

# All in: Creating Synergy in Pediatric Complex Care

March 25, 2021 | Virtual Event

## Made in Alberta Panel

Front Line Innovation Leading to Better Care for Children and Families with Complex Needs

with Nadine Gall, Meridith Yohemas, Tammy Island, and Dr. Tanya Wasielewski



Children's  
Healthcare  
Canada

Santé  
des enfants  
Canada



# A PATH TO EQUITY for Children with Complex Medical and Social Needs

## Neurodevelopmental Disorders (NDD) Care Coordination Project

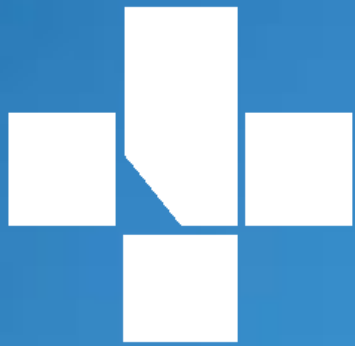
Pediatric Complex Care Conference March 25, 2021

Meridith Yohemas

Nadine Gall



**OWERKO FAMILY FUND**  
for **BRAIN HEALTH**



**Alberta Health  
Services**

Alberta  
**Children's**  
**HOSPITAL**    
FOUNDATION  

Alberta **Children's** Hospital





**Linking Health,  
School &  
Community**

**Reducing Parent  
Stress**

**Improving  
Communication**

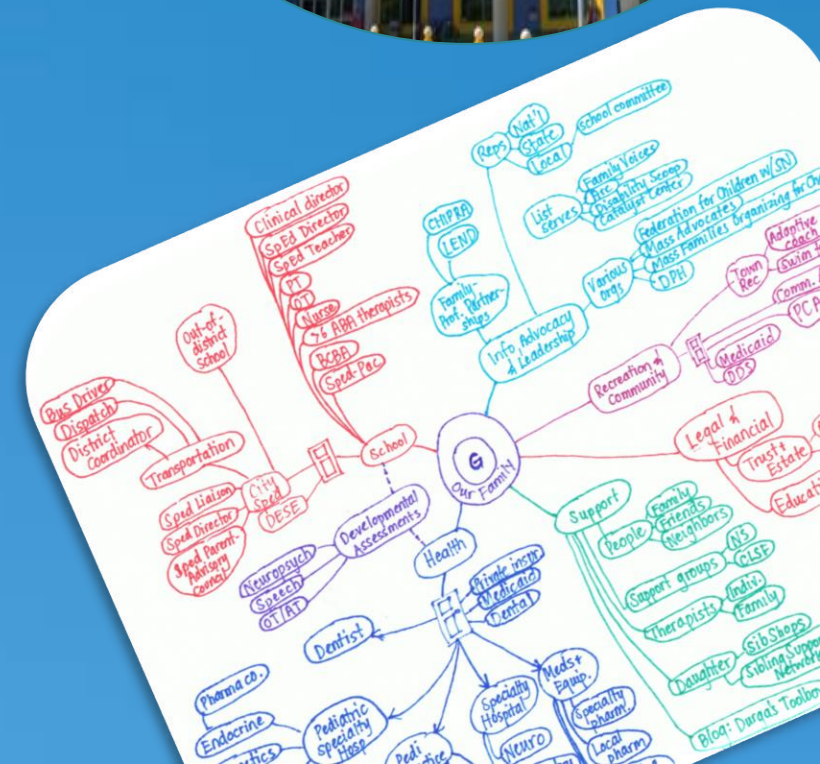
**Accessing  
Community  
Services**

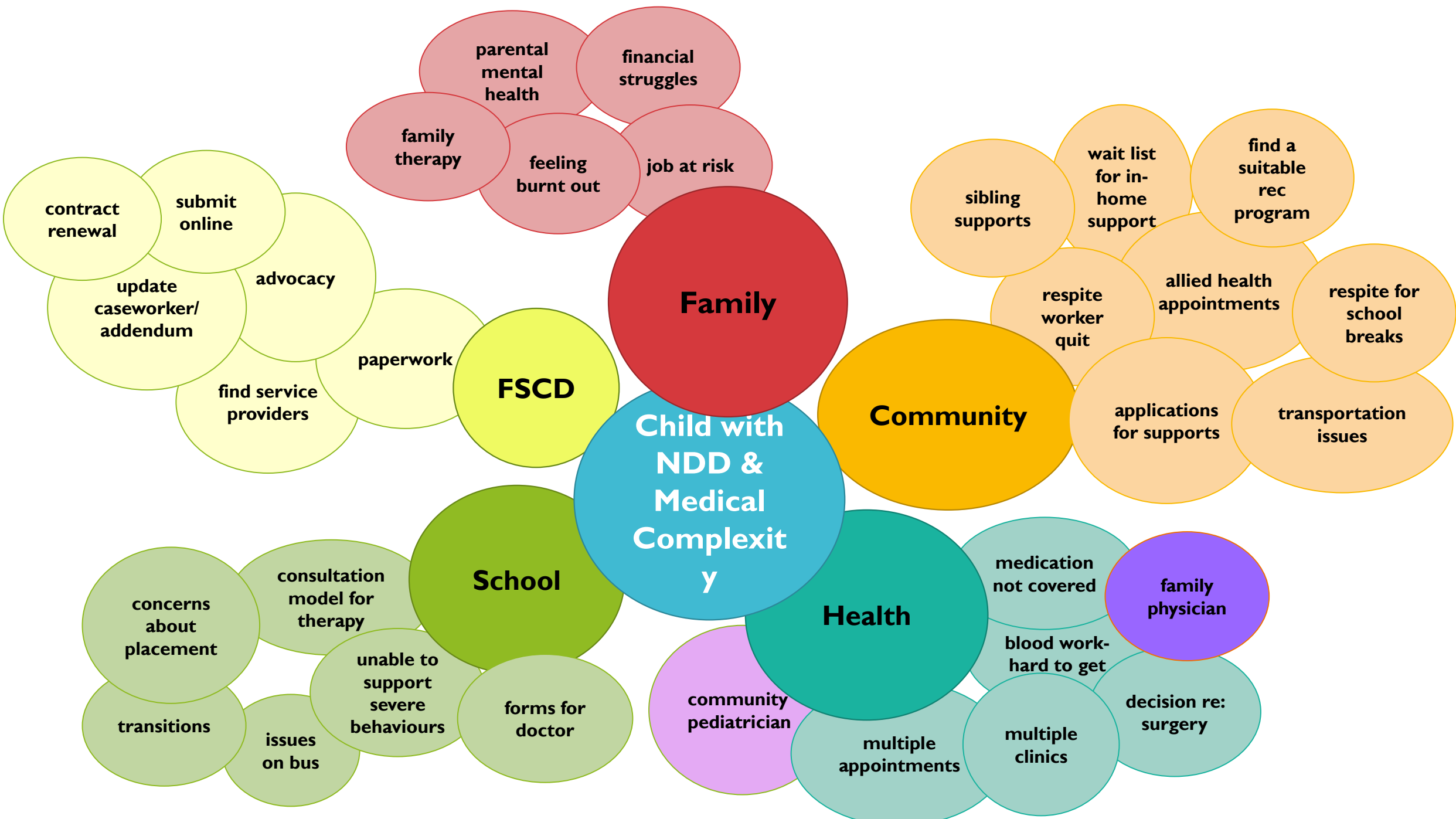
**HELPING FAMILIES THRIVE**

Improving Outcomes through Care Coordination  
and Targeted Family Supports

# A Solution Born out of Necessity...

- Unsustainable models of care for CMC
- High parental stress and family breakdown
- Persistent unmet needs
- High rates of ED visits and unplanned hospitalizations
- Poor access to services for patients and families
- Care team frustration, isolation

