# Program Guidelines for the Integrated Delivery of Rehabilitation Services

## Ontario's Special Needs Strategy for Children and Youth

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**Ministry of Children and Youth Services**

Ontario

## ACKNOWLEDGEMENTS

These guidelines were developed in consultation with the Integrated Delivery of Rehabilitation Services (IR) Program Guidelines Advisory Committee (PGAC). Committee members included regulated health professionals in speech-language pathology (S-LP), occupational therapy (OT), and physiotherapy (PT), individuals with clinical expertise and experience providing rehabilitation services to children and youth in Ontario, as well as those with system management and leadership expertise. Representatives from the Ministries of Children and Youth Services (MCYS), Education (EDU), Health and Long-Term Care (MOHLTC), and Community and Social Services (MCSS) were also included.

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## EXECUTIVE SUMMARY

As part of the Special Needs Strategy, the Integrated Delivery of Rehabilitation Services (IR) will support children and youth with special needs to receive efficient, seamless, and continuous speech-language pathology (S-LP), occupational therapy (OT), and physiotherapy (PT) services from birth through to the end of school. The purpose of these Program Guidelines is to set out the provincial expectations as well as direction on the minimum standards associated with the core service requirements for IR. This document will serve as a foundation for supporting local planning, implementation, and program delivery of IR for all agencies and school boards receiving funding for and involved in serving children and youth with S-LP, OT, and PT service needs.

These Program Guidelines are organized into three parts. Part one provides a high-level overview of IR, including the guiding principles, vision, goals, objectives, and service delivery approach. Part two includes a detailed breakdown of each component of the service pathway, including access, referral, intake, assessment, intervention planning, intervention delivery and service transition. Part three outlines the oversight and accountability activities required to support the service pathway, including roles and responsibilities, public awareness, wait management, and performance monitoring and reporting. The Program Guidelines conclude with a list of the core service requirements for IR in Appendix A.

A summary of the expectations highlighted in parts two and three of the Program Guidelines is presented below. Detailed explanations of the concepts are described in the corresponding sections of the guidelines.

**2A. Access**

- Families and youth will be able to access information about IR supports and services in their local communities through multiple access points and through a variety of means.
- Access to IR support and services, including universal services, will focus on capacity-building of parents[i]/families, educators[ii] and/or community partners to support children's development.

**2B. Referral**

- Children and youth from birth to end of school will enter the system for S-LP, PT, and/or OT based on parent/self-referral or professional referral with parent consent.
- Parents and youth can self-refer for IR services through the toll-free phone number, electronically, or in-person through any partner[iii] agency door.

[i] *Parents* is used throughout this document to refer to parent(s), caregiver(s), and/or guardian(s).
[ii] The term e*ducator* is used throughout this document to refer to professionals working in schools and include both pre-school and school-aged educators as well as education support staff
[iii] *Partner agencies* include service provider agencies with professionals that provide services for children and youth with special needs

**2C. Intake**

- Common intake processes that include mechanisms for obtaining consent, and collection of relevant information will be completed using a variety of means.
- Information-sharing mechanisms between the members of the child's team of service providers, educators and other professionals will be established to facilitate communication and collaboration, with consent as necessary.

**2D. Assessment**

- Age-appropriate and evidence-informed assessment tools and procedures within the child's[iv] natural context of participation will be used to determine level of need, intervention approaches and service locations.
- Where appropriate, the strengths and needs of the child as identified through assessment by a rehabilitation service provider will inform the child's Individual Education Plan (IEP).
- When there is more than one rehabilitation provider, and with appropriate consent, providers will work together to ensure they are integrating practice and service delivery for children, families and youth.
- With consent of the family, families will be connected to the appropriate community agency and services, such as Coordinated Service Planning (CSP), through a 'warm referral' process[v].

**2E. Intervention Planning**

- A service plan is completed with the family and shared amongst providers as per consent.
- Using appropriate evidence-informed tools, and recommended interventions based on common clinical pathway(s), the service plan will outline specific, measurable, achievable, realistic, and time-limited (SMART) goals.
- Evidence-informed pathways will be developed or adapted to guide consistent decisions regarding service levels.

**2F. Intervention Delivery**

- A broad range of interventions within a tiered service delivery framework will be implemented, providing a continuum of services based on functional needs.
- S-LP service providers will serve all school-aged children in their schools, providing both speech and language supports and/or interventions, as appropriate.
- Service delivery location will be determined based on the natural environment of a child that best supports his or her plan/goals developed in collaboration with the family/parent and services will be provided as close to home or in a location as convenient as possible for families.

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[iv] *Child/children* is used throughout this document to refer to child/children and/or youth.

[v] 'Warm referral' is a process by which information that may have already been collected from families is transferred directly to the appropriate receiving agencies they are being referred to so that the family does not need to repeat their story.

**2G. Service Transition**

- Service provider partners will work together to ensure an appropriate and family-centred transition.
- Where possible and applicable, protocols relevant to each transition point will be developed, articulated and implemented (e.g., in a Memoranda of Understanding (MOU)) between service provider partners.

**3A. Roles and Responsibilities**

- A designated steering committee will be established in each Service Delivery Area (SDA) to provide oversight of SDA activities, including implementation.
- A Community of Practice will be established in each SDA to monitor children's outcomes, as well as review and disseminate evidence-informed practices, outcomes, family-centred service, and communication.

**3B. Public Awareness and Communication Plans**

- A comprehensive communication plan with associated strategies to inform families/community partners about a "no-wrong-door" approach and access to a tiered service delivery approach will be developed.
- Both the phone number and website address will be widely promoted to the public as well as throughout the children's services sector.

**3C. Wait Management**

- A consistent wait management approach that measures, monitors, manages and mitigates wait times will be implemented to support consistent, transparent and more timely access to services.
- The wait management approach will include implementation of a tiered service delivery framework, use of standardized wait time definitions and benchmarks, sharing of wait status information with families, and development of local waitlist prioritization strategies.

**3D. Performance Monitoring and Reporting**

- Measuring the outcomes and impact of IR will be an iterative, multi-year process focused on (1) foundational data elements and (2) performance outcome measures.
- Foundational data elements related to client profile, utilization, wait times and family centredness of service provision will be collected regularly by SDAs as implementation progresses.
- Performance outcome indicators in the areas of access, quality and value are in development and will serve as longer term measures of the impact of IR.
- Ongoing work on the development of performance outcome indicators, informed by advice and feedback from the Program Guidelines Advisory Committee and other experts, will continue through 2016 and 2017.

## PART 1: OVERVIEW

As part of the Special Needs Strategy, the Integrated Delivery of Rehabilitation Services (IR) will support children and youth with special needs to receive efficient, seamless, and continuous speech-language pathology (S-LP), occupational therapy (OT), and physiotherapy (PT) services from birth through to the end of school. This marks the beginning of a transformative process that is focused on family-centred care and embeds a holistic view of the child so that the service pathway is experienced by families as a single, seamless delivery of service from birth to end of school.

## 1A. INTRODUCTION AND OVERVIEW

These Program Guidelines will support implementation of the core service requirements for IR and build on the direction originally articulated in the *Integrated Delivery of Rehabilitation Services: Guidelines for Children's Community Agencies, Health Service Providers and District School Boards* (September 2014).[1] The purpose of these Program Guidelines is to set out the provincial expectations and provide direction regarding the minimum standards associated with the provision of IR as one single seamless program for children and youth with special needs. The core service requirements used as the basis of this document are listed in Appendix A.

These Program Guidelines will be used by all agencies and school boards providing services and/or programs to children and youth with rehabilitation service needs to guide local planning and program delivery. These Program Guidelines will also be used to support accountability and reporting of program delivery outcome measures and performance indicators.

### Background and Rationale

Literature on developmental health trajectories demonstrates that early detection of risks and challenges, and timely support of children, youth and families, lays a critical foundation for healthy development and improves long-term outcomes across the lifespan.[2,3] These studies recognize the need for early identification, service delivery, and provision of resources and support for children showing signs of developmental concerns to eliminate or reduce the likelihood of poor developmental outcomes or minimize adverse childhood experiences. A delay in one or more domains of development can have significant long-term effects on their functional behaviour and skills. [4] For instance, when children have delayed language and/or phonological development that is not resolved by kindergarten entry, they are much more likely to be at risk for language learning delay and subsequent academic challenges than their peers.[5]

The Children's Therapy Initiative, which began in 2002, improved the coordination of children's therapy services across Manitoba for S-LP, OT, PT and audiology for children from birth to 21 years of age.[6] Other transformative initiatives such as Ready, Willing and

Able (RWA), which aimed to increase the employment rate of people with intellectual disabilities, have also demonstrated positive impacts from connecting discrete, local initiatives to a broader integrated and multi-sectoral strategy.[7]

Evaluations of recent Ontario initiatives have shown positive service delivery outcomes as a result of integrating rehabilitation services.[8] In addition to increases in parent[vi] and family satisfaction, evaluations of speech and language demonstration sites showed that wait times were shortened through streamlined intake processes and that more children were served through a more flexible delivery model.[9] Integrated Full-Day Kindergarten Children's Treatment Centre (CTC) pilots showed improvements in capacity and collaboration among service providers and educators, as well as improved access to services for children who would otherwise not have received therapy.[10] Results from implementing the Partnering for Change model of service delivery in Ontario showed that implementing tiered integrated school-based OT-intervention models have the potential to reach more children and build capacity of educators and families to better manage children's needs.[11]

The Special Needs Strategy responds to the need for families to have easier access to services that are more timely and effective, and a seamless service experience. Results from these initiatives suggest that integrating the delivery of rehabilitation services will:

- Improve service access for children, youth and their families;
- Reduce unnecessary duplication of assessments;
- Reduce fragmentation of services; and
- Improve service continuity for children and their families, as children enter school.

Such a system takes a holistic view of the child[vii] and will not only improve outcomes for children and youth with special needs, but reorient services to prevent further developmental concerns while optimizing their development and participation in daily activities.[12] In light of this, rehabilitation services, supports and resources will be provided as early as possible to optimize children's health and developmental capacity for life.

[vi] *Parents* is used throughout this document to refer to parent(s), caregiver(s), and/or guardian(s).
[vii] *Child* is used throughout this document to refer to child and/or youth.

