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) ©

INTEGRATED PLAN OF CARE PROCESS

Please √ appropriate use: ☐ Initial ☐ Reassessment ☐ Transition/Discharge

Date: M M D D Y Y

Youth's Name | **DOB** m m d d y y | **Gender** ☐ M ☐ F | **Mother Tongue**

Executive Functioning

0 = no evidence 1 = watch/prevent
2 = act 3 = act now/intensive

	0	1	2	3
1. Decision-making skills	○	○	○	○
2. Ability to pay attention	○	○	○	○

Emotional Regulation Skills

0 = no evidence 1 = watch/prevent
2 = act 3 = act now/intensive

	0	1	2	3
3. Self Management	○	○	○	○
4. Moodiness	○	○	○	○
5. Anger Control	○	○	○	○
6. Over-reaction	○	○	○	○

Social Skills

0 = no evidence 1 = watch/prevent
2 = act 3 = act now/intensive

	0	1	2	3
7. Social functioning	○	○	○	○
8. Building relationships	○	○	○	○
9. Empathy	○	○	○	○
10. Social perception	○	○	○	○

Acculturation

0 = no evidence 1 = watch/prevent
2 = act 3 = act now/intensive

	0	1	2	3
11. Language	○	○	○	○
12. Identity	○	○	○	○
13. Ritual	○	○	○	○
14. Parent/Caregiver's Stress	○	○	○	○

Mental Health Needs

0 = no evidence
1 = history or sub-threshold, watch/prevent
2 = causing problems, consistent with diagnosable disorder
3 = causing severe/dangerous problems

	0	1	2	3
15. Psychosis	○	○	○	○
16. Anxiety	○	○	○	○
17. Mood disturbance	○	○	○	○
18. Attention/Hyperactivity	○	○	○	○
19. Impulse Control	○	○	○	○
20. Eating Disturbance	○	○	○	○
21. Oppositional Behaviour	○	○	○	○
22. Conduct Behaviour	○	○	○	○
23. Adjustment to Trauma	○	○	○	○
24. Attachment Difficulties	○	○	○	○
25. Substance Use	○	○	○	○
26. Autism Spectrum/PDD	○	○	○	○

Risk Behaviours

0 = no evidence 1 = history, watch/prevent
2 = recent, act 3 = acute, act immediately

	0	1	2	3
28. Suicide Risk	○	○	○	○
29. Self Injuring Behaviours	○	○	○	○
30. Other Self Harm	○	○	○	○
31. Aggression – Objects	○	○	○	○
32. Cruelty to Animals	○	○	○	○
33. Danger to Others	○	○	○	○
34. Sexual Aggression	○	○	○	○
35. Elopement/Runaway	○	○	○	○
36. Delinquent Behaviour	○	○	○	○
37. Fire Setting	○	○	○	○
38. Intentional Misbehaviour	○	○	○	○
39. Bullying	○	○	○	○

Educational Needs

0 = no evidence 1 = watch/prevent
2 = act 3 = act now/intensive

	0	1	2	3
40. School attendance	○	○	○	○
41. Classroom behaviour	○	○	○	○
42. Non-class behaviour	○	○	○	○
43. School discipline	○	○	○	○
44. Academic achievement	○	○	○	○
45. Academic persistence	○	○	○	○
46. Learning disability	○	○	○	○
47. Special education	○	○	○	○
48. Intellectual	○	○	○	○

Youth Justice

0 = no evidence
1 = history, watch/prevent
2 = recent, act
3 = acute, act now/intensive

	0	1	2	3
49. Seriousness	○	○	○	○
50. History	○	○	○	○
51. Arrests	○	○	○	○
52. Planning	○	○	○	○
53. Community Safety	○	○	○	○
54. Legal Compliance	○	○	○	○
55. Peer Influences	○	○	○	○
56. Parental criminal behaviour	○	○	○	○
57. Environmental Influences	○	○	○	○

27. Parent-Child Relations	○	○	○	○

Child/Youth Individual Strengths

0 = centerpiece 1 = useful
2 = identified 3 = not yet identified

	0	1	2	3
58. Talents/Interests	○	○	○	○
59. Extra-curricular Activities	○	○	○	○
60. Optimism	○	○	○	○
61. Leadership	○	○	○	○
62. Creativity/Imagination	○	○	○	○
63. Peer Relations	○	○	○	○
64. Self expression	○	○	○	○
65. Flexibility/Adaptability	○	○	○	○
66. Life Skills	○	○	○	○
67. Resiliency	○	○	○	○

Child/Youth Environmental Strengths

0 = centerpiece 1 = useful
2 = identified 3 = not yet identified

	0	1	2	3
68. Family	○	○	○	○
69. Natural Supports	○	○	○	○
70. Community Involvement	○	○	○	○
71. Cultural Identity	○	○	○	○
72. Resourcefulness	○	○	○	○

Parents/Family/Caregiver Needs and Strengths

0 = no evidence 1 = watch/prevent
2 = recent/act 3 = act now/intensive

	0	1	2	3
73. Discipline/Parenting skills	○	○	○	○
74. Supervision	○	○	○	○
75. Problem-solving	○	○	○	○
76. Organization	○	○	○	○
77. Knowledge of child	○	○	○	○
78. Parental responsiveness	○	○	○	○
79. Ability to listen	○	○	○	○
80. Ability to communicate	○	○	○	○
81. Understanding impact of own behaviour on children	○	○	○	○
82. Involvement with care	○	○	○	○
83. Knowledge of service options	○	○	○	○

Family Needs and Strengths

0 = no evidence 1 = watch/prevent
2 = recent/act 3 = act now/intensive

	0	1	2	3
84. Family functioning	○	○	○	○
85. Family nurturance	○	○	○	○
86. Family stress	○	○	○	○
87. Natural supports	○	○	○	○
88. Safety	○	○	○	○
89. Stable living situation	○	○	○	○
90. Financial resources	○	○	○	○

APPENDIX D: Active Offer

Active Offer of Services in French

Integrated Plan of Care (IPC)

What is active offer?