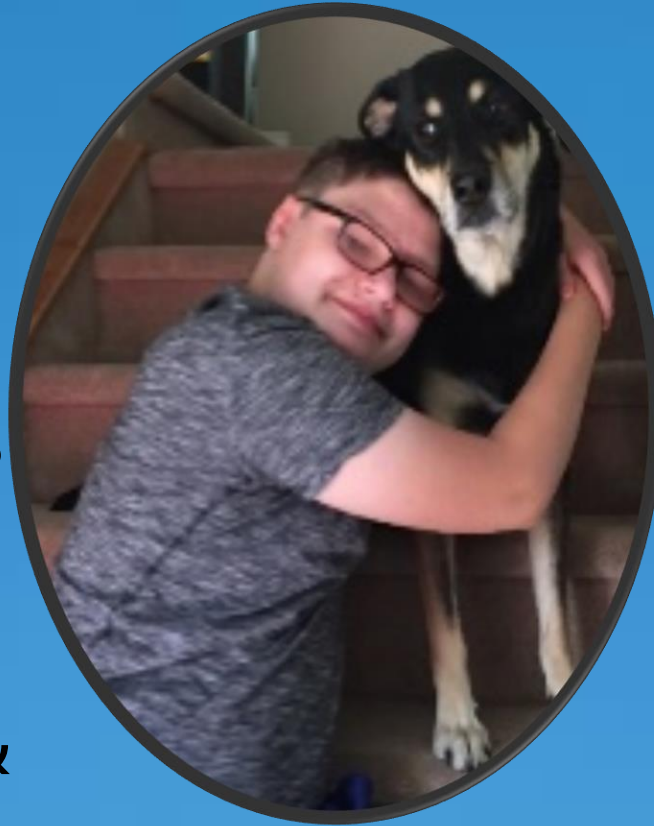




# Opportunities and Practice Challenges

## Care Teams:

- Scope of Practice
- Experience/confidence working with complex cases
- Discharging – hand offs
- Lack of available services for extreme behavioral challenges & psychosocial issues supports



## Health System:

- Cross Sectoral Communication (school, health, social services)
- Frontline innovation impacting system level barriers
- Difficulty shifting from reactive to preventive services

# Care Coordination Project -

## Demographics

- **166 families served**
- Age range 2-17; average age was 11 years
- 36% female; 64% male
- **45% ADHD; 37% ASD; 18% Both** – all with concurrent medical diagnoses
- 33% cultural and/or language barriers (many recently immigrated)
- 87% of families were considered complexity level 2 or 3
- Average length of care coordination was 13 months





# Care Coordination Project

## Outcomes



Reduced number of ED visits at 6 and 12 months compared to baseline:

**78%** reported no ER visits at 12 months compared to **baseline (41%)**

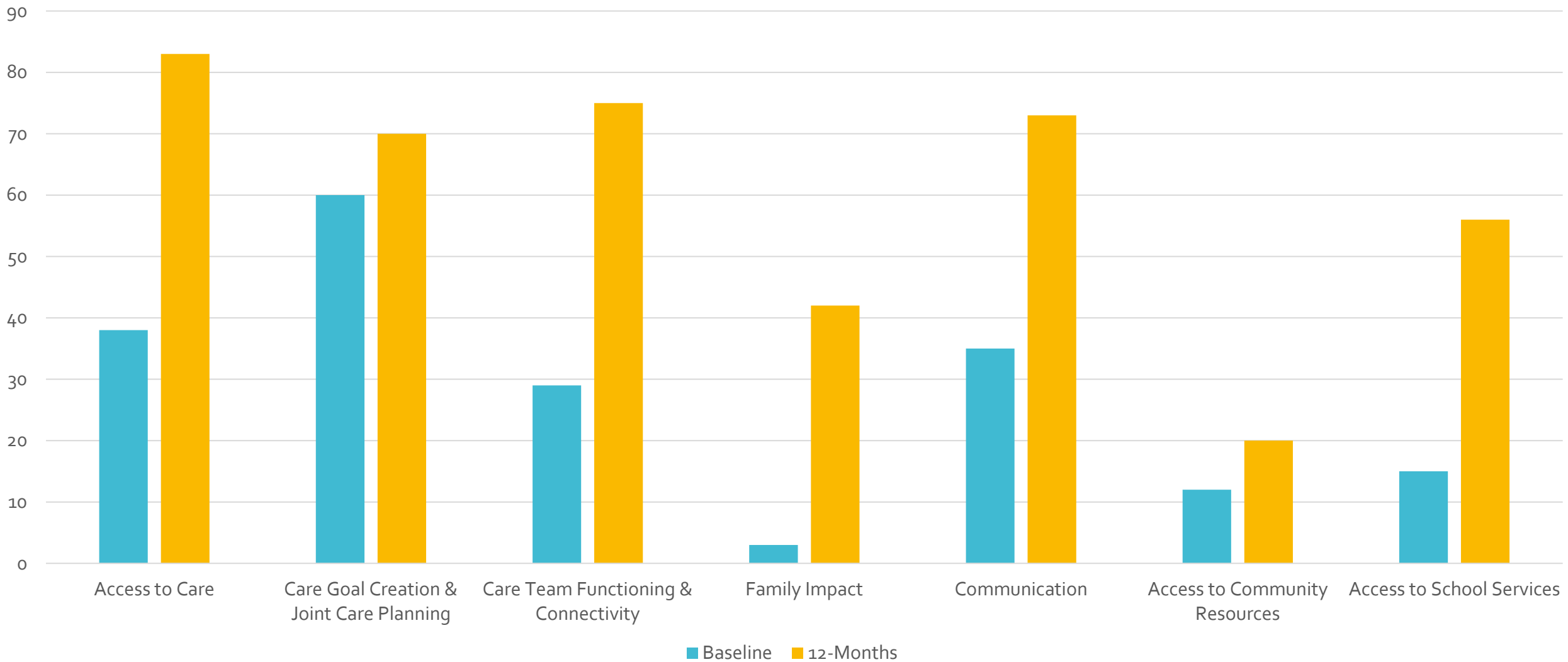
Reduced acute care use from baseline to 12 months