## 1B. GUIDING PRINCIPLES, VISION, GOALS, AND OBJECTIVES

### Guiding Principles


1. Guided by family-centred care, IR is shaped around families, schools and service providers working collaboratively as a team to make informed decisions about the services and supports the child and family receive.[13] Family-centred care recognizes that each family is unique; that the family is the constant in the child's life; and that they are the experts on the child's abilities and needs.[14]

2. Seamless services will be delivered to children and youth in their natural context of participation (e.g., child care settings, schools, community centres, homes). Seamless service delivery means a continuous and unbroken service experience for the child and his or her family as long as they require service. Seamless service delivery involves continuity of supports, information and intervention over time and across transition points such that services are being delivered as one single program.[15]

3. There is a "no-wrong-door" approach to access services. Families can enter the system through any service provider and be connected with the appropriate rehabilitation service providers in the community, regardless of which door they enter the system. Families will also be connected to other community supports and services as appropriate to promote healthy child development and early intervention (e.g., CSP, developmental surveillance process[viii]).

4. Capacity-building for both families and service providers that incorporates evidence-based developmental strategies is an essential component of IR services. Supports and education provided to parents, educators, and regulated health professionals in the community will align with educational goals, and optimize parent engagement.

5. Services will be evidence-informed and based on best practices of regulated health professionals such as those developed through the local Full-Day Kindergarten CTC Pilot and Partnering for Change initiatives.[16,17]

6. Services are rooted in a developmental approach to optimize child outcomes.[18] There will be an integrated and holistic system for S-LP, PT, and OT services based on a child's functional need, regardless of diagnosis, to enhance function and participation of children in their natural context of participation in everyday activities.[19]

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[viii] As a component of the Special Needs Strategy that is in development, *developmental surveillance* is defined as a flexible, continuous process whereby parents in collaboration with early years' service providers perform skilled observations of children in multiple settings (e.g., childcare centres and local early years community programs).

**Program Scope**

For the purpose of IR under the Special Needs Strategy, rehabilitation services in scope include S-LP, OT, and PT provided by and/or supervised by speech-language pathologists (S-LPs), occupational therapists (OTs), and physiotherapists (PTs). S-LPs, OTs and PTS are governed under the *Regulated Health Professions Act*, *1991* (RHPA) and their individual health profession Acts (Acts) and work within scopes of practice defined under those Acts. As regulated health professionals, S-LPs, OTs, and PTs should consult with their respective colleges for rehabilitation discipline-specific legislation, regulations, practices and accreditation standards.

S-LP, OT and PT services considered out of scope for the purpose of these guidelines include those provided by Community Care Access Centres to homeschooled and private school students, as well as those provided by Community Care Access Centres in children's homes.

**Vision**

An Ontario where children and youth with special needs, and their families, get the timely and effective services they need to participate fully at home, at school, and in the community, as they prepare to achieve their goals for adulthood.

**Goals**

The four goals for IR are as follows:

1. Families have easier access to services and know how to get help;
2. Families receive more timely and effective services;
3. Families experience seamless and integrated service delivery that is continuous throughout the calendar year; and
4. The service system is accountable, efficient and provincially consistent.

Core service requirements have been defined for IR as outlined in Appendix A.

**Objectives**

Rehabilitation services will be:

1. Experienced by children, youth and their families as a single, seamless program;
2. Easily accessible;
3. Delivered collaboratively with educators in the school setting for school-aged children and youth whenever possible, in the context of the child's natural context of participation in everyday activities according to the needs of the child and in convenient locations for families;
4. Available as a range of high quality interventions, based on evidence-informed practices and the expertise of regulated health professionals;

5. Sensitive and responsive to the needs and strengths of individual children and youth and their families; and
6. Focused on optimizing child and youth outcomes, including functional capacities across contexts.

**Target Population**

Children and youth from birth to the end of secondary school, herein referred to broadly as "children" with special needs, experience a variety of challenges related to their physical, communication, intellectual, emotional, social and/or behavioural development. They may have needs in only one area of development such as language, or they may have needs across multiple domains.

For the purpose of IR, rehabilitation services include S-LP, OT, and PT only. However, it is recognized that a holistic view of the child encompasses broader social, educational and health systems that include a range of services and/or programs that respond to the range of children's needs.

**Children with Multiple and/or Complex Needs**

Some children with rehabilitation services needs have multiple and/or complex special needs and may benefit from an additional level of support through CSP. These children require multiple specialized services (e.g., rehabilitation services, autism services, developmental services, and/or respite supports) due to the depth and breadth of their needs and are also likely to have ongoing service needs.[20]

## 1C. PROGRAM COMPONENTS AND ACTIVITIES

Integrating the delivery of rehabilitation services consists of the following service delivery components. These components can occur any time from birth to the end of secondary school and interact in dynamic and non-linear ways:

1. **Access** to IR supports and services, including universal services that build the capacity of educators, families and community partners to support children's development. IR supports and services include S-LP, OT, and PT services.
    a. S-LP improves children's communication skills, ability to express their wants and needs, and their understanding and interaction with others.
    b. OT improves the participation of children in everyday activities in the home, child care setting[ix], school and community, including taking care of oneself, engaging in learning activities and acquisition of social skills.
    c. PT improves children's motor development, strength, range of motion, physical endurance, balance, coordination, gait, heart and lung endurance.
2. **Referral** to targeted and individualized interventions for children with special needs.
3. **Intake** to gather information for the child's profile and determine appropriate supports for the child.
4. **Assessment** to identify and plan for a child's individual service needs.
5. **Intervention planning** to develop service goals and a service plan that reflects the child/family needs and strengths.
6. **Intervention delivery** includes a range of intervention types delivered in convenient locations for families.
7. **Service transition** to plan for changes to service provider agencies, rehabilitation service providers and/or service settings, particularly at key transition points (e.g., school entry, school exit, out-of-service).
8. **Oversight and accountability activities** including:
    a. Identification of roles and responsibilities for special needs services,
    b. Development of a comprehensive public awareness and communication plan,
    c. Implementation of a wait management approach, and
    d. Monitoring of performance, outcomes and impact for IR services.

[ix] Licensed child care settings include licensed child care centres and licensed home child care agencies and providers.

## 1D. SERVICE DELIVERY APPROACH

The implementation of a truly integrated model of rehabilitation services requires a paradigm shift from the traditional practice of one-on-one intervention for every child to a continuum of service delivery approaches based on need.[21,22] Models of health promotion that apply evidence-informed supports within a tiered approach have been proven to be effective for OT practices in Ontario.[23] Similar approaches have been implemented in British Columbia.[24] Similar changes to practice have been made in the children's mental health service sector and the PSL program.[25] These approaches have been especially successful in the early years, and shift the focus away from a traditional impairment-focused approach to a development-focused approach to service delivery. [26]

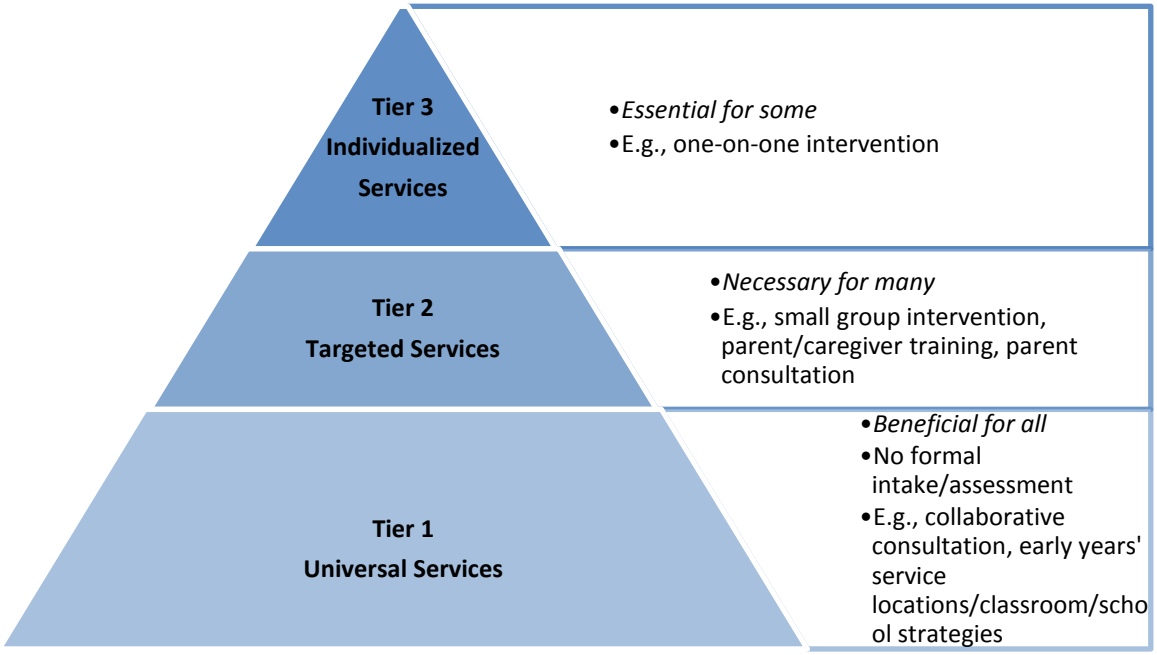
A commonly used preventative model, the Response to Intervention (RTI) process, begins with high-quality instruction and universal interventions supporting parent and educator capacity so that they can implement situationally appropriate strategies with all children in their natural context. Within the RTI approach, children are provided with interventions at increasing levels of intensity to accelerate their rate of functioning and participation in everyday activities.[27] With the implementation of a range of intervention types, outcomes of children who are not meeting developmental milestones can be improved through a systematic method for early identification of children who may require rehabilitation services.[28,29, 30]

A range of intervention approaches will be available for children with special needs, and their families. As the child responds to intervention, different models and types of services/supports need to be available. A range of interventions may include:

- Consultation services provided by rehabilitation service providers in the home, school and/or community settings to parents, educators and/or other service providers to facilitate skill-building techniques that can be used in daily life situations with the child;
- Capacity-building by rehabilitation service providers with groups of parents, educators or service providers to foster growth and development of particular skills in children; and/or
- An individualized program between the rehabilitation service provider and the child, which may be delivered individually or in small groups.

