Services to Adults with Developmental Disabilities

Integrated Service Delivery Model

Version 1.0

Draft for Discussion

Contents

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Interim Concurrence from the Working Group

STADD Integrated Service Delivery Model
Cross-Ministry Concurrence with Content / Direction

As a member of the STADD Service Delivery Model Working Group, I have reviewed the February 14, 2013 version of the attached document, participated in discussions about the feedback and provided my feedback.

I agree that the content reflects my group's feedback to date and concur with the content and direction of the Integrated Service Delivery Model.

Health Authority

Pamela Vickars
Clinical Director
Home Health, Specialized Populations, Tri-Cities, Quality, Contract Performance & Allied Health
Response: Away on vacation

Ministry of Education

Douglas Agar
Learning Division: Diversity, Equity and Early Years
Response: February 18, 2013
Email concurrence provided

Community Living BC

Debra McCormick
Quality Service Analyst
Quality Services
Response: February 18, 2013
Email concurrence provided

Ministry of Health

Betty Weber
Project Director
Home, Community and Integrated Care
Response: February 18, 2013
Email concurrence provided

Ministry of Social Development – Employment Program of BC

Barry L Doucette
Senior Specialized Populations Advisor
Employment Programs Management
Response: February 14, 2013
Verbal concurrence provided

Val Beaman
Manager, Specialized Populations
Employment for Persons with Disabilities
Response: February 18, 2013
Email concurrence provided

Ministry of Children and Family Development

Anne Fuller
FASD Consultant
CYSN Policy
Response: February 18, 2013
Email concurrence provided

Aleksandra Stevanovic
Director
Children & Youth with Special Needs Policy
Response: February 18, 2013
Email concurrence provided

1. Executive Summary

Individuals with developmental disabilities[1] and their families, advocates and service providers have expressed concern with respect to the services delivered to adults with developmental disabilities. The Services to Adults with Developmental Disabilities (STADD) initiative is mandated to address the recommendations in the December 2011, Deputy Ministers' Review of Community Living BC, *Improving Services to People with Developmental Disabilities* (http://www.sd.gov.bc.ca/pwd/docs/Improving_Services_to_People_with_Developmental_Disabilities_Report_FINAL.pdf)

This document provides an overview of the preliminary proposed service delivery model which has been designed to address several of the Deputy Ministers' recommendations. It presents the model at a high-level so that agreement on the direction can be achieved before exploring, in detail changes, processes and roles and responsibilities with respect to government support to youth with developmental disabilities transitioning into adulthood and throughout adulthood[2]. This document is intended to provide a context for discussion and engagement. The model will be consulted on, modified, refined and further detail developed. The work is at an early stage. As the model evolves, service provider delivery will be examined. At this stage, the model focuses on the internal functioning of government.

The proposed service model will facilitate improved government funded and non-government funded services and supports to individuals with developmental disabilities[1]. The implemented integrated service delivery model will help support individuals to improved self-sufficiency, community inclusion and connection. Early pro-active planning and shared information will improve health and wellness through reducing critical incidents.

Input to the proposed service delivery model has been secured from numerous sources including:

- the information obtained from the self-advocate engagement process,
- working sessions with regional and provincial stakeholders,
- interviews with families who are accessing services and supports through Community Living BC (CLBC),
- fourteen community engagement sessions, and
- cross-government working sessions involving organizations that are developing the policies and providing the services and supports.

The project principles are the foundation for the model.

[1] Person with Developmental Disability: as defined by the BC provincial government, is a person who has been professionally assessed by a psychologist and is found to have met the universally accepted DMS IV definition, which reads:
"a. Significantly sub-average intellectual functioning: an IQ of approximately 70 or below on an individually administered IQ test (for infants, a clinical judgment of significantly sub average intellectual functioning).
b. Concurrent deficits or impairments in present adaptive functioning in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health, and safety.
c. The onset is before age 18 years."
Also refers to individuals diagnosed with fetal alcohol spectrum disorder or autism spectrum disorder with three significant limitations in adaptive functioning

[22] For the purposes of the service delivery model, `youth` is defined as a person who is 16 years of age or over but is under 19 years of age. An adult is a person who is 19 years of age or older. In the Cross-Ministry Transition Planning Protocol, a youth can be 14. In discussions with the working group, it was determined that 16 is a more appropriate age at which to directly focus on transition and is therefore used as the starting age for youth.

For individuals with developmental disabilities and their families, the key shifts represented in the model include:

- Smoother and more facilitated transitions, enabled by enhanced earlier collaborative planning engaging the partners involved in providing services and supports and integrated assessments
- Support and opportunities for self-determination and capacity building through information provision about services, service and support eligibility and resources which are available (e.g. Registered Disability Savings Plan)
- Access to a navigator (referred to as a key worker in previous documentation) with defined functions, assigned responsibilities and the authority to engage government organizations
- A single point of contact via the navigator role
- Enhanced information provision, accessibility and coordination
- Enhanced service coordination, predictability and role clarity to understand their responsibilities and those of the government organizations
- Enhanced quality assurance on an individual level involving quality of life outcomes and pro-active monitoring

For government, outcomes associated with implementing the model will include:

- Streamlined processes through strengthening of the Cross-Ministry Transition Planning Protocol and new or improved collaborative operating agreements to ensure consistency as currently there are leading practice areas and areas where clearly defined requirements are not being addressed. An example is the “Guidelines for Collaborative Service Delivery” (CLBC, Ministry of Social Development (MSD), Ministry of Health and the regional Health Authorities)
- Enhanced role and mandate clarity to ensure the partners understand their role and those of their partner organizations
- Clarification of policies and procedures across ministries and organizations to facilitate service integration, which will reduce time lags and negotiations as to what is to occur
- Increased efficiency and effectiveness through completion of activities earlier in the process by reducing last minute and/or crisis management
- Improved predictability, fairness and transparency in service delivery through clear articulation of service delivery and clarification of what can be expected
- Reduction in the time associated with complaint management and waitlist follow-up efforts
- Development of accountability and quality assurance mechanisms across partner organisations and ministries
- Enhanced data capture, management and sharing

Public engagement and cross-government/organization working sessions will help to inform the model going forward.

2. Introduction

This document provides an overview of the proposed integrated service delivery model which has been designed to address several of the Deputy Ministers' Review recommendations. A service delivery model describes the way that government organizes itself to deliver services and supports to people. This model is a tool to present ideas on changes that need to be made and is intended to provide a context for discussion and engagement.

Input to the model has been secured from: information obtained from the self-advocate engagement process; individuals and their families who are accessing services and supports through CLBC and community engagement sessions throughout the province. The project principles are the foundation to the model.

For details on the engagement sessions, please refer to the following documents.

> The Self-Advocate Engagement Report can be found at: http://www2.gov.bc.ca/assets/gov/topic/D53478E6C207D4FEEE8B245A3994CA26/uploads/final_self_advocate_engagement_report_and_recommendations.pdf
>
> The Report on Network Support Mapping with Families, dated November 15, 2012 can be found at: http://www2.gov.bc.ca/assets/gov/topic/D53478E6C207D4FEEE8B245A3994CA26/community_engagement_workshops/family_engagement/177713__report_on_network_support_mapping_with_families__final.pdf
>
> The Report on Community Engagement Sessions, dated December 12, 2012 can be found at http://www2.gov.bc.ca/assets/gov/topic/D53478E6C207D4FEEE8B245A3994CA26/uploads/177895__community_engagement_sessions___final.pdf

For details on the considerations for and organization of the Integrated Service Delivery Model Structure, including the approach to developing the model, anchor points, person-centric focus, services and supports, please access the document: "Integrated Service Delivery Structure", dated November 1, 2012 at http://www2.gov.bc.ca/assets/gov/topic/D53478E6C207D4FEEE8B245A3994CA26/progress__service_delivery_model/177823__integrated_service_delivery_structure__final.pdf

This document also addresses timeframes for proposed changes and expected outcomes in Appendix A and includes:

- Testing / validation
- Rollout: year 1
- Medium-term implementation: years 2-3
- Longer-term implementation: years 4-5

The process of documenting, refining, testing and finalizing the model will require time and consultation. This is an initial step in the change lifecycle. Agreement on the change direction is required on a high-level prior to investment in detailed work being undertaken. Throughout this document, opportunities for improvement will be identified. Decisions as to which opportunities should be further explored, and prioritization of the opportunities will need to occur prior to the detailed work associated with implementation can begin.

At this time, the model does not specifically address individuals diagnosed as Autism Spectrum Disorder or Fetal Alcohol Syndrome Disorder who do not have a developmental disability, or individuals supported through the Personal Supports Initiative. It is important to note that at this stage in the integrated service delivery model the focus is on changes which can be made within and across government. In the future, the service delivery modelling will expand to service providers and contract management.

Separate financial analysis work, based on the proposed service delivery model, will further examine solutions to track demand and wait times across ministries and CLBC. The financial analysis will also examine cost implications of the changes to service delivery, individualized funding, transition support cost options and their respective links to outcomes. It is anticipated that changes in the model will have some financial implications. The model does move forward assessment and planning activities in an individual's life, in particular youth transition. Services and supports are provided earlier. It is anticipated that the pro-active earlier planning, resource allocation and smoother transitions will reduce crisis situations and the need for more acute/intensive services and support. As a result, over the longer term, costs will not increase to the extent that they normally would and will reduce the rate of increase. In addition, process efficiencies through streamlining and duplication reduction will be found through applying the Lean[3] methodology in the detailed design.

Other work currently in progress, which will inform the next level of detail of the integrated service delivery model design, includes:

- An analysis of the navigator role, which will include cross-jurisdictional research, potential job functions and proposed models for the implementation of the role
- Information sharing and privacy management, which outlines the requirements for sharing data, the types of data which will be shared and the privacy considerations
- An examination of methods of extracting common domains from the myriad assessments done on youth during their school years to arrive at a fuller assessment picture of a young person on which to base a service and support plan moving forward
- A quality assurance framework for service delivery, which will provide the structure for determining service and practice performance measures
- A governance management framework, which will include organizational mandates
- An aging strategy, which is being developed in partnership with CLBC and the ministries of Health and Social Development

Recommendation 12, which is associated with innovation, is being addressed through the BC Ideas competition, the Canadian Inclusive Lives Learning Initiative (CILLI) and Housing Family Journey Project. Other opportunities may present themselves through the refinement and implementation of the model and be brought forward for consideration.

[3] Lean methodology seeks to understand value from a customer's perspective and maximize that value through the elimination of wasteful activities and processes. Lean thinking changes the focus from managing individual departments and services toward optimizing end to end processes or value streams that flow horizontally across technologies, assets, and departments to deliver a product or service to the customer.

3. Overview of the Model

3.1 STADD Vision and Principles

A vision is the view of what the future should look like. It helps everyone working on the model, and those people involved in implementing it, to focus on the common end goal. The vision for the STADD initiative is:

> Integrated supports and services for people with developmental disabilities that support individuals to achieve their goals

In this case, "integrated" reflects the fact that people supporting individuals with developmental disabilities will collaborate and work better together. An integrated service delivery model will try wherever possible to simplify the process of receiving services from the myriad of organizations which provide services and supports making the processes easier to complete and rules easier to understand. Where simplification is not possible, the navigator function within the model will guide individuals and their families through the various structures. The end result will be a system of formal and informal services and supports that will be easier to understand with respect to whom to contact, what is available, what to expect with respect to the service/support and when services and supports are available, eligibility and prioritization. In an integrated, one-government approach, eligibility criteria alignment between services and support is a critical component.

Integration does not reduce all of the complexity, as individuals have unique circumstances which may need to be addressed by different organizations/resources. Integration will streamline processes, increase efficiency and reduce duplication.

The vision and the principles were developed by the senior government representatives who are responsible for directing and guiding the STADD initiative. The vision and principles guide the development of the service delivery model and help ensure that the work stays on track. The principles include:

- **Transparency, Predictability and Consistency:** Families and individuals will be able to understand services and supports available. They will be able to understand whether they are eligible for particular services and when they will be provided. This information should be easy to find and understand.
- **Continuity:** Individuals and their circumstances change. We need to make sure that whatever service delivery model we create can adapt to these changes and ensure that individual needs are still addressed.
- **User-friendly:** Services, supports and processes will be easy to use and understand.
- **Administrative Fairness and Respect:** All of the services and supports have to be respectful of individuals and families. We have also to make sure we are fair in how we treat people. We will need to include ways to appeal a decision that doesn't make sense or seems unfair. We will also need to make sure that decisions are balanced and consistent across the province.
- **Efficiency and Sustainability:** We need to remember that whatever we create has to be sustainable. That means we have to be able to afford it. Being efficient is making sure that the funding is focused on the actual services and supports and not on administration.

The ultimate goal of the service delivery model work is to improve services to individuals with developmental disabilities through supporting individuals to realize improved self-sufficiency, community inclusion and connection and better quality of life.

3.2 Strategies and Experience Change

The model creation will incorporate the following strategies.

Principle	Strategy	Experience Change
Transparency, Predictability and Consistency	Clear eligibility criteria, policies and procedures	✓ Information on services/supports that are available and those that are not available, and why ✓ Consistent application and implementation of policies ✓ Comprehensive information packages, at appropriate times in lifespan segments (e.g. 0-15, 16-24, 24+ and potentially at 55 years of age with respect to aging) for planning, decision-making, growth and wellness solutions
	Service standard objectives	✓ Definitive timelines for service/support provision
	Plain language information provision	✓ Receipt of clear, plain language information packages, with a glossary of terms and visuals that are relevant to the individuals/family with concise summaries of critical points in a timely manner at the appropriate points in time
	Clear accountabilities - A consolidated, clearly defined responsibility and accountability matrix, with specific timeframe and deliverables boundaries	✓ Knowledge of which organization and/or specific individual is responsible for activities which are to occur to provide informed expectations within the collaborative service/support partnership ✓ Required regularly scheduled structured self-reporting on how the responsibilities and accountabilities have been addressed; to be successful, the reporting must be enforced and quick and easy to complete on objective measures
Continuity	Circumstances do not stay the same - when changes occur the appropriate adaptations need to be made; a plan must change to reflect the individual's circumstances and/or development changes	✓ Each individual with a developmental disability diagnosis has a comprehensive and current picture of health and services and supports provided and being received, and an evolving individual support plan which can be accessed by the supporting organization ✓ Enhanced quality assurance encompassing monitoring to ensure that the plan is the right one for the individual (e.g. regularly scheduled check-ins) ✓ Access to relevant information quickly and, where indicated, contingency plans to provide safeguards for high-risk individuals in case of unexpected or extreme change in circumstances (e.g. family, health, safety)

	Build capacity and network supports for adulthood before leaving secondary school	✓ Access to WorkBC Employment Services Centres (the Employment Program of BC (EPBC) administered through MSD) during the last year of secondary school; these services are available today but awareness of this opportunity is low and service providers are building knowledge and skill in serving people with developmental disabilities as the new program stabilizes ✓ Enhanced life-skills training (e.g. financial literacy; comfort with transportation, such as transit; cooking and cleaning skills)
	Open opportunities for growth and development beyond the service-centred children's world to a more community and network-centred one with greater scope for independence and fulfilment	✓ Families provided with information on community services and supports and how to access them
	Apply a holistic approach to the individual, their development and services/community	✓ A team approach to transition planning involving representatives from all of the organizations and supporters who will be engaged with the individual; this will reduce the need to duplicate information and for the individuals and families to provide information multiple times and/or re-tell their story
User-friendly	Person-centred, family supportive approach	✓ A single individual support plan, including funded and non-funded services and supports, which will evolve over time as circumstances for the individual change, and will serve as guidance (high-level integrated direction) under which the detailed plans will fall ✓ Strengthened opportunities for self-determination and self-advocacy by the individual through decision making in the individual support plan creation and throughout the delivery of services

	Single point of contact	✓ Access to a navigator[4], if desired by the individual/family, who has defined functions and assigned responsibilities for and through each lifespan segment, especially transition(s) to guide the individual/family through various processes, identify considerations and provide information
	Self-serve Information access	✓ Single source of integrated or linked information (e.g. website, 1-800 number, booklets, social media)
	Build awareness	✓ Consistently provided information sessions with respect to major life transitions (e.g. youth to adulthood) ✓ Enhanced awareness of changes from youth to adult services and options ✓ Information and support in accessing federal government services and supports (e.g. Registered Disability Savings Plan; Disability Tax Credit; exemptions related to service provision such as home share and Tax Credits) ✓ Identification of non-government funded supports
	Consolidated information	✓ An assessment platform with repository of key cognitive, functional and adaptive assessments,; information from assessments and results centralized and accessible as required for planning and service development
Administrative Fairness and Respect	Processes and eligibility criteria are applied in the same way	✓ Consistency in applying the processes and eligibility criteria, for services and supports received, for all individuals and families; that is, all are treated equitably

[4] At the fall 2012 Community Engagement sessions, stakeholders reviewed the potential navigator (then referred to as key worker) role. This analysis revealed a list of key functions which were necessary and not being fulfilled, at least not consistently. These included system navigation, planning, coaching, building individual and family capacity, information and service coordination, community connector, and ensuring that the services are being provided and that they continue to be the right services. Consistently, individuals and families identified a need for an ongoing relationship with someone that they can call for information and assistance. The analysis and discussions reveal that there are advantages to having some navigators who work only with the 16-24 year old age cohort as they remain familiar with youth and youth supports.