- A research and evidence-based approach, the purpose of which is to:
  - Improve service delivery to minority communities;
  - Offer services that are based on client needs;
  - Improve the quality of services offered;
  - Ensure that clients are comfortable requesting and using French-language services (FLS).

- Adapted from the 2009-2010 Annual Report of the French Language Services Commissioner of Ontario:

> "Active offer is the ability of an organization to provide clients and members of the public with a **clear and consistent message** that, wherever they are, they can receive quality French-language health services. For the organization, this means creating an environment that is conducive to demand, that anticipates the specific needs of Francophones and their community, and that guarantees service of the same **quality** as that offered to Anglophone clients."[2]

Why is active offer important?

- Active offer is essential for improving the delivery of health services to Francophones and, ultimately, for ensuring compliance with the legislation (*French Language Services Act*– Bill8, and Bill 36).

- Research shows that Francophones are reluctant to ask for services in French when they are sick because they:
  - feel vulnerable,
  - feel like they are asking for favours and want to avoid a conflict;
  - are afraid of having to wait longer or of receiving lower quality services.

- When given a **real** choice, Francophones choose services in French. Active offer is a measure of equity.

[2] *Application pratique de la Définition inclusive de francophone* (DIF) [Practical Application of the Inclusive Definition of Francophone (IDF)], French Language Health Services Network of Eastern Ontario, 2013

How can you tell whether an organization actively offers French-language services?

- For **clients**, the active offer of French-language services must be perceived as:
  - accessible,
  - visible, and
  - high-quality.
- **Service providers** must ensure that clients:
  - are informed of the services being offered;
  - have access to these services;
  - are satisfied with the quality of these services.

How can active offer be guaranteed?

- By ensuring that management and staff are more fully aware that French-language services are actively offered:
  - ✓ Francophone clients are identified – 2 recommended questions
  - ✓ Staff are trained in active offer – support from MCYS or French Language Health Services Network of Eastern Ontario
  - ✓ Francophone or bilingual staff are recruited, retained, and assigned
  - ✓ French-language services are coordinated at the initial point of contact and throughout the continuum of services

- By raising public awareness and educating the public and clients through:
  - ✓ Visual cues and signage (e.g., posters that say "Ici, on parle français!" and greeting clients in both official languages over the phone and in person)
  - ✓ Print materials and a website that are in both languages (in a single document if possible)

- By developing a protocol for staff to use when greeting Francophone clients to ensure active offer [presence of a bilingual employee, offering FLS directly (if employee speaks French) or indirectly (by referring the client to French-speaking staff)]

- By evaluating progress and the achievement of objectives
  - ✓ Client satisfaction survey

- For the Integrated Care Plan, we suggest that clients be referred to:
  - ✓ A Francophone agency;
  - ✓ A Francophone program or, as a last resort;
  - ✓ A Francophone professional (associated with a Francophone network)

Where can I go for help?

- MCYS/ MCSS
  Kim Séguin
  Program Supervisor
  Kim.Seguin@ontario.ca
  Tel: 613-787-3987

- French Language Health Services Network of Eastern Ontario
  1173Cyrville Road, Suite 300, Ottawa ON K1J 7S6
  Tel: 613-747-7431 Toll-free: 1 877 528-7565
  www.rssfe.on.ca

- Office of Francophone Affairs
  http://www.ofa.gov.on.ca/en/index.html

Reference:

- *Application of the Inclusive Definition of Francophone* (IDF), French Language Health Services Network of Eastern Ontario/ Réseau des services de santé en français de l'Est de l'Ontario (the Réseau)

- *Practical Guide For the Active Offer of French Language Services in the Ontario Governement , Octobre 2012*

- *L'offre active de services de santé en français en Ontario: Une mesure d'équité,* Rapport préparé pour le Bureau des services en français du Ministère de la Santé et des Soins de longue durée de l'Ontario, 2011, Louise Bouchard, Marielle Beaulieu, Martin Desmeules

APPENDIX E: Inclusive Definition of Francophone

Réseau Recommendation

Application of the Inclusive Definition of Francophone (IDF)

Goal:

A clear and health-care-specific recommendation for the LHINs and health service providers on applying the Inclusive Definition of Francophone (IDF)

Background:

In 2009, the Ontario Office of Francophone Affairs adopted a new inclusive definition of Francophone (IDF), which takes into consideration the significant diversity of the Francophone community and is based on more than just mother tongue.

"This new inclusive definition captures those whose mother tongue is neither French nor English, but who have a particular knowledge of French as an Official Language, and use French at home, including many recent immigrants to Ontario."[1]

> "Those persons whose mother tongue is French, plus those whose mother tongue is neither French nor English but have a particular knowledge of French as an Official Language and use French at home."[2]

This definition should be used by the Government of Ontario from now on. For example, the IDF should be used for the next analyses of data from the 2011 Census.

Challenges:

Establishing a client's linguistic identity is a key part of ensuring that he or she receives proper care in a health-care facility and within the health-care system. The three questions outlined above, although well suited to census purposes, present certain practical difficulties when it comes to offering health-care services. Having to ask three questions to determine a client's linguistic may prove to be arduous (for example, in comparison with a sole question asked to any other linguistic group). Particularly in emergency situations, neither the client

[1] Office of Francophone Affairs. *More Inclusive Definition of Ontario's Francophone Population.* Page viewed on June 19, 2012 on the Web Site of the Office of Francophone Affairs: http://www.ofa.gov.on.ca/en/franco-definition.html.
[2] Ibid

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nor the professional will want to prolong the conversation. Moreover, more questions mean more complicated information technology systems. And lastly, the use of three questions is not necessarily possible or appropriate in all surveys and questionnaires.