A continuum of service delivery approaches based on functional needs will be implemented, so that children with greater needs receive increasingly intense levels of support. The pyramid illustrated in Figure 1 includes an adaptation of the three tiers of service from both the Partnering for Change and Learning for All models.[31,32]

**Figure 1: Tiered Service Delivery Framework**




### Tier 1 Universal Services

As a foundational element of the tiered service delivery framework, universal services consist of changes to the instructional methods and/or environments that benefit all children in their natural context of participation. These services are designed to provide tips and tools to educators, families, and/or community partners to build their capacity and change practice. No formal intake or assessment of individual children are required.

### Tier 2 Targeted Services

Targeted services are designed to meet the needs of children who require additional support beyond universal services or whose needs require a specific strategy or accommodation. Services may be offered in collaboration with other service providers, service provider partners and families, or wholly by rehabilitation service providers. Formal intake and assessments, with appropriate consent are required.

### Tier 3 Individualized Services

Tier 3 includes individualized services for children who are only able to participate within their natural context with specialized strategies or skill development. These services provide intensive individualized support. Services are outcome-focused, consist of a higher frequency of intervention and involve needs that usually cannot all be addressed in group settings. Formal intake and assessments, with appropriate consent, are required.

Additional details regarding each service delivery level are described in Table 1.

**Table 1: Service Delivery Approach for Rehabilitation Services**

| | Universal | Targeted | Individualized |
|---|---|---|---|
| Target population | All children within a specified context (e.g., school, classroom, early years' service locations) with mild or no rehabilitation needs; or service providers/educators/ parents who need education and/or capacity-building at a universal level | Children who are not meeting developmental milestones who:<br>• Have rehabilitation service needs that can be met in a small group setting, and/or<br>• Do not respond to universal services alone | For children with rehabilitation service needs who:<br>• Have specific time-sensitive needs<br>• Need a rehabilitation service provider to promote specific functional skills in their natural context of participation, and/or<br>• Do not respond to targeted or universal services |
| Description | • Effective strategies and/or environmental modifications that benefit all children<br>• Rehabilitation service provider is available for support and professional /parental learning within the child's natural context<br>• Children at risk may be flagged<br>• No formal intake or assessment is required | • Specific child goals are identified after assessment<br>• Family and child priorities are incorporated into goal-setting process<br>• Established goals are addressed through the use of targeted strategies that are developmentally appropriate and designed to improve the child's functioning<br>• Intervention is goal-specific and presented within a small group setting in context (e.g., a classroom or early learning environment) when appropriate<br>• Rehabilitation service provider is available for support and capacity-building within children's natural context<br>• Rehabilitation service providers work in collaboration with parents or educators/classroom teachers or other service provider partners to determine strategies for targeted instruction and intervention and to establish goals<br>• Consultations/updates are available to families or other professionals as appropriate<br>• Formal intake and assessments, with appropriate consent, will be required | • Individual specific therapy program with at least one identified goal<br>• Regular therapy is provided over a specified period<br>• Adult support and coaching with parents and other service providers are provided to support the child's development of functional capacities across contexts<br>• Formal intake and assessments, with appropriate consent, will be required |
| Intervention types | • Evidence-based strategies and education sessions<br>• Collaborative Consultation | • Parent/Caregiver Training<br>• Small Group Intervention<br>• Dynamic strategies combining assessment and intervention in context | • One-on-one intervention with child, combined with consultation/coaching with parents, educators, etc. |

## PART 2: SERVICE PATHWAY

**Service Requirement #1**: A streamlined service pathway includes: access, referral, intake, assessment, intervention planning, intervention delivery, and service transition (as required).

Children with special needs require S-LP, OT and PT and/or supports to enhance their health, development, and participation in everyday activities in the home, school or in their communities. The service delivery pathway as illustrated in Figure 2 below includes access, referral, intake, assessment, intervention planning, intervention delivery, and service transition (as required).

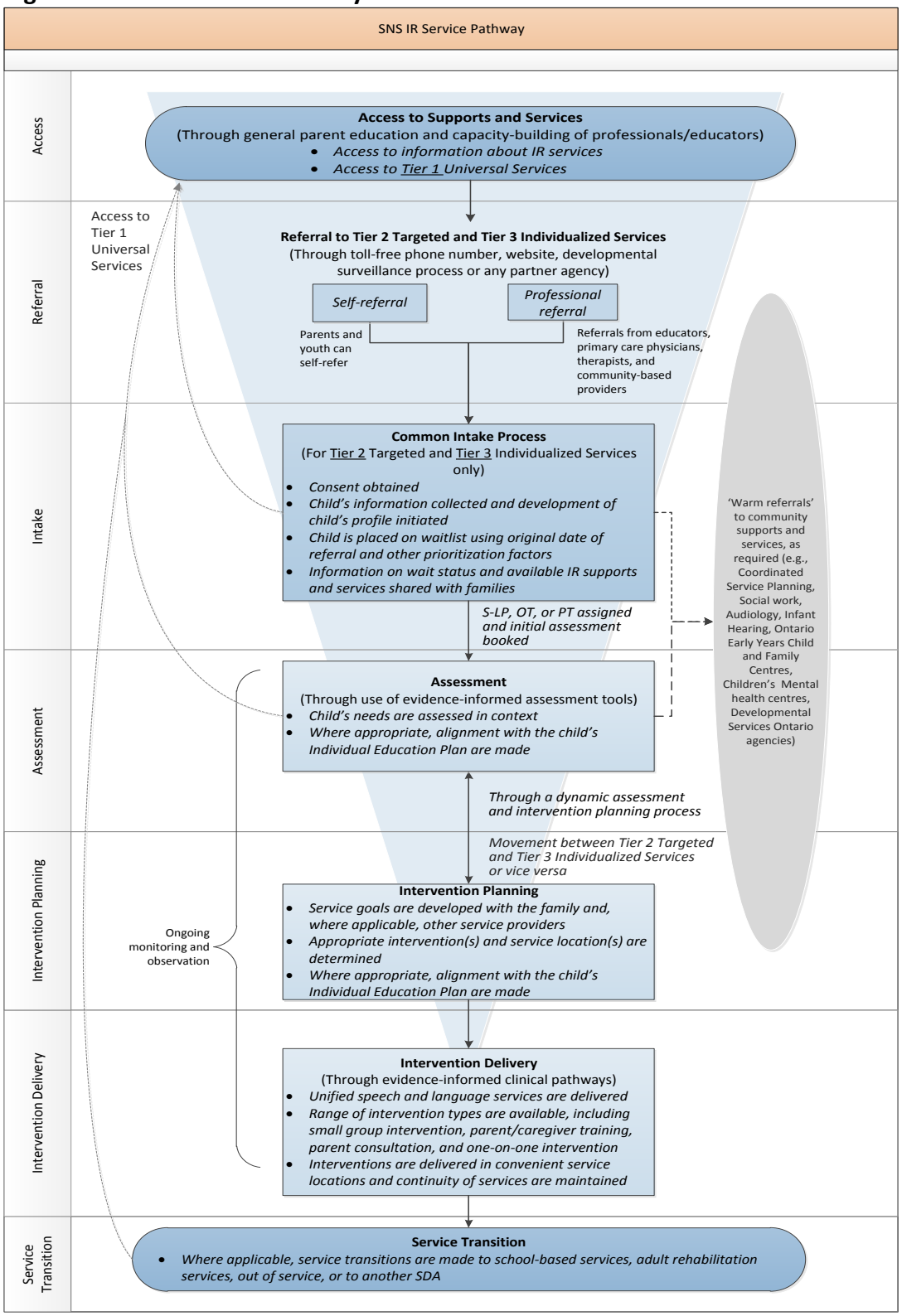
**Figure 2: Simplified Service Pathway**


As illustrated in Figure 3, the characteristics of this service pathway that will enable families to experience components as a single, seamless program of rehabilitation services include having:

- Access to information about IR services and universal services,
- Parent and/or self-referral through any partner agency door (i.e., including having concerns identified through a developmental surveillance process),
- Multiple points of access (i.e., a well-publicized toll-free phone number and electronic access),
- Common intake processes, including mechanisms for obtaining consent and development of the child's profile,
- "Warm transfer"[x] processes to connect families with appropriate services,
- Continuum of service delivery approaches based on the need(s) of the child/family, and
- Transition planning at key points involving service provider changes.

[x] A *"warm transfer"* is a transition process in which one service provider does not end service until the next provider begins providing service so that there are no gaps in service delivery

## Figure 3: SNS-IR Service Pathway Flowchart



## 2A. ACCESS


### Access to Information about Services

**Service Requirement #2:** A single, well-publicized toll-free phone number and electronic access (e.g., email, website) for intake as an entry point for rehabilitation services.

Access to information about IR services is fundamental to a family's ability to make decisions that affect their child's life. Access refers to knowing what services are available and how to locate those services and connect to other services their child or youth requires. Access to rehabilitation services includes the procedures and mechanisms for access to information and services, as well as the option of self- or professional referral. Families will be able to find information about IR supports and services in their local communities through multiple access points (such as schools, early years' service locations, health service providers, and other community agencies) and through a variety of means (e.g., in-person, online, telephone). These will include, but will not be limited to, a single, well-publicized toll-free phone number and electronic access (e.g., email, website) for information about rehabilitation services in the SDA. Parents may, for instance, access information about IR services as a result of having developmental concerns identified through a developmental surveillance process[xi]. Primary care providers, service agencies and/or schools will also be able to use the toll-free phone number and/or website as a go-to resource for information about where and how to access rehabilitation services. Information will be made available in French, English and other languages, as required.

### Access to Tier 1 Universal Services

Capacity-building can optimize healthy child development and prevent compounding effects of developmental issues. Universal services that focus on knowledge transfer, capacity-building and awareness of early identification of development concerns will be made available to parents/families, educators and/or community partners. Evidence-based information is shared between rehabilitation service providers, health professionals, educators and families to build everyone's capacity to support the participation and development of children with special needs within the home, child care setting, school and community environments. With rehabilitation service providers collaborating with parents and service provider partners, children who require targeted or individualized services within a given context can be systematically identified. A description of Tier 1 universal interventions is included in Table 2.

[xi] As a component of the Special Needs Strategy that is in development, *Developmental Surveillance* is defined as a flexible, continuous process whereby parents in collaboration with early years' service providers perform skilled observations of children in multiple settings (e.g., childcare centres and local early years community programs).