	Support self-determination	✓ Support and opportunities for self-determination and independence through planning, and participation in chosen activities and supports ✓ Ensure educational information is made available to individuals and families with respect to changes in rights and responsibilities associated with becoming an adult ✓ Investigate opportunities for informal but approved mechanisms for supported decision-making in managing specific financial requirements (rather than formal legal representation)
	Equitable funding supported by empirical evidence The existing data does not provide sufficient cumulative and per-individual statistics on services funding	✓ Understand who is and who is not receiving services, and what the value of those services are and the impact of not providing them ✓ Understand levels of funding: e.g. how many received $0 - $10K, $10 K- $15K, etc; distribution regionally or by other criteria; funding by service type; when funding ends and will be available for next applicant
Efficiency and Sustainability	Avoid duplication (e.g. services, supports and assessments)	✓ Improved communication and sharing of current information in a timely and relevant manner to ensure the right supports are available to the individual at the appropriate time, without gaps in service ✓ Clarity with respect to roles, responsibilities and accountability and who to contact
	Provide services and supports earlier if there are benefits to doing so and where the services/ supports would normally be provided at a later time	✓ Earlier and more holistic planning for the individual, including access to assessments, at every stage in lifespan; focus on strengths and abilities, realistic expectations of growth, supports, services, and outcomes
	Increased utilization of general government and municipal services (e.g. school, Employment Program of BC, recreation centres) and supports in adolescence	✓ Individuals and families will experience increased focus on life after school through vocational planning and employment preparation during the later secondary school years ✓ Intentional and focused community access and inclusion; innovative opportunities to build community connections

Areas of concern which were identified through the engagement sessions and will **not** be addressed in the service delivery model include the following.

- Funding of services surfaced in the self-advocate engagement and was identified as a theme in the community engagements. The service delivery model does not explore the adequacy of the funding levels.

- In the self-advocate and community engagement sessions, it was identified that bullying remains a problem and that rather than having a separate anti-bullying awareness program for persons with developmental disabilities that this could be incorporated into the anti-bullying program as a whole.
- Segregation of youth with developmental disabilities from other youth (e.g. special recreational programs) was also mentioned.
- Also identified in the self-advocate and community engagement sessions, was the need for service provider monitoring. The service delivery model has not explored the delivery side quality assurance aspect as yet; this is separate work, which is planned, but not included at this stage.

3.3 Model Structure

3.3.1 Model Components

A service delivery model provides a view of the approach to services and supports and how they all work together. This picture is important as it provides a mechanism for examining and understanding the system of supports and services. The system must work for individuals in the full range of circumstances: for individuals or families who are well-positioned to advocate on their own behalf; individuals who are unable to advocate on their own behalf and who either have no family or whose families do not have the resources to act as advocates, and individuals and families whose socio-economic and cultural backgrounds may make understanding and access more challenging.

The model combines four key elements:

1. The individual and their family (either biological or created) – use of a person-centred approach
2. The key transition points in an individual's life
3. Government services and supports
4. Community inclusion (e.g. culture, personal/social networks, non-government services, municipalities)

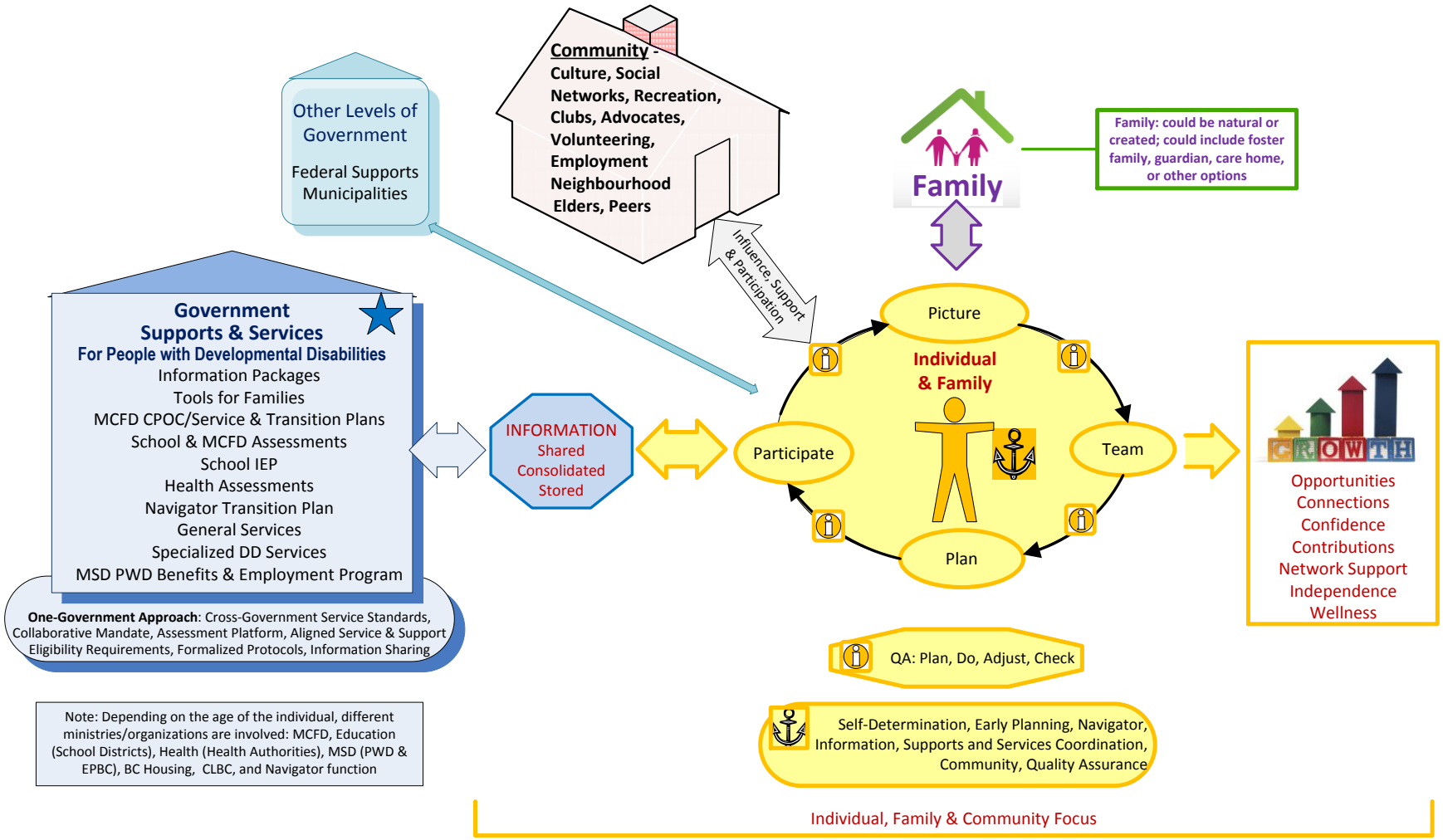
In the depiction of the model which follows, the second element (time) has been removed in order to show how the other three elements relate to each other. The other elements (individual/family, government and community) evolve but remain involved. This will remain true throughout each individual's life regardless of how circumstances and support needs change.

For example, when the individual is a child:

- the community aspect may play a lesser role for the child and a greater one for the family;
- government services, especially Ministry of Education (school) and MCFD will have a larger influence; and
- planning is focused solely on childhood supports and services such as health, assessments, school, social, recreation, inclusion.

The roles and influences change significantly for the youth through adolescence and transitioning into adulthood. For example, the focus of supports and services should move into life after secondary school, adult services and supports, life skills and self-sufficiency.

INTEGRATED SERVICE DELIVERY MODEL – "To Be"



For a list of all ministries and their services, see **Services and Supports for Individuals Who Would be Eligible for CLBC Services at Age 19** Revised: January 12, 2012

See Appendix B for the Services and Supports document

3.3.2 Description of Transition Points

The model is divided into three major life transition points, which all people progress through as they develop and age – childhood, adolescence and adulthood. Each individual will progress through these life stages at different rates. In order to reflect this, the transition from youth to adulthood has been expanded. The three segments are: 0 - 15, 16 – 24, and 24+ years of age. Through the work being done on the Aging Strategy, a fourth a segment for 55+ may be considered.

The age groupings are based on the fact that the youth to adulthood transition is a significant transition for most individuals and can be more complex for individuals with developmental disabilities. Planning and developing life skills at this age, while the child supports are still in place, can have positive life-long impacts. In working sessions with subject matter experts, it was determined that developmentally 16 years of age (around Grade 10) was an appropriate age for identifying aspirations and engaging in planning for adulthood. Post-24 years of age was identified as a time when an individual has moved into adulthood and is typically more established and self-sufficient. It is viewed as the end of the youth transition.

Between 0-15 years of age, the focus is on child developmental milestones in the early years and maximizing potential for growth, discovering the child's abilities and strengths as they grow, identifying adaptive functioning and supports which can help the individual participate in daily activities as much as is possible, developing community and social networks, and learning about future options.

During 16-24 years of age, a number of changes which can be stressful occur including leaving the school system, loss of child-based supports, seeking post-secondary education and employment, exploring expanded community and social worlds, and potentially leaving home and finding independent housing. As well, youth take on more responsibility for decision making as they get older and culminating at age 19 when they assume legal adult status. This growing self-determination for the individual requires their increased participation and involvement in future planning as they enter the mid teen years.

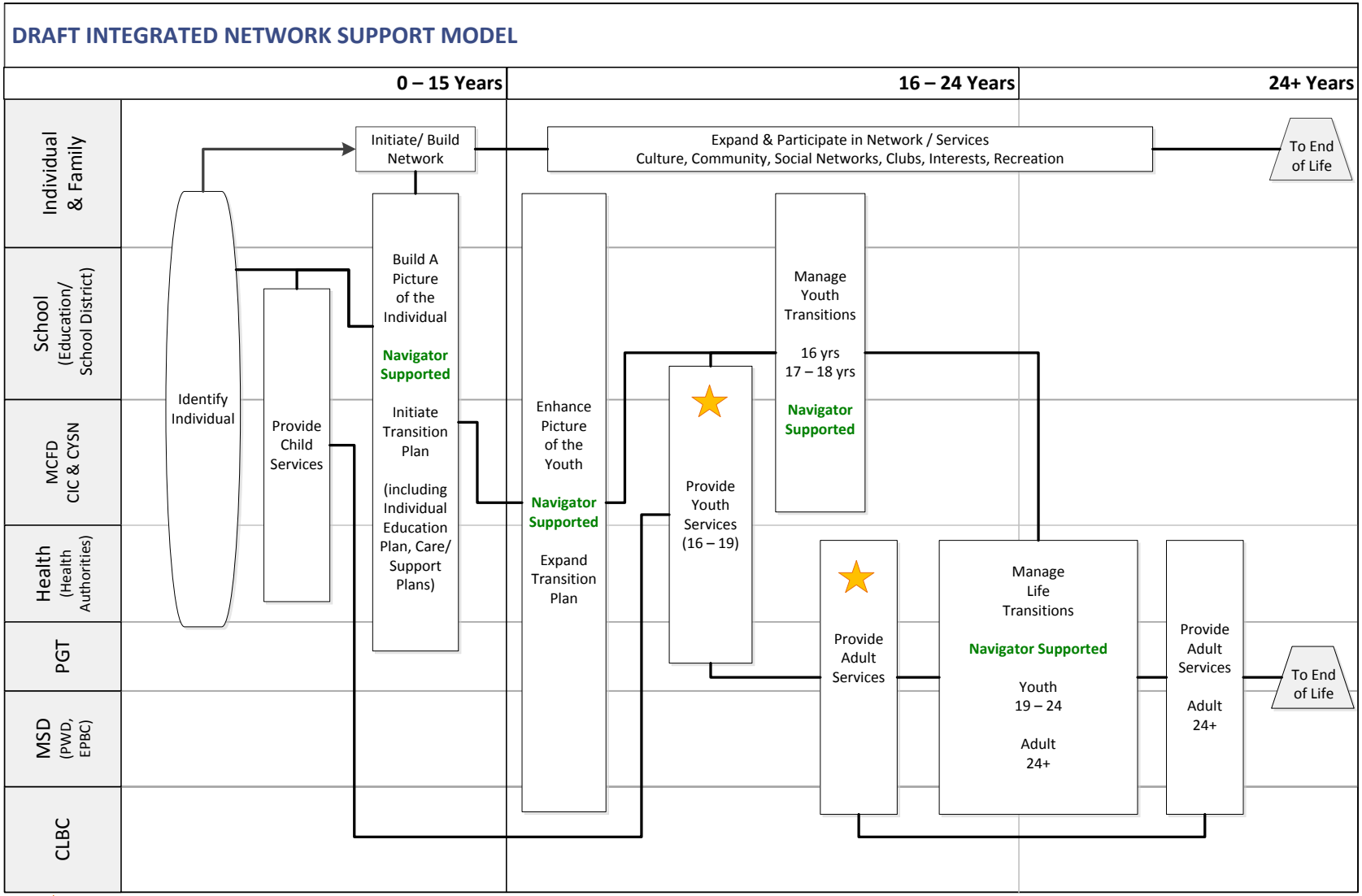
After 24 years of age, some of the big life changes have occurred, but others may happen which have an impact. Change types may be different but the magnitude and impact may be as significant: retraining, new jobs, changing residence, potentially new physical challenges and subsequently need for additional supports and aging of the individual and parents.

For each segment, the following aspects are described in the model:

- Desired Outcomes –the desired milestones which are to be achieved
- Current Service Delivery – the individuals/families being served and supported, the organizations which are providing support, tools being used, strength and opportunities for improvement
- Proposed Service Delivery Model – specific to the age segment under discussion, proposed changes:
    - Provide services and supports
    - Identify the individual – determine who may need transition support
    - Build a picture of the individual – collect assessment, medical, support, service, interest, and goal information to build a holistic picture of the individual
    - Transition planning – initiate/expand the process
    - Develop network support – proactively engage with the community and non-government funded services and supports
    - Keep the picture / transition plan up-to-date

- Benefits and Costs
- Outstanding Items - to be worked through with the working group once the high-level model has been accepted and strategic decisions to be made by the cross-government Steering Committee

Each segment includes a high-level diagram which shows an overview of the organizations and activities. As the project goes forward, each diagram will need to be broken down into more detail to the procedure level. For example, a single entity in the diagram called 'complete assessments' may have several processes in the final version of the model. The next level of detail will be examined once direction is provided with respect to the high-level model and which opportunities should be pursued.


DRAFT INTEGRATED NETWORK SUPPORT MODEL
0 – 15 Years
16 – 24 Years
24+ Years
Individual & Family
School (Education/ School District)
MCFD CIC & CYSN
Health (Health Authorities)
PGT
MSD (PWD, EPBC)
CLBC
Initiate/ Build Network
Expand & Participate in Network / Services
Culture, Community, Social Networks, Clubs, Interests, Recreation
To End of Life
Identify Individual
Provide Child Services
Build A Picture of the Individual
Navigator Supported
Initiate Transition Plan
(including Individual Education Plan, Care/ Support Plans)
Enhance Picture of the Youth
Navigator Supported
Expand Transition Plan
Provide Youth Services (16 – 19)
Manage Youth Transitions
16 yrs
17 – 18 yrs
Navigator Supported
Provide Adult Services
Manage Life Transitions
Navigator Supported
Youth 19 – 24
Adult 24+
Provide Adult Services
Adult 24+
To End of Life
Navigator Involved to ensure that the services and supports are addressing the disability needs and the planned outcomes

4. Segment 0-15 – Initiate and Build Network

Child-centred supports are outside of the mandate of the STADD initiative, with the exception being activities which can help to smooth transition to adulthood. Discovery with respect to an individual's needs and abilities through assessments, information gathering and sharing and family awareness of the next stage of life could smooth the transition to adulthood. Based on this dependency, the model does examine early planning, information provision to the family and, to a degree, coordination of supports and services.

The changes described in this section address the following Deputy Ministers' Review recommendations:

- One government policy framework for persons with developmental disabilities
- Improve cross-government planning
- Assessment platform across the ministries of Children and Family Development, Health, Education and Social Development, along with CLBC
- New government capacity focused on transition supports

4.1 Desired Outcomes

Each individual will develop differently; nevertheless, the following high-level milestones should be achieved by the time a youth reaches their 16th birthday.

Individuals and Families

- ✓ Families have been introduced to the:
  - planning process
  - legal requirements for consent for information sharing
  - the fact that their children will become adults and will have the sole ability to independently provide consents and receive information
  - benefits of starting the planning process for transition when the youth is 16 or younger
  - documentation needed to be gathered and the sources (assessments, current Individual Education Plan (IEP); a listing of services and supports provided through the Ministry of Children and Family Development (MCFD) and schools; medical information including all medical tests completed and services and supports provided
  - the need for proactive, long-range financial planning (e.g. Federal government tax credits and Registered Disability Savings Plan) and developing the individuals financial literacy
- ✓ Families are aware of the role of a navigator and their choices for moving forward given that transition planning is a choice and that working with a navigator is optional
- ✓ Families are aware that the services and supports provided by the government will change as the individual reaches 19; transition planning is a choice; however, realization that transition will happen and services and supports will change is not a choice and must be occur
- ✓ Families receive a plain language information package identifying:
  - the services that the individual is eligible for, services and supports which they may be eligible for and those that they will not receive
- ✓ Families are made aware of regularly scheduled information sessions on transition to adulthood which will include representatives from child-based and adult services

Note: It is not sufficient to provide the information once or in one format. Individuals and their families may need the information a few times and while circumstances are changing for them to resonate.

Government

- ✓ For Children in Care (CIC) with MCFD or a Delegated Aboriginal Agency (DAA), provide contact and age information to CLBC for service eligibility assessment and accurate budget forecasting purposes
- ✓ MCFD – Up-to-date information as it relates to services and supports; Comprehensive Plan of Care (CPOC) for youth in care
- ✓ Ministry of Education (Education) – Up-to-date, initial Individual Education Plan (IEP) and services and supports provided

Assessments

- ✓ Assessment including a diagnosis confirming developmental disabilities by a registered or school psychologist has been completed; an assessment as close as is possible to the 16th birthday is desirable to help with transition
- ✓ Behavioural and functional assessments have been completed
- ✓ The new assessment platform has been used to streamline the assessment process[5]

4.2 Current Service Delivery for 0-15 Years of Age

Throughout the childhood years, child-based services and supports are provided primarily by MCFD and the school districts (schools). Almost all children with developmental disabilities are supported by MCFD or the school system.

