Community Network of Specialized Care Toronto Region

A review of the refreshed mandate

Human Services and Justice Coordinating Committee

November 6, 2018

Presentation Agenda

CNSC Refreshed Mandate

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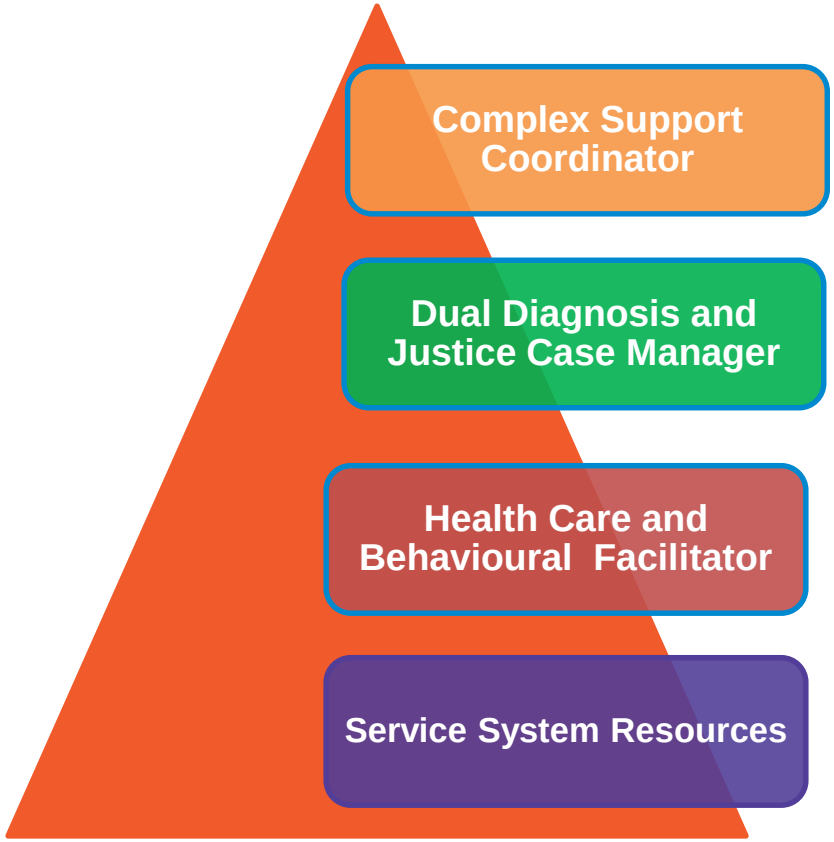
Community Networks of Specialized Care
Refreshed Mandate

Mandate

To serve adults with developmental disabilities with complex and multiple needs by:

- Coordinating support and service within and across sectors, by providing complex support coordination for individuals;
- Acting as a resource to service agencies, Developmental Services Ontario and local planning tables (including urgent response and service solutions / case resolution);
- Building system capacity to better support individuals with complex needs through education, mentorship and support to other case managers and service agencies; and
- Providing provincial coordination of videoconferencing and French Language specialized resources.

Key Functions & Roles



☑ CNSCs will…	⌦ CNSCs won't…
• Be responsible for coordinating support and service for adults with developmental disabilities and **complex and multiple** needs. • Be responsible for **building capacity** through education, mentorship and support to other case managers and service agencies. • Be responsible for overseeing coordination and delivery of the four functions. • Promote and reinforce service integration (e.g. linkages between justice and health). • Promote provincial consistency, and address the Ombudsman's recommendations, by improving access to complex support coordination.	• **Assume responsibility for all case management**. • Be responsible for delivering the services and supports that people with developmental disabilities with complex and multiple needs require (e.g. residential services; Urgent response; specialized services). • Impact funding for service agencies currently providing complex support coordination.