**Table 2: Description of Tier 1 Universal Intervention Types**

| INTERVENTION | DESCRIPTION |
|---|---|
| Early years' service locations/classroom/school strategies | • **Rehabilitation service providers** deliver integrated services in the early years' service locations/classrooms/schools which may include direct modeling of appropriate on-site/in-class strategies that build the capacity of early years/school staff to benefit all children.<br>• Effective strategies will be relayed and/or demonstrated to parents by the appropriate professional with a view to ensuring consistent use between the home and early year setting/school environments.<br>• Embedding rehabilitation practices into the early years' service locations/classrooms (e.g., Partnering for Change model).[33] |
| Collaborative Consultation | • Rehabilitation service providers **work in collaboration with each other, educators, other service provider partners**[xii]**, and family members** to facilitate the development and implementation of changes to the physical, social, and learning environments in the school or early year locations and/or activity demands.<br>• Through collaboration with educators, service provider partners and family members, rehabilitation service providers provide a variety of tools and materials that that enable early years/school staff and family members to maximize the ability of all children to participate.<br>• Rehabilitation service providers may provide and monitor alternative instructional strategies.<br>• Children for whom universal services do not seem to be sufficient are collaboratively identified. |

[xii] Service provider partners include those who provide services outside of the child/youth's home or anyone coming into the child/youth's home to provide a specific service. These may include Education Assistants, child care Staff, Early Childhood Educators, Ontario Early Years Child and Family Centre staff, Parks and Recreation staff, etc.

## 2B. REFERRAL


**Service Requirement #4:** Parents and youth can self-refer to rehabilitation services.

Children from birth to end of school will enter the system for S-LP, PT, and/or OT based on parent/self-referral or professional referral with parent consent. Parents and youth can self-refer for rehabilitation services through a toll-free phone number, electronically (i.e., email, online form, website), or in-person through any partner agency door as an entry point for intake. A physician referral is not required in order to access services. Professional referral can include educators, primary health care providers, rehabilitation service providers, or community-based agencies/providers. Where applicable, referral guidelines may be developed as a resource for service delivery agencies to streamline the referral of services to the most appropriate agencies in their respective SDA.

## 2C. INTAKE


### Common Intake Process

Common intake processes facilitate accessibility and promote equitable services. A common intake process includes mechanisms for obtaining consent, and collection of information that will be used to begin to populate a child's profile (e.g., the child's strengths and needs). This process may be completed using a variety of means (i.e., telephone interview with the parent, tools to obtain additional information about the child's development, and/or screening through a multi-disciplinary clinic). Personnel completing intake functions will have relevant professional background and training to effectively complete the intake process and initiate the development of the child's profile (where applicable). As part of the common intake process, parents will be provided with information regarding the available IR services and community services that may be appropriate for their needs.

**Information-Sharing Mechanisms**

**Service Requirement #6:** With parental consent, rehabilitation service information for a child/youth is shared with relevant service providers, educators, and other professionals to support seamless and efficient service delivery.

Information-sharing mechanisms among regulated health professionals will support seamless service provision, so that children, youth and families experience consistent and transparent rehabilitation services. Established information-sharing mechanisms amongst the members of the child's team of service providers, educators and other professional will facilitate communication and collaboration among regulated health professionals and organizations.[34,35] Examples of information-sharing mechanisms among regulated health professionals include having a shared philosophy of practice, information-sharing agreements among service providers, joint clinical assessments or service transition sessions.

Every SDA will develop an information-sharing and management strategy for the protection of information and common privacy practices so that families will not have to tell their stories multiple times. Formal partnership and information-sharing agreements between service delivery agencies related to privacy, security, consent and confidentiality for the use of personal health information will be developed, signed, and implemented. All service providers share responsibility for protecting the privacy of accurate and up-to-date information that is collected, used, and/or disclosed and for ensuring adequate safeguards for Personal Health Information or personal information.

Consent

Parental/youth consent (verbal and/or written) for the collection, use and/or disclosure of personal health information will be obtained at intake and will include a process for providing parents/youth with information about the sharing parameters between service provider agencies delivering rehabilitation services that may pertain to the assessment and the development of the service plan. This process may include, for example, memoranda of understanding and/or the development of a common consent form, which may also be available in multiple languages, as required. Ongoing consent will be obtained from parents/youth at necessary stages in the process of assessment, intervention planning and intervention delivery in compliance with the *Health Care Consent Act, 1996,* and other relevant privacy legislation (e.g., *Personal Health Information Protection Act 2004*, *Freedom of Information and Protection and Privacy Act, Municipal Freedom of Information and Protection of Privacy Act 1990*, *Education Act 1990, Child and Family Services Act 1990,* employer requirements). Processes to prevent the unnecessary duplication of consent will be in place.

## 2D. ASSESSMENT

Access | Referral | Intake | **Assessment** | Intervention Planning | Intervention Delivery | Service Transition

**Service Requirement #5:** Children and youth from birth to the end of school can access appropriate rehabilitation assessments to determine their specific needs regardless of their age, severity of disorder and/or diagnosis.

The purpose of the assessment is to determine the child's individual rehabilitation service needs. For every child referred through the intake process for "Tier 2 Targeted" and/or "Tier 3 Individualized" services, an assessment is completed. As part of the assessment, a rehabilitation service provider will collect relevant information about the child and their context to determine their needs and develop service goals in collaboration with the child/family, and collaborate as appropriate with educators, childcare or other regulated health professionals in the community supporting the child/family (e.g., pediatrician, social worker, mental health worker). Parents will be engaged throughout the process as essential members of the IR team and will actively contribute to the child's goal setting, ongoing monitoring and observation of progress.

Based on the child's needs, an assessment may be completed within one session or require multiple sessions, and will be completed in convenient locations for families. Age-appropriate and evidence-informed assessment tools and procedures in accordance with discipline-specific regulatory college requirements will be used to determine level of need, intervention approaches and service locations. Based on the assessment, an appropriate service plan is required. During assessment, access to information/supports about IR services will be made available to parents/youth.

All rehabilitation service providers will work with the child, parents and child care/educator to advance the child's rehabilitation goals within the context in which the child is participating. Where appropriate, S-LPs, PTs and OTs will provide clinical assessment and supervision of Communication Disorder Assistants (CDAs) and Therapy Assistants (TAs) delivering therapy programming and will work with the Service Planning Coordinators[xiii] for children with multiple and/or complex special needs and/or associated Care Coordinators[xiv].

[xiii] Service Planning Coordinators are for those children and youth with multiple and/or complex special needs requiring CSP

[xiv] Services from a Care Coordinators are provided for those children requiring in-home services with needs that may require a specialized therapeutic care plan that also includes personal support, Applied Behavioural Analysis (ABA), Intensive Behavioural Intervention (IBI), therapeutic recreation, nursing, and medical equipment.

**Alignment with Individual Education Plan (IEP)**

**Service Requirement #8:** Rehabilitation service providers and educators collaborate so that rehabilitation service goals and supports can support a child's educational program and vice versa.

Consultation and collaboration with the family, school staff, board support personnel and representatives of outside agencies or services provides valuable information to inform the child's educational program. With appropriate consent, program planning is individualized and focussed on developing the child's knowledge, understanding and skills that will be of use to him/her currently and in the future in school, home and community. [36,37] A principal must ensure that the development of the IEP is informed by relevant and current information. This information may be provided by personnel who have previously worked with or are currently working with the child. These personnel are able to bring perspectives and recommendations regarding effective and appropriate supports and services. Assessment information from service providers may be helpful to educators for determining and documenting learning strategies, and suitable accommodations, modifications or alternative expectations within the IEP.

If a student does not have an IEP, similar consultation and collaboration can be enabled through case conferences.

**Ongoing Monitoring and Observation of Progress**

Families of children who have received an assessment for Tier 2 and/or Tier 3 services will need different levels of support at varying times. For some, that level of support will be relatively consistent, whereas others may have periods where they need less intensive service, or come to a point where they no longer wish to access the service. Monitoring and observation of progress of individual children towards their goals and participation as it relates to their "Response to Intervention" will be made based on the clinical judgement of rehabilitation service providers and will be reflected throughout an ongoing assessment and intervention planning process. [38]

**Interprofessional Collaboration**

**Service Requirement #7:** Rehabilitation service providers communicate and collaborate with educators, and the range of professionals/paraprofessionals[xv] serving a child/youth (e.g., primary care practitioners, autism providers, and educators), and participate in the child's/youth's Coordinated Service Planning processes, as applicable.

[xv] *Professionals* include those in the education, health and community sectors

As a foundational element of a tiered service delivery framework, it is important that service providers communicate and collaborate with one another so that services will be wrapped around the needs of the child and family.

Collaboration should underlie the assessment, intervention planning, and intervention delivery process of IR; that is, services should be child and family-centred. When there is more than one rehabilitation provider, and with appropriate consent, providers will work together in an effort to ensure they are integrating practice and service delivery for children and families. Partnerships among health professionals, parents, and educators will be required to create environments that facilitate successful participation for all children. Rehabilitation services will be delivered by rehabilitation service providers and will include, where appropriate, CDAs as well as TAs.

**Warm Referral**

If S-LP, OT, and/or PT is not seen as an appropriate response to a child's needs or if the child requires additional community supports, referrals to the appropriate services will be completed through a "warm referral" process. With consent of the family, families will be connected to the appropriate community agency and services (e.g., local Infant and Child Development program, mental health services, parenting supports, early years centres, CSP, developmental services organizations) using information that may have already been collected so that families do not need to repeat their stories multiple times. All relevant referral information will be transferred directly to the receiving agencies so that the family does not need to repeat the same information.

Referrals to Coordinated Service Planning (CSP)

Referrals to CSP will support families of children with multiple and/or complex special needs who may require a coordinated service plan (i.e., require a formalized process where multiple cross-sectoral partners communicate about the needs and goals of a child and work towards a common vision and goals identified in a formal plan). Parents of children with multiple and/or complex special needs should be referred to CSP through the Coordinating Agency within the SDA in which the family lives (if they would require or benefit from the service). The Coordinating Agency within the SDA is responsible for establishing information-sharing mechanisms and agreements between organizations to enable relevant service providers to participate in and contribute to the development and ongoing monitoring of coordinated service plans.