Ministry of Children and Family Development (MCFD) provides a range of programs and services for children and youth with special needs (CYSN) and their families. Its services and supports are intended to promote children's healthy development, maximize quality of life, assist families in their role as primary caregivers and support full participation in community life. Services and supports for CYSN include:

- Foundational Programs available in early years such as Early Intervention Therapy, School-age Therapy, Infant Development and Supported Child Development
- Family Support Services such as respite, parenting support and behavioural support
- Services for Children in Care with Special Needs such as residential care
- Specialized Provincial Services such as:
  - Nursing Support Services
  - At Home Program (medical benefits and respite)
  - Autism Funding

While a CYSN worker's referral is not necessary for accessing foundational programs and Fetal Alcohol Syndrome Disorder (FASD) Key Worker services, the rest of MCFD CYSN services are accessed through CYSN workers, who make arrangements for assessments, referrals and financial supports.

[5] Work is in progress on developing the assessment platform, which will consist of common domains from a suite of assessments. A draft for review will be available at the end of February 2013.

- Children with developmental disabilities can access foundational programs and are eligible for the CYSN Family Support Services. Developmental disability is defined as the DSM-IV diagnosis.

Ministry of Education (EDUC) has a partnering relationship with school districts. EDUC does not deliver services directly. The ministry allocates funds and develops overarching policy and procedures; each school district and school is responsible for determining the educational program of individual students. Their responsibilities include planning and service provision for all students, including students with special needs, i.e., the development of individual education plans. Districts and schools undertake their planning activities based on available resources, local needs and priorities.

EDUC has established the elements to be addressed in an IEP. More information about IEP development is available in the ministry document Special Education Services, A Manual of Policies, Procedures and Guidelines: http://www.bced.gov.bc.ca/specialed/ppandg.htm and in the document "Parent's Guide to Individual Education Planning" (co-developed by EDUC and the BC School Superintendents Association).

Schools - It is in the school system that most of the children will be assessed for a developmental disability in order to receive learning supports. The assessment is vital to receive adult services with CLBC and Persons with Disabilities Benefits (PWD) with MSD. The draft changes to the MSD PWD regulation allowing assessments from school psychologists will simplify the PWD application process.

- Learning specialists develop IEPs which focus on educational goals and objectives and transitions throughout school (elementary, middle and secondary school); as with all plans, the quality of an IEP is dependent on the person preparing it; the Ministry of Education can direct school districts to the policy about IEPs and what they need to contain
- Learning specialists arrange/make referrals for cognitive and adaptive functioning assessments which are funded by the school district
- Other services include: school district counsellors, school age therapies, learning specialists, sports, clubs and other network-building opportunities.
- The Ministry of Education provides the funding for each student and supplemental funding for the special assistance supports as required
- Education-funded cognitive, adaptive and behavioural assessments are paper based and managed at the school level

As can be seen from the description, the services and supports are primarily provided from a single source or two sources, which differs from the service provision in the adult world in which services and supports are provided by eight different government organizations. When MCFD is involved as well as the school, there are no formal information sharing process or procedures in place between MCFD and all the school districts. When health services and supports are required, MCFD makes the arrangements with the health authorities.

Public Guardian and Trustee (PGT) acts as co-guardian with the MCFD or Delegated Aboriginal Child and Family Service Agencies for youth under Continuing Custody Orders (CCOs), and is responsible for the protection of the financial and legal interests of children and youth under a CCO.

Ministry of Health (HLTH) develops policies and allocates funding to the health authorities, which deliver specific services for specific needs. For children and youth, these services include:

- Regional psychologists who complete requisite assessments, e.g. PHSA Autism assessments
- Primary physician and psychiatrist services which are sourced via Medical Services Plan and Alternate Payments Program
- Referral to a health care professional for Developmental Disabilities Mental Health Services (DDMHS) once the individual reaches 14 years of age and meets the DDMHS criteria; the service encompasses assessment, planning and some limited short-term support
- HLTH also provides services to children in the form of pediatric teams and some children are very involved in hospital based services
- Community Developers (Vancouver Coastal Health Authority) have assisted parents in transition groups for children aging into adulthood)

The Cross Ministry Transition Protocol for Youth with Special Needs

The Cross-Ministry Transition Planning Protocol for Youth with Special Needs (the Protocol) came into effect on November 1, 2009. The focus is on young people between the ages of 14 and 24 who require significant additional educational, medical and social support. It is an agreement between eight government organizations on how they will work together to support youth with special needs transitioning to adulthood and their families. The Protocol outlines the roles and tasks of team members, youth, family, and staff from schools, youth and adult services. It outlines the activities which should occur and when. The Protocol itself is generally recognized as solid and including all of the needed activities, milestones and partners. The Protocol Working Group includes community organizations as well as the partner government organizations.

Still, significant numbers of families with children with developmental disabilities seem to be unaware how services and supports will change when they reach adulthood, resulting in a lack of preparedness. Those who are more aware often do not know what information is available or cannot find it. In addition, they report having to deal with multiple access points, re-telling of stories, confusion regarding what services are available, difficulty communicating their needs and wishes. They are also facing uncertainty about what level of support they can anticipate receiving post age 19 as this will be a significant change from services receiving through MCFD.

A vulnerability in the Protocol is that the role of 'team/transition coordinator', whose roles and responsibilities involve bringing all of the necessary components (organizations, services, assessments, medical information) together is not formally assigned and has no authority to bring key contributors to the planning process or to hold them to account for tasks which belong to that organization. In addition, only MCFD, MSD and CLBC are consistently actively engaged in the Protocol activities. MCFD, including Delegated Aboriginal Agencies and CLBC have signed an Operating Agreement related to provision of services to transitioning youth. It is important to note that MCFD continues to work on the Protocol by developing policies and tools/templates for the ministry's social workers. These are solid efforts which should be built upon. However, these efforts will have a limited impact unless the other service providing ministry organizations are formally involved and required to participate.

Today, the Protocol generally works well for MCFD CIC, as does the Operating Agreement. These transitions generally work smoothly as the MCFD Children and Youth with Special Needs (CYSN) worker[6] takes on the role of the transition coordinator in these cases. While the majority of the transitions do go smoothly, relatively

[6] A Children and Youth with Special Needs (CYSN) worker is a person employed by MCFD who provides support to children and youth with special needs and their families to plan for and access supports and may include case management. The CYSN worker is responsible for confirming eligibility for CYSN services (e.g. eligible for Autism or At Home programs, or has a developmental disability) and acts as liaison with community partners and service providers.

frequently, CLBC facilitators are not receiving important materials, such as the CPOC. Anecdotally, the most time consuming aspects of these transitions for both MCFD CYSN workers and CLBC facilitators[7] are associated with gathering the proper assessment material and arranging for health services through the health authorities. There is no formal tracking of workload time allocations.

The following table provides an analysis of the current service delivery model

Lack of…	Proposed Solution
Transition coordinator (navigator) with formal authority to ensure activities are completed by various service and support organizations Currently, the function of coordinator/team lead is not assigned to a job position in the cross ministry youth to adulthood transition protocol	✓ Navigator position with the authority to engage all of the needed government organizations (those who are providing services to the child or will be providing services to the future adult) ✓ This position would complete the coordinator/team lead role described in the Protocol
Consistent transition planning and supports for children/families with lower support needs. Individuals with high support needs and their families meet with MCFD CYSN workers on a more frequent and consistent basis and receive support whereas transition planning does not consistently occur for individuals with lower support needs	✓ A transition plan will be developed for each youth for those families who would like to have one; the plan should include future living arrangements, education and employment, financial arrangements/planning and community and social involvement ✓ If there are health-related issues, and a health-related need exists, the Heath Authority must be involved
Family awareness of the extent of change resulting from moving into adulthood and being fully informed on the implications of those changes	✓ Earlier initiation of transition plans to orient the families on the future (approximately age 16); educate them on coming changes; provide opportunities for capturing and implementing their own decisions ✓ Realistically manage expectations of families by being clear, honest and fair in presenting options and eligibility ✓ Clarification of legal status changes at 19 ✓ Access to recognized but informal supports for financial planning, decision-making and transactions

[7] A CLBC Facilitator coordinates and plans services for eligible adults and their families as well as information to transitioning youth and their families.

Relevant, consolidated, easy to find and understand information for the individual/families	✓ Plain language information package for families ✓ Single website for information on youth to adult transition ✓ Better coordination and standardization of channels and content of transition sessions ✓ Full alignment of partners in planning and service delivery (particularly HAs and CLBC) ✓ More outreach to individuals and families involving both youth and adult services (e.g. regularly scheduled, orientation sessions, transition fairs and presentations by adult services,) ✓ Information on services and supports which are available within the community in which individuals live ✓ Information on federal government supports and benefits ✓ Orientation for families will include clear prerequisites for eligibilities and transition activities
Reliable information on recommended financial options, such as federal benefits and tax credits, including optimal timing for maximum benefit	✓ Information to families to include links to sites detailing recommended financial planning and legal issues such as Representation Agreements ✓ Access to recognized informal supports for the individual to do financial planning, decision-making and transactions ✓ Consideration of 3rd party administration of benefits ✓ Provide families and individuals information on community resources to support tax filing, Disability Tax Credits application and setting up Registered Disability Savings Plan
Automation of data – CYSN workers cannot flag within their system children who are approaching adulthood; they need to maintain their own systems of making sure families are provided with timely information and transition planning is in place; this data is being provided on an annual basis to CLBC. . Currently, while ICM is being used by CYSN worker, the particular transition flag is not in place.	✓ ICM, the Integrated Case Management system used by MCFD and MSD, will be examined to identify how this type of query can be accomplished
Consistently up-to-date assessment information – cognitive and adaptive functioning assessments	✓ Assessments to be updated as close to age 16 as is possible; within the school districts, this could be accomplished through clarification in the Special Education Policies, Procedures and Guidelines Manual

Health Authorities are not engaged during these early years in the Protocol	✓ HSCL / HCC will be involved in an individual's transition team as required ✓ Consultative Mental Health Services for individuals with developmental disabilities begin at age 14 when an individual meets the criteria (under the Community Living Authority Act: DSM-IV)
Schools do not consistently engage in transition planning as identified in the Protocol; the majority of the teachers are not aware of the Protocol and their role within it	✓ Supply a list of youth who have developmental disabilities to the navigator organization ✓ Identify youth who receive required supports including an annual IEP, counselling, vocational and life skills training and exposure to considerations for future planning ✓ Ensure parent understanding of transition milestones and the role the school can plan in their achievement; ensure as much as possible that assessments are up-to-date and available ✓ Schools are included as part of the transition team
Post-secondary preparation and opportunities for youth with developmental disabilities (e.g. most community colleges have evolved into degree granting institutions and have reduced or eliminated programs)	✓ Enlist the Ministry of Advanced Education (AdvEd) to advance the needs of individuals with developmental disabilities and encourage reinstatement of programs ✓ Increase focus on new approaches like Steps Forward which are more inclusive than old segregated programs
Not all children with developmental disabilities have a formal diagnosis	✓ Both MCFD and school districts are diligent in trying to ensure that assessments are in place for all of the children who require them; identification of children with developmental disabilities is improving through existing efforts ✓ Ensure that assessments are completed as close to 16 as is possible so that current information is available for transitioning
Assessment integration	✓ Implementation of an assessment platform with incorporating common domains from the various assessments done on youth during their school years to arrive at a fuller assessment picture of a young person on which to base a service and support plan moving forward. Speech and language pathologists; nurses; OTs, PTs; psychologists; school personnel; families; navigator, would all contribute specific clinically based information on adaptive and functional strengths and challenges which could be viewed and used holistically

4.3 Proposed Service Delivery Model for 0-15 Years of Age

There exist five main processes during this period:

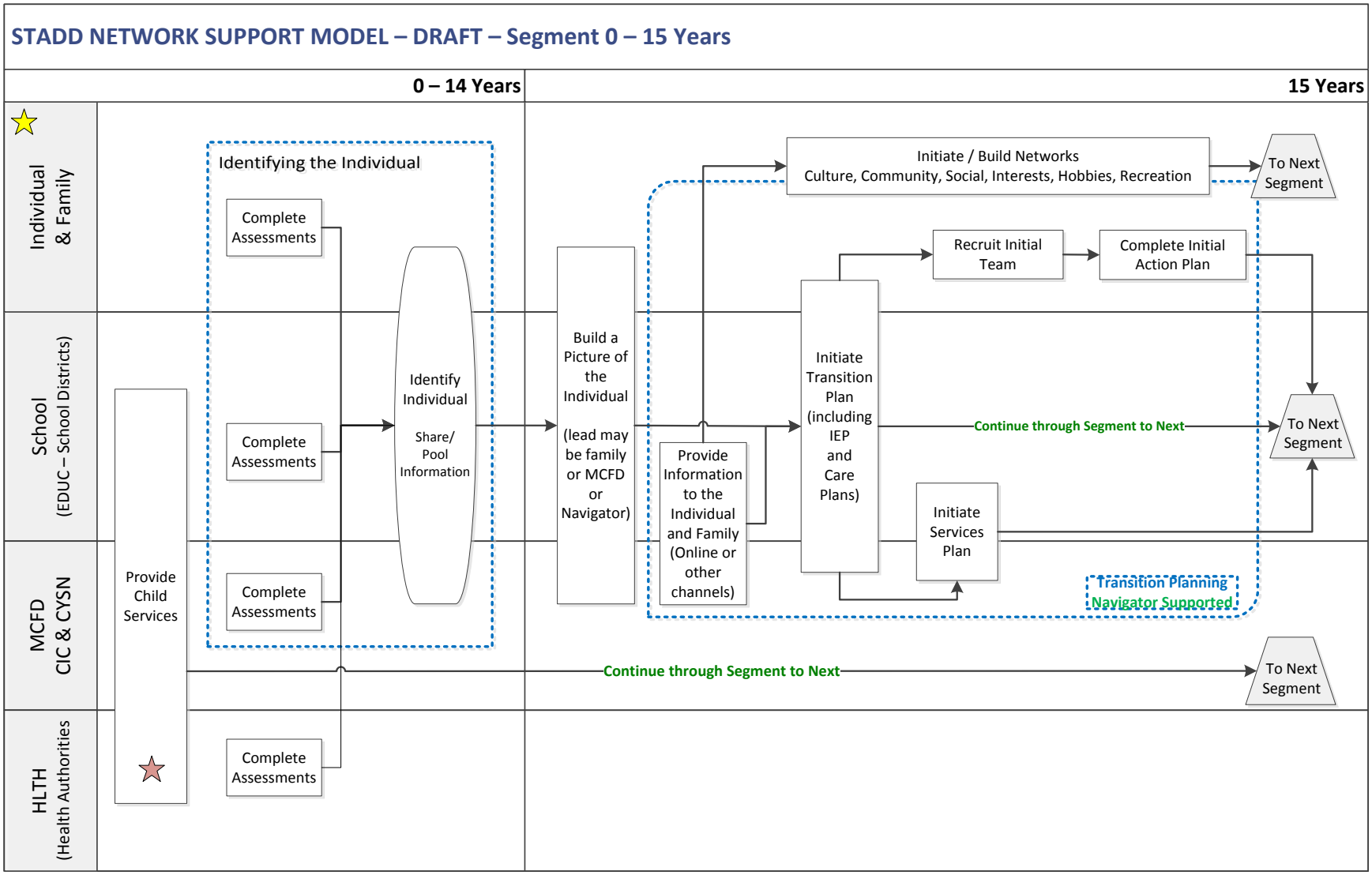
1.0 Provide child-centred services and supports

2.0 Identify the individual – determine who may need transition support

3.0 Build a picture of the individual – collect assessment, medical, support, service, interest, and goal information to build a holistic picture of the individual

4.0 Begin transition planning – initiate the process

5.0 Develop network support – proactively engage with the community and non-government funded services and supports



Family can also be Guardian (OPGT), Foster Family, or other relationship

For children to age 14, provide generic services; at age 14, may be eligible for DDMHS

1.0 PROVIDE (PARTICIPATE IN) CHILD-BASED SERVICES AND SUPPORTS – There are no significant changes to existing processes with the new service delivery model for children under the age of 16 but any new model should allow for flexibility in initiating planning and setting the stage for collaborative planning for future transition

WHO – Individuals included in this group include children supported by MCFD and/or School Districts

WHAT – Provide services and supports to children and their families

- Enhance inter-agency communications protocols and processes to optimize service delivery

WHEN – Beginning in the early child development years with MCFD and the school system once the child is attending elementary school

WHY – To enable learning and daily activities for those individuals who need and are eligible for them

WHERE – MCFD and Education are the two primary sources for supporting children and families who need it

2.0 IDENTIFY THE INDIVIDUAL

WHO – Children supported by MCFD and/or School Districts

Children diagnosed as having intellectual developmental disability within the school system, including public, private and registered home-schooled individuals. The only individuals excluded from this population are home-schooled children who are not registered in any program.