Target Population:
Definition: High Support & Complex Care Needs

- **Extraordinary medical and/or behavioural support needs**: determined by scores on SIS sections 3A (medical; scores of 7 or greater) and 3B (behavioural; scores of 10 or greater); and

- **High overall support needs**: individuals with overall SIS percentiles of greater than 70%; and

- **Safety concerns:** the caregiver has concerns about the individual's safety because of his/her medical and/or behavioural support needs (ADSS s6.3 and 6.5); and

- **Overnight supports:** individuals with exceptional medical supports also require overnight supports.

Target Population:
Reasonable Grounds

Reasonable Grounds criteria may apply to individuals who have not yet completed the DS Application Package where they are identified by the DSO as being eligible.

A person may be accepted with **Reasonable Grounds** if:

SIS SCORE:

- The person does not have a SIS completed
- The SIS assessment/score is dated
- The SIS score does not reflect the person's current needs (complex but SIS does not reflect this)
- The SIS does not present enough information

NEEDS:

- Multiple partners are involved in the person's support
- There are complex systemic considerations for the person
- There is no agency or case management involvement
- The Network is able to walk alongside (i.e. conduct the orchestra) or is able to stay involved until the person's needs are met or decrease

Service Pathway:

- Referrals to the CNSC Toronto services will be made through the DSO TR
- Referrals to the DDJCM can be made directly to the DDJCM as well as to the DSO
- Individuals, care providers, service agencies can contact the DSO to identify and determine the support pathway
- Individuals may access multiple paths concurrently (e.g., Urgent Response, CNSC, Specialized supports)

Complex Support Coordination:

Leading, developing, facilitating and coordinating, a person-centred approach:

The

- With existing Case Managers who request supports
- When there is other sector case management
- When there is no current capacity for case management
  - Transition planning across sectors (health/justice/mental health) including case resolution
  - Facilitating access to specialized resources (e.g.. Psychiatric, behavioural, etc.) and Specialized accommodations

When to refer: The complexities are not within your capacity-i.e. there is a need to engage multi-sectors, it is more time then you are mandated to offer, support needed to lead multi sector/multi level meetings, the complex situation would benefit from co-case coordination due to the complexities.

Health Care Facilitator:

Capacity building and bridging within and between systems:

- For DS agencies
- For Health Care services (primary, community, hospitals, LTC)
- For caregivers
  - Developing and implementing resources and tools, such as the Primary Care Guidelines.
  - Identify specialized training needs and gaps
  - Provide information regarding community health care systems.
  - Facilitate and/or complete referrals and linkages to appropriate medical resources and social services.

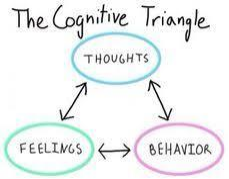
When to refer: difficulties engaging the health sector, medical complexities, the medical complexities are a barrier to service, a health needs falls under the Regulated Health Professions Act-i.e. G-tube, Tracheotomy, etc.

Dual Diagnosis and Justice Case Manager:

Work collaboratively and support court diversion for people with developmental disabilities and/or dual diagnosis:

- With DS agencies and community partners
- With court support workers, discharge planners, mental health services, local correctional and custody facilities
  - Be a central point of contact
  - Coordinate a continuum of services to plan appropriate discharges and maintain community engagement
  - Refer to mental health services and other supports

When to refer: Justice or risk of Justice involvement-incarcerated, probation, bail, police involvement, etc. Does not have to eligible but must be found eligible within 6 months. Does not need to meet the complex criteria so can be refrred directly.