Réseau recommendation:

Given these challenges, the Réseau conducted a thorough examination on the application of the new definition. We discussed the issues with a number of provincial and national stakeholders: the Ministry of Health and Long-Term Care's French Language Health Services office, the Office of Francophone Affairs, the French Language Service Commissioner, the Champlain and South-East LHINs, the Société Santé en français and the Consortium national de formation en santé. We also reviewed the relevant literature, particularly a study on the current practices of health-care providers in the Champlain region.

The Réseau thus recommends that the following two questions be used when it is not possible to apply the full IDF:

- **What is your mother tongue?**
- **If your mother tongue is neither French nor English, in which of Canada's official languages are you more comfortable?**

This combination is in favours of the inclusion of new immigrants whose mother tongue is not French but who know and understand French as an official language, as hoped for by the IDF. The two-variable system will also be easier to integrate into forms, databases, and other client identification processes than a three questions algorithm. These two questions are used to establish a client's linguistic identity.

"Preferred language"

In addition to the recommendation above, the Réseau recommends not asking clients about their "preferred language" of health services because data provided by this question tends to be unreliable. The literature indicates and a number of data pairing exercises confirm that at moments of vulnerability such as health problems, Francophones may not request service in French for fear that their language preference may have a negative effect on quality of service, accessibility of all treatment options, wait times, etc. As well, a recent study by Statistics Canada clearly shows that the presence of health professionals capable of holding a conversation in French and the proportion of Francophones in a given area have an impact on

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the use of French with various health professionals.[3] Moreover, it is important to understand that this question does not determine a client's linguistic identity, but rather his or her linguistic preference in a particular situation.

Relation to an active offer

When linguistic identification of clients occurs as part of the admission or reception process, we strongly recommend that French-language services be actively offered.[4] An active offer is one that is visible, audible, non-random and guarantees quality service. It has been proven that this improves the process of identifying Francophone clients.

[3] Corbeil, J.P. & Lafrenière, S. (2011). *Portrait of Official-Language Minorities in Canada: Francophones in Ontario*. Statistique Canada, p. 48.

[4] Active offer: Active offer is the capacity of an organization to provide clients and citizens with a clear and consistent signal that, no matter where they are, they can receive quality health services in French. For a health facility, this means creating an environment that encourages demand, anticipates the specific needs of Francophones and their community, and guarantees quality service comparable to that offered to Anglophone clients. *Adapted from the French Language Services Commissioner's Annual Report 2009–2010.*

APPENDIX F: Integrated Plan of Care Process Information Pamphlet

What is the Integrated Plan of Care process?

The Integrated Plan of Care process brings a team of service providers together with a child/ youth and their family/ supporters to reach a shared vision that supports the health and well being of children/youth with complex needs. It involves service providers from different agencies, organizations and sectors working together with the child/youth and their family/ supporters as equal partners. The IPC process is about creating a holistic care plan that is focused on the strengths and needs of the child/youth and their family/supporters.

Integrated Plan of Care Process

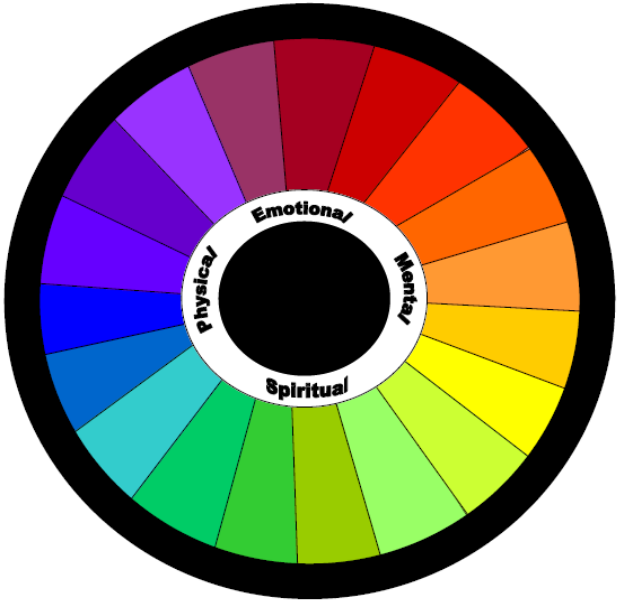
Service providers working together to support young people with complex needs and their families/ supporters by developing holistic care plans.

The Integrated Plan of Care process is available for children/youth who receive or want to receive services in both official languages.

An Aboriginal Integrated Plan of Care process is also available.

Contact your service provider with any questions or for additional information.

The Integrated Plan of Care Process



Holistic care plans that get everyone working together to achieve the child/youth's goals.

What does "children/youth with complex needs" mean?

Children/youth whose needs cover health, mental health and social issues, leading to major challenges participating in society. They have worked, or are working, with two or more services from different sectors. The child/youth is experiencing minimal success with their services and is at serious risk of harming themselves and/or others.

What is the role of Service Providers in the Integrated Plan of Care process?

Service providers take a team approach to care by working together with the child/youth and family/supporters to set goals and put together a plan of care. A service provider will identify and refer the child/youth to the IPC process and then bring together a team of service providers from different organizations and agencies. One member of the service provider team is identified as the Lead and will be the central point of contact for the child/youth and their family/ supporters. The Lead also guides the implementation of the plan of care.

What is the role of Children/ Youth in the Integrated Plan of Care process?

The child/youth plays a central part in the IPC process. The child/youth can take a lead role in creating their plan of care, with the support of their service provider team and family /supporters. The child/youth consent to the plan of care and decide which service provider will take a lead role in implementing it.