Children supported by MCFD

- Children/Youth in Care with special needs, where the ministry is the legal guardian
- Children/Youth with special needs living at home. They could be eligible for the At Home Program, Autism Program, Family Support Services or Nursing Support Services. Children with developmental disabilities and mental health challenges

WHAT – Identify individuals with developmental disabilities who may need transition support

WHEN – Beginning at age 14 up until the individual's 19th birthday on a regularly scheduled annual basis for all transitioning youth with a developmental disability

WHY

- To make CLBC, the adult serving organization, aware of individuals who may be eligible for CLBC services so that preparations for eligibility determination and high level forecasting projections can be made (this does not guarantee the funding)
- To make the navigator organization aware of individuals/families who may need transition support so that they can ensure that those families who wish to have support in developing a plan, receive it
- To ensure all those who may need transition information are aware of where and how to find it
- To identify individuals with complex medical needs to begin their transition planning as soon as possible to ensure continuity of services and supports and reduce stress on the family

WHERE – MCFD and Education are the two primary sources for identifying youth who are aging into the transition group

MCFD – The ministry will have information on the individuals/families who have received services and/or supports

EDUC – The ministry will have information within their central database on the individuals/families who are receiving learning supports

HOW – ***Changes in service delivery are highlighted in green italics***

1. Schools (Primary)/MCFD (Secondary) – Complete required assessments by age 16 ***(as close to age 16 as is possible so that current assessments are available for the transition)*** – psychological, cognitive, adaptive functioning and behavioural assessments
2. Schools – flag for required supports including an annual IEP, counselling, vocational and life skills training (e.g. financial literacy) and exposure to considerations for future planning
3. MCFD – flag for required services and supports - indicators of programs or services that the individual is enrolled such as Family Support Services, At Home Program, Nursing Support Services
4. MCFD – make a referral to health authorities DDMH Youth and Adult Services, when required, beginning at age 14
5. MCFD – Semi-annually provide CLBC and ***navigator organization*** with a list of youth who:
    - Are in care by court order and are known or believed to be eligible for CLBC services (youth`s name, date of birth and whether the developmental disability is confirmed or suspected)
    - MCFD does not have guardianship and where the family is receiving support services for the youth or the child is in care by agreement (non-identifying information)
6. ***EDUC/MCFD – Semi-annually provides the navigator organization with the list of individuals with a diagnosed developmental disability. EDUC/MCFD indicates which youth and their families would most benefit from having a navigator take on the key role in supporting their transition. MCFD CYSN Worker and the navigator may discuss other families, who may benefit from the navigator's involvement.***

Outstanding Items

a. Issues regarding data collection, storage, retrieval, and sharing require definition, clarification, and solution.
b. Are there opportunities to make the IEPs more focused on life after school, in other words, transition to adulthood; there are areas of province which have implemented leading practices (e.g. Burnaby); IEPS can be key in matching a student's educational programs and experiences to their post-school goals?
c. Education – Cognitive assessments are typically completed by the school in order to determine the need for learning supports. However, the assessments at school-leaving age are not always current and can date back to pre-teen years. Facilitate updates to the Special Education Policies, Procedures and Guidelines Manual requiring that an updated assessment be available as close to age 16 as is possible to help with the transition and, if not already in place ensure that any assessment meet language requirements for CLBC eligibility.

Strategic Decisions

S01. Navigator position – *Should this position (service delivery model change) be explored further through piloting its implementation?*

A navigator position has been proposed as a support during transition; with the youth transition being the first to be explored. Families have identified that: this role is required as a single point of contact; it would help smooth transition; and it should be at the family's discretion as to whether or not they would like this support.

The navigator job position is being further examined through cross-jurisdictional research, analysis of the role and how it would fit into the British Columbia context and costs. Three models of the position are being considered, the first being strong engagement during youth transition with light engagement thereafter, a hybrid model with a single point of contact and stronger engagement throughout life's transitions and a full case management model. A draft of the analysis will be available at the end of January, 2013.

S02. Navigator organization – Should there be a decision to proceed with the navigator position, the question of which organization they should work out of needs to be considered. Within Alberta, this position resides within the children serving organization but transition support stops at 18. By having CLBC responsible for the transitioning role, which they are to some extent currently, are all individuals being directed to the disability sector as an unintended consequence*? Who should be engaged in identifying the best organization for hosting the navigator position?*

S03. Education – Provision of transitioning youth contact information and age would be a new function for the ministry. *Is this a function which Education could take on? It is believed that the capacity to complete this exists. A reporting framework would be required.*

S04. MCFD – Cognitive assessments, where they have not been completed by the schools, can be funded through MCFD where regional funding is available for youth not in care, however, the assessments on file when the youth leaves school are not always current and can date back to pre-teen years. *Should an update be made to the ministry`s policies requiring that an updated assessment be available as close to age 16 as is possible to help with the transition?*

3.0 Build a Picture of the Individual

WHO – Children diagnosed as having developmental disabilities within the school system and/or being supported by MCFD

WHAT – Collect assessment, medical, support, service, interest, and goal information to build a holistic picture of the individual

WHEN – Beginning when services and supports are first provided and ensuring as a comprehensive collection of information as is available by the youth's 16th birthday

WHY – To have the information in place needed for planning transition activities

WHERE

MCFD when an individual is a CIC with developmental disabilities, or where the youth with developmental disabilities lives at home and the family is eligible for CYSN Family Support Services.

Education – schools for the majority of the children with development disabilities

HOW – *Changes in service delivery are highlighted in green italics*

1. Schools/MCFD – Identify required assessments
2. Schools/MCFD – Complete required assessments
   Ensure that required assessments are completed before, and as close as possible to, age 16.
   To ensure consistent findings and centralized information, the consolidated matrix of assessments on the assessment platform will be utilized
3. Health Authorities – Participate in planning, advise of health care considerations including services and supports being provided; ***ensure required assessments are completed when and as required***
4. ***Schools/MCFD – Complete the summary of assessments conducted and where they are filed (Note: these summaries may be completed today but there is no way of ensuring this nor is there an electronic repository for them)***
5. ***Schools/MCFD – Provide support services (e.g. assessments, teaching and after-school programs.); ensure a complete summary of supports (case notes, a Service Plan or CPOC in the case of MCFD) is provided and key health issues (currently done inconsistently); ensure the information is available as required***
6. Schools – Ensure up-to-date IEP and listing of supports
7. MCFD – Update summary of services and supports being provided
   (Note: not clear as to whether this is automated and if it is consistently done as this information is not being provided consistently to CLBC)
8. ***MCFD – Both at the point of identification and later in the relationship, indicators set on the records identifying special circumstances need to be taken into account. These indicators may highlight a specific ministry or agency would have to be represented on the individual's transition team.***
9. ***MCFD Social Worker/School Counsellors/Family/Individual – identify the individual's interests and informal network. Part of the discovery will include learning and recording information on the following with the individual involved (currently done inconsistently):***
   - Current community: cultural background, friends, faith affiliations, clubs
   - Interests: extracurricular activities, recreation, leisure activities, music, art, sports, educational and/or occupational aspirations
10. Individual/Family – build a portfolio of the individual's services, supports and assessments

Outstanding Items

a. Work on the assessment platform is in progress and will be completed for review at the end of February 2013. Information sharing capability will influence the efficiency and effectiveness of the assessment platform.

b. Checklists and templates for collecting the required information

c. Mechanism and methodology for coordination and sharing of information, including communication protocols and requisite consents. A single repository for at least the summary information would be beneficial, reduce duplication of effort and identify where key information can be found.

Strategic Decisions

S05. Whether or not MCFD CYSN workers will be using ICM to file all of the collected information; thereby, making the information available within a single repository

4.0 Begin Transition Planning

WHO – Children diagnosed as having developmental disabilities within the school system and being supported by MCFD and their families

WHAT – Start the Transition Planning Process

WHEN – Before a youth's 16th birthday

WHY

- To ensure that the transition activities occur while the youth is still in secondary school
- To achieve the goal to create supports and opportunities that enable a youth with developmental disabilities to be self-determining
- To provide a basis for financial forecasting for future need

WHERE

MCFD when a youth is a CIC with developmental disabilities, or where a youth with developmental disabilities lives at home and the family is eligible for CYSN Family Support Services.

Education – schools for the majority of the children with development disabilities

HOW – ***Changes in service delivery are highlighted in green italics***

1. ***MCFD CYSN Worker/School Counsellor – Provide an information package on how to build community networks, transition planning and what services and/or support are available within the community; it should also provide information on the legal implications of an individual turning 19.***
2. ***MCFD CYSN Worker/School Counsellor – Explain to the individual and family, at a high-level, the changes which will occur as a result of transitioning into adulthood, that services and supports will change, the benefits of transition planning, the role of the navigator and the choices which are available***

3. ***MCFD CYSN Worker/School Counsellor – If the family is interested in working with a navigator, obtain a signed consent form for sharing MCFD and school information with the navigator so that the navigator can brief themselves on the key pieces of information***
4. ***MCFD CYSN Worker/School Counsellor – If the family is not ready to sign a consent form, ask permission for a navigator to contact them in the future***
5. ***Health Authorities should be consulted on complex health issues and/or changes in the health status of an individual and become an active participant in planning when such issues are identified.***
6. ***Navigator – (in 15th year)***
    - ***Introduce themselves to the individual/family***
    - ***Identify the services and supports and that are available***
    - ***Answer questions that the individual/family has about the transition package***
    - ***Clarify their (the navigator's) role***
    - ***Clarify the role of the individual and family***
    - ***Provide information on transition information sessions which are available within the community***
    - ***Clarify which services and supports are available during the transition period and in adulthood***
    - ***Provide information on benefits of early financial planning (e.g. Registered Disability Savings Plans) and where to find details on federal programs (e.g. tax credits)***

Outstanding Items

a. A plain language information package needs to be developed, which would allow an insert for community services and supports

b. It is assumed that the navigator organization would be responsible for coordinating quarterly information sessions

c. The need for Information Sharing Agreements will need to be examined

Strategic Decisions

S06. Decision as to whether or not a transition plan should be developed for each youth for those families who would like to have one

S07. Support for regularly scheduled, quarterly transition sessions involving the navigator, transitioning services from schools and WorkBC Employment Services Centres and adult services (CLBC and MSD); the provision of these types of sessions have been identified within the Protocol but do not occur

S08. Decision to proceed with a single developmental disability website from which all government and non-government information, services and supports could be accessed

S09. Whether or not to increase emphasis on maintaining Health Care Plans/Plan of Care by schools and MCFD and having that information, with the proper consents, to the adult serving organizations to help with transition

5.0 Develop Network Supports

WHO - Families/Foster Families and service providers.

WHAT – Develop community networks

WHEN – Beginning when services and supports are first provided and ensuring as comprehensive collection of information as is available by the youth's 16th birthday

WHY – To support the transition to adulthood by ensuring that non-paid resources and supports are in place for fuller inclusion

Beyond the immediate family unit, an anchor point for the individual and their network of support is found in those closest to them – their community and culture. The effects and influence of these components are important as the child reaches puberty and beyond. Peers, friends, relationships, social groups, and the organizations they join become central to healthy development, a sense of self-determination and growing independence.

Some examples would be:

- Cultural groups and relationships (ethnic, religious, other affiliations)
- Family Support Institute and similar social network resources
- Recreation Centres
- Local Organizations: Care, Residence, Training, Volunteering
- Transportation providers
- Schools – after-hours programs such as clubs, sports, interest groups
- Access to alternative or additional training

It is important for families and service providers to learn about opportunities in their area, and build these activities into daily routines as the child becomes older and encourage the individual to explore new pursuits.

WHERE – Community, neighbourhoods and municipalities

HOW – ***Changes in service delivery are highlighted in green italics***

1. MCFD/Schools – Offer suggestions to youth and family on activities they can do to promote skill development, self-confidence and self-determination of the individual (e.g. budget management, cooking, laundry, taking public transportation). It is important to ensure goals are being worked on whether it is the family or a contracted service who is working with the individual.
2. Individual/Family – Engage in peer networks
3. Individual/Family – Plan a network of support

Outstanding Items

a. The extent to which government organizations and staff should help in the development of community networks
b. The CYSN contracts and expectations of providers; language in these contracts should refer to supporting skill development for youth

Strategic Decisions

S10. Should the government formally establish peer networks

4.4 Tools

The following is a summary of the tools and templates that are most often used to assess an individual's strengths, interests and challenges so that the family, counsellors, school personnel, CYSN workers and other team members can establish goals, activities and plans. As in all information sharing, a mechanism to obtain and share appropriate consents will be in place.

1. **Assessment of developmental disability**, initiated by the school districts (Note: EDUC will facilitate updates to the Special Education Policies, Procedures and Guidelines Manual requiring that an updated assessment be available as close to age 16 as is possible to help with the transition). In cases where the school district is not able to provide an assessment, MCFD would provide funding to cover the costs of a psychological assessment for CIC or, where budgets allow, for children eligible for the Family Support Program.
2. **Individual Educational Plan** – created annually with a teacher and/or learning specialist at the school; tied directly to transition plan outlines
3. **Transition Plan** –template with mandated and optional components; minimum level would be an outline plan from the mandated components, discussed with and reviewed by the family
4. **MCFD Plan of Care for children in care or Support Plan/documentation for children not in care**; contains a summary of lifespan services and detailed information on current services at a point in time
5. **Health care information** - when a child has medical needs; assessments (e.g. Inter-RAI) to assist with eligibility decisions

4.5 Benefits and Costs

4.5.1 Benefits

1. More empowered, knowledgeable individuals and families, who have an awareness of what the future holds with respect to legal, financial and service implications and the options which are available (service and employment opportunities). ***Principles – Transparency, Predictability and Consistency; User-friendly; Continuity***
2. Focus on planning earlier which will help to ensure that transition activities occur while the individual is in secondary school and child-based services are in place to provide support. ***Principles – Transparency, Predictability and Consistency; User-friendly; Continuity***
3. Enhanced clarity on the role of the schools regarding children and youth with developmental disabilities. ***Principles – Transparency, Predictability and Consistency; User-friendly; Continuity; Efficiency and Sustainability***
4. Earlier strengthening of community connections/inclusion for the individuals and preparation for a fuller role in their personal network. ***Principles – User-friendly; Continuity***
5. Reduced last minute scrambling and crisis aversion to secure services and supports to address gaps in service. ***Principles – Transparency, Predictability and Consistency; User-friendly; Continuity; Efficiency and Sustainability***
6. Consistency of transition plan development for youth with developmental disabilities; even those with lower support requirements. ***Principles – Transparency, Predictability and Consistency; User-friendly; Continuity; Efficiency and Sustainability***
7. Definitively identify downstream benefits: it is assumed that there will be less stress, confusion and frustration for the youth and families; there will be fewer incidences of crisis management and decreased requirements for expensive interventions, services and supports in the future. It is believed the investment will pay off in the same manner as preventative medicine does. ***Principles – Transparency, Predictability and Consistency; User-friendly; Continuity; Efficiency and Sustainability***

4.5.2 Costs

1. It is anticipated that there will be additional investment costs associated with the navigator job position. A workload and cost analysis on the position is in progress and is expected to be completed by the end of February, 2013. There will be subsequent savings from crisis avoidance, last minute efforts to provide services and CLBC facilitator time in supporting individuals and families.
2. Providing requested support services (baseline services) without extensive discussion and waitlist procedures and repeated contact with families who are waiting will save significant work time at CLBC for facilitators and analysts.
3. With respect to the school system, there may be additional supports required by resource teachers, transition workers and/or learning specialists. A workload and cost analysis is also in progress to estimate the impacts.

5. Segment 16-24 years – Strengthen Network / Support Transition

A youth and their family have many choices to make about education, entering the workforce, living arrangements, establishing a financial plan and finding new supports for adult success. Youth with developmental disabilities have even more to consider as they face adulthood.

The changes described in this section address the following DMs' Review recommendations:

- One government policy framework for persons with developmental disabilities
- Improve cross-government planning
- A system to track demand, wait times and service delivery across ministries and CLBC
- Assessment platform across the Ministries of Children and Family Development, Health, Education and Social Development, along with CLBC
- New government capacity focused on transition supports
- Increase employment services planning and supports

5.1 Desired Outcomes

The following high-level milestones should be achieved between 16-24 years of age.

Individuals and Families

- ✓ Transition plan for each youth with developmental disabilities whose family wishes to participate in the process
- ✓ Individual actively involved in transition activities between the youth's 16th and 19th birthday
- ✓ Confirmation of Persons with Disabilities Benefits eligibility, where applicable, by age 17.5
- ✓ Confirmation of CLBC services and supports eligibility, where applicable, by age 18
- ✓ Confirmation of health authority services and supports (Home and Community Care – HCC, Mental Health and Addictions) by age 18
- ✓ Knowledgeable families assisting individuals with planning for and participating in post-secondary training, meaningful employment and/or community inclusion, consistent with capabilities; discovering and meeting goals
- ✓ Smoother transition from youth to adulthood with services and supports confirmed by age 18
- ✓ Increased awareness and smoother transition to employment services and supports

Government

- ✓ Health service and supports continuity
- ✓ Residential continuity
- ✓ Navigator organization engagement begins when the individual is 16 years old

5.2 Current Service Delivery for 16-24 Years of Age

Between the ages of 16 and an individual's 19th birthday, child-based services and supports are provided primarily by the MCFD and school districts (schools). The process details included in the following are taken from the Protocol and Operating Agreements between the related parties.

Ministry of Children and Family Development (MCFD) provides a range of programs and services for children and youth with special needs and their families. Its services and supports are intended to promote children's healthy development, maximize quality of life, assist families in their role as primary caregivers and support full participation in community life. The services provided by MCFD end when the youth reaches 19 years of age with the exception of very specific special agreements.

Services and supports for CYSN include:

- Family Support Services such as respite, parenting support, behavioural support
- Services for Children in Care with Special Needs such as residential care
- Specialized Provincial Services such as:
  - Nursing Support Services
  - At Home Program (Medical Benefits and Respite)
  - Autism Funding
- MCFD CYSN services are accessed through CYSN workers, who make arrangements for assessments, referrals and financial supports.
- Children with Developmental Disabilities are eligible for the CYSN Family Support Services. Developmental Disability is defined as the DSM-IV diagnosis.