## 2E. INTERVENTION PLANNING


**Service Requirement #9:** Families and regulated health professionals work in collaboration with educators and other professionals/paraprofessionals to determine the child's service needs and goals.

Following an assessment, a service plan is completed with the family and shared amongst providers. Parents will also receive copies of the service plan and/or be able to access their child's profile. Ongoing communication with parents will be integrated as part of the service plan through various formats (e.g., written notes, face-to-face discussions during therapy sessions, team meetings, phone) so that parents know what interventions their child is receiving. Where there is more than one rehabilitation need identified, service planning will be a shared process shaped by families and rehabilitation service providers working together to make informed decisions. Each provider will add relevant information to the child's profile and service plan about the services and supports the child and family receive. The development of the service plan may be completed through a dynamic assessment and intervention planning process.

The service plan will outline child- and family-centred goals that are specific, measurable, achievable, realistic, and time-limited (SMART) using the domains in the World Health Organization's *International Classification of Functioning, Child and Youth Version* (ICF-CY), and based on appropriate evidence-informed tools, and recommended interventions based on common clinical pathways.[39] To support consistent decisions regarding recommended interventions, SDAs will develop or adapt evidence-informed pathways to guide this process. The service plan will also include any planned service transitions, be communicated to or developed with educators to inform educational program planning such as the IEP (where applicable), and be regularly updated and adapted/adjusted.

## 2F. INTERVENTION DELIVERY


**Service requirements #10:** A broad range of intervention types (e.g., collaborative consultation, small group intervention, parent/caregiver training, parent consultation, and one-one-one intervention) are available, as appropriate for the child's needs.

**Service Requirement #11:** Early intervention is prioritized and supported through the provision of parent/caregiver training/education and capacity-building of regulated health professionals.

Interventions will be delivered by rehabilitation service providers following intervention planning and the development of a service plan. Depending on the needs of the child and in accordance with defined pathways, services will include a broad range of interventions included in Table 3. Where possible, and to support seamless transitions, the same rehabilitation service provider will follow the child and family through all settings. Where there are changes to a child's rehabilitation service provider, the new service provider will have access to the child's profile and service plan so that service delivery will be provided to the child seamlessly.

A child may access one or more of these interventions over the time that service is provided.

**Table 3: Description of Tier 2 Targeted Intervention Types**

| INTERVENTION | DESCRIPTION |
|---|---|
| Small group intervention | • The **rehabilitation service provider** implements a specific program with two or more children that have been assessed. Sessions occur on an ongoing basis.<br>• The program must have at least one pre-set goal that has been developed by the rehabilitation service provider in collaboration with the family/parent/educator/service provider partner. Coaching of the parents/ educator/service provider partners to facilitate their comprehension of the child's goals (and their ability to support implementation of the strategies) are considered an integral part of this intervention.<br>• In this intervention, there may be separate goals for the parents/service provider partners and children.<br>• The rehabilitation service provider demonstrates and coaches the parent to enable the parents to support their children's goals at home.<br>• Parents/service provider partners are provided with information about changes are expected to occur and advised to let the rehabilitation service provider know should those changes not be realized, if unanticipated changes occur or if all the set goals are achieved. |
| Parent/Caregiver Training | • The **rehabilitation service provider** delivers an instructional training program to parents of assessed children for a specific purpose. Children may or may not be not be present during parent/caregiver training.<br>• Training may be more traditional, such as parent education sessions with a small group, or could be mediated through which the rehabilitation service provider 'trains' the parent to independently carry out specific strategies with children.<br>• Parents are encouraged to reflect on the strategies and information provided to them and how the information applies directly to their child and are provided with the opportunity to ask questions and discuss and practice specific strategies with the rehabilitation service provider. |
| Parent consultation | • The **rehabilitation service provider** provides consultation services to parents in the child's home or other convenient location for the family to address a targeted need.<br>• The parent is provided with education in order to implement an individualized program over a specified period of time and is coached by the rehabilitation service provider on the individualized program.<br>• The program must have at least one pre-set goal that has been developed by the rehabilitation service provider in collaboration with the family. Parents must be able to demonstrate that they comprehend the goal and can implement strategies necessary to facilitate goal achievement.<br>• The rehabilitation service provider is available to the family either in person, by phone, and/or other means as necessary, throughout this intervention period.<br>• Parents are provided with information about what changes are expected to occur between visits and advised to contact the rehabilitation service provider should these changes not be realized or if unanticipated changes occur, or all of the home program goals are achieved.<br>• Visits with the rehabilitation service provider may occur at the family's request to assist the family with implementing the individualized program or to modify or set new goals. |

**Table 4: Description of Tier 3 Individualized Intervention Types**

| INTERVENTION | DESCRIPTION |
|---|---|
| One-on-one intervention | • The **rehabilitation service provider** implements a specific, individualized intervention with one child (alone or with their parent) in the natural context of the child's participation. Sessions occur on an ongoing basis.<br>• The program must have at least one pre-set goal that has been developed by the rehabilitation service provider in collaboration with the parent/educator/other rehabilitation service providers. Coaching of the parent to facilitate their comprehension of the child's goals and their ability to implement strategies is considered an integral part of this intervention.<br>• In this intervention, there may be separate goals for the parent and child.<br>• The rehabilitation service provider demonstrates and coaches the parent in an effort to ensure they are able to support their child's goals at home.<br>• Parents are provided with information about what changes are expected to occur between visits and are advised to let the rehabilitation service provider know should those changes not be realized, unanticipated changes occur or if all the set goals are achieved. |

**Unified Delivery of Speech and Language Services**

**Service Requirement #12:** Children and youth have a single assessment (i.e., there are no redundant assessments) and individualized service plan (i.e., there is a unified delivery of speech services and language services).

All SDAs will reflect an integrated speech and language approach. S-LP service providers will serve all school-aged children in their school, providing both speech and language supports and/or interventions, as appropriate. S-LP service providers will be assigned to geographically-based rehabilitation teams advancing capacity-building, evidence-informed practice and family-centred care.

The individualized service plan will determine the most appropriate location(s) for the provision of services. Where possible, services required in multiple locations (e.g., home and school) will be provided by the same rehabilitation service provider. Services may be delivered by rehabilitation service providers or paraprofessionals who are trained, supported and supervised by a rehabilitation service provider. Depending on the child's need, services may include information, recommendations and coaching to educators, service providers or parents/families as well as direct therapy to children individually or in groups. Particular attention is placed on building the capacity of parents, and school/educator teams to facilitate children's development. Service modality and service plans may change over time depending on needs, progress, family engagement, evidence-based research, and available resources.

**Convenient Service Locations**

**Service requirement #13:** Children and their families receive services in a child's natural context of participation that are as convenient to them as possible, and appropriate to their needs.

**Service requirement #14:** Whenever possible, school-aged children access rehabilitation services in the school setting.

Service delivery location will be determined based on the natural environments of a child that best supports his or her plan/goals developed in collaboration with the family/parent and will be provided as close to home or at a location as convenient as possible for families. Wherever possible, rehabilitation services for school-aged children will be primarily delivered within the school setting. Notwithstanding special circumstances, schools should be considered the first option for delivery when the goals are appropriate for school-based delivery. For instance, special circumstances may include a need for specialized clinical space or the goals of the child cannot be reached in a school environment (e.g., use of public transportation goals).

In cases where it is not feasible to provide services in school, services may take place at alternative service locations based on parent preference and/or the child's needs.

Alternative service locations may include: early years' service locations, community program locations, treatment or clinical sites and family homes. Services may also be available during extended hours by rehabilitation service provider agency staff. In exceptional cases and depending on available resources, some SDAs may choose to offer services in the child home and/or explore other avenues to minimize travel for certain types of services (e.g., parent education).

**Specialized Services**

Some specialized services may need to be provided in established clinics where appropriate equipment is available. Where there is a need for a child and his or her family to access these services, service provider agencies will work with the family to support the family's access to the service (e.g., through helping the family access volunteer driver programs). Specialized services may include: videofluroscopy for feeding and swallowing concerns, augmentative communication, gait analysis, casting and splinting, custom seating and mobility, Enhanced Augmentative and Alternative Communication clinics, home and vehicle modifications, and/or services through neuromuscular, chronic pain or oncology clinics, etc.

**Continuity of Services**

**Service requirement #15:** Families experience seamless and continuous service across providers, geographic regions, developmental ages and stages, and calendar year.

The integrated delivery of rehabilitation services includes the expectation of continuous service delivery throughout the calendar year within the natural contexts in which children participate. Therefore, SDAs will establish a mechanism for continuing rehabilitation services over the summer months. This may include providing services in a different location such as in the home, community, within schools (if available), through service provider agencies (where applicable), or through partner/community agency sites.

The service delivery model should take into consideration access and convenience for families, including the provision of resources for after school hours, in evening periods or on weekends, in order to best meet the needs of families. Every SDA will, at a minimum, provide parents with a home program so that the child's rehabilitation goals can continue to be addressed during the summer months. A variety of community supports or intervention models could also be available during the summer months (e.g., monitoring, home visits, clinics, workshops, and/or camps). For instance, rehabilitation service providers may be available for evening appointments through clinics if need is determined by the rehabilitation team with the family. SDAs may also offer a 'camp-like' summer experience for children receiving school-based services.

## 2G. SERVICE TRANSITIONS


**Service Requirement #16:** Rehabilitation services are continuous and seamless for children across transition points (i.e., no disruptions in service upon entry to school, during transitions between schools, and elementary to secondary school transitions).

Service transitions refer to changes in the situation of a child or youth that impact his or her service delivery, either as they age or their service needs change (e.g., when a preschool child receiving speech and language services enters into Kindergarten, a youth ages into adult developmental services, or a child and family move from one SDA to another).[40] Service transitions may include changes to service provider agencies, rehabilitation service providers, and service settings. Service transitions do not include typical developmental processes that are experienced by all children as they age. Appropriate supports and processes at key transition points will aim to ensure that there are no gaps in the service pathway and will allow for a more timely, consistent and seamless delivery of rehabilitation services. Key transition points may include:

- At school entry - when the child is entering school and is transitioning to school-based services,
- At school exit - when the youth has reached end of school and is transitioning to adult developmental services,
- Moving – when the child moves to a different SDA, and/or
- Out of service - when the child's needs have been addressed or when the youth/family chooses to discontinue services and is transitioned out of service.