No hospital admissions at **baseline = 44%**

No hospital admissions at **6 months = 78%; 12 months = 74%**

**1794** negative outcomes were **prevented**:

Medical escalation / avoided missed appointments / test duplication / need for multiple visits / family crises



# Family & Provider Feedback



# Key Success Factors

- Dedicated care coordinator positions
  - Not embedded in any specific clinic
  - Collaboration with other centres (e.g., BCH)
- Importance of defining levels of medical & family complexity
  - Anticipating intensity and duration of support needs
- Importance of clear role description and focused clinical population
- Defined measures that reflect impacts of integrated care for CMC





Meridith Yohemas

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# Thank You



Nadine Gall

[Nadine.Gall@ahs.ca](mailto:Nadine.Gall@ahs.ca)



NDD Care Coordination Project

<http://fcrc.ahs.ca/coordination/>

[Care.Coordination@ahs.ca](mailto:Care.Coordination@ahs.ca)

# COAST

Community  
Outreach  
Assessment &  
Support Team

March 25, 2021

Tanya Wasielewski



COAST is the product of a cross-ministerial initiative between Alberta Health Services and the Government of Alberta, both Disability Services (Persons with Developmental Disabilities and Family Support for Children with Disabilities) and Children's Services that aims to meet the needs of children, youth and adults with complex needs



Multi-disciplinary  
approach  
Accessible,  
responsive and  
impactful  
Community-based  
Broad scope that  
encompasses  
multiple levels of  
support  
Recovery focused

- COAST delivers a recovery-oriented service that promotes mental health and wellness in a manner that meaningfully contributes to the client's quality of life and their participation in community
- Through the provision of specialized assessment, consultation, intervention and education, the team builds the capacity of family, caregivers, community and the larger systems by imparting support and planning into complex cases



**Eligibility:  
People eligible  
to receive  
supports from  
COAST need  
to meet all of  
the following:**

- Person is currently accessing supports from Disability Services (PDD or FSCD) or Children's Services programs.
- Person has multiple diagnoses, including a neurodevelopmental disorder (i.e. autism, FASD, genetic disorder, brain injury, etc.) along with at least one complex mental health concern.
- Secondary level addiction/mental health services have been received and it has been deemed that they require more intensive services.
- Person's support network is open to receiving and working with COAST. Caregivers/families and supports are ready to be engaged in COAST process, understanding of expectations of services and timelines. The current placement has supports in place that are stable and available to build capacity with.
- Person meets Complex Service Needs (CSN) criteria.

# Complex Needs Definition

(Disability Services/GOA)

Complex service needs are defined as individuals who currently pose a significant risk, and/or are destructive to themselves, others or property. They require intensive services and have, or have had, a history of one or more of the following diagnoses or life experiences:

- Mental health disorder
- Terminations from services due to challenging behaviours
- Specialized treatment for psychiatric and/or behavioural issues
- Multi-system involvement
- Incarceration(s) or criminal justice involvement
- Chronic substance abuse/dependency problem