Ministry of Education (EDUC) has a partnering relationship with school districts. EDUC does not deliver services directly. The ministry allocates funds and develops overarching policy and procedures; each school district and school is responsible for determining the educational program of individual students. Their responsibilities include planning and service provision for all students, including students with special needs, i.e., the development of individual education plans. Districts and schools undertake their planning activities based on available resources, local needs and priorities.

Schools - It is in the school system that most of the children will be assessed for an intellectual disability in order to receiving learning supports. The assessment is vital to receipt of adult services with CLBC and Persons with Disabilities Benefits with MSD.

- Resource teachers/learning specialists develop IEPs which focus on educational goals and objectives and transitions throughout school (elementary, middle and secondary school)
- School board teams or administrators arrange/make referrals for cognitive and adaptive functioning assessments which are funded by the school district
- Other services include: school district counsellors, learning specialists, sports activities, clubs and other network-building opportunities
- EDUC provides funding based on student enrollment. In addition, the ministry provides supplemental funding to support students with exceptional needs (e.g. moderate to profound intellectual disability). It is at the discretion of the school district as to whether or not an additional school leaving year will be provided

- Education-funded cognitive, adaptive and behavioural assessments are paper based and managed at the school level

Ministry of Health (HLTH) develops policies and allocates funding to the health authorities, which deliver specific services for specific needs. For children and youth, these services include:

- Regional psychologists who complete requisite assessments, e.g. PHSA Autism assessments
- Primary physician and psychiatrist services which are sourced via the Medical Services Plan and the Alternate Payments Program
- Developmental Disabilities Mental Health Services (DDMHS) once the individual reaches 14 years of age

When an individual reaches 19 years old, the following services are provided based on the needs identified -through inter-RAI (Residential Assessment Index) assessments, time task analysis assessment, and clinical judgement.

- HSCL provides health care planning, nursing, rehabilitative consultation, nutritional and dental support to adults with developmental disabilities; services are designed to provide non-emergency health services that augment existing community resources
- Supports to residential care when complex medical conditions exist; and facility-based care when engaged
- Individuals with developmental disabilities are eligible for Adult Day Programs when the situation indicates it is in the best interests of the individual
- Mental Health and Addictions Services
- Home and Community Care Supports

The HA responsibilities as outlined in Guidelines for Collaborative Service Delivery for Adults with Developmental Disabilities between Community Living BC, Regional and Provincial Health Authorities, Ministry of Health and Ministry of Social Development are:

- Develop and implement services consistent with the needs of persons with developmental disabilities;
- Ensure services for adults with developmental disabilities are funded in an equitable and appropriate manner;
- Plan and provide services in a manner that is consistent with the Planning Guidelines for Mental Health and Addiction Services for Children, Youth, and Adults with Developmental Disabilities;
- Provide services which support individuals with developmental disabilities in accordance with the above principles, Ministry of Health and health authority policies and service guidelines, and within available resources;
- Work collaboratively with professionals and support individuals and families in the community to provide coordinated care, participation in program review and evaluation, conflict resolution, crisis response and recommendations for future service development;
- Provide information to other service partners included in these guidelines on the type and volume of health services delivered.

Youth Transition Process – Services transition from MCFD to Health Authorities or CLBC at age 19

1. MCFD/CLBC – obtain a signed consent form to share information with HLTH/HA from the parents/guardian when the individual is less than 19 years of age; ideally, the consent form should be signed by both the parents and the youth as adult services are being sought

   Note: A consent form is not needed in the case of MCFD CIC as MCFD is the guardian

2. MCFD – If the individual is receiving health services through the ministry and will be eligible for CLBC services as an adult, a referral will be made for Mental Health and Addictions and/or Home and Community Care (HCC) to the appropriate health authority ***(proposed enhancement would be: to have the MCFD Plan of Care or Service Plan and school service plan provided to HCC; and to ensure that the child Nursing Support Services nurse meet with their colleagues in adult services to provide information on the services and supports being provided and optimal steps for changing service levels (this information exchange and meeting do not occur consistently and are time-consuming and difficult to co-ordinate)***

3. HCC – determine the need for an inter-RAI assessment[8] ***(if cognitive, behavioural and functional assessments are performed as close to 16 years of age as possible, it is anticipated that the need for inter-RAI assessment may be reduced)***

4. HCC – determine whether DDMHS needs to be involved; if required a referral would be made to DDMHS

5. HCC – complete the inter-RAI and/or time task analysis assessment

6. HCC – identify the health services required

7. HCC – contact CLBC to identify which health services will be provided and funded by HCC or whether or not there should be cost sharing between HCC and CLBC and the extent of the cost sharing is negotiated

8. CLBC – document the costs and responsibilities of the services to be provided

Note: The high level steps are easy to follow and are straightforward. This is, however, a very time-consuming process, with lag times between steps; a great deal of effort is invested in providing and securing information. MCFD/CLBC spends a significant amount of time on this process; however, there is no supporting data to quantify this work allocation. It is frustrating for all of the stakeholders and very confusing to the individuals and families. The services covered by HCC do vary between health authorities and the cost sharing arrangements negotiated are dependent on the individuals involved.

Suggestions identified to resolve this include:

- ***Enhanced referral mechanism, which identifies the status of the referral and who it is with (point 2 above)***
- ***Defined service level objectives with defined timelines all steps of the process***
- ***Complete inter-RAI and/or time tasks analysis earlier, at age 17.5-18 years (point 5 above):***
  - ***so that families know what services they will receive when the individual turns 19 and there will be service continuity, although the services may be different;***

[8] Inter-RAI consists of a suite of assessment tools which go across health care needs

  - ***moving the time forward for the assessments, when they are required, will not impact costs***
- ***Clearer policy and associated operating guidelines as to costs which should be covered by HCC or CLBC; it should not be a negotiation; the lack of clarity generates misunderstandings as to who is responsible for what and inconsistencies across the province (all steps of the process)***
- ***Providing a completed CLBC Guide to Support Allocation (GSA)[9] to HCC so that HCC can see the assessed level of disability need of the individual***

Ministry of Advanced Education, Innovation and Technology (AEIT) currently has no specific involvement with youth with developmental disabilities. The ministry has a partnership relationship with universities and colleges. AEIT does not deliver services directly. The ministry allocates funds and develops overarching policy and procedures; each university and college is responsible for determining the educational program.

Most community colleges who had previously offered training programs for youth with developmental disabilities have evolved into degree granting institutions and as a result have dramatically reduced or eliminated these programs. Public post-secondary institutions are not obligated to provide programming for individuals with developmental disabilities. While there are programs available, the nature of these programs, the target audiences and the management of admission and waitlists is within the decision making of the institution. Likewise, funding for adult special education is within the block allocation to institutions and is not targeted funding. The institutions allocate funding based on their established priorities.

BC Housing administers subsidized housing and programs which offer residential options to individuals 19+ years of age.

Application Process

While CLBC and BC Housing work closely in partnership with each other, there is no direct referral process from CLBC.

A CLBC facilitator may help with the application process, which requires confirmation of a disability and that income and assets of the individual are below certain ceilings depending on the part of the province in which the individual is seeking housing to allow for housing cost variations across the province. Meeting the eligibility criteria is not a guarantee of housing provision.

Public Guardian and Trustee (PGT) acts as co-guardian with the MCFD or Delegated Aboriginal Child and Family Service Agencies for youth under Continuing Custody Orders (CCOs), and is responsible for the protection of the financial and legal interests of children and youth under a CCO.

In addition, the PGT acts as a Temporary Substitute Decision Maker (TSDM) for health care decisions when an adult may not be mentally capable of handling their own affairs or if there are no family/friends available, and may authorize others to act as a TSDM. The PGT may investigate concerns of abuse, neglect or self-neglect, generally when there are financial assets at risk or needing management. The PGT may consult and assist in Adult Guardianship investigations conducted by CLBC or health authority staff. A representative may be appointed as "Committee of Estate" to manage

[9] The Guide to Support Allocation is a tool which is used by CLBC to determine the services and supports for which an individual is eligible.

financial and legal affairs of an incapable adult (as a last resort and when there are substantial assets to manage). Lastly, the PGT is responsible for monitoring Private Committees.

Transition Process

1. MCFD/PGT – work closely throughout the individual's childhood and youth
2. PGT – for eligible youth in continuing care, apply for and maintain RDSPs
3. PGT – take on the guardianship when the individual turns 19 in those cases where the adult cannot make health or financial decisions independently; all other avenues of self-determination and supported decision-making are explored prior to this occurring

Community Living British Columbia (CLBC) funds and delivers or coordinates supports and services to adults with developmental disabilities and their families to live as fully and independently as possible in the community including providing residential supports, family support, connections with community services to support individuals, families or caregivers and community inclusion supports that focus on employment, social and life skills.

CLBC services and support include:

- Providing information on CLBC services regarding transitioning from youth to adult at age 19
- Providing individual planning, support and service coordination for eligible adults
- Providing relevant care, service and financial information to health authorities and Ministry of Health , as appropriate, to facilitate individual service delivery and to effectively plan for services to this population
- Providing information to the health authorities on services provided and application of funding when the health authorities contribute funds to CLBC to support an individual with complex clinical care needs
- Providing community inclusion and family support services to individuals with developmental disabilities in accordance with available resources
- Providing customized employment opportunities in accordance with available resources
- Making available referral and service composition information to health authorities, HLTH, service providers and individuals with developmental disabilities and their families
- Coordinating support services for individuals with developmental disabilities through CLBC staff and other funded support services, and when required, provide planning supports, service coordination, information and referral service and problem solve with individuals and their families
- Working collaboratively with professionals in the community to provide coordinated care, program review and evaluation, problem solving, crisis response and recommendations for future service development

Youth Transition Process – Services and Supports begin at age 19

1. MCFD – make a referral for all children supported by MCFD
2. MCFD – provide material required for determining CLBC eligibility decision making; the material involves an assessment with a summary statement of a diagnosis of mental retardation from a registered psychologist or school psychologist, a letter from a psychologist or an attestation from a registered psychologist or school psychologist
3. CLBC – determine CLBC eligibility (this is not guarantee of services and supports)
4. Individual/MCFD – provide information about their circumstances, assessment information and the kind of support that the youth may need when they are an adult
5. CLBC Facilitator completes the Guide to Support Allocation (GSA) and the Request for Service Priority Tool (RFSPT)
    - Completion of the GSA does not guarantee provision of services and supports
    - The GSA identifies the disability-related needs of the individual
    - Based on the GSA, the facilitator uses the Catalogue of Services to identify which services and supports are appropriate if funding is available
    - The RFSPT considers the circumstances of the individual and family and assigns a priority to the services and supports to be provided if funding is available
    - Immediate priority is given to health and safety services and supports
    - Secondary priority is given to inclusion supports depending on availability of funding (e.g. employment preparation, skills development, community inclusion activities)
    - In fiscal year 2012/13, individuals transitioning to adult supports receive a minimum of $2,800 a year for respite or inclusion supports

Application Process – Services and Supports begin at age 19

1. Individual/Family – initiates planning and application for CLBC services after the youth's 16th birthday
2. Individual/Family – provides material required for determining CLBC eligibility decision making; the material involves an assessment with a summary statement of a diagnosis of mental retardation from a registered psychologist or school psychologist, a letter from a psychologist or an attestation from a registered psychologist or school psychologist
3. CLBC Facilitator –determines CLBC eligibility (this is not guarantee of services and supports)
4. Individual/Family – provides information about their circumstances, assessment information and the kind of support that the youth may need when they are an adult
5. CLBC Facilitator completes the GSA and the RFSPT

Note: CLBC is rolling out the CLBC facilitator completion of the GSA province-wide based on the success of initial pilot trials of this change.

Individuals/Families find that the eligibility, followed by the GSA process, frustrating in the sense that there is a lack of understanding that there is no guarantee for services and supports.

Proposed solution for transition

- ***Some guaranteed services and supports involving adequate levels of respite and community inclusion funding while the individual is between the ages of 19-24 to help smooth the transition.***
- ***Confirmation of services and supports that will be received as close to the youth's 17 birthday as it possible to enable the individual/family more time to plan and put in place alternative supports***
- ***Navigator assumes responsibility for elements currently under CLBC mandate -eligibility confirmation; orientation, etc.***

Ministry of Social Development (MSD) administers the British Columbia Employment and Assistance (BCEA) Program. It provides persons with disabilities a higher income assistance rate, access to health supplements, other supplementary assistance (i.e. low cost bus pass) and employment supports in order to meet the challenges of daily living and move towards greater independence. The Advocate for Service Quality, who supports adults with developmental disabilities and transitioning youth with special needs, can assist in situations involving transitioning youth with developmental disabilities and their families who could benefit from the intervention of someone working independently of ministries and agencies.

Application Process for Persons with Disabilities Designation – individuals are eligible to receive the benefit at 18 years of age (19 years for Children in Care)

1. Individual/Family – complete the online web-based Self Service Application Assessment[10]
2. Individual/Family – participate in an interview at MSD with an Employment Assistance Worker (EAW)
3. MSD EAW – determine financial eligibility with respect to the individual based on income and assets of the individual, not the family
4. Individual/Family – complete the Person with Disabilities (PWD) Application form which has three sections requiring information from the individual, medical practitioner and health professional. Information required pertains to the medical condition, duration of impairment and the impact the impairment has on the ability to perform daily living activities, including social functioning.
5. Individual/Family – obtain medical practitioner's sign-off confirming the duration of the impairment. The medical practitioner also provides information on cognitive functioning and impact on daily living activities.
6. MSD Health Assistance Branch adjudicators – determine eligibility for PWD designation

Note: The completion of the PWD Application Form is an extensive process. PWD designation procedures and a consent form exist for 17-year-old MCFD At Home Program Medical Benefits (AHP) recipients to streamline their transition to disability assistance with MSD. These applicants (or their parent/guardian) may consent to the MSD HAB adjudicators requesting relevant portions of their AHP files (such as medical reports and therapists' assessments) to determine PWD designation eligibility, as an alternative to completing a PWD Designation Application form. The consent form also allows the AHP to share information that will enable HAB to assess an applicant's

[10] Support for the Self Service Application Assessment does exist and when required can be completed with assistance with an MSD Employment Assistance Worker

needs for continuing medical supplies prior to the applicant's 18th birthday. These youth are no longer eligible for benefits at age 18.

MSD, in partnership with MCFD and CLBC, is examining how to lever the At Home Program transition process and utilize youth assessments to determine Persons with Disabilities Benefit eligibility; thereby, eliminating the need for a PWD Form for this group. [11]

Application Process for Employment Program of BC

Individual – presents at a WorkBC Employment Services Centre in their community and is eligible to work within BC; youth with disabilities in their last year of school are eligible for services

Note: There is no automatic referral process from MSD as individuals with developmental disabilities are designated as Persons with Disabilities and as such do not have employment obligations. Individuals are encouraged to access the Employment Program of BC for employment services and supports.

Strategic Decisions

S11. Extend the period for EPBC supported employment beyond the current maximum for individuals with developmental disabilities (currently 48 weeks); this would improve outcomes for persons with developmental disabilities.

Under the existing model, the Protocol is supported by the Services for Transitioning Youth Operating Agreement between MCFD/DAA and CLBC and the Guidelines for Collaborative Service Delivery for Adults with Developmental Disabilities between CLBC, Regional and Provincial Health Authorities, Ministry of Health and Ministry of Social Development.

The following table provides an analysis of the current service delivery model

Lack of…	Proposed Solution
Transition coordinator (navigator) with formal authority to ensure activities are completed by various service and support organizations	✓ Navigator[12] position with the authority to engage all of the needed government organizations (those who are providing services to the child or will be providing services to the future adult) ✓ Mechanism to capture participation, at working level, for follow up by the ministry

[11] For details on the July 2013 implementation on the enhanced PWD application and approval process see the following link: http://www.newsroom.gov.bc.ca/2013/03/youth-transition-to-disability-assistance-simplified.html

[12] Separate work, as part of the STADD initiative, is underway to examine the governance structure.