### Transition Protocols

Where possible and applicable, protocols relevant to each transition point will be developed, articulated and implemented (e.g., in a Memorandum of Understanding [MOU]) between service provider partners in each SDA. A transition protocol will outline when and how service transitions will occur, including:

- Standard information-sharing processes,
- Transition planning to identify and plan for potential issues/concerns in advance of key transition points,
- Communication to parents/family outlining the transition process in preparation for the service transition, as well as,
- The timing for which a "warm transfer" of responsibilities from the referring service provider to the receiving service provider will take place.

In the absence of a transition protocol or MOU, service provider partners will work together to ensure an appropriate and family-centred transition, including:

- Sharing assessment information, plans of service and other relevant information (with appropriate consent);
- Reviewing existing information and incorporating where relevant into plans of services; and
- Collaborating to ensure a "warm transfer" from referring service provider to the receiving service provider.

**Transition Planning for IR**

Transition planning for IR enables children and their families to receive appropriate information and services when moving from one environment and/or service provider to another, without interruption or delay. An IR transition plan includes consideration of the nature and extent of IR transition support required and any combination of strategies/activities that helps a family prepare for and ensure a smooth service transition. Parents should be involved with all transition processes, and IR transition planning will be a joint responsibility of both referring and receiving service providers involved in the service transition.

IR transition planning will vary depending upon the service transition. For example, at school entry, IR transition planning will involve both preschool and school-based service providers, and designated school and/or board staff in consultation with the family. IR transition planning involving schools (e.g., school entry or school to school transitions) will be made in accordance with existing school board policies and procedures as well as community processes. [41, 42]

An IR transition plan involving a school-aged child should be developed in collaboration with parents, members of the school team, the child's service provider(s) and other community agencies or professionals involved with the child's IR. Consultation with community agencies or post-secondary school staff may also be appropriate. Where a child has an existing transition plan as part of his or her IEP, the IR transition plan should co-ordinate with the child's IEP transition plan. An IR transition plan may also be developed in collaboration with school personnel for a child who does not have an IEP.

**Warm Transfer**

A "warm transfer" is a transition process in which one service provider does not end service until the next provider begins providing service. A "warm transfer" will be such that service providers involved in the service transition will share information directly with one another and develop joint plans to review service plans, goals and progress as the child moves between these services.

Transitioning into Adulthood

Planning for transition into adulthood takes place in an integrated way and can be initiated by the school, where relevant, or rehabilitation service provider agency. The integrated transition process connects closely with the Individual Education Plan (IEP) process and the Integrated Transition Planning (ITP) process that supports young people with developmental disabilities to prepare for adulthood. School staff and service providers should therefore consult with community agencies and post-secondary institutions to prepare children/youth receiving special education and/or rehabilitation services and assist them and their families in making a smooth transition.

Where applicable, transition planning processes to support Integrated Transitional Planning (ITP) of youth into adult developmental services will include the family, youth, school-aged rehabilitation service providers, school staff and adult developmental service organizations (e.g., Developmental Service Ontario). Transition planning does not guarantee adult developmental services/resources to youth into adulthood, rather this facilitates the process for youth accessing adult developmental services once they turn 18.

As part of ITP processes, transition planning will align with the IEP process and a transition plan will be shared with parents, youth and all relevant rehabilitation service providers.

Moving between Schools/Service Delivery Areas (SDAs)

Children moving from one SDA to another will be seamlessly transitioned by service providers through a “warm transfer” process. Where possible, rehabilitation service providers will begin preparing the family for transition several months in advance and will contact or meet with the receiving service provider to provide documentation, review the child’s needs and coordinate a “warm transfer” process. A transfer of information to the receiving SDA will be completed in advance of the move to identify needs and supports that will be required to support the child entering the SDA. All relevant dates (i.e., referral, assessment, and intervention initiation) will be honoured and a full transition plan will be developed and implemented.

Transitioning Out of Service

Children and their families who access rehabilitation services will need different levels of support at varying times. For some, that level of support will be relatively consistent from the time they enter service until the time they leave high school. Others may have periods where they no longer need service, or come to a point where the family no longer wishes to access rehabilitation services.

A child will be transitioned out of service:

- When his or her identified goals have been addressed, or
- When the child's parents or the child, where applicable, no longer consent to service.

Once a child is transitioned out of service, children may be re-referred whenever a new need is identified or circumstances require addressing previous needs in a new setting or situation. In such cases, the existing profile of the child may be re-opened and the child will re-enter the waitlist for services based on his or her original referral date.

## PART 3: OVERSIGHT AND ACCOUNTABILITY

The following section will outline the service and system management activities in order to support the service pathway for IR. These include:

a. Roles and Responsibilities,
b. Public Awareness,
c. Wait Management, and
d. Performance Monitoring and Reporting.

## 3A. ROLES AND RESPONSIBILITIES

### A1. Steering Committee

Each SDA will have a designated steering committee for the oversight of SDA activities, including implementation. This steering committee will consist of senior management and rehabilitation service provider representatives from the SDA's service provider agencies whose resources are supporting integrated rehabilitation services of S-LP, PT, and OT services. Service providers through the oversight structure are accountable to Ministry of Children and Youth Services (MCYS) for reporting on rehabilitation services within their SDA and are expected to review results on a regular basis, as defined by MCYS.

### A2. Community of Practice

Each SDA will have a Community of Practice (CoP) established for the monitoring of child and family outcomes, review and knowledge transfer of evidence-informed practices, outcomes, family-centred service, and communication. The CoP will consist of clinical representation from each of the service provider agencies whose resources are supporting integrated rehabilitation services who will work collaboratively with a view to ensuring the needs of children and their families are met.

A description of the responsibilities for both the steering committee and CoP is included in Table 5.

**Table 5: Roles and Responsibilities**

| | RESPONSIBILITY |
|---|---|
| **Steering Committee** | This committee will be responsible for the following activities:<br>• Lead system change in SDA, including, but not limited to strategic planning processes, setting direction/vision, building relationships, capacity-building of professionals, development of terms of reference and memoranda of understanding to outline roles and responsibilities<br>• Develop comprehensive public awareness and communications strategy<br>• Monitor quality, consistency, resource needs, outcomes, waitlist, wait times, volume, and trends across the SDA<br>• Review and monitor outcome measures with a view to ensuring alignment with provincial direction and consistent use across the SDA<br>• Use data and promote a culture of Continuous Quality Improvement<br>• Balance the resources available to address inequities or other needs identified, and develop mitigating strategies, where needed<br>• Oversee formal training and mentorship for service providers<br>• Oversee implementation activities |
| **Community of Practice (CoP)** | The CoP will be responsible for the following activities:<br>• Engage clinical representation on the review, use and dissemination of existing care pathways, evidence-informed practices, and outcome aimed at ensuring alignment with provincial direction and consistent use across the region<br>• Identify areas for professional development<br>• Ensure adherence to provision of data for outcome measurement<br>• Provide organizational mentorship as part of professional development of rehabilitation service providers |

## 3B. Public Awareness and Communication Plans

**Service Requirement #17:** Promotion of the importance and availability of rehabilitation services among parents, professionals, educators and caregivers has been included.

The steering committee in each SDA will work together to develop a comprehensive communication plan with associated strategies to inform families/community partners (see Table 6 for key community partners) about a "no-wrong-door" approach to accessing services, including access to a tiered service delivery approach that benefits all children. The communication plan will focus on increasing awareness of the importance and availability of rehabilitation services and encouraging referrals in places where families who may need to access these services are already connected. Key messages from the communication plan will include how services can be accessed and where people can go for information, and will be supported by communication materials to accurately present services to parents, educators, primary care providers and community agencies supporting children and families, wherever possible.

**Table 6: Key Community Partners for Public Awareness**

| Key Audience | Examples |
|---|---|
| Health Sector | Local Health Integrated Networks, physicians, hospitals and birthing units, public health units, health care providers, family health teams, children's mental health lead agencies, Children's Treatment Centres |
| Early Years Sector | Child care settings, Ontario Early Years Child and Family Centres, Healthy Family Coalitions |
| Education Sector | Schools, Special Education Advisory Committees, school councils, Parent Involvement Committees |
| Community | Children's Services Agencies, libraries, Family Resource Centres, community centres, community breakfasts, communities of practice, community planning tables, municipal government offices, First Nations organizations, Aboriginal organizations, provincial non-for-profit associations, Welcome Centres |

Both the phone number and website address will be widely promoted to the public as well as throughout the sector. Information about rehabilitation services will be posted on the websites of all partner agencies with links to/from partner agency websites. This will include descriptions of S-LP, OT, and PT services, and contact information. Materials

may be produced in English, French and other languages. Where appropriate, printable resources and online parent webinars will also be made available.

Strategies will range from those designed to inform and educate, for example, through newsletters and brochures, to those designed to directly involve key stakeholders such as focus groups and consultation. Communication media may include: social media (website and digital outreach), radio stations, television, websites, print materials (e.g., newsletters, posters, brochures), local media outreach (e.g., newspapers), on location/sites (e.g., information sessions with parents and providers).

## 3C. WAIT MANAGEMENT APPROACH

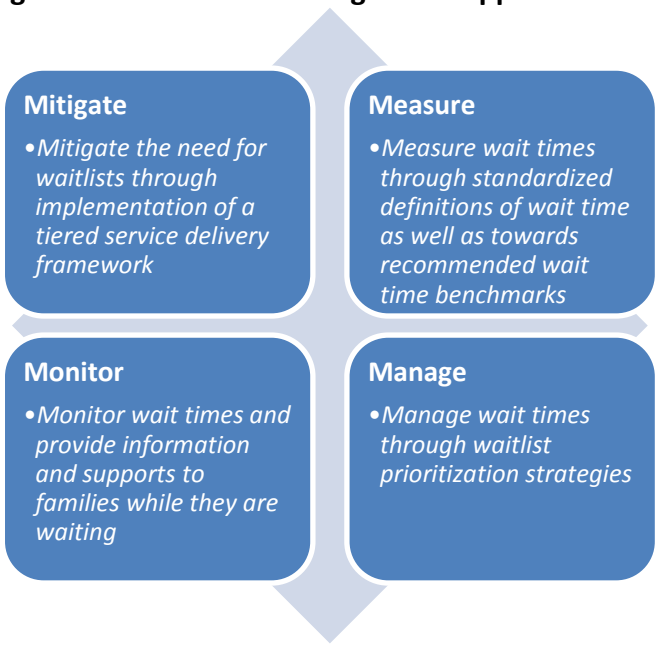
**Service Requirement #17:** The waitlist management approach is consistent and transparent for families across the service delivery area, based on relevant evidence-informed practices (e.g., families are aware of their wait status and approximate duration).