# Who is on the Team?

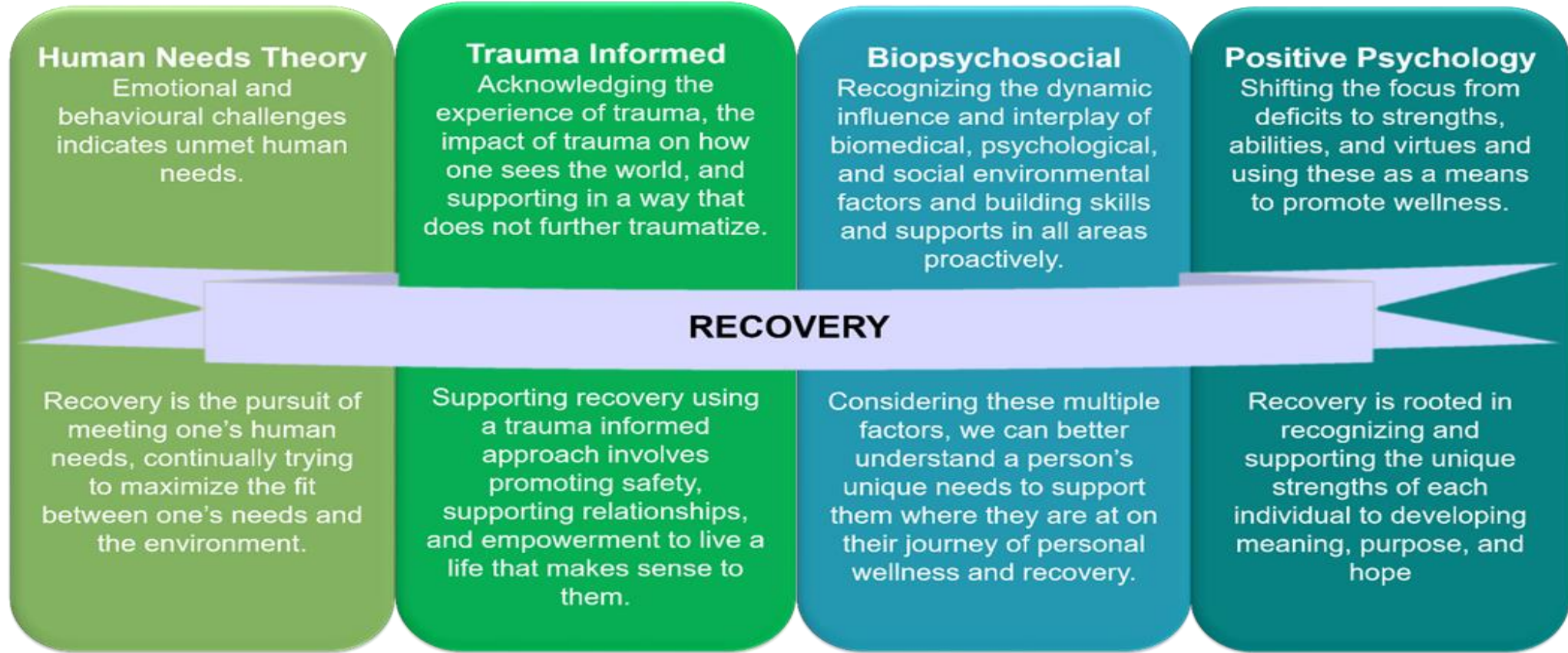
- Care Manager
- Clinical Supervisors
- Occupational Therapists
- Psychologists
- Behavioural Specialists
- Social Worker
- Mental Health Therapist
- Psychiatric Nurse
- Therapy Assistants
- Learning Disability Psychiatrists



# Risk Levels

The following is used to assess the risk at intake and at discharge from the program:

Risk Level	Description: Meets 1 or more of the following criteria
5 - Urgent	<ul style="list-style-type: none"> <li>Imminent risk to cause death to self or others.</li> </ul>
4 – High Risk	<ul style="list-style-type: none"> <li>High frequency of behaviours (happens weekly or a few times a week, it is likely the behaviour could occur during the course of a week) <ul style="list-style-type: none"> <li>Major injury to self or others (causing bleeding, concussion, broken bones, severe emotional distress, may be at high risk for overdose)</li> <li>Property destruction leading to significant monetary costs (i.e. fire setting, flooding, damage to vehicles)</li> <li>Person leaves for extended periods of time and has no skills to keep themselves safe (i.e. exploitation, leaving in inclement weather without proper clothing)</li> </ul> </li> <li>High risk to being exploited such as being affiliated with gangs, sex trade, criminal activity</li> <li>Has transitioned out of hospital, treatment facility, or prison.</li> <li>Crisis situations, urgent mental health needs that may lead to need for hospitalization.</li> <li>High risk of eviction, loss of home, residential placement breakdown. Includes school expulsions.</li> <li>High risk for justice involvement and/or incarceration (i.e. major aggression, property destruction, sexual assault, theft)</li> <li>Heavy users of service (i.e. frequent ER presentations, crisis services, and emergency services).</li> </ul>
3-Moderate Risk	<ul style="list-style-type: none"> <li>Medium frequency of behaviours (Happens monthly or bi-monthly. It is quite possible for the behaviour to occur again monthly or bi-monthly) <ul style="list-style-type: none"> <li>Moderate to minor injury to self or others (i.e. causing minor bruising, scratches/abrasions, may cause some emotional distress to others, may use substances)</li> <li>Property destruction such as holes in walls, broken windows, throwing items, broken possessions</li> <li>Threatening, posturing, spitting</li> </ul> </li> <li>High risk to lose community services such as employment, SIL supports, community access, day program, including school suspensions.</li> <li>Unlikely to be evicted from residence/home.</li> <li>Unlikely to need hospitalization and mental health needs can be addressed in community.</li> </ul>
2- Low Risk	<ul style="list-style-type: none"> <li>Low frequency of behaviours (Happens annually or a few times each year. The behaviour is unlikely to occur and does not occur on a regular basis)</li> <li>Low intensity behaviours. No physical injury to self or others.</li> <li>Behavior intensity, duration and frequency have low impact on self or others.</li> </ul>
1 – Quality of Life Concerns	<ul style="list-style-type: none"> <li>No maladaptive behaviour or behaviour has happened once before, but the last occurrence was more than 2 years ago. It would be rare for the behaviour to happen again.</li> <li>Desire to improve quality of life by pursuing recreation, leisure or vocational opportunities in the community.</li> <li>Enhance skills for the purpose of supporting community inclusion.</li> </ul>