Adherence to the Protocol, which indicates that MCFD, Education (school districts/schools), CLBC and Health Authorities all are tasked with assisting families with preparing initial transition plans; currently MCFD and CLBC are the only partners consistently involved in the transition team Lack of adherence to the Protocol can be attributed in part to the fact that many frontline people are unaware of the Protocol (e.g. teachers within the school system) and the lack of a position to fill the team lead/coordinator role	✓ Active involvement by all of the Protocol partner organizations in the transition team; in particular Education (schools) and health authorities ✓ Sign-off of the Protocol by all school district superintendents ✓ Sign-off of the Protocol at the Health Authority level ✓ Raise awareness of the Protocol and build practice guidelines and commitment ✓ Add MSD EPBC to the transition team to bolster employment opportunities where appropriate ✓ The individual/family needs to have a say in who should be involved in the transition team ✓ Self-reporting process, within ministries, regarding quality of adherence to protocol
MCFD is not providing Child's Comprehensive Plan of Care (CPOCs) for CIC 100% of the time; there is no data available on the extent to which this is an issue and awareness of this was raised through discussions with CLBC facilitators MCFD is not consistently providing a Youth's CYSN Transition/Service Plan (Part 2 of PST) to CLBC	✓ A CPOC for CIC must be in place by age 18; if one is not provided to CLBC by age 18, the request for one should be escalated through a formal mechanism ✓ A CSYN Transition/Service Plan must be in place by age 18; if one is not provided to CLBC by age 18, the request for one should be escalated through a formal mechanism
Transition protocol for MCFD CIC youth with a developmental disability that are receiving medical supplies and equipment through MCFD	✓ A MOU or consent to share information regarding supplies and equipment for this group should be in place. (Process similar to medical benefits AHP youth.) The only difference is that these youth are in care and not living at home
Consistent MCFD, Schools, and Health assessments (may be outdated or have not occurred)	✓ Development of an assessment platform which enables all relevant assessment materials to be gathered, consolidated, and stored in a jointly maintained repository. Access levels to be determined with objective of reducing duplication and increasing effective use of information to support planning and decision-makings.
Standardized transition plan templates which can support the information collection and planning processes; currently there is local customization including developing and using their own tools, checklists and forms	✓ Checklist of standardized content ✓ Checklists for transition planning preparation and transition plan components to help ensure that the various aspects of an individual's life are considered

Transition planning and supports for children/families with previously lower support needs due to varying family circumstances; these families may experience difficulties related to a lack of planning and the loss of the school system supports	✓ A transition plan will be developed for each youth for those families who would like one; the plan should include future living arrangements, education and employment, financial and community and social involvement ✓ The transition planning process will help individuals/families understand transition implications in terms of changing funding, levels of support and the options and related conditions of choices in, for example, housing, training and employment
Focus on abilities and skills with funding and formal supports and services directed at requirements	✓ Specific CLBC resources, separate from safety and health, for skills development, community engagement, respite and home support as required
Resources to support individual and family capacity building; resources (MCFD, CLBC) are primarily committed to health and safety	✓ Formal individual and family peer network
Up-to-date community, unfunded and formal and informal services and supports information	✓ Single website with directions to community specific services
Information on adult services and supports that will or may be provided	✓ Overview of services and supports which will or may be provided based on eligibility
Automatic mechanisms for tracking health authority referrals and their status; MCFD and CLBC spend time tracking referrals and assessment statuses, quantification of which is not possible because of lack of data; referral mechanisms are determined at the local level	✓ Automated referrals with mechanisms determined at the regional level

Information sharing and coordination • Health authorities are not receiving GSA information from CLBC which would help identify required health services and supports • There is no central repository for sharing assessment or summary of service and/or supports provision • Consolidated information and coordination of effort: both for the families (who, what, where, when, how) and the ministries (assessments, consents, progress, plans) • Information sharing consent form required for each organization sharing information with another organization serving the individual/family • Information Sharing Agreements required for each organization sharing information with another organization	✓ Research and analysis needs to be invested in order to look at opportunities for 'blanket' or graded consents; e.g. an individual or parents for a youth providing consent to all organizations serving the individual/family to share relevant information ✓ Global Information Sharing Agreements should also be explored as well as specific protocols for assessment platform and other elements of model implementation. ✓ In the interim, a proposed solution is to better help the individual/family manage their own information (e.g. a tool kit for managing all of the assessments and plans)
Consistency in youth-based and adult medical support Currently, medical/nursing services and supports for children and youth may be greater than those available for adults; it may be that the level of support was appropriate for a child but that transition to less intensive services should occur while the individual is a youth and the youth's needs align closer to those of an adult than a child	✓ Examine where youth may receive higher services and supports than what is available as adult and begin making the service and support transitions earlier ✓ Reduce instances where clinical judgements conflict unnecessarily ✓ Reduce instances where mandates of programs collide and conflict at a transition point (e.g. nursing support)
Coherence in application and transition of housing supports; particularly in the youth to adulthood transition Currently, youth who may be in a stable and positive foster environment are not able to remain in that setting because the foster relationship ends at 19; foster families can apply to be home share providers; however, the compensation for home share is often lower than the foster funding, as MCFD staff have made rate exceptions for the child which are no longer applicable for the adult. This situation deters some foster family from continuing; also not all foster partners are able to make the transition to supporting the individual as an adult with independent decision making capacity	✓ Earlier information to foster parents as well as individuals on changes occurring at transition and the options which are available ✓ Given the importance of a good home as a foundation of a good life, the Family Journey process identified housing innovation as a top priority for immediate action. It created a working group called the Home Team to develop approaches to address the issue of housing. The working group includes representatives from families, service providers, CLBC, BC Housing, VanCity and the Housing Policy branch at the Ministry of Energy, Mines and Natural Gas. A representative from UBCM is also participating in specific elements of the review, on an ad hoc basis. Consultants are in the process of conducting an assessment of what resources can be leveraged to create more housing choice for individuals and families and an inventory of best practices of housing projects for persons with developmental disabilities.

Consistency in application of health services policy across health authorities; time is invested at the local level between CLBC and HCC as to the most appropriate organization to cover the costs and the extent of cost-sharing which should occur	✓ Clearer policy as to each organization's fiscal and policy responsibilities[13]
Health authorities are not actively involved during these early years in the Protocol	✓ Increased emphasis on maintaining health care plans by schools and MCFD ✓ Early involvement of HSCL and/or HCC as a whole ✓ Consultative Mental Health Services for individuals with developmental disabilities begin at age 14 when an individual meets the criteria (under the Community Living Authority Act: DSM-IV) ✓ Adult Mental Health and Addictions Services will be involved in an individual's transition team as required.
Fully leveraged CLBC and EPBC employment services and supports Both CLBC and EPBC offer employment services and supports. CLBC provides employment supports variably across the province both in employment focussed options and through traditional community inclusion programming. CLBC has identified the need to promote employment opportunities in its strategic plan, and to achieve this in conjunction with its community partners has developed an employment action plan. EPBC, which is a new program available province-wide, is developing knowledge and skill in better supporting individuals with developmental disabilities. Some of the service providers delivering the services to individuals on behalf of CLBC and EPBC are contracted by both organizations. There is an opportunity to leverage EPBC more fully, using the strategies suggested in the CLBC community action plan. [14]	✓ Increased awareness and utilization of EPBC ✓ Continued skills and knowledge building of the EPBC service providers in supporting individuals with developmental disabilities ✓ Integrate existing CLBC employment services with EPBC ✓ EPBC as an active participant in transition planning pre and post high-school graduation ✓ Examination of the EPBC policy to provide follow-up supports beyond the 48 week maximum allowable ✓ Increase the developmental disability confidence of the EPBC contractors

[13] A working group, including representatives from each of the health authorities and CLBC, to examine the cost-sharing financial policy is being planned for March 2013.

[14] A working group will launch in late February 2013 between CLBC, Employment and Labour Market Services Division – MSD (the group responsible for managing EPBC) as well as representatives from the contractors across BC to further develop communities of practice with respect to employment and people with developmental disabilities.

School planning for post-graduation: youth receiving Evergreen diplomas are not participating in the Grade 10 Career and Personal Planning Course, CAP programs nor are they required to have a graduation portfolio	✓ Earlier engagement and better utilization of the Employment Program of BC; this program is available to individuals with disabilities within their final school leaving year but is not used a great deal due to lack of awareness within the schools, MCFD and amongst families ✓ Vocational skills, life skills and employment preparation during additional school leaving year provided eligibility is met and approved by the local school board ✓ Earlier connections of youth to employment experiences such as those available to 'typical' students
Post-secondary opportunities: while some exist throughout the province (STEPS Forward, CILLI), there is no consistent, focused effort on providing this support	✓ Consistent access by eligible individuals, during or after final year(s) of secondary school, to alternative supports for employment (e.g. EPBC), alternative training (vocational, apprentice) to encourage self-determination and independence ✓ Potentially expanded role for colleges, universities and alternative training opportunities to increase availability
Alignment of eligibility documentation required between youth and adult services	✓ Wherever possible, use of youth assessments for service and support eligibility for adult services should be explored ✓ MSD, in partnership with MCFD and CLBC, is examining how to utilize the youth assessments to determine Persons with Disabilities Benefit eligibility; thereby, eliminating the need for a PWD Application Form for this group
Reliable information on recommended financial planning, such as federal benefits and tax credits, including optimal timing for maximum benefit	✓ Information to families (all channels) to include links to sites detailing financial planning considerations ✓ Transition plans to include a financial component ✓ Access to recognized but informal supports for financial planning, decision-making and transactions ✓ Consideration of 3rd party administration of benefits ✓ Navigator ensures families and individuals are aware of community resources to support tax filing, Disability Tax Credits application and setting up Registered Disability Savings Plan ✓ Families and individuals are aware of how to set up and use Representation Agreements

5.3 Proposed Service Delivery Model for 16-24 Years of Age

The following are the processes which should occur during the youth to adult transition years.

In many cases, the following five processes would have been initiated prior to the youth's 16th birthday. The activities associated with providing services and supports, building the picture of the individual and developing network support should continue and be more focused between the ages of 16-24.

1.0 Provide child-based services and supports

2.0 Identify the individual – determine who may need transition support

3.0 Build a picture of the individual – collect assessment, medical, support, service, interest, and goal information to build a holistic picture of the individual

4.0 Begin transition planning – introduce the navigator role to the individuals/families

5.0 Develop network support – proactively engage with the community and non-government funded services and supports

The following processes are the focus for the transition to adulthood years.

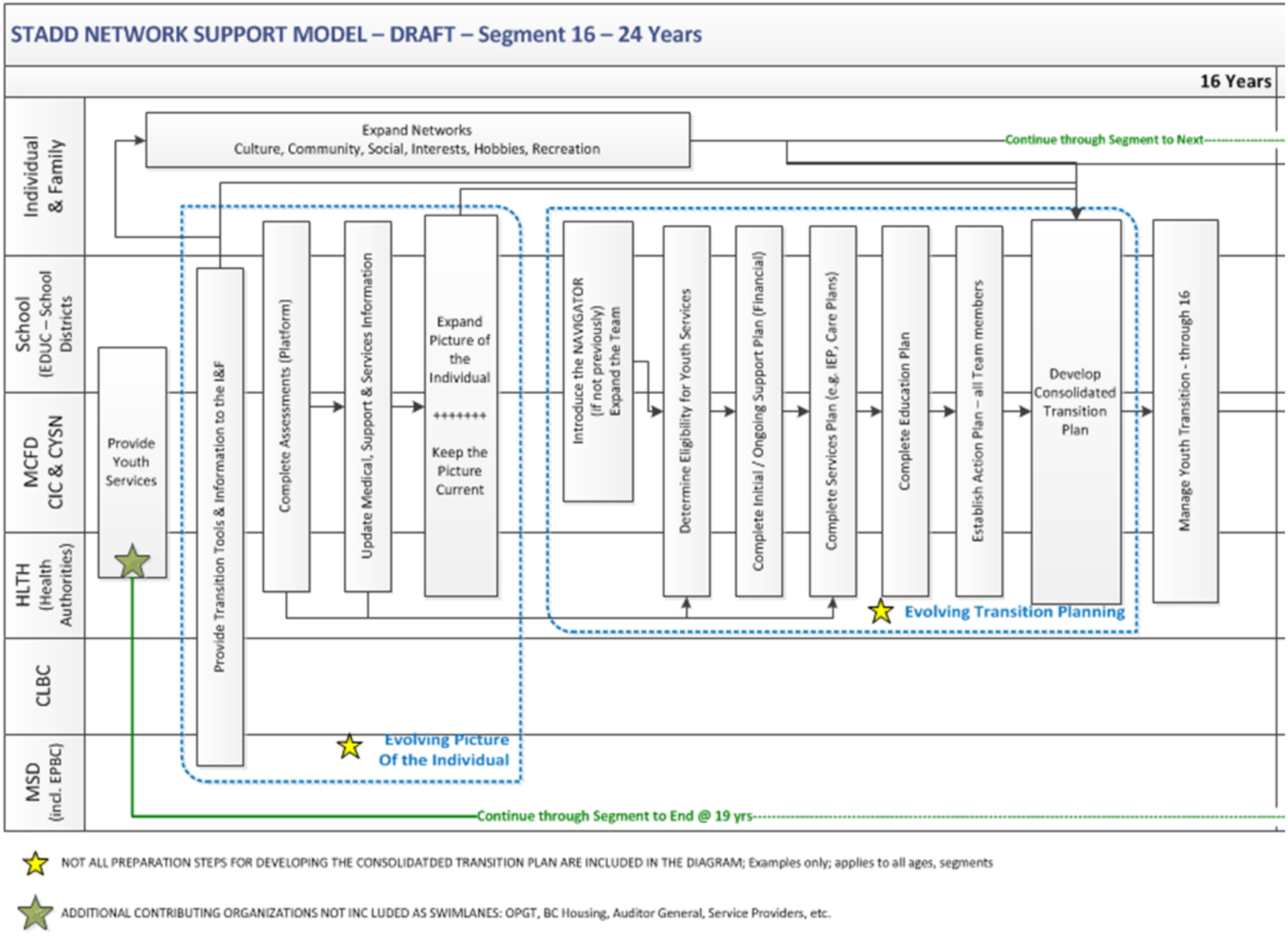
6.0 Develop the Transition Plan – identify the activities, services and supports which will occur prior to the youth turning 19 and through to age 24 and those which will occur later in adulthood

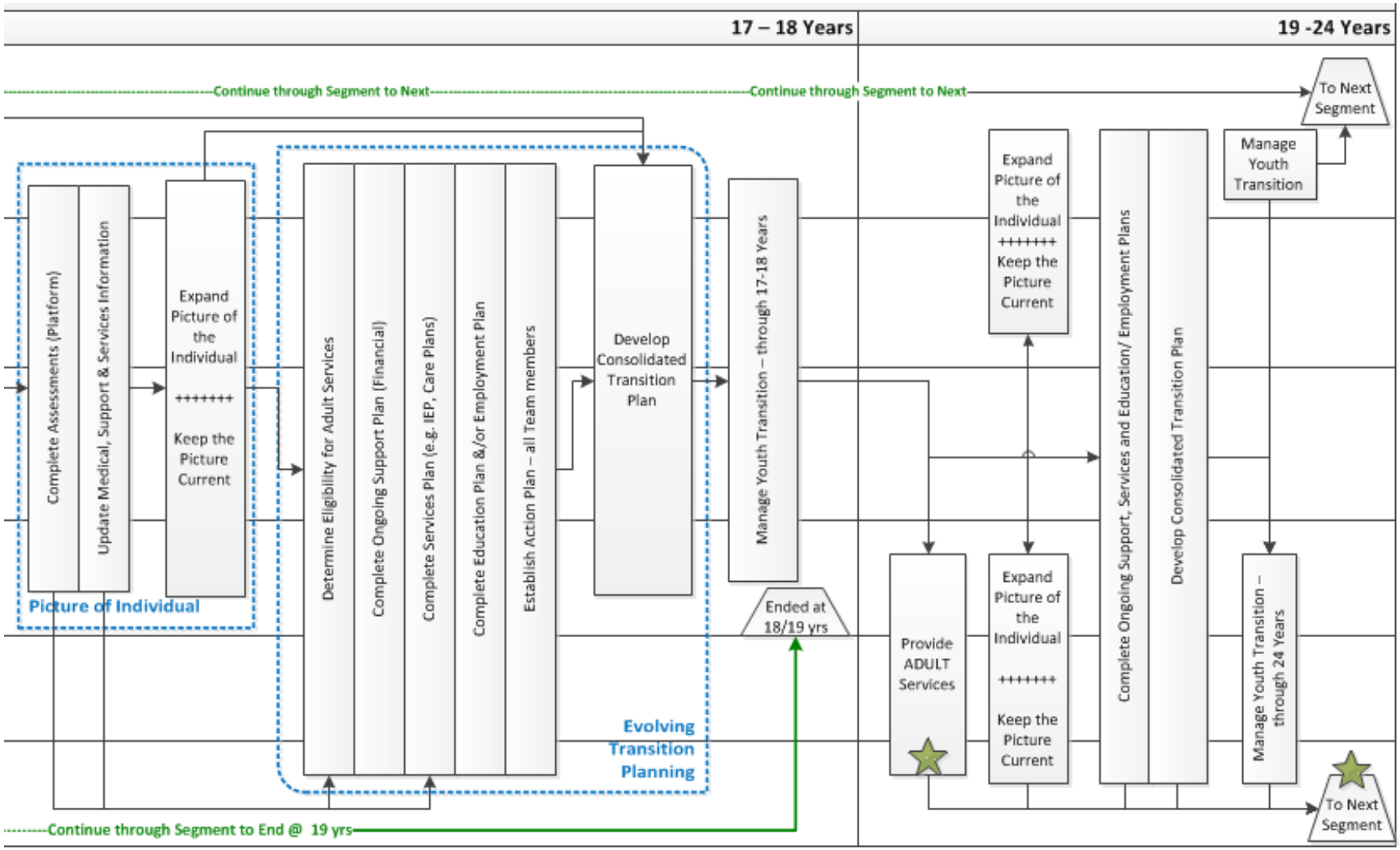
7.0 Implement the Transition Activities which must be completed prior to the19th birthday followed by those which can only be implemented in adulthood; making the transition occur while youth-based supports are still available

8.0 Proceed with transition to Adult Services and Supports while continuing to build Support Network – engage services and supports which bolster health, daily living, and community living and support the move to desired living arrangements

9.0 Keep the picture of the individual up-to-date – continue to build and update the picture of the individual to plan for and address changing circumstances

While service delivery models are frequently depicted with linear processes, it is recognized that life, other than aging chronology, is not linear. As a result, processes may be repeated at different points in time with a different emphasis.