**Service Requirement #18:** Families experience rehabilitation service in the service delivery area as a single waitlist for each of speech-language pathology, occupational therapy and physiotherapy, and there are no gaps or additional waits when transitioning among providers and sectors.

Improving the wait experience for families is a key component of Ontario's Special Needs Strategy. Parents, families and youth have reinforced the importance of avoiding additional waits as children with special needs transition between services, either as they age or as their service needs change.[43] In particular, families are frustrated when there is a lack of transparent waitlist information and by reassessments and subsequent waits for services during transitions (either when they move or a child changes schools).[44] Shorter wait times will facilitate earlier identification and referrals to other agencies and will reduce parental anxiety.

As illustrated in Figure 4, a consistent wait management approach that *mitigates, measures, monitors and manages* wait times across the province will support consistent, transparent, and more timely access to services. [45, 46, 47]

**Figure 4: SNS-IR Wait Management Approach**[48, 49, 50]



### C1. Mitigate Waitlists through Tiered Service Delivery Framework

Implementation of a tiered approach to a continuum of services will be an important step towards mitigating waitlists. Delivery of universal services within a tiered service delivery framework allows for all children to access and benefit from Tier 1 universal services. For some children with mild needs, Tier 1 universal services through parent education and training will reduce the likelihood that they will require additional rehabilitation services. For other children with identifiable Tier 2 targeted and/or Tier 3 individualized needs, access to Tier 1 universal services will be provided while they are waiting for assessment and/or intervention. Accordingly, since there is no formal intake or assessment required, there is *no wait for Tier 1 universal services*.

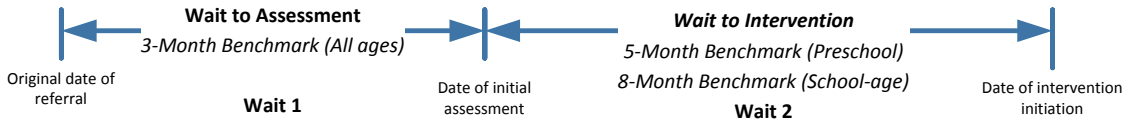
### C2. Measure Wait Times Towards Recommended Wait Time Benchmarks

Standardized definitions of wait times and collection of comparable wait time data elements across all SDAs will be developed to drive evidence-based decision-making and measure system performance. Wait time benchmarks, defined as system performance goals that reflect a broad consensus on reasonable wait times for services delivery, are an essential first step towards improving access and reducing wait times for S-LP, PT, and OT services across Ontario.[51,52]

While there is limited research evidence on wait time benchmarks for OT and PT services, clinical consensus and evidence-based recommendations for S-LP services across Canada have been established.[53,54,55]

Notwithstanding urgent or acute needs, recommended reasonable wait times ranged from one to three months for wait to assessment, regardless of age, and one to eight months for wait to intervention (preschool children ranged from one to six months while school-aged children ranged from one to eight months).[56,57] Based on the upper end of these ranges, the wait time benchmarks illustrated in Figure 5 and standard wait time definitions below will be used as an aspirational goal in the long-term and a starting point from which to measure progress.

**Figure 5: Wait Time Benchmarks for Tier 2 Targeted and Tier 3 Individualized Interventions**




***(1) Wait 1 – Wait to Assessment:*** Defined as the length of time a child waits for the date of the first available appointment for an assessment following receipt of a referral/self-request for service and accompanying intake information. Where possible, the window of time from referral to initial assessment should *not be longer than three months (i.e.,90 days), regardless of age*.

***(2) Wait 2 – Wait to Intervention:*** Defined as the length of time a child waits for their first intervention following the rehabilitation service provider's assessment (i.e., with identifiable Tier 2 targeted and/or Tier 3 individualized intervention needs). Where possible, the window of time from initial assessment to intervention initiation *should not be longer than five months for preschool and eight months for school-aged children*.

### C3. Monitor Wait Times and Provide Information and Supports to Families

Established mechanisms for sharing information with families will help reduce anxiety for parents/families. Information such as the types of targeted and/or individualized services their child is waiting for, wait status and approximate length of wait will be provided to families as soon as possible (i.e., at intake). Tier 1 universal services as well as information about the range of resources and supports that may be appropriate for families while they are waiting for their assessment will also be provided to families, as well as advice on how to get information or contact other providers or parent/educator workshops or information sessions.

**C4. Manage Wait Times through Waitlist Prioritization Strategies**

Children and their families will experience rehabilitation services in the Service Delivery Area (SDA) as a single waitlist for each of S-LP, PT and OT through the common intake process based on the date of referral. When a child is transferred from one agency to another or from one SDA to another, provider agencies will place the child on the waitlist according to the original date of referral. Original date of referral is defined as the point of contact at which the provider agency begins to collect information about the child. Children with special needs will be prioritized for service based on factors that increase their risk for further difficulties should they not be seen in a timely manner.

Children presenting with issues that warrant immediate service may be prioritized to move immediately to assessment/intervention. Specialized services and clinics may have distinct priority criteria based on the nature of the service. These may include children requiring acute medically-based or urgent care that require more immediate access to services (e.g., babies with plagiocephaly/torticollis, children with feeding issues, transfers from rehabilitation hospital, safety concerns, other medical/health-related needs and accessibility).

Waitlist prioritization may be influenced in a SDA by other factors shaped around the needs of the child, such as risk, demand, type of service required, and complexity of needs. To best meet local needs, SDAs will identify local prioritization strategies to determine priority of assessment and/or intervention for children waiting for targeted and/or individualized interventions through their Community of Practice. Local prioritization strategies will be evidence-informed and based on the clinical expertise of regulated health professionals.

## 3D. PERFORMANCE MONITORING AND REPORTING

The implementation of an integrated approach to the delivery of rehabilitation services involves a large scale transformation across ministries and sectors. Measuring the outcomes and impact of IR is an iterative, multi-year process. Performance measurement is the shared responsibility of all service providers receiving funding for and delivering rehabilitation services.

The framework in Figure 6 is organized in two sections:

a. Foundational Data Elements have been identified to establish a descriptive baseline related to clients served, utilization, wait times and family centredness of service provision.
b. Performance Outcome Measures in the areas of access, quality and value will be used to measure and monitor the impact of the program over time. These are in development for 2018 and onwards in alignment with the key goals of the integrated delivery of rehabilitation services.

As a first step, the performance outcome measurement areas described below are prioritized for monitoring and measurement for continuous improvement beginning in 2018:

- Early identification,
- Timeliness of service provision,
- Family satisfaction, and
- Capacity-building.

<u>Early Identification</u>

Increased provision of universal services by service delivery area will improve the capacity of families at home, educators in the classroom, and children's rehabilitation service providers to address rehabilitation concerns as early as possible and identify children who may need additional help. Provincial coverage by service delivery area of eligible kindergarten to grade twelve classrooms receiving universal services will be measured.

<u>Timeliness of Service Provision (Wait Times)</u>

Wait time targets by service delivery area for Tier 2/Tier 3 services have been identified for both preschool and school-aged children. Collection of wait time data beginning in 2017 will establish a baseline for measurement, with targets established in subsequent years.