# Recovery Model



## Case Management

To ensure quality continuation of care throughout the multiple systems and services, COAST uses a case management approach that focuses on coordination, collaboration, and accountability to ensure that all supports for the person and family understand the person holistically.

## Services Provided

- Facilitate effective collaboration with families, service providers and a range of other stakeholders
- Provide increased supports to families and service providers during times of crisis to facilitate stabilization in community
- Develop preventative strategies to avoid the need to initiate a critical response
- Empower families and service providers with the ability to implement and maintain high quality support and service provision
- Build capacity and promote personal wellness
- Supporting transitions from hospital/ facilities to community
- Specialized Psychiatric consultation

CONNECT · SUPPORT · ADVOCATE



FIRST NATIONS  
HEALTH CONSORTIUM

# FIRST NATIONS HEALTH CONSORTIUM LTD.

Enhanced Service Coordination

For Jordan's Principle: A Child-First Initiative







# First Nations Health Consortium

The Consortium has representation from all 3 Treaty areas in Alberta and provides a **Regional** coordinated approach to enhanced service coordination to all First Nations residing on and off-reserve (approximately 47% of applications are from off-reserve members).

The Tri-Party MOU signed between FNHC, Government of Canada and Government of Alberta supports the seamless coordination of access to both Federal and Provincial programs and services needed by First Nations children on and off reserve.

FNHC is comprised of a multi-disciplinary team of nurses, educators and child & youth/social workers that share their knowledge of existing resources across the province. This allows us to connect First Nation families to service providers and provide resource links to all Albertans.

Our solid understanding of the application requirements of Jordan's Principle ensures families are supported throughout the process, increasing the likelihood of a complete application and/or appeal submission (approximately 75% of appeals are successful).

# What we do for Children and Families



**CONNECT** children to health, social and education services



**SUPPORT** families with applying for Jordan's Principle funding



**ADVOCATE** for First Nations children

# Jordan River Anderson



Jordan River Anderson was a First Nation child from Norway House Cree First Nation born with complex medical needs that required hospitalization.

When Jordan was 2 years old his medical team determined he could go home with the aid of in-home care. However, there was a payment dispute between the Province of Manitoba and the Federal government as to who would pay for his in-home services. Jordan did not get to go home to his family and community and died in the hospital at the age of 5.

## Jordan's Principle

In 2007, the First Nations Child and Family Caring Society advocated for all First Nations and Inuit children to receive supports and services through the creation of Jordan's Principle: A Child-First Initiative. This initiative calls upon the government of first contact to ensure First Nations and Inuit children have access to public services on the same terms as other children.

As a result of multiple Canadian Human Rights Tribunal (CHRT) rulings, First Nations and Inuit children now have equal access to health, social and education services both on and off reserve through Jordan's Principle.





## Who can access Jordan's Principle?

On November 25, 2020, the Canadian Human Rights Tribunal (CHRT) released a ruling about Jordan's Principle eligibility.