STADD NETWORK SUPPORT MODEL – DRAFT – Segment 16 – 24 Years
16 Years
Individual & Family
School (EDUC – School Districts
MCFD CIC & CYSN
HLTH (Health Authorities)
CLBC
MSD (incl. EPBC)
Expand Networks
Culture, Community, Social, Interests, Hobbies, Recreation
Continue through Segment to Next
Provide Youth Services
Provide Transition Tools & Information to the I&F
Complete Assessments (Platform)
Update Medical, Support & Services Information
Expand Picture of the Individual
+++++++
Keep the Picture Current
Introduce the NAVIGATOR (if not previously) Expand the Team
Determine Eligibility for Youth Services
Complete Initial / Ongoing Support Plan (Financial)
Complete Services Plan (e.g. IEP, Care Plans)
Complete Education Plan
Establish Action Plan – all Team members
Develop Consolidated Transition Plan
Manage Youth Transition - through 16
Evolving Transition Planning
Evolving Picture Of the Individual
Continue through Segment to End @ 19 yrs
NOT ALL PREPARATION STEPS FOR DEVELOPING THE CONSOLIDATDED TRANSITION PLAN ARE INCLUDED IN THE DIAGRAM; Examples only; applies to all ages, segments
ADDITIONAL CONTRIBUTING ORGANIZATIONS NOT INC LUDED AS SWIMLANES: OPGT, BC Housing, Auditor General, Service Providers, etc.


17 – 18 Years
19 -24 Years
Continue through Segment to Next
Continue through Segment to Next
To Next Segment
Complete Assessments (Platform)
Update Medical, Support & Services Information
Expand Picture of the Individual
+++++++
Keep the Picture Current
Picture of Individual
Determine Eligibility for Adult Services
Complete Ongoing Support Plan (Financial)
Complete Services Plan (e.g. IEP, Care Plans)
Complete Education Plan &/or Employment Plan
Establish Action Plan – all Team members
Develop Consolidated Transition Plan
Manage Youth Transition – through 17-18 Years
Ended at 18/19 yrs
Evolving Transition Planning
Expand Picture of the Individual
+++++++
Keep the Picture Current
Manage Youth Transition
Provide ADULT Services
Expand Picture of the Individual
+++++++
Keep the Picture Current
Complete Ongoing Support, Services and Education/ Employment Plans
Develop Consolidated Transition Plan
Manage Youth Transition – through 24 Years
To Next Segment
Continue through Segment to End @ 19 yrs

6.0 Develop the Transition Plan

WHO – All youth with developmental disabilities; this is a voluntary planning process and it is at the discretion of the families involved, as a result, it is critical that families have the information needed to make decisions about participation

WHAT – Identify the activities, services and supports, milestones and roles and responsibilities for the youth and those required into adulthood

WHEN – As close to the youth's 16th birthday as is possible

WHY

- To develop individual capacity and provide opportunities for self-determination
- To help the individual and family make the transition to adulthood, while minimizing stress and confusion
- To ensure a proactive approach to transition with the recognition that services and supports will change and network supports will play a bigger role in the future

WHERE – Primarily within the youth environment with adult services and supports reaching into this environment to provide information and supports for the future. Individuals and families will need to reach further into the community environment to build formal and informal community network supports.

HOW– ***Changes in service delivery are highlighted in green italics***

1. ***Navigator – if the individual/family would like to take on the role of the navigator, this option should be made available***
   - ***Meet with the individual/family to identify goals, objectives, interests and aspirations for the transition plan, ideally after the individual/family has attended an information session on the youth to adult transition (this is not mandatory and individuals/families are not forced to attend the information session)***
   - ***Identify with the individual/family who they would like to have on their transition team (e.g. learning specialist, health authority representative, employment specialist, CLBC facilitator, representative(s) of critical community support (e.g. cultural, ethnic or religious))***
   - ***Secure consent for sharing the information with the transition team members***
2. ***Navigator – establish the first transition team meeting date and arrange the meeting***
3. ***Navigator – facilitate the initial team meeting***
   - ***The outcome of the initial transition team meeting should be an initial transition plan with transition activities assigned to the team members and agreement on how frequently the team needs to meet***
   - ***The plan will be refined over time and team members may be added or removed from the team depending on the evolution of the plan***
   - ***The plan should identify which adult services and supports the individual/family will pursue and what support they will require to do so***
4. ***Navigator – escalate issues which cannot be resolved at the team level (e.g. unresolved issues, team members frequently not attending, activities not being completed by team members)***

5. ***Schools – incorporate IEP and service/support plans into the overall Transition plan, coordinating to ensure consistency of goals, and incorporation of post-education skills***
6. ***MCFD, CLBC & HLTH – incorporate Care/Service Plans into the overall Transition plan***
7. ***Assessments Platform – MCFD/HLTH/School - anticipate and utilize appropriate tools to inform plans based on needs, abilities and strengths***
8. ***CLBC – if the family chooses to enlist the assistance of a navigator, services (residential, respite and community inclusion) would continue to be provided through CLBC contracts.***
9. ***All - access and utilize consolidated information on services/support; including links to non-government sources (community, cultural, social networks)***

Outstanding Items

a. Guide to Support Allocations (GSA) is a tool used in CLBC, and which may be shared with HAs in the future to better share information about disability related needs.

Strategic Decisions

S12. Implement navigator position with the authority to engage all of the needed government organizations (those who are providing services to the child or will be providing services to the future adult) and government funded programs (e.g. EPBC)

S13. Active involvement by all of the Protocol partner organizations in the transition team; in particular Education (schools) and Health

S14. Add MSD EPBC to the transition team to bolster employment opportunities where appropriate

S15. Implement standard checklists for transition planning preparation and transition plan components to help ensure that the various aspects of an individual's life are considered

7.0 Implement the Transition Activities between 16 up until 19th Birthday

WHO –Youth and adult service providers

WHAT – Start making the transition occur while youth-based supports are still available

WHEN – 16 years of age until 19th birthday

WHY –

- To proactively participate in activities which will build capacity and prepare the individual for making the transition into adulthood
- To identify potential tangible opportunities for individuals following transition from school and into adulthood

WHERE – School system and within the community; with adult services coming into the youth environment to begin the introduction to the adult system of services and supports

HOW – *Changes in service delivery are highlighted in green italics*

1. Individual/Family – participate in transition activities (e.g. skills development, employment preparation, volunteer activities, community activities, expand individual's network beyond school)
2. ***School – focus IEP on preparedness for school leaving***
3. ***School – prepare individual's school leaving package with IEP and assessments in paper and electronic copy to be provided to the individual/family***
4. ***MCFD – review health services and supports to ensure that the level is appropriate for a youth; less intensive services/supports may be appropriate as the individual has developed capabilities***
5. ***Navigator – manage the transition plan by working with the individual/family to ensure that the plan is addressing the needs and incorporating community resources, supports and connections wherever possible***
6. ***Navigator – proactively work with the individual/family to explore community supports and social networks to expand the community network of supports***
7. Individual/Family – complete eligibility requirements for Adult Services and Supports
8. Individual/Family, supported by CLBC (when the individual is eligible for CLBC services and supports) and ***Navigator*** – build Individual Support Plan (the adult plan), which should include non-funded activities and community/network building activities
9. ***Navigator – coordinator and facilitate team meetings when required to make adjustments to the transition plan or to obtain the needed help with the Individual Support Plan***
10. Individual – where appropriate, a student who turns 19 prior to July 1st of the current school year may attend for an additional year of secondary school to complete his or her individual plan goals. This provision of an additional secondary school year is a decision made by the local school board and upon the available funding.
11. HCC – complete assessments and identify services and supports which will be provided
12. CLBC – determine CLBC eligibility and provide confirmation for those who are eligible
13. Employment Program of BC – WorkBC Employment Services Centres – provide services and supports during last year of school
14. MSD – complete PWD Benefits adjudication; once determined eligible, determine level of financial support available and other services and supports that are required
15. MSD – ensure medical supports and equipment are in place by the time the individual is eligible for PWD Benefits at 19 years of age; this will be 18 years of age for the At Home Program individuals
16. ***MCFD/CLBC/HLTH – utilize regional referral mechanism to automate triggering / generating and subsequent tracking referrals to ensure minimal wait time and timely delivery of service***

Outstanding Items

a. Develop matrix of services from all government sources which will be provided based on eligibility; ensure clarity on core services, policies, costs and dependencies across all services and standardized responses regarding which services may or may not be provided across all populations in all regions

b. Approach to streamlining the consents required

c. Mechanism for secure sharing of information

d. Clarification of health services and supports policies and costs

Strategic Decisions

S16. Whether or not to pursue exploration of combination of variable and fixed funding for services with maximum caps within a range as opposed to having services and supports without ceilings and being subject to negotiations.

S17. How to best assess and serve youth with complex health care needs for appropriate care through youth to adulthood. Alignment between child and youth nursing support services and those provided to adults needs to occur. Both the child/youth and adult services are delivered through the health authorities yet there is incongruence in the assessment of the required services.

S18. How to best address the misalignment of foster care and home share rates. A CLBC review of the rate structures reveals that there is congruence between the rates and that it appears that the exceptional rates applied through social worker discretion is the cause of the misalignment.

S19. Capacity to develop an informal supported decision-making framework for financial interactions (similar to that of health care consents) as an alternative to more formal legal representation.

8.0 Proceed with Adult Services and Supports while continuing to build Support Network

WHO – Adult service and support organizations, community, navigator, family

WHAT – Engage services and supports which bolster health, daily living, community living and support the move to desired living arrangements

WHEN – Most of the adult services and supports will be available at age 19, when the eligibility criteria are addressed; the exception is PWD Benefits, which are available at age 18

WHY – To continue to build community connections, while receiving services and supports for daily living based on need

WHERE – As much as is possible within the community

HOW – ***Changes in service delivery are highlighted in green italics***

1. Provide Adult Services and Supports
- CLBC – respite, housing, community inclusion (e.g. employment services funded by CLBC)
- Health authorities – health services to support community living
- PGT – adult guardianship

- MSD – Employment Program of BC and PWD Benefits
- BC Housing

2. ***Navigator – monitor the Individual Support Plan to ensure that the plan is the right plan for the individual to achieve the identified goals, make adjustments as necessary and work with the individual/family to continue to build community networks***
3. Individual/Family – continue to develop community network

Strategic Decisions

S19. Determination with respect to the extent with which the navigator should be engaged in the adult system of supports and services post age 24. There is support for the role continuing throughout the youth to adult transition period, with the role specializing in youth transition only.

S20. Consider modified navigator role for those over 55

9.0 KEEP THE PICTURE OF THE INDIVIDUAL UP-TO-DATE

WHO – Navigator, individual and the family working with adult service providers, community and social networks

WHAT – Continue to build and update the picture of the individual to plan for and address changing circumstances

WHEN – Throughout the transition period, on a regular basis as needed by the individual

WHY – To address changing circumstances and better anticipate future needs

HOW – ***Changes in service delivery are highlighted in green italics***

1. ***Navigator – Coordination of new assessments and monitoring of the Individual Support Plan***
2. ***All – proactively escalate significant changes in family circumstances (e.g. financials, health, behaviours, or external stresses) which indicate priority re-planning and support modification is required to avert or remediate a crisis.***
3. ***Educate and inform on community and network growth; examples include: personal social network links (clubs, hobbies, etc); cultural affiliations; organizations with opportunities for volunteering; employers, school- or training-based extracurricular activities.***

5.4 Tools

The following is a summary of the tools and templates that will be used to determine the capabilities of the individual so that the family, counselors, school personnel, social workers and other team members can realistically establish goals, activities and plans.

1. **Assessments** – using the matrix of specialized assessments based on the assessments platform
   - Psychological
   - Cognitive
   - Functional
   - Behavioural
   - Clinical, e.g., speech; OT; and PT
2. **Health Care Plan** – health care needs, which would be housed at MCFD or the school depending on who the primary service organization is
3. **Individual Educational Plan** – created annually by the learning specialist at the school
4. **Individual Support Plan** – a document that includes information about goals and support requirements, and the funding and lifespan services identified to meet them; the activities included in the plan need to include non-funded activities and community inclusion and community network development
5. **MCFD Plan of Care or Service Plan** – depends on what level of support is required by the family whether the Plan of Care (higher needs) or Service Plan; cumulative; contains a summary of lifespan services and detailed information on current services at a point in time
6. **Transition Plan** – template with mandated and optional components; minimum level would be an outline plan from the mandated components, discussed with and reviewed by the family
7. **Service Determination Tools**
   - GSA used by CLBC to determine disability-related needs
   - Inter-RAI and time-task assessment used by health authorities to determine the health services and supports which are needed

5.5 Benefits and Costs

5.5.1 Benefits

The benefits from section 4.5 apply to the 16-24 age group as well.

1. Participation in transition activities while the youth is in secondary school and child-based services are in place to provide support. ***Principles – Transparency, Predictability and Consistency; User-friendly; Continuity***
2. Formal coordination of adult services through the navigator role. ***Principles – Transparency, Predictability and Consistency; User-friendly; Continuity; Efficiency and Sustainability***
3. Earlier strengthening of community connections inclusion for the individuals and preparation for a fuller role in their personal network. ***Principles - User-friendly; Continuity***
4. Enhanced services and support predictability for the individual and family. ***Principles – Transparency, Predictability and Consistency; User-friendly; Continuity; Efficiency and Sustainability***

5.5.2 Costs

1. As identified in section 4.5.2, it is anticipated that there will be additional investment costs associated with the navigator job position.
2. With respect to the school system, as identified in section 4.5.2, it is anticipated that there will be additional resource allocation required for resource teachers and/or learning specialists. A workload and cost analysis is also in progress to estimate the impacts. In addition, greater utilization of an additional school year will increase costs.
3. If a decision is made to proceed with guaranteed CLBC services and supports between ages 19 and 23 for respite and community inclusion, there will be increased costs.

6. Segment 24+ Years: Move to Network Services and Supports

After 24 years of age, some of the big life changes have occurred, but others may happen which have an impact. Change types may be different but the magnitude and impact may be as significant: retraining, new jobs, changing residence, potentially new physical challenges and subsequently need for additional supports and aging of the individual and parents.

6.1 Desired Outcomes

The following high-level outcomes should be experienced when an individual is in adulthood.

Individuals and Families

- ✓ Individuals are more empowered and knowledgeable about planning for and participating in community activities and meaningful employment
- ✓ Individuals have the tools to discover and meet new goals
- ✓ Families and individuals make successful transitions through situations that arise from changing health, family or community changes
- ✓ The individual is established in an appropriate residence, adjusted over time for changing needs
- ✓ Transparent, consistent and predictable supports and services, based on need and eligibility from all government organizations

Government

- ✓ Reduced crisis management given that transitions are planned as early as is possible
- ✓ Increased response effectiveness when crises do occur given that key information is available on the individual and their supports
- ✓ Reduced acute support requirements because natural supports have been increased
- ✓ Service and support continuity

6.2 Current Service Delivery: 24+ Segment

Through the adult years, services and supports are provided primarily by MSD, CLBC and the Health Authorities.

Situations during this lifespan age group cause varied stresses which require help and mitigation. Examples are:

- Loss of employment or daily activities
- Changing residential requirements and support needs
- Significant health changes or death of a parent, guardian, or caregiver
- Health crises for the individual or within the family or their support network
- Aging health related changes for individuals. Example: Those with Down Syndrome may experience Alzheimer's as early as 45
- Financial or economic crisis

CLBC can assist individuals and family

- Assessments – keep current when a major change (e.g. loss of eye sight) occurs in case emergency support might be needed
- Planning - generate both a lifespan plan and contingency plan in case of emergency
- Community Living inclusion
- Behavioural Supports
- Respite
- Shared Living and Staffed Residential housing
- Service Providers communication (e.g. third-party managed residences, EPBC Service Providers)

Ministry of Health / Health Authorities

- Support ongoing individuals' health care plans and related activities such as assessments
- Establish and maintain care plans; ensure consistent delivery of services
- Regional psychologist: complete requisite assessments
- Primary physician & psychiatrist services: via Medical Services Plan and Alternate Payments Program
- HCC through HSCL or HCC case managers (assessment)
- Mental Health and Addictions and DDMHS

MSD

- PWD Benefits and supplements
- Employment Program of BC

Office of the Public Guardian/Trustee

- Acts as a Temporary Substitute Decision Maker (TSDM) for health care decisions when an adult may not be mentally capable of handling their own affairs or if there are no family/friends available, and may authorize others to act as a TSDM
- May investigate concerns of abuse, neglect or self-neglect, generally when there are financial assets at risk or needing management
- May consult and assist in Adult Guardianship investigations conducted by CLBC or Health Authority staff
- May be appointed as "Committee of Estate" to manage financial and legal affairs of an incapable adult (as a last resort and when there are substantial assets to manage)

- Monitors Private Committees

BC Housing

- Administering subsidized housing and programs which offer residential options to individuals 19+ years of age

Analysis of Current Service Delivery

Lack of…	Proposed Solution
Planning for financial and services support changes over time with increasing and earlier dependence on health services (earlier aging) and changing family circumstances (e.g. aging or illness of parents)	✓ Maintenance of transition plans to orient the families on the future (e.g. aging family, change in residence needs, increasing health issues); expand plans to include contingency plans, powers of attorney, representation agreements, trusts or other financial arrangements; encourage families to look after these critical details
Family awareness of the extent of change resulting from aging and changing circumstances for both the family and the individual	✓ Assessments matrix – consistently utilized, universally available and universally mandated ✓ Ongoing assessments to capture changes in physical or mental health
Reliable information on recommended financial options, such as federal benefits and tax credits, including optimal timing for maximum benefit	✓ Information to families to include links to sites detailing recommended financial planning and legal issues such as Representation Agreements ✓ Access to recognized informal supports for the individual to do financial planning, decision-making and transactions ✓ Consideration of 3rd party administration of benefits ✓ Provide families and individuals information on community resources to support tax filing, Disability Tax Credits application and setting up Registered Disability Savings Plan
Relevant, consolidated, easy to understand information for the individual/families	✓ Plain language information package for families ✓ Single website for information on adult transitions ✓ Information on services and supports which are available within the community

Consistent and cohesive cross-ministry agreements to ensure better coordination of activities such as assessments and health-specific activities	✓ Mandated collaboration between ministries and agencies: minimize overlap and close gaps; ensure contact is not lost with vulnerable or at-risk individuals ✓ Defined responsibility and accountability matrix, with timeframe and deliverables boundaries ✓ Well-trained and up-to-date employees, service providers, consultants – participants in culture shift
Coherence in application and transition of housing supports; particularly in the youth to adulthood transition	✓ Given the importance of a good home as a foundation of a good life, the Family Journey process identified housing innovation as a top priority for immediate action. It created a working group called the Home Team to develop approaches to address the issue of housing. The working group includes representatives from families, service providers, CLBC, BC Housing, VanCity and the Housing Policy branch at the Ministry of Energy and Mines. A representative from UBCM is also participating in specific elements of the review, on an ad hoc basis. Consultants are in the process of conducting an assessment of what resources can be leveraged to create more housing choice for individuals and families and an inventory of best practices of housing projects for persons with developmental disabilities.