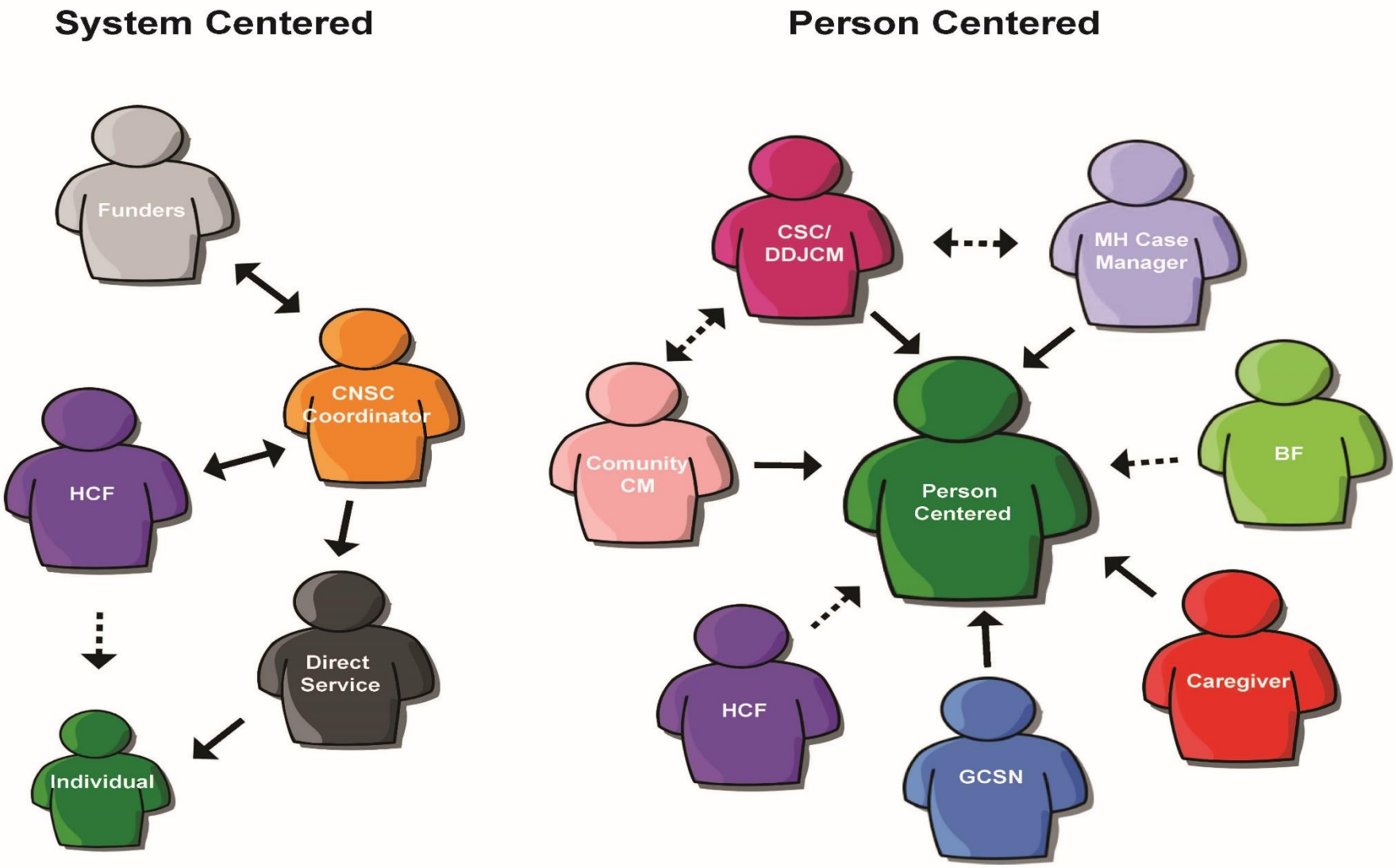
Behaviour Facilitator:

Identifying and supporting changes for transitions, environments and interactions that enhance challenging situations:

- Create Safety Plans and provide training to families, care providers and community partners to enable improved safety;
- Provide support in implementation of existing behavioural plans in new environments (e.g., hospitals, new housing, shelters)
- Create changes in existing behavioural plans to adapt to new situations
- Have BCBA certification or equivalent experience

When to refer: there is a need for a safety plan, review current behavioural plan, when it is not clear if there is a need for long term BT supports, when the behaviours are a barrier to services.

Shifting to Improved Consistency in Planning Functions



Questions