What is the role of Family/ Supporters in the Integrated Plan of Care process?

The families/supporters can act as valuable partners in the IPC process. They play a key role in supporting the child/youth to communicate their vision and goals for their plan of care. They may also be actively involved in some of these goals. Family/supporters can also be responsible for giving consent if the child/youth is unable.

What are the steps involved in the Integrated Plan of Care process?

Step One

A service provider suggests the IPC process when current services are not able to meet the child/youth's needs. The child/youth and their family will be asked to name any service providers who should be included in their care team.

Step Two

The service provider will make the referral to Coordinated Access with the youth or family's consent. The child/youth and family will be invited to present at Coordinated Access.

Step Three

If the criteria is met, a team of providers from different agencies/ organizations is brought together for a meeting with the child/youth and their family to create a holistic plan of care.

Step Four

Ongoing meetings and updates to the plan and the team may occur to support the child/youth in reaching their goals.

APPENDIX G: IPC process consent form

Ottawa Service Collaborative

Consent for Information Sharing and Participation in the Integrated Plan of Care Process

Child or Youth's Name	Date of Birth

I am providing consent for:

- ☐ Me
- ☐ My child
- ☐ My child and family
- ☐ The child for whom I am a Guardian

I have been given information on the Integrated Plan of Care process and understand that my Integrated Care Team is a partnership between myself, family members and/or supporters I identify and the following organizations:

- ☐ Centre psychosocial
- ☐ Children's Aid Society of Ottawa
- ☐ Children's Hospital of Eastern Ontario
- ☐ Community Care Access Centre
- ☐ Conseil des écoles catholiques du Centre-Est
- ☐ Conseil des écoles publiques de l'Est de l'Ontario
- ☐ Crossroads Children's Centre
- ☐ Family Services Ottawa
- ☐ Maison Fraternité
- ☐ Ottawa Carleton District School Board
- ☐ Ottawa Catholic School Board
- ☐ Ottawa Children's Access and Referral to Services
- ☐ Ottawa Inuit Children's Centre
- ☐ Parents' Lifelines of Eastern Ontario
- ☐ Rideauwood Addiction and Family Services
- ☐ Roberts Smart Centre
- ☐ Royal Ottawa Mental Health Centre
- ☐ St. Mary's Home
- ☐ Wabano Centre for Aboriginal Health
- ☐ Youth Services Bureau
- ☐ youturn Youth Support Services
- ☐ Other agencies for which you are providing consent to participate: specify _____

I understand that my/my child's personal information will be collected, shared, recorded and used by my Integrated Care Team in order to have the information they need to offer services that best meet my/my child's needs and my identified goals, and for the following purposes:

1. To plan, monitor and review services to be provided;
2. To assess my/our strengths and needs in order to develop an integrated plan of care to be provided by the agencies and organizations that make up my Integrated Care Team and who require access to my personal information;
3. To allow my Integrated Care Team to provide health, mental health, addictions, education, and social services, as directed by me

I understand that I have the right to put limitations on the information that is shared about me. I choose to make the following limitations:

Agency/Organization	Limitations

I have had the opportunity to discuss the Integrated Plan of Care process and the alternatives to this process. I understand that my/my child's participation in the Integrated Plan of Care process is voluntary and my/my child's continued involvement is based on my consent.

Ottawa Service Collaborative

Consent for Information Sharing and Participation in the Integrated Plan of Care Process

The principles of confidentiality apply to any of my/my child's information that is shared amongst the Integrated Care Team members. I understand that the Integrated Care Team will not willingly disclose any confidential information it obtains about me/my child without my consent.

I understand that there are three circumstances that would require reporting of information without my consent:

- If a service provider was told that someone is planning to seriously harm someone
- If a service provider believes that a child under the age of 16 is at risk of harm
- If there is a court case and the judge demands it, the service provider must release the file to the judge who will decide if any of the information is relevant to the trial.

I understand that this consent is also for the purposes of collecting information for the evaluation of the Integrated Plan of Care process to help understand the factors involving coordination of care and to improve services. The information collected will remain confidential, will be coded and I will not be identified by name. My consent means that I agree to allow information about me/my child, which does not identify me/my child by name, to be included in this evaluation. My/my child's name and/or family/supporters will not be associated in any way with the results of the evaluation. I understand that not consenting to participating in the evaluation will in no way impact the services I will be receiving.

I understand that I can withhold or place conditions upon my consent. I understand that I may withdraw my consent at any time, by providing written notification to my Integrated Plan of Care process Lead, but the withdrawal of consent shall not have retroactive effect.

I have read and understand the information above. I have been encouraged to raise any concerns that I have, and all my questions have been answered. In signing below, I am consenting to receive services from my Integrated Care Team as part of the Integrated Plan of Care process. I acknowledge that I will receive a completed copy of this form for my records.

This consent remains in effect for a period of not more than one year from the date set out below.

Printed Name: _____ (child/youth)

Signature: _____ Date: (M/D/Y): _____

Printed Name: _____ (parent or guardian)

Signature: _____ Date: (M/D/Y): _____

I have reviewed the above information with the client:

Printed Name: _____

Staff Signature: _____ Date: (M/D/Y): _____

_____

To withdraw consent:

My signature below indicates that I am withdrawing my consent to participate in the Integrated Plan of Care process.

Printed Name: _____ (child/youth)

Signature: _____ Date: (M/D/Y): _____

APPENDIX H: Initial Vision Statement

The client and family's visions are the common framework that all Integrated Team Members use to formulate their goals. This approach creates an integrated, client centered plan that respects the client and family's wishes. The Orientation Meeting assists the client and family to determine the focus of the Integrated Plan of Care for the next 6 to 12 months, based on the identified strengths and needs of the client and family. The client and family are assisted to frame vision statements around this focus and these visions are documented for all Integrated Team members to review.