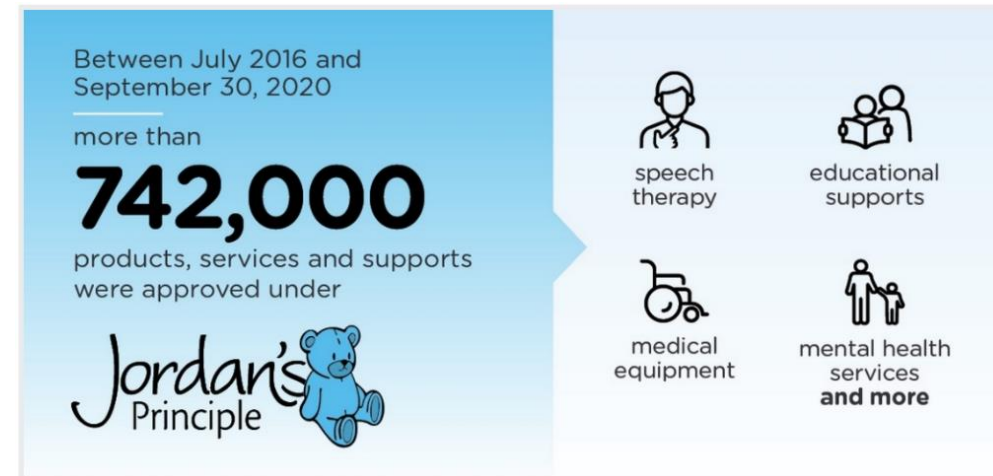
A child under the age of majority in their province or territory of residence can access Jordan's Principle, if they permanently reside in Canada and if the child meets one of the following criteria:

- is registered or eligible to be registered under the Indian Act
- has one parent or guardian who is registered or eligible to be registered under the Indian Act
- is recognized by their Nation for the purposes of Jordan's Principle
- is ordinarily resident on reserve

The eligibility above replaces the CHRT interim motion ruling of February 2019.

# Examples of Individual Jordan's Principle Application Requests

- Occupational Therapy
- Physiotherapy
- Speech and Language
- Registered Massage therapy
- Sensory Items
- Psych-Ed Assessment
- Tutoring
- Specialized/Cultural Camps
- Assistive Technology
- Behavioral Therapist
- Audiology
- Counselling Services
- Mobility/Medical Equipment
- Specialized Respite
- Podiatrist
- Educational Assistant





# How to Access FNHC Services

**Who Can Refer a Child?** Family, Caregivers, Service Providers, Youth 16+yrs

Call **1-844-558-8748**  
and speak to an  
Access Worker

- Who will obtain your child's **demographic information** and **consent form**
- Provide available resources

A Regional Service  
Coordinator (RSC)  
receives the file

- Connect children and families to existing Provincial and Federal services that meet the child's needs;
- Assists with identifying gaps in services and if the need is above normative standard, RSCs will support the family with the Substantive Equality Questions

Jordan's Principle  
Application

- When all the information and **supporting documents** are gathered, the application is sent to the Regional Focal Points/National Office for review and decision
- If the application is denied, the family has 1 year to appeal the application decision



# Types of Supporting Documentation

## Documentation required to support the applications:

- Diagnosis, assessments
- Support Letter from a professional
- Budget for product/service

### *Example: Psych-educational Assessments*

- Copy of previous assessments or diagnoses
- Letters of support from teacher and/or school counsellor
- Letter from the Principal stating reason why the school cannot provide requested services
- Psychologist budget

## Documentation varies depending on Type of Service/Product requested:

Orthodontics, Medical needs, Prescriptions, Eyewear, Temporary Coverage of Medical/Dental without Status, Educational Supports, Allied Health Social Supports



## Normative Standards

Needs are to be assessed against normative standards when there is not a direct gap in services of publicly funded health, social and education programs and supports for First Nations and Inuit children.

*Normative standard* means the health, social and educational standard for the average Canadian child compared to that of First Nations and Inuit children.

- Is this product or service normally available in Alberta through other publicly funded programs, such as Non-Insured Health Benefits or through extended health benefits?

When an application is submitted to Jordan's Principle, Indigenous Services Canada considers the needs and circumstances of First Nations children, which could be cultural, social, economic and often due to disadvantages because of the past mistreatment of First Nations in Canada.

Jordan's Principle aims to ensure equity through substantive equality considerations.



# Substantive Equality

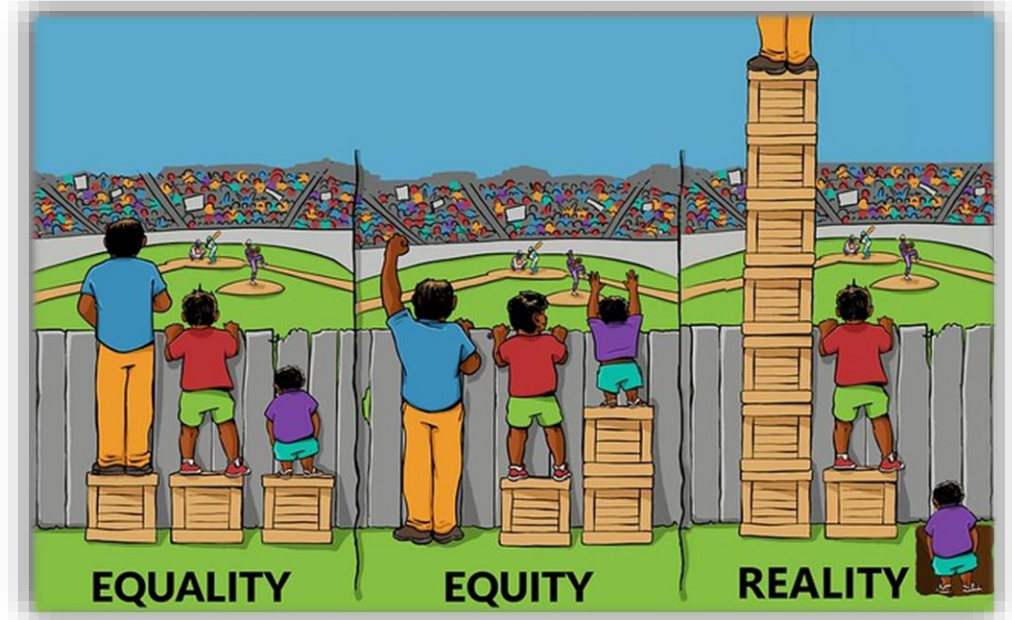
Substantive equality is the recognition that not all people start off from the same position and that these unequal opportunities make it harder for some to be successful/thrive.

This means giving extra help when it is needed, so that First Nations children have the same opportunity to access services as other children in Canada.

## 9 Questions

In assessing whether a product or service should be provided, there are 9 questions used as a guide to help achieve substantive equality.

- Jordan's Principle recognizes each application is unique
- RSC supports families in answering these questions
- Only the questions that best support your child's application should be answered



# Community-Managed or Group Requests for Multiple Children

Community-Managed or Group Requests are appropriate when the needs of children/youth seeking services are more effectively met in the context of the collective needs of a defined group.

A group request may be submitted for:

- A group of children (more than one child) within one family, or from multiple families/guardians with specific needs
- A group of children with specific needs (assessment/diagnoses) within the same community, or under the care of the same organization/educational institution
- Group proposal should be clear, concise and to the point and include what you are striving to achieve, timeline, anticipated budget and target audience/number of children

If a Community Application is approved the payment will be made to the community or group that made the request.

Examples of Group Requests: Equine Therapy Horsemanship Program, Health and Wellness Food Truck, Library Resource and Support, Mental Health Mobile Treatment





# FNHC Pilot Project with Indigenous Services Canada

## [Service Access Resolution Fund - SARF]

FNHC & ISC have undertaken a pilot project to facilitate payments to provide on-going and post approval support for Individual Requests.

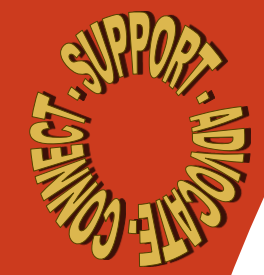
Once approved, Families/Clients or Vendors/Service Providers are required to fill out all documentation/forms and submit them to the FNHC.

Examples are:

- direct deposit form
- financial privacy consent form
- reimbursement form
- other necessary forms related to the Case Approval

All invoices and receipts with forms should have the Case Approval Number, child's name and can be sent to the SARF email. Once all documentation required has been provided, payments will be processed which can take up to 15 business days. **Email:** [sarfaccount@abfnhc.com](mailto:sarfaccount@abfnhc.com)

Group Request payments are processed by the Alberta Region Jordan's Principle Team.



# Advantages of Enhanced Service Coordination

- ❖ Reduce stress of navigating systems and Jordan's Principle applications
- ❖ Link families to provincial and federal resources
- ❖ Work collaboratively with other service providers
- ❖ Advocate for the children, their families and communities
- ❖ Support the family in telling their story (Substantive Equality)
- ❖ Provide assistance to families with the appeals process
- ❖ Support a community driven group application



## First Nations Health Consortium

Enhanced Service Coordination;  
the link between the child & the needed  
program, service, supplies, equipment &  
support



Call Toll Free  
**1-844-558-8748**

Visit our Website  
[www.abfnhc.com](http://www.abfnhc.com)

Email  
[nochild4gotten@abfnhc.com](mailto:nochild4gotten@abfnhc.com)



**FIRST NATIONS**  
HEALTH CONSORTIUM



**First Nations Health Consortium**  
Nonprofit Organization



Liked

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