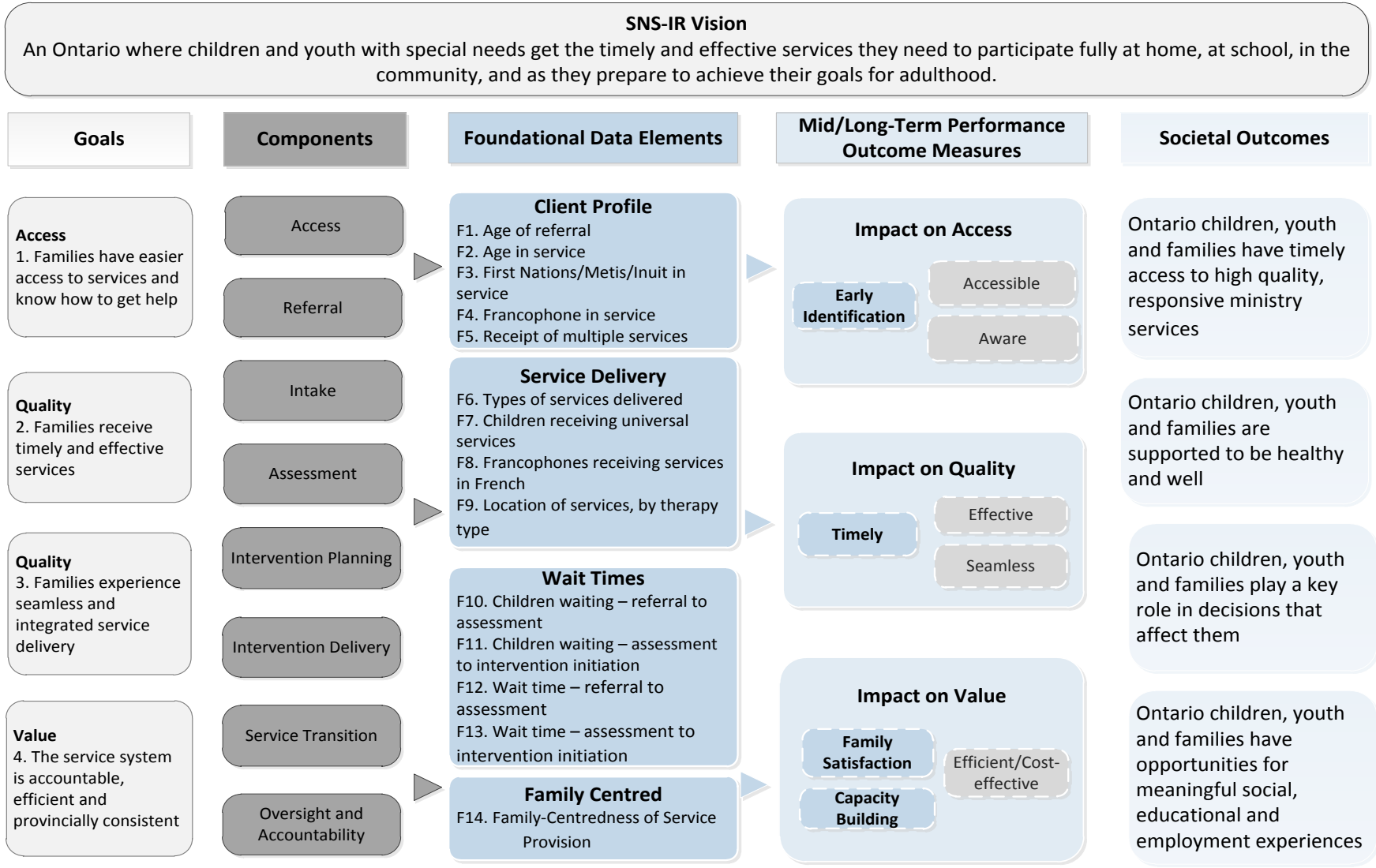
Family Satisfaction

Evidence of increased client satisfaction, including family-centredness of service provision and family satisfaction with services, will be measured and monitored through anonymous surveys to families. Measures will focus on understanding the long-term impact of the delivery of a family-centred program on family functioning (e.g., family participation in goal setting and decision making; reduction of stress; increased family participation at home, at school, and in the community).

Capacity-Building

Evidence of improved knowledge and skills of parents to support rehabilitation goals at home; and improved knowledge and skills of professionals to meet the functional needs of children in the natural context of children's everyday activities, e.g., universal design services in school settings.

**Figure 6: Outcome Measurement Framework**



### D1. Foundational Data Elements

Data elements establish utilization and descriptive information as a baseline for outcome measurement. These minimum data elements are required as a starting point for assessing changes in performance and for establishing targets for future performance. These data elements in Table 7 will be collected regularly by service delivery areas as implementation progresses, and will serve ongoing as "feeders" to support performance outcome indicators.

**Table 7: Foundational Data Elements**

| FOUNDATIONAL DATA ELEMENTS | | MEASURES |
|---|---|---|
| Client Profile | F1. Age at referral | #/% children/youth being referred, by age, by therapy type (OT/PT/S-LP) (Tier 2/3) |
| | F2. Age in service | #/% children/youth receiving service, by age, by therapy type (OT/PT/S-LP) (Tier 2/3) |
| | F3. First Nations/Métis/Inuit in service | #/% children/youth self-identifying as FNMI (Tier 2/3) |
| | F4. Francophone in service | #/% children/youth self-identifying as Francophone (Tier 2/3) |
| | F5. Receipt of multiple services | #/% children/youth receiving multiple rehabilitation services (Tier 2/3) |
| Service Delivery | F6. Types of services delivered | # hours of service provision, by therapy type (OT/PT/S-LP), (Tier 1/2/3) |
| | F7. Provincial coverage of children receiving universal services (Tier 1) | #/% classrooms in elementary and secondary school (K-12) that have received universal services (Tier 1) |
| | F8. Francophones receiving services in French | #/% Francophone children identified as Francophone who are receiving services in French (Tier 2/3) |
| | F9. Location of services, by therapy type | #/% children/youth served by therapy type (OT/PT/S-LP), by setting (Tier 2/3) (Clinic/Centre, School, Community, Home) |
| Wait Times | F10. Wait 1 – Referral to Assessment | # children/youth in Wait 1 (Tier 2/3), by therapy type (OT/PT/S-LP) |
| | F11. Wait 2 – Assessment to First Intervention Initiation | # children/youth in Wait 2 (Tier 2/3), by therapy type (OT/PT/S-LP) |
| | F12. Wait 1 wait time – Referral to Assessment | Variable measure on # days waiting in Wait 1 (Tier 2/3), by therapy type (OT/PT/S-LP) - TBD |
| | F13. Wait 2 wait time – Assessment to First Intervention Initiation | Variable measure on # days waiting in Wait 2 (Tier 2/3), by therapy type (OT/PT/S-LP) - TBD |
| Family Centred | F14. Family-centredness of service provision | % families reporting positive perception of family-centred service |

**D2. Performance Outcome Indicators**

Performance outcome indicators related to the four goals are in development. They will monitor the impact of integration on system performance and family satisfaction for performance management and continuous improvement over time. Measuring and monitoring our progress, along with the identification of specific targets in key areas, will support local service delivery areas to improve over time, as well as guide our priorities for provincial consistency of the implementation of the integrated delivery of rehabilitation services as a whole.

The examples of key areas of inquiry associated with each of the identified goals are included in Table 8 to signal broad policy direction and expectations over the longer term. Performance outcome indicator development will inform introduction of key indicators targeted for implementation in 2018.

Developmental work through 2016-17 includes refinement of outcome indicators and associated data elements, identification of tools and sources for data collection and measurement, definitions of technical specifications, mechanisms for reporting and analysis, and approaches to continuous quality improvement. This work will be informed by advice and feedback from the Program Guidelines Advisory Committee and other experts, in alignment with provincial priorities.

**Table 8: Performance Outcome Indicators in Development**

| GOALS | OUTCOME MEASURE | EXAMPLES AREAS OF INQUIRY IN DEVELOPMENT |
|---|---|---|
| **ACCESS**<br><br>Easier for Families to Access Services | Available | *Availability of universal services across the province* |
| | Early Identification | *Age of referral to services* |
| | | *Age of intervention initiation for identified children* |
| | Convenient | *Proportion of school-age children receiving targeted and/or individualized services in schools/community locations* |
| | Aware | *Awareness of where to access information about services* |
| | | *Use of children's rehabilitation service referral pathways in the service delivery area* |
| **QUALITY**<br><br>Timely and Effective Services | Timely | *Achievement of wait time targets* |
| | Effective | *Goal attainment at home, at school and in the community (e.g. rehabilitation, participation in everyday activities, family functioning)* |
| | | *Alignment of rehabilitation goals with Individual Education Plans (IEPs)* |
| **QUALITY**<br><br>Seamless and Collaborative | Collaborative | *Interprofessional collaboration in support of an integrated delivery model* |
| | | *Interprofessional collaboration in support of intervention planning and goal-setting for school-aged children* |
| | Seamless | *Support to families through transition periods, e.g. entry to school, and transition into adulthood* |
| **VALUE**<br><br>System is accountable, efficient and consistent | Efficient/cost effective | *Match between level of services provided and level of need* |
| | Family Satisfaction/<br><br>Centredness | *Family perception of child and family functioning (e.g. participating in decision making process around their children's service plan; experiencing less stress and worry; participating more fully in daily activities at home, at school, and in the community)* |
| | Capacity-Building | *Knowledge and skills of children's rehabilitation service providers to deliver an integrated rehabilitation model in schools* |
| | | *Knowledge and skills of families to support their children/youth at home* |

| Appendix A: Core Service Requirements for the Integrated Delivery of Rehabilitation Services | |
|---|---|
| **Component** | **Core Service Requirements** |
| **Access, Referral and Intake** | **1.** A streamlined service pathway includes: access, referral, intake, assessment, intervention planning, intervention delivery, and service transition (as required).<br><br>**2.** A single, well-publicized toll-free phone number and electronic access (e.g., email, website) for intake as an entry point for rehabilitation services.<br><br>**3.** Parents and youth can self-refer to rehabilitation services.<br><br>**4.** With parental consent, rehabilitation service information for a child/youth is shared with relevant service providers, educators and other professionals to support seamless and efficient service delivery. |
| **Assessment** | **5.** Children from birth to the end of school can access appropriate rehabilitation assessments to determine their specific needs regardless of their age, severity of disorder and/or diagnosis.<br><br>**6.** Rehabilitation service providers and educators collaborate to align rehabilitation service goals and supports with education needs.<br><br>**7.** Rehabilitation service professionals communicate and collaborate with educators, and the range of professionals/paraprofessionals serving a child/youth (e.g., primary care practitioners, autism providers, and educators), and participate in Coordinated Service Planning, as applicable.<br><br>**8.** Rehabilitation service providers and educators collaborate so that rehabilitation service goals and supports can support a child's educational program and vice versa. |
| **Intervention Planning and Delivery** | **9.** Families and regulated health professionals work in collaboration with educators and other professionals/paraprofessionals to determine the child's service needs and goals.<br><br>**10.** A broad range of intervention types (e.g., collaborative consultation, small group intervention, parent/caregiver training, parent consultation, and one-one-one intervention) are available, as appropriate for the child's needs.<br><br>**11.** Early intervention is prioritized and supported through the provision of parent/caregiver training/education and capacity-building of professionals.<br><br>**12.** Children and youth have a single assessment (i.e., there are no |

| Component | Core Service Requirements |
|---|---|
| | redundant assessments) and individualized service plan (i.e., there is unified delivery of speech and language services).<br><br>**13.** Children and families receive services in a child's natural context of participation that are as convenient to them as possible, and appropriate to their needs.<br><br>**14.** Whenever possible, school-aged children access rehabilitation services in the school setting.<br><br>**15.** Families experience seamless and continuous service across providers, geographic regions, developmental ages and stages, and calendar year. |
| **Service Transitions** | **16.** Rehabilitation services are continuous and seamless for children across transition points (i.e., no disruptions in service upon entry to school, during transitions between schools, and at entry into high school). |
| **Oversight and Accountability** | **17.** Promotion of the importance and availability of rehabilitation services among parents, professionals, educators and caregivers has been included.<br><br>**18.** The waitlist management approach is consistent and transparent for families across the service delivery area, based on relevant evidence-informed practices (e.g., families are aware of their wait status and approximate duration).<br><br>**19.** Families experience rehabilitation service in the service delivery area as a single waitlist for each of speech-language pathology, occupational therapy and physiotherapy, and there are no gaps or additional waits when transitioning among providers and sectors.<br><br>**20.** Services are delivered using a holistic view of the child/youth, encompassing their needs/strengths in the home, community and school (for school-aged children) contexts. |

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