The Orientation Meeting is conducted by the Integrated Plan of Care Lead who engages in dialogue with the client and family to assist them to develop their visions. Visions are captured in the client and family's words, documented and identified as the client and family's priorities for their child. Visions are documented as follows:

Initial Client and Family Vision # :

APPENDIX I: Service Summary

Having a complete view of all Integrated Care Team members' current work with the client provides everyone with the knowledge they need to build a comprehensive integrated plan of care. A service summary from each service provider should be shared with all Integrated Care Team members and the client and/or family and/or supporter ahead of the IPC Initial Meeting. This prepares everyone at the meeting to focus efforts on working together to write goals vs. updating each other on their own isolated work with the client and family.

The summary should be brief and can be in point form, highlighting key information relevant to integrated goal writing aligned with the client/family's vision.

The Service Summary should include the following information:

- Integrated Care Team Member Name
- Agency/Organization
- Summary of current involvement
- Goals currently working on

Service Summary Template Example:

Service Summary	
Integrated Care Team member:	
Agency or Organization:	
Summary of Current Involvement:	
Goals currently working on:	

APPENDIX J: Team Commitment

All Integrated Care Team members are committed to the guiding principles of the IPC process. This includes promoting inter-agency and inter-professional collaboration within a healthy working environment. The goal is team-informed decision making that strives for consensus and ensures a client-centered approach.

We as the Integrated Care Team commit to the following:

- We will involve the client in a meaningful way that is client-centered and recognizes them as a central decision maker in their own care.
- We will engage the family in a meaningful way that is considerate of supporting families and equipping them with the knowledge required to ensure a better care experience for clients.
- We all take part in deciding how work should be allocated.
- We will help each other learn.
- We will handle disagreements and conflicts constructively.
- We will give constructive criticism to one another and to accept it ourselves.
- We will actively participate in meetings.
- We will make sure that everyone knows what's going on.
- We support each other to outsiders.
- We will discuss collectively any changes related to our own agency involvement being contemplated.
- We will remain flexible and open-minded.
- We will be respectful of skills, knowledge and strengths of other team members.
- We will have open and transparent communication in order to promote trust-building and collaboration.

APPENDIX K: Tips for an Effective Meeting

Phase/Task	Issue/Role	Comment
Teammate	• Determining who is on the team	
Working Out Team Function	• Forming – Exploration of team skills & attitudes • Storming – Working out differences – disputes • Norming – Establishing responsibilities and routines • Performing – Getting the job done	As you become more experienced the time necessary to go through these steps decreases. Recognizing the progression can increase your efficiency.
Exploring & Accepting Teamwork Roles	• Roles: Meeting Recorder – Meeting Visualizer – Analyst – Writer – Facilitator – Leader – Task Tracker	Remember that they can rotate.
Record Keeping	• Documents: Meeting agenda – Meeting Summary and Action Items – IPC	Preparing and using documents effectively can help you greatly.
Meetings	• To be Effective: regular time; everyone comes; end on time; use an agenda; do summary notes and action items; recognize everyone	Make good use of meeting time
Decisions	• Tools: differentiate between major and minor decisions; allow time; use criteria; hear everyone's opinion	Making wise decisions has rules that can help.
Disputes	• Tools: act calmly; classify the dispute; look for compromise	Make them productive, or at least limit their duration and magnitude

Mistakes Teams Have Made:

- Assuming it's "natural" – it isn't. Working at teamwork can make a real difference.
- Assuming someone else will do it – usually they'll assume you're doing it – be explicit.
- Going too fast at the beginning – skipping necessary steps at the beginning will cost time at the end.