6.3 Proposed Service Delivery Model for 24+ Years of Age

The steps in the model are non-linear, with some processes being repeated as the individual's life changes. At each repetition, the age and needs of the individual will determine what features or characteristics of that aspect will be foremost in that iteration. This list is not exhaustive, but indicative.

There exist four main processes during this lifespan period:

- Identify the individual – determine new individuals who may need support
- Expand the picture of the individual – collect assessment, medical, support, service, interest, education, employment and goal information to build a holistic picture of the individual
- Continue transition planning – transitions will be for residence, age, health and circumstances changes
- Develop network support – proactively engage with the community and non-government funded services and supports

1.0 IDENTIFY THE INDIVIDUAL

WHO – Individuals included in this group include all existing and new adults with developmental disabilities who wish assistance with supports and services

WHAT – Identify individuals who may need transition support either as new in the system or transitioned from youth

WHEN – Beginning at age 24 and up

WHY

- To make CLBC, the adult-serving organization, aware of new individuals who may be requesting CLBC services so that preparations for eligibility determination can be made and budget forecasting projections can be accurately made
- To make the navigator organization aware of new individuals who may be requesting support so that they can ensure that those families who wish to have support in developing a plan, the needed support

WHERE

- The ministry which makes the initial contact with any new individual is the primary source for identifying new adults who move into a region or whose circumstances now require they find assistance and services.

HOW

1. Complete required assessments needed to make informed decisions on needs and services: cognitive, adaptive functioning and behavioural
2. HLTH: make a referral DDMH, Adult Services and CLBC - flag for required services and supports - indicators of programs or services in which the individual should be enrolled such as home care, nursing assistance, medical equipment

Outstanding Items

Contingency Plans: is there a benefit to structuring a support team and 'template' of key components to plan for contingency action in the event of a significant life event (e.g. death of a parent)

Strategic Decisions

Whether or not to continue a navigator for the population of age 55 and over

2.0 EXPAND PICTURE OF THE INDIVIDUAL

WHO – Adults diagnosed as having developmental disabilities

WHAT – Continue to collect assessment, medical, support, service, interest, education, employment and goal information to build a holistic picture of the individual

WHEN – Beginning when the adult is 24 with a potential changes at age 55

WHY – To have the information in place needed for planning responses to life events and natural changes associated with aging

WHERE

- CLBC when an individual reaches 24 years of age and is no longer considered a youth
- HLTH – when individuals and their families present for assistance
- MSD – when individuals and their families present for assistance (i.e. medical equipment, health supplements)

HOW

1. HLTH – Identify required assessments
2. HLTH – Complete required assessments
3. CLBC – Offer assistance with eligibility criteria, update the summary of assessments completed and note where they are filed
4. HLTH – Ensure a health care plan addresses the health needs of the individual is completed and includes health-related services and supports provided and key health issues
5. CLBC – Update summary of services and supports being provided

3.0 CONTINUE TRANSITION PLANNING

WHO – Adults supported by CLBC and, potentially, HLTH, MSD or EPBC

WHAT – Continue the Transition Planning Process

WHEN – From the adults 24th birthday into late adulthood

WHY

- To ensure that the adult is supported through physical, mental and relationship changes associated with family and themselves aging.
- To achieve the goal to create supports and opportunities that enable a person with developmental disabilities to experience a self-directed life

WHERE

- CLBC, through the transition planning process, CLBC employment and inclusion programming
- HLTH, through health care and service plans
- MSD with health and general supplements
- EPBC, with employment programs and support

HOW

1. Navigator
   - Identify services and supports eligibility criteria
   - Identify the services and supports and that could be provided
   - Answer questions that the individual/family has about contingency plans
2. Navigator – establish a schedule of transition team meetings that suits the family. The outcome of the first transition team meeting should be an action item list assigned to the team members for activities such as financial planning, legal representation, residential needs, employment plans / programs / supports, etc.

Outstanding Items

a. A plain language information package needs to be developed, which would allow an insert for contingency plan issues
b. It is assumed that the navigator organization would be responsible for coordinating information sessions
c. Consent forms will be required
d. The need for Information Sharing Agreements will need to be examined

6.0 Expand Network Supports

WHO – Families and care givers.

WHAT – Develop community networks

WHEN – Beginning when services and supports are first provided and ensuring as comprehensive collection of information as is available by the youth's 16th birthday and going forward

WHY

- To enrich adulthood; focus on community inclusion with the individual with developmental disabilities as a contributing, independent and self-determining person
- Beyond the immediate family unit, the individual's community and culture continue to influence and support his/her efforts. Peers, friends, relationships, social groups, and the organizations they join continue to be central to health, self-determination and independence.
- Some examples would be:
    - Cultural groups and relationships (ethnic, religious, other affiliations)
    - Family Support Institute, BCACL and similar social network resources
    - Recreation Centres: clubs, sports, interest groups
    - Local Organizations: Care, Residence, Training, Volunteering
    - Transportation providers
    - Access to alternative or additional training
    - Employers, friends and peers at work

WHERE

- Community, neighbourhoods, municipalities and online social media

HOW

1. Individual/Family – Engage in peer networks
2. Individual/Family – Plan a network of support

- Participate / Do - act on the Plan
    - Individuals and their families participate in planned activities, complete 'to-do' lists;
    - Expand family capacity – cultural connections, social networks, ongoing education, employment, professionals
    - Ministries and agencies deliver services
    - Utilize resources and information from expanded network
    - Exercise self-determination and opportunities for independent action
    - Act on need for early intervention or crisis management where indicated – Services and Supports
- Quality Assurance
    - Plan compared to actual – goals, activities, strategies, services
    - Participate / Do – Report successes and issues to inform the next iteration of the plan
    - Updates to the individual and their family from Team and vice versa
    - Performance management on services and supports
    - Statistical reporting, budgets, forecasts; plans to actuals; cost/benefit analysis of existing and new programs

6.4 Tools

1. **CLBC Individual Support Plan** – summary of lifespan services and current at point of time
2. **Health: Plan of Care and Service Plan** - former is for complex, high-needs care and the latter is for individuals with less complex needs; both maintain a summary of lifespan services and current at point of time

6.5 Benefits

1. Continued strengthening of community connections and inclusion for the individuals and a fuller role in employment, peer groups, continued education and personal networks
2. Reduced last minute planning to secure some services and supports and service gaps because a crisis or significant life change has occurred
3. Consistency as individuals will all have support plans; even those with lower support requirements

Appendix A: Model Implementation Timelines ("To Be" Changes)

1 Pilot

Pilot in 5 high readiness areas Short Term – then expansion to a region, then province-wide

- Would not include ICM system platform; would have to be small and manageable (e.g. on Excel) and incorporated later
- Information Package – reasonable to include as much as available - consolidated version: predictable services, cumulative data and consents; transition plan 'template'. Leverage existing plans for child-to-adult transition. Also include capacity expectations
- Governance: needs to be defined.
- Education: for the transitional plans and IEP's, implement for the pilot as there are no legislative or regulatory changes (to be confirmed); will need to review and change policies and procedures; update their document: *Career/Life Transitions for Students with Diverse Needs: A Resource Guide for Schools (2001)*, currently found at: http://www.bced.gov.bc.ca/specialed/docs/moe_clt_resource_rb0144.pdf
- Navigator
    - Specialized for age group 16-24 years; requires additional planning for 24+ to avoid crisis states
    - Develop role to next level: information access (what, where, how); build tools; change policies in Education and other ministries to enable mandated collaboration; settle timelines and other issues with Health; selectively resolve all aspects of functions with all parties in pilot areas
    - Potential for specialized role for those over 55
    - Potential for specialized role for community connector

2 Short Term Changes – 1st year

- **Developmental Disability website** (based on concept of the seniors' site)
  - All of the information on one site
  - Tools
  - Links to community resources and programming
  - Interactive Discussion Board
- **Greater family awareness** of what is next – build family capacity
  - Information package
    - Provided at the time of diagnosis
    - Online and hard-copy versions - utilize leading/best practice model
    - Information that they need to collect and what purpose
    - Tool to build personal story
  - Mentoring program – families helping families
  - Self-Advocacy mentors
  - Awareness sessions – topic-specific, community engagement
- **Policy-driven triggers** to engage partners; defined responsibilities at each segment
- **Data Sharing**
  - Cumulative – to other ministries so that planning and demand estimation and budgeting can occur
  - Consents – information sharing pertaining to an individual
    - MCFD and CLBC
    - Education and CLBC
    - MSD and CLBC
    - MCFD and MSD – At Home and will occur for PWD Benefit
      - Assessment information
      - Health information
    - Education and MSD – will occur for PWD Benefit
      - Assessment information
    - Blanket Consent – all parties on the Team; all parties providing services
  - Assessments : what assessments have been completed and where they reside
- **Education:** review as of approximately ages 14 / 15 (entering secondary school)
  - Add additional components to transition planning. Currently, the focus of the transitions within school are between schools (grade, middle and secondary school);
  - incorporate employment preparedness and community inclusion planning for after secondary school – employment/post- secondary training
- **Navigator** – involved in the transition
  - Initially CLBC Facilitators for the purposes of the pilots
  - Engaged at age 16
  - Provides information to individual/family on sources, resources, process
  - Support family in addressing their expectations within the resources available
  - Identifies which organizations need to be engaged

  - Team conference
- MCFD – working on their transition plans and roles /responsibilities of a case worker; will need to rationalize this role with the developing plans/roles/responsibilities of the Navigator and ensure the two parallel projects align and have no conflicts. In addition, two documents will require updating: (1) *Your Future Now: A Transition planning & Resource Guide for Youth with Special Needs and their Families (2005)* and (2) *Transition Planning for Youth with Special Needs: A Community Support Guide (2005)*. These are currently found at: http://www.mcf.gov.bc.ca/spec_needs/pdf/your_future_now.pdf and http://www.mcf.gov.bc.ca/spec_needs/pdf/support_guide.pdf

3 Medium Term Changes – 2nd and 3rd year

- Clear policy driven triggers to engage partners
  - Diagnosis of developmental disability
  - Partners
  - Service Level agreement – consolidated, mandated
- Formal requirement for all parties to be involved in the transition planning
- Structured Transition Plan with multiple components: Health, School, Goals, Employment, Community Inclusion, life skills training (such as financial literacy)
- Benchmarks and measurements of compliance, delivery, quality, quantity; track re-planning
- Incorporation of Best Practices in policies, procedures, processes
- Service Predictability – initial plan should be confirmed by age 18
- Program Eligibility Alignment
  - Example of PWD Benefits
  - Rationalize forms and eligibility requirements

APPENDIX B: Services /Supports for Individuals Who Would be Eligible for CLBC Services at Age 19

Revised: January 12, 2012

<table>
<tr><th>Services & Supports</th><th>0 – 5 yrs.</th><th>6 – 13 yrs.</th><th>14 – 17 yrs.</th><th>18 yrs.</th><th>19+ yrs.</th></tr>
<tr><td colspan="6">GENERIC SERVICES</td></tr>
<tr><td>Primary & Specialist Physician Services including Psychiatry</td><td colspan="3" rowspan="2">Ministry of Health via Medical Services Plan and Alternate Payments Program</td><td>HLTH via MSP; APP</td><td></td></tr>
<tr><td colspan="2">HSCL Medical Consultant & Clinical Services (HLTH)[i]
Developmental Disabilities Mental Health Services (DDMHS) – assessment, consultation and care planning</td></tr>
<tr><td>Supply & Equipment Support</td><td colspan="3">At Home Program – Medical Benefits
Giving in Action – CYSN Fund (MCFD via Vancouver Foundation)</td><td colspan="2">Persons with Disabilities (PWD) designation health benefits via MSD Health Supplements
Giving in Action – Family Independence Fund (equipment, convert vehicles, home renovation: CLBC via Vancouver Fndn)
BC Palliative Care Benefits Program (HLTH)
Equipment And Assistive Technology Initiative (EATI – MSD)</td></tr>
<tr><td>Care Management</td><td colspan="4">Family Support Services – Professional Supports
Nursing Support Services</td><td>CLBC</td></tr>
<tr><td rowspan="3">Assessment & Monitoring of Services</td><td colspan="3" rowspan="2">Family Support Services – Professional Supports
Nursing Support Services</td><td>FSS; NSS</td><td>CLBC</td></tr>
<tr><td colspan="2">HCC[i] through HSCL or HCC case managers (assessment)</td></tr>
<tr><td colspan="3">DDMHS</td><td colspan="2"></td></tr>
<tr><td>Education</td><td>Special Child Care</td><td colspan="2">School Districts</td><td>“Over year” (Schools)</td><td>Adult Special Education (AvEd)</td></tr>
<tr><td>Day Program Services</td><td colspan="4"></td><td>CLBC Community Inclusion (community-based) services</td></tr>
</table>

<table>
<tr><th>Services & Supports</th><th>0 – 5 yrs.</th><th>6 – 13 yrs.</th><th>14 – 17 yrs.</th><th>18 yrs.</th><th>19+ yrs.</th></tr>
<tr><td colspan="6">SPECIALIZED SERVICES</td></tr>
<tr><td rowspan="4">Clinical & Rehab Support Services</td><td>Autism Funding
under 6 yrs.</td><td colspan="3">Autism Funding 6 – 18 yrs.
Community Brain Injury
School Age Therapy</td><td rowspan="4">CLBC
HSCL Services[i] as required</td></tr>
<tr><td colspan="4">Nursing Support Services
FSS – Professional Supports</td></tr>
<tr><td colspan="3">At Home program</td><td></td></tr>
<tr><td colspan="4">HLTH - PHSA Autism Assessment Program</td></tr>
<tr><td>Psychological consultation, assessment and therapy</td><td colspan="2">FSS - professional behavioural support
Community Brain Injury
CYMH Mental Health Services</td><td colspan="2">FSS; CBI; CYMH MHS
DDMHS</td><td>CLBC – Psychological</td></tr>
<tr><td rowspan="3">Behavioural Therapy</td><td colspan="2"></td><td colspan="2">DDMHS</td><td rowspan="3">CLBC – psychological services (consultation, assessment & therapy) for clients with MH support needs</td></tr>
<tr><td>Autism Funding
under 6 yrs.</td><td colspan="3">Autism Funding Program 6 – 18 yrs. – for eligible out-of-school autism intervention services</td></tr>
<tr><td colspan="4">FSS – Behavioural Support, Professional Support
Provincial Outreach
HLTH - PHSA Autism Assessment Program</td></tr>
<tr><td rowspan="2">Training/Supported employment, customized employment, self-employment</td><td rowspan="2">N/A</td><td>School Districts</td><td>“Over year” (Schools)</td><td rowspan="2">CLBC Community Inclusion (community/home-based) Services; skill dev't, employment
MSD Employment Prgms
Adult Special Ed. - AvEd</td></tr>
<tr><td colspan="2">Planning for CIC through Comprehensive Plan of Care
Planning for CYSN through Transition Coordinator</td></tr>
<tr><td>Respite: Directly Funded or Contracted; in home/out of home</td><td colspan="4">FSS – Directly funded or contracted respite, and approved child care
FSS – Child & Youth Care Worker
At Home program – Directly Funded Respite</td><td>CLBC – Directly Funded or Contracted Respite</td></tr>
<tr><td rowspan="3">Family Support and Care Planning</td><td colspan="4" rowspan="2">FSS – CYSN Social Worker, Child and Youth Care Worker
– Parent Support / Professional Support
Nursing Support Services
FASD Key Worker</td><td rowspan="2">CLBC – Support Coordination;
Personalized Supports Initiative</td></tr>
<tr><td colspan="2">HCC through HSCL or HCC case managers</td></tr>
<tr><td colspan="3">DDMHS</td><td></td></tr>
</table>

Services & Supports	0 – 5 yrs.	6 – 13 yrs.	14 – 17 yrs.	18 yrs.	19+ yrs.
Housekeeping, Personal Care, Household Management Skills	FSS – Home-Maker/Home Support Services At Home Program				CLBC Home-Maker, Supported Living, Community Inclusion (home-based) Services; and Individualized Funding
Home Share / Foster Care	CYSN Residential				CLBC – Shared Living HSCL Services[i] as required
Residential Care Services – 24/7 support by a team for an individual or group	Specialized Residential Facilities				CLBC – Staffed Residential HSCL Services[i] as required

[i] Ministry of Health, through the regional health authorities, provides a variety of specific home and community care services to adults with developmental disabilities including Health Services for Community Living (HSCL), which involves specialized nursing and rehabilitation supports at the community level, and Medical and Clinical Consultant Services; Nutrition and Specialized Dysphagia Services; Dental Health Services; In-Hospital Services; End of Life Care; and Added Care for individuals with high intensity needs, which includes usually home support services or residential care services, or funding in lieu of services.

NOTE: HLTH also provides a suite of other services funded through various means, for a person who would be eligible for CLBC services, including diagnostic, laboratory, pharmaceutical and hospital services. These are not included on this chart, as they are provided “cradle to grave”.