APPENDIX L: Integrated Plan of Care Template

Client Name:_____
Date of Birth:_____
IPC Lead:_____

Integrated Plan Of Care

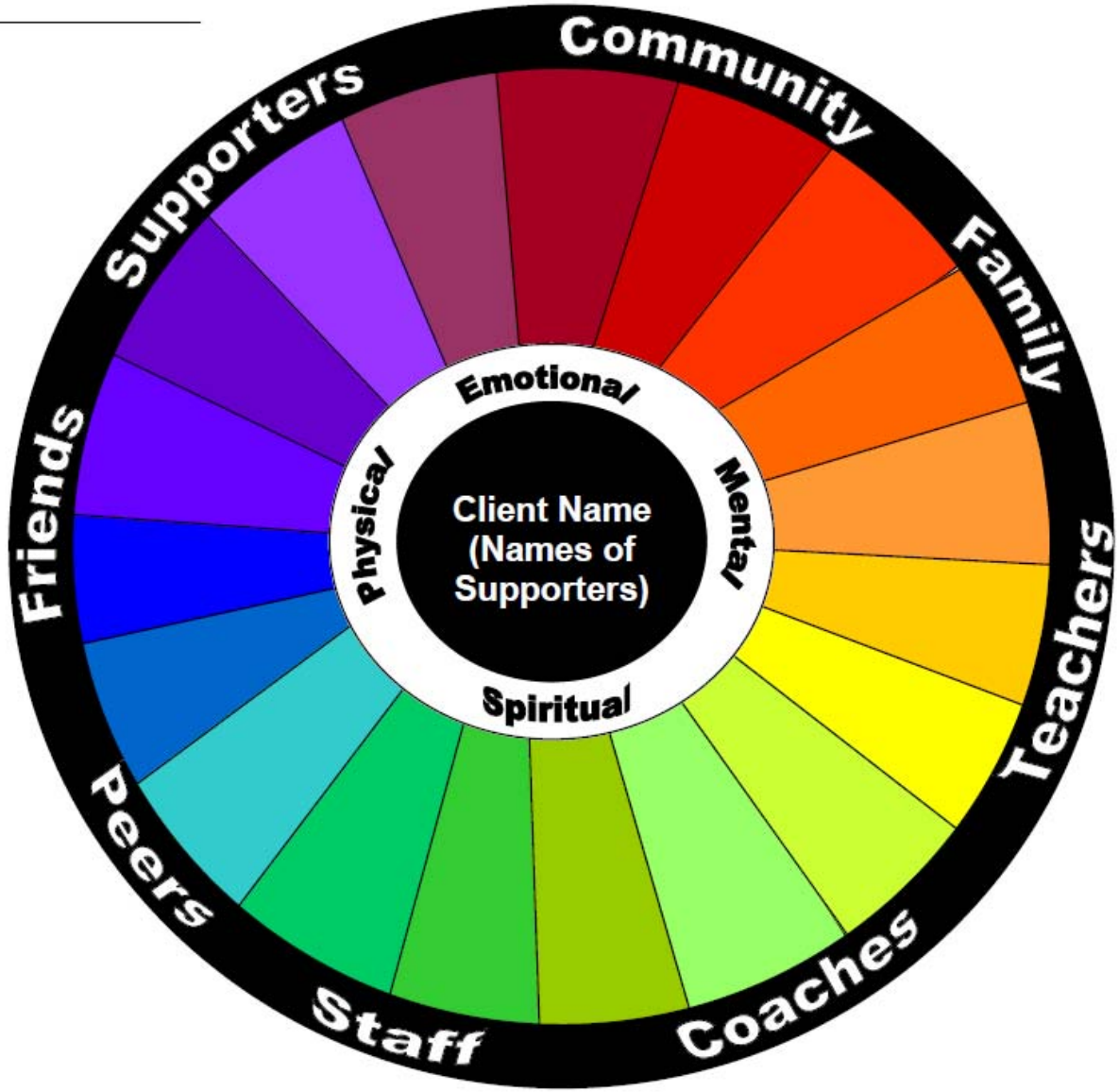
Last Update:_____

Adapted from Ottawa Aboriginal Coalition—Life Cycle Model (2013) & Stroul, B., & Freidman, R. (1986).

Client Name:_____
Date of Birth:_____
IPC Lead:_____

Integrated Plan Of Care

Last Update:_____



Integrated Plan of Care

Guiding/Vision Statement:

Goal:

Supports Needed:

Integrated Care Team Member Roles in Goal Achievement:

Goal:

Supports Needed:

Integrated Care Team Member Roles in Goal Achievement:

Goal:

Supports Needed:

Integrated Care Team Member Roles in Goal Achievement:

Goal:

Supports Needed:

Integrated Care Team Member Roles in Goal Achievement:

Goal:

Supports Needed:

Integrated Care Team Member Roles in Goal Achievement:

Goal:

Supports Needed:

Integrated Care Team Member Roles in Goal Achievement:

Goal:

Supports Needed:

Integrated Care Team Member Roles in Goal Achievement:

Goal:

Supports Needed:

Integrated Care Team Member Roles in Goal Achievement:

APPENDIX M: Crisis Management Strategy

Preparing a Crisis Management Strategy reduces the risk, surprise and short decision time that make crises stressful and worrisome for both the client, family and the Integrated Care Team. Preparation will enable timely action to help respond to the crisis by outlining the coping strategies and supports that clients can use preceding or during a crisis. The Crisis Management Strategy is also meant to help communicate the client's wishes in the event that they are unable to do so.

The Crisis Management Strategy could include the following information:

- Warning signs that the client isn't feeling well (Help the client and family to think about and describe what it means to feel well and unwell in an age appropriate manner.)
- Internal coping strategies (things that the client can do to take their minds off their problems without contacting another person, i.e. relaxation techniques, physical activity, etc.)
- People and social settings that provide distractions to the client
- At what point the client wants support (As soon as warning signs appear, once the symptoms can no longer be managed on their own, etc.)
- Where to go for help or who to contact in the case of an emergency (Discuss what services the client has used before and would utilize again.)
- What treatment options they prefer (Discuss what treatment options they have undergone in the past and would repeat.)
- List of current medication and any allergies
- Contact information of the Integrated Plan of Care Team, nearest emergency department and family or supporters that should be notified

The strategy could also include steps that the client's family or supporters will take to offer support (i.e. calling the Integrated Plan of Care Lead, paying bills if there is an extended hospital stay, looking after any dependants of the client, etc).

The client and family or supporters should review the plan and confirm that it reflects their needs, concerns and wishes. A copy should be given to the client and family or supporters, each member of the Integrated Care Team and placed in each agency/organization client file.

APPENDIX N: Conflict Resolution Pathway for Integrated Care Teams

Conflict is a normal experience and a part of working collaboratively. Most conflict situations are caused by miscommunication or a lack of clear expectations or agreements between team members and/or agencies. Conflict may also emerge when an unforeseen or unexpected situation presents itself to the team. Regardless of how it emerges, conflict provides a "team learning" opportunity to clarify team member roles, responsibilities and expectations when faced with a new challenge. In this view, conflict is viewed as a strength building opportunity for the Integrated Care Team. Below is one suggested process pathway that might assist an Integrated Care Team to better understand and resolve a particular conflict experience.

Step 1: The IPC Lead organizes a team meeting with **all members** of the Integrated Care Team to discuss the conflict situation.

Step 2: The IPC Lead or designated Integrated Care Team member facilitates the team meeting. Key aspects of the meeting are to ensure a safe place for people with different views or experiences, to make the intent of the meeting clear, and to create ground rules for the meeting.

Step 3: The IPC Lead should make a brief presentation to "normalize conflict". The main talking points to communicate are listed:

- Develop an attitude of resolution
- Most conflict is structural in nature (not from bad intention); different needs and lack of clear explicit agreement
    - no matter how good a plan may be at the beginning, conflict will arise because of unforeseen circumstances
- Skills that are useful to engage in a conflict resolution dialogue are
    - basic communications skills (self-awareness, listening, emotional intelligence)
    - desire to embrace principles of "attitude of resolution"
    - knowledge of the conversational steps

Step 4: The IPC Lead facilitates a team dialogue by hearing each IPC team member's personal perspective on the issue related to the conflict. Suggested questions are:

- What is your understanding of what occurred?
- How has this issue affected you?
- How does this issue affect you on the Integrated Care Team?

The IPC Lead encourages the expression of divergent perspectives and views on the issue.

Step 5: The IPC Lead facilitates another round of dialogue, focused on the lessons learned, actions and solutions that can strengthen the Integrated Care Team. Suggested questions are:

- What are the lessons for us as an Integrated Care Team from this experience?

- What do you think should be done about this issue to strengthen our collaboration as an Integrated Care Team?

Step 6: The IPC Lead guides a discussion with the team to solicit the advantages and disadvantages for each of the suggestions proposed.

Step 7: The IPC Lead guides and facilitates the decision making process. Once each solution has been reviewed, the Integrated Care Team selects which option(s) they would like to implement.

In the unlikely event that the Integrated Care Team is unable to arrive at a team-based resolution, each Integrated Care Team member should ***inform their own individual Agency Implementation Lead (AIL)*** *of their current inability to resolve the conflict at hand. Once all AILs have been informed, they will convene a meeting in order to identify some constructive recommendations to enable and assist the Integrated Care Team to overcome the challenges.*

Step 8: The IPC Lead solicits feedback from each team member regarding their perception of the conflict resolution meeting and their degree of satisfaction that the issue is resolved.

APPENDIX O: Perception of Care Measure - Initial

Client identifier: _____

Completing this questionnaire is important to the evaluation of the IPC process. There are no right or wrong answers. We are interested in your thoughts and experiences within the IPC process. Please answer the following questions based on **your experience in the IPC process**. Indicate if you **Strongly Disagree, Disagree, Agree,** or **Strongly Agree** with each of the statements below. If the question is about something you have not experienced, fill in the circle for **Not Applicable** to indicate that this item does not apply. Your answers are confidential and will not influence current or future services you will receive. Some of the questions are very personal. We appreciate your completion of them. Please answer each question honestly and accurately.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable	Comments
1. I actively participated in the Coordinated Access process to the level that I was comfortable with.	1	2	3	4	NA	
2. I was involved in the selection of the IPC team.	1	2	3	4	NA	
3. I chose the IPC lead.	1	2	3	4	NA	
4. My cultural values were respected by the IPC team.	1	2	3	4	NA	
5. My linguistic needs were respected by the IPC team.	1	2	3	4	NA	
6. The IPC team worked well together.	1	2	3	4	NA	
7. The IPC team met often enough to provide appropriate support.	1	2	3	4	NA	
8. I was able to choose the IPC Plan of Care goals.	1	2	3	4	NA	
9. I have made progress achieving the set goals.	1	2	3	4	NA	
10. The IPC team encourages me to have hope.	1	2	3	4	NA	
11. The IPC process has been more beneficial than my usual treatment planning.	1	2	3	4	NA	

12. Were there any agencies who should have been involved that were not? Yes □ No □

If yes, who was missing? _____

13. Is there anything else you would like to share about your experience in the IPC process?

14. Please indicate how you are participating in the IPC process:
    - ☐ as the primary client OR
    - ☐ as a family member or supporter.

    a. If you are the primary client, please respond to the following question:

In general, would you say your health is:	**excellent**	**very good**	**good**	**fair**	**poor**	**Comments**
	1	2	3	4	5	

    b. If you are a family member or supporter, please respond to the following question:

In general, would you say your child's health is:	**excellent**	**very good**	**good**	**fair**	**poor**	**Comments**
	1	2	3	4	5	

APPENDIX P: Perception of care measure – Ongoing

Client identifier: _____

Completing this questionnaire is important to the evaluation of the IPC process. There are no right or wrong answers. We are interested in your thoughts and experiences within the IPC process. Please answer the following questions based on **your experience in the IPC process**. Indicate if you **Strongly Disagree, Disagree, Agree,** or **Strongly Agree** with each of the statements below. If the question is about something you have not experienced, fill in the circle for **Not Applicable** to indicate that this item does not apply. Your answers are confidential and will not influence current or future services you will receive. Some of the questions are very personal. We appreciate your completion of them. Please answer each question honestly and accurately.

	Strongly Disagree	**Disagree**	**Agree**	**Strongly Agree**	**Not applicable**	**Comments**
1. My cultural values were respected by the IPC team.	1	2	3	4	NA	
2. My linguistic needs were respected by the IPC team.	1	2	3	4	NA	
3. The IPC team worked well together.	1	2	3	4	NA	
4. The IPC team met often enough to provide appropriate support.	1	2	3	4	NA	
5. I have made progress achieving the set goals.	1	2	3	4	NA	
6. The IPC team encourages me to have hope.	1	2	3	4	NA	

7. Were there any agencies who should have been involved that were not? Yes □ No □

If yes, who was missing? _____

8. Is there anything else you would like to share about your experience in the IPC process?

9. Please indicate how you are participating in the IPC process:
   - ☐ as the primary client OR
   - ☐ as a family member or supporter.

   a. If you are the primary client, please respond to the following question:

In general, would you say your health is:	**excellent**	**very good**	**good**	**fair**	**poor**	**Comments**
	1	2	3	4	5	

   b. If you are a family member or supporter, please respond to the following question:

In general, would you say your child's health is:	**excellent**	**very good**	**good**	**fair**	**poor**	**Comments**
	1	2	3	4	5	

APPENDIX Q: Fidelity Checklists for Service Providers

Client identifier: _____

Identification Fidelity Checklist			
Action Item:	**Completion Date:**	**Comments (including challenges, improvements, and successes):**	**Outcome Questions:**
Identify a need for IPC process			
Review IPC Criteria			
Ask First Nations, Inuit and Métis identifying questions			If the child/youth/family self-identifies as aboriginal, which cultural group did they indicate? ❑ First Nations - Community: o Cree o Algonquin o Mohawk o Mi'kmaq o Ojibway o Other (please specify): _____ ❑ Métis - Community: _____ ❑ Inuit: Region/Community: _____ 1. Other (please specify): _____ 2. was a referral to the Aboriginal Integrated Plan of Care process made? Yes □ No □
Ask Francophone identifying questions			If the child/youth/family self-identifies as Francophone, was an active offer made to continue the process in the cultural and linguistic services of their choice? Yes □ No □ What was the outcome?

Identification Fidelity Checklist

Action Item:	Completion Date:	Comments (including challenges, improvements, and successes):	Outcome Questions:
Connect with Agency Implementation Lead			
Seek Informed Consent			
Connect with potential Integrated Care Team members (through Agency Implementation Leads)			Which agencies were contacted to participate as members of the Integrated Care Team?
Receive agreement from service providers to participate as Integrated Care Team members			
Identify potential IPC Leads			Please list the potential IPC leads that were identified: _____ _____
Complete IPC-CANS			Did the youth/family have an opportunity to provide feedback and make changes to the IPC-CANS before its submission to Coordinated Access? Yes □ No □
Connect with AIL to determine whether or not to proceed with application			

Referring Service Provider Name: Email: Date Checklist Completed:	Total Estimated Hours:
Agency Implementation Lead Name: Email:	Total Estimated Hours:
Potential Integrated Care Team members:	

Name: Organization: Email: Name: Organization: Email: Name: Organization: Email:

Client identifier: _____

Selection and Criteria Approval Fidelity Checklist

Action Item:	Completion Date:	Comments (including challenges, improvements, and successes):	Outcome Questions:
Complete CA application forms			
Submits IPC-CANS and Coordinated Access application form to Mental Health Committee at Coordinated Access			
Client and family is supported and encouraged to actively participate in CA process			What role did the child/youth and/or family have in the Coordinated Access presentation?
Referring Service Provider follows up with the client and family once decision is made			
Determine Integrated Plan of Care Lead with child/youth/ family			Who did the child, youth, and family choose for the IPC Lead? Who is the back-up IPC Lead?

Referring Service Provider Name: Email: Date Checklist Completed:	Total Estimated Hours:
Agency Implementation Lead Name: Email:	Total Estimated Hours:

Client identifier: _____

Orientation Meeting Fidelity Checklist			
Action Item:	**Completion Date:**	**Comments (including challenges, improvements, and successes):**	**Outcome Questions:**
Organize Orientation meeting			What is the date of the Orientation meeting?
Vision statement is developed and documented			
IPC initial meeting is discussed			

IPC Lead Name: Email: Date Checklist Completed:	Total Estimated Hours:
Agency Implementation Lead Name: Email:	Total Estimated Hours:

Client identifier: _____

IPC Initial Planning Meetings Fidelity Checklist			
Action Item:	**Completion Date:**	**Comments (including challenges, improvements, and successes):**	**Outcome Questions:**
Organize IPC initial team meeting			What is the date of the Initial Team meeting? Did the client and/or family attend the first portion of the meeting? Yes □ No □
Service Summaries are distributed			Did all Integrated Care Team members complete service summaries? Yes □ No □ If no, which summaries were missing? _____
IPC template is completed			How many meetings did it take to complete the IPC template?
Crisis management strategy is developed			How many meetings did it take to complete the crisis management strategy?
Team Commitment was reviewed			
Tips for an Effective Meeting document was reviewed			
Conflict Resolution Pathways document was reviewed			
Meeting frequency, progress checks and ongoing communication is established			What is the meeting frequency for this client? How was it established?

IPC Lead Name:	Total Estimated Hours:

Email: Date Checklist Completed:	
Agency Implementation Lead Name: Email:	Total Estimated Hours:
Integrated Care Team members (if different from Identification stage) Name: Organization: Email: Name: Organization: Email: Name: Organization: Email: Name: Organization: Email: Name: Organization: Email: Name: Organization: Email: Name: Organization: Email:	

Client identifier: _____

IPC Ongoing Meetings Fidelity Checklist			
Action Item:	**Completion Date:**	**Comments (including challenges, improvements, and successes):**	**Outcome Questions:**
Identify if the IPC needs to be revised if an Integrated Care Team member identifies a need			How many meetings occurred this month? Who called these meetings?
Review and monitor progress toward the vision and the goals outlined in the IPC			Was the IPC revised? Yes □ No □
Assess if changes to Integrated Care Team are necessary			Did any changes to the Integrated Care Team take place? Yes □ No □ If yes, what was the reason?
Client and/or family completes the Perception of Care measure (at 1st meeting and 6 month intervals)			
Review IPC-CANS, every 6 months after initial completion			

IPC Lead Name: Email: Date Checklist Completed:	Total Estimated Hours:
Agency Implementation Lead Name: Email:	Total Estimated Hours:
New Integrated Care Team members Name:	

Organization:
Email:

Name:
Organization:
Email:

Leaving Integrated Care Team members
Name:
Organization:
Email:

Name:
Organization:
Email: