An Evaluation of the Healthy Babies Healthy Children System Service Coordination Pilot Project

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For information, please contact

James Madden, Program Evaluator
Middlesex-London Health Unit
50 King St.
London, Ontario
N6A 5L7
phone: 519-663-5317
fax: 519-663-9430
e-mail: jim.madden@mlhu.on.ca

Middlesex-London Health Unit
50 King Street
London, Ontario
N6A 5L7

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Authors: James Madden, MSc, Program Evaluator, Middlesex-London Health Unit
Susan Ralyea, BScN, MHSc, Manager, Healthy Babies Healthy Children, Middlesex-London Health Unit
Lorna Larsen, BScN, IBCLC, Manager, Health Promotion, Oxford County Board of Health

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James Madden, MSc
Program Evaluator
Research Education Evaluation and Development Services
Middlesex-London Health Unit

Administrative Partners to the System Service Coordination Pilot Project

Liz Prendergast, Executive Director	Community Services Coordination Network, London, Ontario
Janet McKillop, Program Manager, Health Promotion	Elgin-St. Thomas Health Unit, St. Thomas, Ontario
Marlene Price, Division Manager, Healthy Babies Healthy Children	Huron County Health Unit, Clinton, Ontario
Susan Ralyea, Manager, Healthy Babies Healthy Children	Middlesex-London Health Unit, London, Ontario
Lorna Larsen, Manager, Health Promotion	Oxford County Board of Health, Woodstock, Ontario
Pat Hanly, Public Health Manager, Healthy Babies Healthy Children	Perth District Health Unit, Stratford, Ontario

Executive Summary

This document reports the results of a formative evaluation of the Healthy Babies Healthy Children (HBHC) *System Service Coordination Pilot Project*.

Service coordination is an integral part of working with families who experience barriers to service. In most agencies and programs, service coordination is generally implemented as an *add-on* role of the service provider. *System-level* service coordination is a new level of service coordination designed to improve the effectiveness and efficiency of the HBHC system of prevention and early intervention services for a certain segment of high-risk families - that is, those with highly complex needs crossing multiple service systems.

The System Service Coordination Pilot Project investigated the question of whether a *dedicated, third party service coordinator* would provide significant gains for selected families by enhancing their functioning and well being. Significant gains were also anticipated for the service system because of reduced demand for more costly, intrusive downstream or "deep end" interventions in the future.

Study Design

An evaluation study was designed by a subcommittee of the partnership of HBHC Program Managers from the five Southwestern Ontario health units participating in the six-month pilot. A multi-method, multi-informant approach was used. Administrative data collected by the System Service Coordinator and PHNs was tracked and analyzed. Focus groups were conducted with the administrative partners and PHNs involved in the pilot. A questionnaire was administered with families who were receiving system service coordination. An in-depth interview and follow-up interviews were conducted with the System Service Coordinator hired for the pilot phase.

Evaluation Questions and Findings

1. **What were the activities and what was workload demand required of the coordinator in providing service to 20-26 multi-complex families across the five-county area?**

   - System service coordination was enacted as seven overlapping sets of activities (see Appendix H).
   - The values enacted by the System Service Coordinator were crucial determinants of the success observed during the pilot phase, particularly: being *relationship-centred*, keeping the *family in the driver's seat, holistic planning*, and *empowerment.*
   - Working intensely with 20 families at any one time is a reasonable service capacity for one full-time System Service Coordinator.
   - System service coordination required on average, an estimated 2.1 hours per case per week.
   - There was sufficient demand for system service coordination services to justify dedicating at least one full-time worker to the position.
   - A large portion of the time required for system service coordination was consumed by essential indirect service work, particularly *organizing and preparing for meetings*, *creative digging* (including identifying informal supports and helping families build community support networks,*) and writing up plans.*

2. **Did the model improve PHNs' ability to deliver direct service?**

   - System service coordination significantly increased the amount of time PHNs are able to devote to providing the direct nursing services.
   - There was evidence that the System Service Coordinator was able to deal more effectively with potentially contentious inter-agency issues.
   - The System Service Coordinator cultivated a broader range of community resources and informal supports to integrate into family service plans than PHNs performing the service coordination role.
   - The System Service Coordinator provided professional and "moral" support to PHNs, enhancing the quality of service provided to challenging multi-complex families.

3. **How did the model impact multi-complex families?**

   Insufficient time has elapsed to evaluate more than the most immediate impact of system service coordination on families served. However, PHNs who worked with the System Service Coordinator did observe first hand and report the following impacts on families:

   - Rekindled sense of hope
   - Increased sense of efficacy
   - Learned more effective way of advocating for family
   - Increased involvement of informal supports

Families reported the following outcomes of system service coordination:

- All families felt listened to and perceived a high degree of influence in the process of developing community action plans.
- Most families perceived good follow-up on the plans and thought the plans would make a difference for their families.
- Most of the families surveyed described positive or very positive outcomes resulting from system service coordination, such as elimination of "chaos" at home, "making a huge difference in my life [by giving] me confidence to advocate for my child and family..." and helping reunite a family after delays and frustrations.

4. Did this model improve access to the system of prevention, early intervention services and informal supports for multi-complex families?

The role of System Service Coordinator improved access to the system of prevention, early intervention and informal support by:

- Reducing fragmentation and gaps in services to multi-complex families because of a greater capacity to identify and bring together previously untapped or unconnected services and resources.
- Increasing integration between families, informal supports and formal service providers through facilitating the collaborative development community action plans.

It is argued that these improved system-level outcomes may be attributed to the following key advantages that are conveyed by the position or location of the role within the overall system. System service coordination:

- Occupies a position in the system (autonomous, dedicated role) that makes possible greater potential for bridging and connecting work.
- Is mandated to develop knowledge of, and is skilled in cultivating a host of community resources.
- Is in a position to increase the capacity of PHNs and other service providers by providing informal mentorship as well as through formal training opportunities.

5. Is the model of *one coordinator serving five counties* adequate, or should there be separate service coordinators in each county?

- Carrying out the role of System Service Coordinator across the five-county catchment area was extremely time-consuming and taxing on a person who by all accounts is an very dedicated, high energy, highly skilled worker.
- One key dilemma has to do with how to efficiently cover such a large geographic area, while honouring the key principles of being relationship-centred and family focused in terms of scheduling and conducting community meetings and other tasks associated with the role.
- Given available resources, two feasible options were identified, each with advantages and disadvantages: split the FTE between two workers to realize administrative efficiencies, or deploy the role as a dedicated FTE, and find ways to mitigate the disadvantages associated with travel time.
- The collective judgement of the administrative partners and the System Service Coordinator was that the dedicated FTE option was more desirable.

Recommendations

Upon reviewing the findings reported in this document, the administrative partners developed the following set of recommendations:

1. That one full-time equivalent System Service Coordinator position be funded on an annual basis serving multi-complex families in HBHC in Elgin/St. Thomas, Huron County, Middlesex-London, Oxford and Perth Counties.
2. That the full-time equivalent position be undertaken by one worker and deployed in a manner, which reduces travel time and associated costs.
3. That a resource consultant role to enhance community capacity be enacted as part of the role of System Service Coordinator.
4. That the partners meet on a quarterly basis to monitor, direct and support the initiative.
5. That the results of this evaluation be disseminated to the Ministry of Community and Social Services, South West Regional Office, the Integrated Services for Children Division, Healthy Babies Healthy Children, all HBHC programs across Ontario, participating counties children services' planning committees and through other networking and educational opportunities.

Conclusions

This pilot demonstrated that system service coordination was effective for families and providers alike. Families perceived a high degree of influence over their care – a determinant of health – and thought the plan would make a difference to their families. Families experienced enhanced community integration demonstrated by increased involvement of informal supports. PHNs increased the amount of time they were able to provide professional nursing services to families and benefited from mentoring by the System Service Coordinator in a team approach.

Service coordination was demonstrated to take time. A number of invisible tasks were highlighted as being essential to the role and thus to outcomes for families.

The positive results of this pilot project are thought to be causally related to the autonomous, dedicated nature of the System Service Coordinator position.

A significant limitation of this study is that the data analyzed was collected after only four to six months of operation. The findings reported here are extremely useful for purposes of formative evaluation, but suggest only the most immediate outcomes on the social service system and the limited number of families served during the pilot.

While it cannot be stated on the basis of this study that this type of early intervention will prevent more costly intervention in the future, the nature of the challenges faced by multi-complex families are consistent with those of families that often require more costly and intrusive types downstream interventions from the community social service system. It is reasonable to infer that enhanced functioning and well-being of multi-complex families brought about through early intervention will lead to downstream benefits for both families and the service system.

Further study is necessary to determine the longer-term impact on families, service providers and the service system. An approach that would provide more definitive evidence of longer-term impacts would be a *multiple time series* evaluation design.

Introduction

This document reports the results of a formative evaluation of the Healthy Babies Healthy Children (HBHC) *System Service Coordination Pilot Project*. The six-month pilot was a collaborative effort between Elgin/St. Thomas, Huron County, Middlesex-London, Oxford County and Perth District Health Units, and the Community Services Coordination Network (CSCN).

System service coordination is a new level of service coordination designed to improve the effectiveness and efficiency of the HBHC system of prevention and early intervention services for a certain segment of high risk families—that is, those with highly complex needs crossing multiple service systems. It does not replace, but enhances both agency and interagency service coordination.

The innovative element in *system-level coordination* is the set of coordination activities provided by a highly skilled, specially trained, *dedicated, third-party System Service Coordinator.* By *dedicated* is meant that service coordination is the worker's only job; it is not a responsibility added on to an already heavy caseload. By *third-party* is meant that the System Service Coordinator is unattached to any particular service-providing agency.

An evaluation study for the pilot was designed using a multi-method, multi-informant approach. Administrative data collected by the System Service Coordinator and PHNs was tracked and analyzed. Focus groups were conducted with the administrative partners and PHNs involved in the pilot. A questionnaire was administered with families who were receiving system service coordination. An in-depth interview and follow-up interviews were conducted with the System Service Coordinator hired for the pilot phase.

This report is organized in the following manner. The *Background* section describes the organizational and service system context in which the pilot and evaluation were conducted. In the *Evaluation Design and Methods* section, the formal evaluation questions are stated, and the evaluation design, methods, data sources, and analytic procedures are described. The *Findings* section, presents the results of the evaluation study, organized according to the five formal evaluations questions. Conclusions are drawn and stated for each evaluation question. The *Recommendations* section presents a set of recommendations developed by the administrative partners in light of the findings presented in this report, followed by *Conclusions*.

Background

The Healthy Babies Healthy Children Service System

The Healthy Babies Healthy Children Program was introduced across Ontario on January 1, 1998. It is a joint initiative of the Ministry of Health and Long Term Care, and the Ministry of Community and Social Services under the direction of the Integrated Services for Children Division. The program is administered locally by Public Health Units. The expected outcomes of Healthy Babies Healthy Children are:

- Increased child health and development
- Increased parenting confidence and knowledge
- Decreased parental stress and increased parental support
- Increased family integration into the community
- Increased integration of programs and services that support healthy child development

One program component of Healthy Babies, Healthy Children is *service coordination* for identified families. This component supports the attainment of the expected outcomes of HBHC by:

- Improving integration of supports and services for children and their families at the community level
- Increasing access to and use of services and supports for children who are at risk of poor physical, cognitive, communicative and psychosocial development and their families
- Improving coordination of care
- Developing new linkages amongst service providers
- Removing unnecessary barriers to coordinated and integrated services for children and their families

Across Ontario, virtually every service system and organization share these general objectives and are striving to work in a collaborative manner to ensure the most efficient and effective use of resources.

HBHC programs across Ontario were thus encouraged to work with their respective community partners to develop service coordination frameworks that would achieve these objectives and reflect unique local needs.

In London Middlesex, the HBHC Service Coordination Committee articulated their local model in a document entitled *London-Middlesex Community Service Coordination Framework*. Published in November 2000, this model built on the work of the *Coordinated Access to Services Project*, Ministry of Community and Social Services, South West Regional Office.

The *London Middlesex Community Service Coordination Framework* model proposed three distinct levels of service coordination, defined as follows:

Agency Service Coordination

Families entering an agency can expect support from the agency to understand, choose and navigate the appropriate services that the agency has to offer and be of assistance when other service options are needed. The service coordinator is initially assigned to the family by the agency, but may change depending on the family's preference and/or agency circumstance.

Interagency Service Coordination

All families with multiple agency involvement will be offered a service coordinator to coordinate across agencies and services. The Service Coordinator is determined by the family and involved service providers, considering the following criteria:

- Has a strong working relationship with the family
- Is able to organize family conferences and support the family in the process
- Will continue to work with the family over time
- Is committed to open communication and interdisciplinary collaboration
- Respects and facilitates the family's goals

System Service Coordination

When the needs of the family exceed the capacity and expertise of an individual's service coordinator/agency, specialized system coordinators will be available to support and consult with service coordinators and/or provide coordination services

directly to a family. System coordinators will be considered in consultation with the family when:

- More than one agency, service cluster and/or service sector is involved, e.g. health, social services and education
- When the issues are very complex and families and service providers require support to meet the family's needs

In most communities, there is an ability to provide service coordination at the agency and interagency levels. It is an integral component of working with families. However, for some families, the intensity of the service coordination function that is required jeopardizes the provision of professional services. With such families the identification of a *System Service Coordinator* who can bring a higher skill level, neutrality and a focus on service coordination - rather than service delivery - to the planning process was desired.

The Community Social Services System

Concurrently, The Ministry of Community and Social Services' policy framework, *Making Services Work for People*, set out the government's expectations of the service system and clearly articulated the outcomes that are expected. In response to this policy framework, a model for service coordination was developed. The Community Services Coordination Network (CSCN) has responsibility for the implementation of the Coordinated Access to Services model for Middlesex- London, Oxford, Elgin, Huron and Perth counties for MCSS funded services and supports for Children's and Developmental Services. A number of expected outcomes were identified that would occur as a result of the model. Those expected outcomes are:

- Families and individuals will have an easy way to find out about services that are available.
- Families and individuals will have help in gaining access to services that are the most appropriate to respond to their needs.
- A fair mechanism will be established for setting priorities for providing services to all who need them.
- Those who need help the most will receive essential supports first.
- Families and individuals will receive a minimum number of assessments and provide necessary information only once.
- Families and individuals will have a single agreement for the services they receive.
- A single person or team will be accountable for the agreement[1]

A number of guiding principles have been identified and integrated into the service coordination process. They are:

- Services and supports are focused on individuals and families
- Fairness, sensitivity and respect for diversity are provided to those accessing services
- Consumers of service should have individual choice regarding the service they receive
- Consumers of service are involved in decision making regarding the service they receive
- Consumers of service have the right to be their own service coordinator
- A review and appeal mechanism is in place and available
- Accurate information is provided
- Confidentiality is respected and consumers of service have a right to access the personal information that has been collected.

The role of the CSCN service coordinator has been articulated as having primary responsibility for the coordination of accommodation supports and residential services funded by MCSS for Children and Developmental Services. In addition, CSCN facilitates a resolution process for individuals with multi-service, complex needs. Currently, CSCN is not funded to provide service coordination beyond this scope. However, the role that is articulated for System Service Coordination in the *London-Middlesex Framework* is highly consistent with the role of the CSCN community service coordinator and the skill set that is inherent in the job description. Of particular note are the key skills that are identified in the job description of the CSCN community services coordinator:

- Mediation, negotiation and facilitation skills
- Systems perspective
- Excellent problem solving skills
- Diverse background in Case Management
- Knowledge of community development principles
- Strong understanding of and commitment to a service coordination model

[1] Ministry of Community and Social Services, South West Region, London Office, Coordinated Access to Services Model, Draft Service Protocol Agreement, June 1999, page 1.

- Proven ability to work both independently and collaboratively as a member of a multidiscipline team
- Knowledge of and ability to access community resources[2]

The Pilot Project: Toward an Integrated System

Health Units delivering Healthy Babies Healthy Children programs in the counties of Elgin, Huron, London and Middlesex, Oxford and Perth and the Community Services Coordination Network recognized an opportunity to join forces to enhance one another's ability to serve families. They recognized that there were many commonalities including consistent service coordination frameworks, service philosophies, principles and approaches to program delivery. These common elements created the synergy to explore a potential pilot project that would test the system service coordination level through a unique partnership. The group envisioned that such a project would promote a dynamic relationship among families, service providers and informal supports that would result in an integrated and effective plan to support multi-complex families to achieve their potential with the least amount of intervention.

Following a series of planning meetings between representatives of Health Units and the Community Services Coordination Network, a proposal for a pilot project was developed.

In January 2000, a six-month pilot project was launched through a combination of financial and in kind contributions from the partners:

- Elgin St. Thomas Health Unit
- Huron County Health Unit
- Middlesex-London Health Unit
- Oxford County Board of Health
- Perth District Health Unit
- Community Services Coordination Network

The purpose of the pilot was to test the service coordination model articulated in the London Middlesex Service Coordination Framework. This level of service coordination did not exist prior to the pilot project.

The system service coordination component would be delivered to families that were identified by the HBHC programs because of the complexity of their needs. It was thought that these families would require a multi - system response to develop a comprehensive plan of service. Experience suggested that, these families' need for service coordination often jeopardized the provision of direct professional services.

The estimated need for the system level of service coordination was identified at approximately 70-90 families in HBHC programs across the five-county area on an annual basis.[3] Therefore, it was estimated that 35-45 families would require system service coordination during the course of a six month pilot.. The actual period of system service coordination delivery was fifteen weeks, targeting 20-26 families.

A decision was made to evaluate the pilot project at the outset. The Middlesex-London Health Unit Program Evaluator was engaged to collaborate in designing and conducting the evaluation.

[2] Community Services Coordination Network, Job Description, Community Services Coordinator, Feb. 2000

[3] This estimate was based on discussion with Andrew Debicki, Wraparound Coordinator, Hamilton, Ontario. Debicki estimates that 1% to 2% of high-risk families are not able, for reasons such as those described above, to access services in the traditional manner.

Evaluation Design and Methods

An evaluation subcommittee of the administrative project partners formed in February 2001 to work with the Program Evaluator.

Purpose of the Evaluation

The following evaluation purposes were established:

1. To determine the impact of the *system service coordination* model on the Community Services Coordination Network (CSCN) service system and multi-complex families in the Healthy Babies Healthy Children program.
2. To demonstrate the value of this approach to service coordination.
3. To obtain feedback from families and service providers for possible revisions to model if needed.

A program logic model was developed to assist in determining the specific evaluation questions, and appears as Appendix A.

Evaluation Questions

The following formal evaluation questions were derived from the purpose statement and logic model:

1. What are the activities and what is the work load demand required of the coordinator in providing service to 20-26 multi-complex families across the five-county area?
2. Does the model improve PHNs' and other Healthy Babies Healthy Children service providers' ability to deliver direct service?
3. How does the model impact multi-complex families?
4. Does this model improve access to the system of prevention, early intervention services and informal supports for multi-complex families?
5. Is the model of *one coordinator serving five counties* adequate, or should there be separate service coordinators in each county?

Evaluation Plan

An evaluation plan was developed which incorporated the following methods:

- Tracking of referral data collected by the System Service Coordinator and participating PHNs, gathered through tracking forms and administrative records
- Tracking of activities and assessment of workload associated with the role of System Service Coordinator gathered through an activity log kept by coordinator
- Focus groups conducted with PHNs and administrative partners to gather their perceptions of the impact of the model on clients and the service system
- Brief questionnaire administered face-to-face with families receiving system service coordination to assess their perception of the service and its impact on their situation
- In-depth interviews and follow-up interviews with the System Service Coordinator to gain an overview perspective on the development and enactment of the role

Various data generated by these methods were assembled and analyzed in order to answer the formal evaluation questions. Data collection methods and analysis procedures are further described below. An overview of methods, time frame, data sources, and data collected is presented in Table 1.

Table 1: Overview Of Methods And Data Sources

Method/Time Frame	Data Source(s)	Data Collected
Track Referral Data (Data collection period, March through June)	**System Service Coordinator and Public Health Nurses** working in HBHC • Elgin County • Middlesex-London • Oxford County • Perth County	• Numbers of families identified and referred • Numbers of families declining or refusing system service coordination • Reasons for decline/refusal
Activity Log (Data collection period, March through June)	**System Service Coordinator**	• Tracking of coordinator's activities and workload
Focus group (June 13)	**Public Health Nurses** • Elgin County • Middlesex-London • Oxford County • Perth County	• Assessment of impact on service delivery • Assessment of short-term outcomes from service provider point of view
Family questionnaire (Administered by Public Health Nurses, last 2 weeks of June)	**Families being served by System Service Coordination** • 14/14 returned	• Assessment of multi-complex families' experiences of service under the pilot
In-depth interview (August 9)	**System Service Coordinator**	• Overview perspective/qualitative account of the role
Focus Group (September 18)	**5 Administrative Partners** Representatives from Health Units in Elgin County, Middlesex-London, Oxford, and Perth, and from Community Support Services Network	• Administrative perspective on working of model
Focus group (October 22)	**Administrative Partners, System Service Coordinator**	• Member checking of preliminary findings • Recommendations
Follow-up Interview and Request for Additional Data (October 24)	**System Service Coordinator**	• Clarification/validation regarding key activities

Tracking Referral Data

Participating PHNs across the five-county area were asked to identify and refer to the System Service Coordinator, multi-complex families that met established criteria (see Appendix B). Tracking forms were developed and distributed though the administrative partners (see Appendix C). PHNs were to identify and track families identified and referred during the months March through June. The System Service Coordinator also tracked families identified, referred and linked to service.

Tracking Coordination Activities through Activity Log

The System Service Coordinator was asked to track key activities associated with her role. A tracking spreadsheet was developed using MS Excel. Key activities were tracked during the period March through June. The System Service Coordinator was interviewed to obtain additional information for constructing best estimates around various parameters (for example, frequency and/or duration of key activities such as phone calls and meetings) in order to perform a "case/time" analysis (see Appendix D). This analysis permitted the calculation of estimated hours required to coordinate each case per week.

PHN Focus Group

A focus group was conducted three and a half months into the pilot to obtain the perceptions of PHNs on the working of the model and its short-term impact on service delivery and families. All PHNs working in the HBHC Home Visiting Program across the five counties who had referred families for system service coordination were eligible to participate. Participation of eligible PHNs was to be elicited by their managers (participating administrative partners). An interview schedule for the PHN focus group was developed in collaboration with the evaluation subcommittee (see Appendix E). The focus group was moderated by the MLHU Program Evaluator. Twelve PHNs were eligible; eight participated (67%). The session was tape-recorded and transcribed by an outside professional transcriber. The transcript was content analyzed for key themes. Results of the preliminary content analysis were examined for evidence pertaining to the formal evaluation questions.

Family Questionnaire

A brief questionnaire (see Appendix F) was designed in collaboration with the evaluation subcommittee, to survey families' experiences with system service coordination. Questionnaires were to be administered face-to-face by the PHN who had originally referred the family for system service coordination. In order for any family to be eligible for the survey, a community action plan needed to have been in place by May 15. This would allow the plan to have been in effect for at least one month prior to administration of the questionnaire. PHNs were given orientation to survey procedures at the conclusion of the PHN focus group by the MLHU Program Evaluator. The questionnaire was administered during the last two weeks of June. Questionnaires were returned for all 14 (100%) of families eligible to complete the survey. The data was entered into an Excel spreadsheet by administrative support staff and analysed by the MLHU Program Evaluator using SPSS 10.0 statistical software package. Open-ended comments were transcribed verbatim and analyzed for evidence of impact on the model on families. Open-ended comments are reported in Appendix G.

In-Depth Interview with System Service Coordinator

A semi-structured, in-depth interview was conducted by the MLHU Program Evaluator with the System Service Coordinator a little more than five months into the pilot. The purpose of the interview was to obtain an overview perspective on the working of the model, it's effectiveness, and qualitative account of the enactment of the role. The interview schedule was based on the formal evaluation questions and short-term outcomes listed in the program logic model. The interview was tape-recorded and transcribed by a professional outside transcriber. The transcript was content analyzed for key themes. Results of the preliminary content analysis were examined for evidence pertaining to the formal evaluation questions. A second interview was conducted with the System Service Coordinator by telephone after the first administrative partners focus group (see immediately below) to fill in data gaps and validate findings regarding key activities.

First Focus Group with Administrative Partners

A focus group was conducted with the administrative partners in mid-September, after the scheduled end of the pilot. Participants included the HBHC Program Managers from four of the five participating public health units, plus the administrator of CSCN. The purpose of the focus group was to obtain the administrative partners' perspectives on the working of the model. The focus group was conducted by the MLHU Program Evaluator. The interview schedule was slightly adapted from the PHN focus group. The session was tape-recorded and transcribed by an outside professional transcriber. The transcript was content analyzed for key themes. Results of the preliminary content analysis were examined for evidence pertaining to the formal evaluation questions.

Second Focus Group with Administrative Partners

A draft report of findings based on the above steps was prepared and presented to the administrative partners to validate findings and generate a list of recommendations which would be included in the final report. Participants included the Program Managers from all five public health units, the administrator of CSCN, and the System Service Coordinator. The meeting was conducted by the MLHU Program Evaluator. The meeting was not tape-recorded. Notes were taken based on comments of the participants and incorporated into this report as recommendations.

Results of the analysis reported in the following section have been organized according to the evaluation questions.

Findings

Characteristics of the Role

What Are The Activities And What Is The Work Load Demand Required Of The Coordinator In Providing Service To 20-26 Multi-Complex Families Across The Five-County Area?

Activities

The basic roles and responsibilities of the System Service Coordinator were set out in a document entitled *London-Middlesex Community Service Coordination Framework* (November 2000). Working from these basic terms of reference and supported by CSCN, the person hired as the System Service Coordinator for the pilot project essentially invented the role as she enacted it.

The role of System Service Coordinator was enacted as seven overlapping sets of activities.

1. Initial consultation(s) with PHN(s)
2. Initial home visits: *breaking the ice* and identifying and developing immediate *mini-plans* to address the most pressing solvable problem
3. Following-up on immediate mini-plans
4. Setting up community planning meeting(s)
5. Building the *community action plan* and facilitating the emergence of a community support network
6. Monitoring and following-up on community action plans
7. Disengagement process (returning family to inter-agency level service coordination)

The specific activities associated with each of these is described in Appendix H along with first person narrative accounts of the process, drawn from interviews with the System Service Coordinator.

Key Principles and Values

It should be noted that in her account of enacting the role, the System Service Coordinator placed a great deal of emphasis on the centrality of key principles and values. Those principles and values - which are highly congruent with those articulated in the London-Middlesex Community Service Coordination Framework - are summarized as follows.

- *More relationship-centred than agency-centred*. The System Service Coordinator seemed to deliberately concern herself less with agency prerogatives such as administrative efficiency, and more with doing whatever was necessary to make connections and build trust–particularly with the families, but as well with the various service providers.

- *Family-focused*. The family is *in the driver's seat* of the planning and coordination process. Treat each family as unique and with respect.

- *Holistic planning*. Treat the family as a whole, embedded in a social context. Attend to the family as a unit rather than focusing on which member is covered under agency mandates. Strive to connect families to a community support network.

- *Empowerment*. Empower families by encouraging them to find their own strength, while providing tangible supports, such as material support and advocacy, to address basic needs.

It can be concluded that 1) the character of the coordinator and values enacted by her were crucial determinants of the success observed during the pilot phase and 2) the values enacted by the System Service Coordinator were congruent with key values written into the project proposal.

Workload

As mentioned in the background section, it was estimated that 20-26 high risk families from the five-county area would require this level of service coordination over the course of the pilot project.

The System Service Coordinator met with PHNs in each health unit to develop the referral process and to define their respective roles. See Appendix B for referral criteria and documentation processes.

For the period March 1 through June 15 (15 weeks):

- 23 families were referred for system service coordination across the five counties.

- Of those referred, 22 were connected, that is, accepted services offered.

- Only one family actually refused service. According to the referring PHN, the family felt "too many people are involved already, (the family) doesn't understand how one more person could help."

Table 2: Geographic Distribution Of Families Receiving System Service Coordination

Geographic Area	Number of Families
City of London	9
Middlesex County	5
Oxford County	4
Elgin County	2
Perth County	2
Huron County	0
Total	**22**

By the end of October, the System Service Coordinator had obtained an active workload of 28 families.

Unless otherwise indicated, the analyses reported in this evaluation are based on the 22 families that were served during the period March 1 through June 15.

Demand for Service

What evidence is there of demand for system service coordination services?

It is clear from the PHNs' and partners' focus groups, as well as from interviews with the System Service Coordinator that the number of referrals made was not an accurate reflection of the ultimate demand for service.

The evaluation design called for participating PHNs to *identify all multi-complex families* they encountered in the course of their work in the HBHC program, so that demand for service could be tracked. This aspect of the evaluation plan was not clearly understood and communicated to PHNs in the field. Many of the PHNs as well as some of the administrative partners participating in the pilot operated under the assumption that they were to limit their referrals to one or two families.

Consider the following statement made by one of the county nurses during the PHN focus group:

> …when [the System Service Coordinator] first came out, I think upon our discussion -- I mean a lot of our families would meet the criteria—a lot of our families…. we really were encouraged… not to say "Here's my client list" [group laughter]. [The need is] so widespread. And I think we really were encouraged to…keep it to one or two families. There were five of us working.

This comment was followed up during the subsequent interview with the System Service Coordinator. Her comments strongly support the conclusion that there is greater demand for system service coordination than is reflected in the actual number of referrals received.

> I guess there is still a lot of unknowns in terms of possible referral or not, and what is (the role of System Service Coordinator). I think there is still a lot of uncertainty and lack of understanding, in terms of even the Public Health Nurses' understanding of is this an appropriate referral or not…. (I)n discussions, for example, in [one] county… the PHN's thought they were supposed to only refer one or two families, they didn't know they could refer more. So it's whatever people have heard at those initial meetings….I would say there are probably lots of families out there that could really benefit if they knew and if the word was out there.

Another factor which has begun to influence the demand for system service coordination are the positive outcomes the system service coordination has already produced for both clients and service system. As one of the administrative partners stated:

> Certainly, even within our county, just the results of those few referrals we had, I'm now seeing an increase in referrals from other agencies had that been a part of the process for families to come to Healthy Babies Healthy Children hoping to maybe get a systems service coordination piece as part of it.

Case/Time Analysis

The System Service Coordinator was asked to keep a log of activities associated with performing her responsibilities.

The following table reports activity counts and/or time spent for key activities. The figures reported in the third column are estimates based on information

tracked by the coordinator. It can be conservatively estimated that on average, each case required at least 2.1 hours per week. It should be kept in mind that this time analysis applies to the developmental phase of the project. At any given time, different families are in different stages of service coordination, requiring varying degrees of time commitment from the System Service Coordinator. (For a more detailed explanation of how these estimates were derived from tracking data, refer to Appendix D.)

Activity	Activity Counts and/or Time Spent	Estimated hours per case (over 15 weeks)
Consultations with PHNs and FHVs	27 consults, approx. 60 min. each	1.2
Home Visits	48 visits, approx. 2 hours each	4.4
Phone calls	Approx. 700 calls, from 1 min. to 1 hour	8.9
Research Time (not including phone calls)	75 hours (approx. 5 hrs/week)	3.4
Community Meetings	Estimate 1/week @ 2hr/meeting	1.4
Preparation Time for Community/Family Conferences	23 conferences, approx. 2 hours each	2.0
Community/Family Conferences	23 meetings, approx. 3 hours each	3.1
Writing, Editing and Distributing Plans	3 hours/plan	1.8
Number of Plans	13 complete; 7 plans in process	
Kilometers traveled	Feb: 2700; March-May: 4617; Total KM: 7317	
Travel time	Approx. 104 hrs	4.7
Estimated total hours/case over 15 weeks		**30.9**
Estimated hours/case per week		**2.1**

The System Service Coordinator emphasized how time-consuming were many of the tasks associated with the role. Three essential indirect service tasks listed in the preceding table were deemed especially important by the System Service Coordinator, and are therefore described in some detail below. They were: preparation for meetings, research time, and writing plans.

Preparation Time for Community/Family Conferences

Among the things involved in preparation for meetings mentioned by the System Service Coordinator were:

Building relationships with agency people in advance of meetings. This involved many, many phone calls.

Design work such as physical preparation of meeting space in order to create an atmosphere of warmth. Also included are preparation of agendas and visual aides such as flip charts.

Mental preparation to support good facilitation.

The System Service Coordinator emphasized that there "has to be a really supportive environment" in order to support what can be very difficult interactions between families and people drawn into community planning sessions.

Research Time or *Creative Digging*

What the System Service Coordinator referred to as *research* in her activity log encompassed a variety activities that might be best described as creative problem solving and development of local resources. It also includes the crucial work of identifying and involving additional formal and informal supports and integrating them around the particular needs and strengths of each family. In characterizing this aspect of the work the System Service Coordinator used phrases like:

- Creative digging
- Thinking outside of the box
- Going down many paths
- Looking for informal solutions
- Making linkages
- Looking for local solutions

The System Service Coordinator related a story that illustrates this aspect of the role. It involved a family that included a couple and their infant and pre-schooler. This mother had many challenges and the father had just recently gotten a job. It was mutually decided that if an appropriate daycare situation could be found for the older child, the family as a whole would benefit. After exploring a range of formal and less formal daycare options, all of which proved unsatisfactory in some way, the System Service Coordinator discussed with the mother the possibilities for a very local informal solution. The System Service Coordinator initiated a conversation with neighbours.

> So I …had a chat and said, "Hi, gosh it's hot….Do you know your neighbours?" They said, "Oh yeah, oh yeah, my kids got invited to their birthday party but we didn't get to go".... So I said…."I'm really helping to sort out some things, trying to…[find] some day care or even support in this neighbourhood. Do you know anybody?" [One of the neighbours said she had worked as a resource worker in the school and] understood what I was saying because it's about building a community…. [She referred me to an "amazing"] babysitter who lives around the corner….
>
> I called the babysitter and she is just a remarkable, energetic woman. She has four or five children that she does daycare for and takes the kids out every day. She has set up a …[crafts] room in the area…and she has everything sort of organized. It is literally around the corner from their home. So I introduced them and it's looking like that [the child] may go there every day because [the neighbour] is going to walk over and pick him up and walk him over to her house. We are talking about building community, not going thirty minutes in a van to a daycare, because that is what's available. That's thinking outside the box. That's creative digging. And you have to be somewhat courageous to feel comfortable talking to a neighbour and just have a chat.

Writing Plans

As indicated in the preceding table, the process of writing up each *community action plan* takes approximately three hours.

Some of the key characteristics of the process of writing plans include:

- Each plan is tailored to the needs of the family and is usually *visual* in format (less textual, use more graphics and diagrams)
- Plans may take a variety of forms. Families may be involved in creating one or more *mini-plans* or *tools* that may be subsequently incorporated into formal community action plans
- Mini-plans or tools are developed to help families deal with and keep on track with very specific problems. For example:
  - *Keeping up the house* tool
  - *Finding the balance* tool (designed to help a mother balance her family's demands and needs with what she needs to enhance her own coping abilities)
  - *What happens if* tool (designed to help a person of limited mental capacity decide how to respond to a variety of daily situations)
- A formal action plan becomes the basis for "accountability around the action pieces"
- Plans are to be revisited and adapted as circumstances change

Conclusions

- Referrals fell within estimated target projection.

- The role of system service coordination has been enacted as seven overlapping sets of activities.

- The character of the coordinator and values enacted by the System Service Coordinator were crucial determinants of the success observed during the pilot phase. Particular emphasis was placed on being *relationship-*

centred, keeping the *family in the driver's seat*, *holistic planning*, and *empowerment.*

- The values enacted by the System Service Coordinator were congruent with key values written into the project proposal.

- Working intensely with 20 families at any one time is a reasonable service capacity for one full-time System Service Coordinator.

- During the pilot phase, the various activities involved in the role of System Service Coordinator required on average, an estimated 2.1 hours per case per week. This can be considered a conservative estimate.

- There is a greater demand for the service than is reflected in the observed workload of 22 families as of June 15.

- There is sufficient demand for system service coordination services to justify dedicating at least one full-time worker to the position.

- A large portion of the time required for system service coordination is consumed by essential indirect service work, particularly *organizing and preparing for meetings*, *creative digging, and writing up plans*. *Creative digging* includes the critical and time-consuming process of identifying informal supports and helping families build community support networks. The importance of these indirect service tasks was emphasized by the System Service Coordinator as being critical to producing desired outcomes for families.

Impact Of Model On PHN Service Delivery

How Does System Service Coordination Impact Public Health Nurses' And Other HBHC Service Providers' Ability To Deliver Direct Service?

Case coordination for multi-complex families is extremely time consuming. There was strong agreement among PHNs participating in the focus group that involvement of the System Service Coordinator significantly increased the amount of time they were able to devote to providing health services.

The following statement captures how system service coordination helps free up PHNs to focus on providing the actual services they are trained and mandated to deliver.

> The one that I am specifically thinking of is a mom who [has multiple challenges] and has a two-month old child and a two-year old. There are certainly lots of issues related to the care of the infant. With [the System Service Coordinator] being in there to look at getting supports for her and getting daycare for the older one, all of this, then I've been able to focus on the health and well-being of the two babies and not have to look at all those other factors. It's the same with a young woman who is just a new immigrant, no language, no money, all of this. She had a baby die. I've been able to focus on the mom and her mental health in grieving the baby and not look at ESL classes, immigration issues, all of that type of thing.

Another PHN discussed how system service coordination relieved her of the burden involved in negotiating inter-agency issues. Partly because the System Service Coordinator *specializes* in (and is thus highly skilled with) coordination, and partly due to her *third party status*, she was more readily able to cut through "turf" issues that sometimes accompany inter-agency coordination.

> There was another agency that tended to be somewhat blocking the family's goals. That agency was the case coordinator, coordinating for this family. So I felt somewhat that I wasn't aggressive enough in taking more action for the family because I thought that it was the responsibility of the other agency and I certainly had more than enough on my plate than I probably was able to cope with at the time. So I didn't use my energy or time the way I might have to facilitate getting the other agencies moving. And [the System Service Coordinator] was able to do that.

Another benefit that flows out of the specialized nature of the role, is that the System Service Coordinator is able to devote time to developing community contacts and explore a greater range of possibilities for involving informal supports. This is reflected in the following comment by one of the PHNs.

> It has allowed me to do more of the nursing role rather than 110 phone calls trying to find out [about community resources]. So that has been really good. And also, she has accessed more of the informal supports. In one of the families that we are working with, they needed funding. Well she has gone to community groups to get funding, write proposals to get funding from those groups, like the Optimists, or the IODE. And I never would have done that or had the time to even pursue those, who to call.

It was also noted during the administrative partners focus group how the System Service Coordinator role impacted the work of PHNs. From an administrative point of view PHNs benefit by the support provided by the System Service Coordinator as a colleague in difficult cases by freeing up their time to devote to direct service, and by virtue of greater effectiveness in performing the coordination function accruing to specialization.

> I think that it's been a support for the nurse to have [the System Service Coordinator] in that family. It felt like somebody is shoulder-to-shoulder. I think there has been a time saving. They have not had to do those calls and all of that kind of stuff, and that they have been able to address some health issues that they have previously been unable to address.

> (T)he PHN's who are involved with families that were service coordinated by [the System Service Coordinator] felt that they were able to deliver a better service when they could separate that from the service coordination role so that they weren't wearing two hats at one time.... (T)he nurse would have more time to do some of those other pieces if she wasn't bogged down trying to do all the calls.

Conclusions

In summary, system service coordination had the following impacts on nursing service provided by PHNs:

- System service coordination increases the amount of time PHNs are able to devote to providing the direct nursing services they are trained and mandated to perform.
- By virtue of being a highly skilled specialist in tasks and activities related to system service coordination, as well as by virtue of her third party status, the System Service Coordinator may be in a position to deal more effectively with potentially contentious inter-agency issues.
- Because it is a dedicated role, the System Service Coordinator is able to spend time learning about and cultivating a broad range of community resources and informal supports that may be integrated into family service plans.
- The System Service Coordinator provides professional and "moral" support to PHNs, enhancing the quality of service provided to challenging multi-complex families.
- No evidence was collected pertaining to the impact of the model on other service providers. However, it is reasonable to infer that the same kinds of positive impacts experienced by PHNs would also be experienced by other service providers acting as the designated inter-agency coordinator for multi-complex families.

Impact Of Model On Multi-Complex Families

How Does The Model Impact Multi-Complex Families?

After less than four months of operation, it is possible to assess only the most immediate impact of system service coordination on the families served. There are two sorts of data that have been gathered for this evaluation that suggest impacts on families.

First, evidence can be gleaned from the PHN focus group and administrative partners' focus group as to their perceptions of impacts on families.

Second, we can examine findings from the questionnaire that was administered to families. Though the questionnaire was not designed to directly assess the impact of the service on families, it did ask families to rate the service along several key dimensions of service coordination. It is reasonable to infer positive impacts for families from positive ratings on these dimensions of service coordination. Families were also asked to indicate how much of a difference they expect their service plans will make.

PHNs' and Administrative Partners' Perceptions of Impact of System Service Coordination on Families

As each family served by the system coordinator was contending with a unique set of problems, the outcomes produced by system service coordination for the families were also to some extent unique. Given the short time frame and small number of families from which data was collected, it is difficult to make generalizations about outcomes observed. The following outcomes were reported by PHNs and administrative partners:

- *Rekindled a sense of hope.* One PHN reported, "With the ones that I've worked with I think they have felt that there is hope again. They were feeling exhausted and just feeling almost like giving up."

- *Increased sense of efficacy*. Another PHN reported that the encouragement and support provided to one mom resulted in her accomplishing a long standing goal "she always knew she wanted but could just never get there." This in turn created a sense of efficacy ("moving on") in her life.

- *Parent learned more effective way of advocating for family*. This outcome reported by both a PHN and one of the mothers interviewed. Coaching the parent, and facilitating meetings between the parent and school officials helped a family break a pattern of negative interaction with the school system and begin to learn more effective ways of advocating for themselves.

- *Increased involvement of informal supports.* As of the time data was being collected for this report, only a handful of the 14 families surveyed reported an increased involvement of informal supports in their lives. However, several of the PHNs remarked on how extensive, effective and significant were the System Service Coordinator's efforts in involving informal supports. A list of informal supports that had been identified and involved by the System Service Coordinator after eight months of operation is presented as Appendix I.

In summing up the impact of system service coordination on families, one of the administrative partners stated:

> I think if we looked at some of the outcomes that individually have been achieved, I think it would be fair and safe to say that when (the System Service Coordinator) turns a family back to the Public Health Nurse, that she turns that family back in way better shape than when they first arrived. And if you look at the resources that she has been able to ferret out of the community for families, I think it's quite astounding.

Survey of Families' Perception of System Service Coordination

As discussed in the methods section of this report, only 14 families were eligible to be surveyed on their experience of receiving system service coordination, based on having had a *community action plan* in place for at least one month. Questionnaires were administered by the PHNs who had referred them for system service coordination. Responses were returned for all 14 families (100%).

<u>Families Felt Listened To, Perceived Influence Over Plan</u>

The most unequivocal survey findings were that *families felt listened to* and perceived they *had influence* in the planning process.

Figure 1: Degree Client Felt Listened To

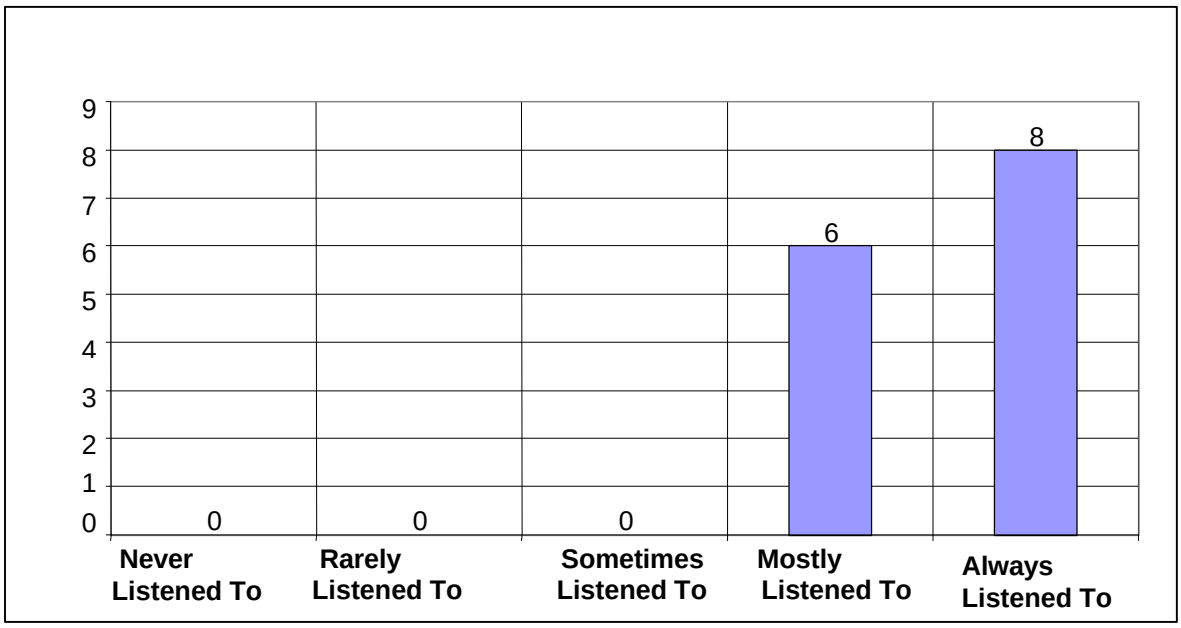


Figure 2: Perception of Influence Over Plan

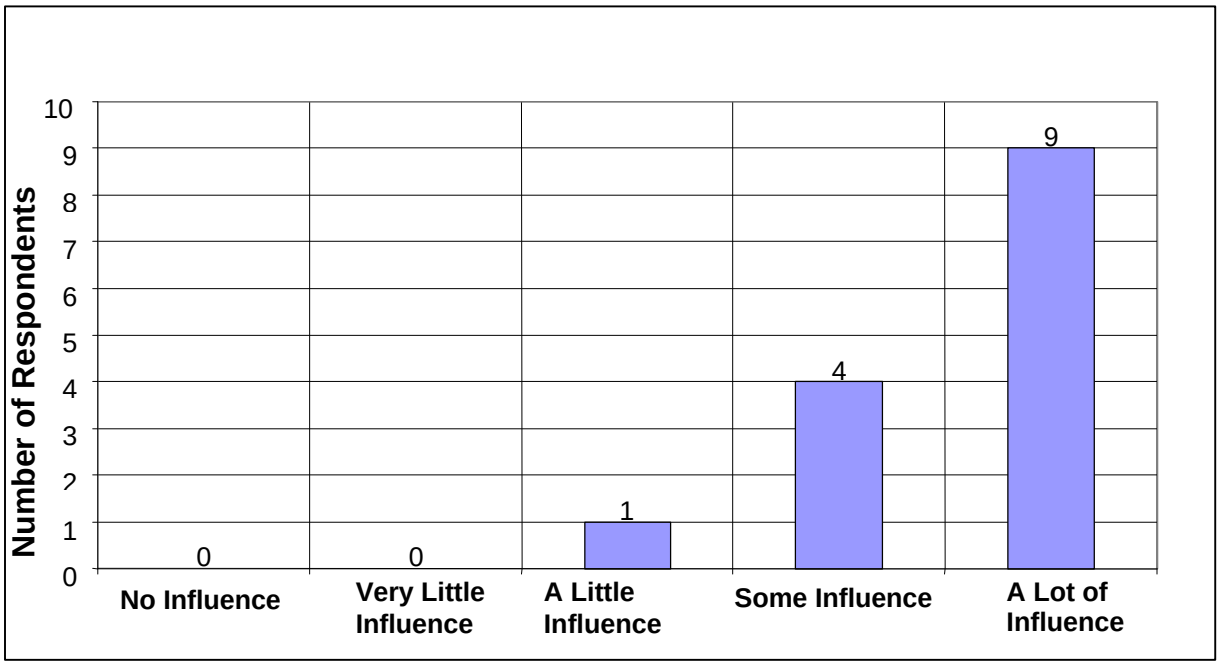


Figure 3: Assessment of Follow-up On Plan

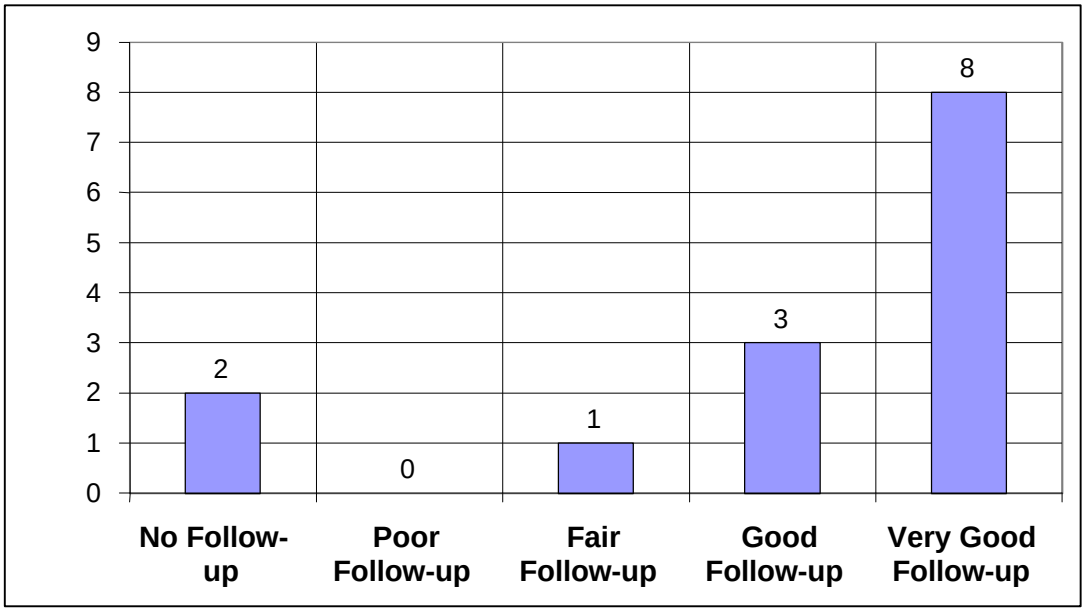
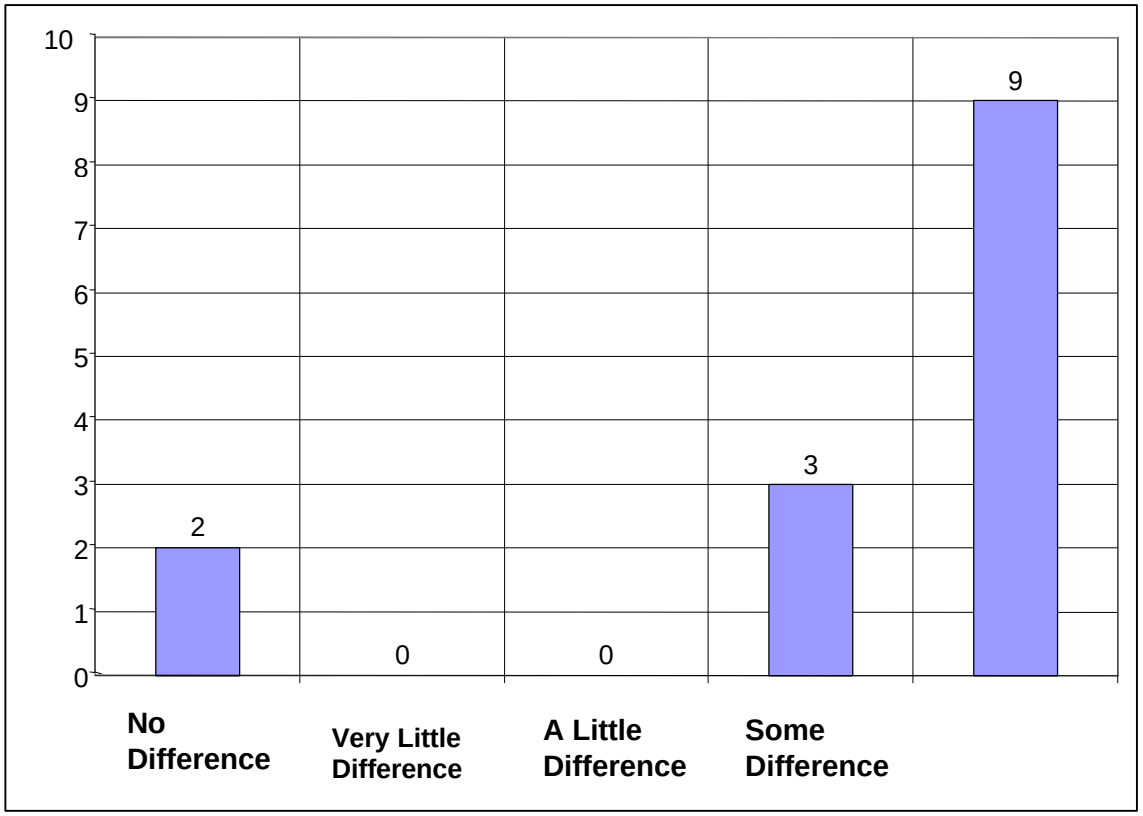


Figure 4: Assessment of Difference Plan Will Make



Eight of 14 (57%) families indicated they felt "always listened to", 6 of 14 (43%) families felt "mostly listened to."

Nine of 14 (64%) families indicated they had "a lot of influence", 4 of 14 (29%) indicated they had "some influence" in the development of the community action plan.

Families Perceived Good follow-up, Thought Plan Would Make a Difference

Most families (11 of 14, or 79%) felt there had been *good or very good follow-up* on their plans to date. A few families, indicated that the plan had been in effect long enough for them to make a judgement.

Most indicated they thought their *plan would make "a lot of difference" for their family* (9 of 14, or 64%), while 3 of 14 thought the plan would make "some difference."

Takes Time To Involve Informal Supports

Just over one third (5/14) of the families indicated that informal supports had become involved in helping them to date. This comparatively low proportion reflects the fact that family survey took place less than four months into the pilot project. This finding is consistent with statements made by the System Service Coordinator about the time and care required to introduce new social supports to into the lives of families.

Families' Comments About System Service Coordination

Thirteen of 14 families took the opportunity when invited to make any comment they cared to about their experience with system service coordination. Of these, four could be characterized as pointing to very positive outcomes, five as pointing to positive outcomes, and three as indicating reservations as to what the outcomes will be. The full set of open-ended comments are presented in Appendix G.

The following statements drawn from the family questionnaires are examples of very positive outcomes reported by families:

- "Great at what she does. She has done me a lot of good…It has changed things so much at home."
- "Before she came it was chaos. [Now it is] a lot easier; setting up meetings, have appointments more organized, have worked with the community, i.e., VON, to help get service…"
- "[The System Service Coordinator] has made a huge difference in my life. She has given me confidence to advocate for my child and family, and that my opinion and the needs of my family are a priority. I still have difficulty with some agencies at times, but I feel I can better address my needs to them now. I feel I am listened to more, and am given some of the respect I deserve. In essence, I found my backbone. I was very nervous about dealing with another agency but am grateful I consented to speaking with [the System Service Coordinator]."
- "Helped coordinating agencies organize a plan. Things are in order: court papers, written plan, family reunited. Family and steps to reunite family seemed to be on hold prior to involvement. There has been movement."

Conclusions

Insufficient time has elapsed to evaluate more than the most immediate impact of system service coordination on families served. However, PHNs who worked with the System Service Coordinator did observe first hand and report the following impacts on families:

- Rekindled sense of hope.
- Increased sense of efficacy.
- Learned more effective way of advocating for family.
- Increased involvement of informal supports

Families reported the following outcomes of system service coordination:

- All families felt listened to and perceived a high degree of influence in the process of developing community action plans.
- Most families perceived good follow-up on the plans and thought the plans would make a difference for their families.
- Most of the families surveyed described positive or very positive outcomes resulting from system service coordination, such as elimination of "chaos" at home, "making a huge difference in my life (by giving) me confidence to advocate for my child and family…" and helping reunite a family after delays and frustrations.

Impact Of Model On Access Of Families To Service System

Does System Service Coordination Improve Access To The System Of Prevention, Early Intervention And Informal Support For Multi-Complex Families?

Based on accounts presented by the System Service Coordinator, PHNs and administrative partners during the course of the evaluation, system service coordination increased access to the system of prevention, early intervention and informal supports in at least two direct ways.

- The System Service Coordinator actively identified and brought to the table theretofore untapped or unconnected formal service providers and informal supports. (See Appendix I). This, in combination with development of community action plans that serve as the basis for accountability, served to integrate previously fragmented services and supports. It also facilitated access to services for families that had previously "fallen through the cracks" in the system.

- By incorporating formal service providers and informal supports, there was an increase in the *breadth* and *level* of services provided to families. One administrative partner spoke directly of the "breadth of services" that families would not have experienced without this level of coordination. Another stated that system service coordination afforded multi-complex families a "substantially greater…level and scope of service" at a higher skill level than could be delivered by PHNs.

These two points are linked to broader *system-level* effects that may be attributed to system service coordination. How and why does system service coordination produce *better outcomes at the system level* than relying solely on interagency coordination for multi-complex families?

- **System service coordination conveys advantages that are inherent in the *autonomous* and *dedicated* character of the role.**

The System Service Coordinator's primary allegiance is not to a direct service-providing agency. Third-party coordination allows the worker to occupy the in-between spaces, in which she can empathize and experience the dilemmas and challenges of both the families and the service providers. She becomes the bridging agent. While the creation of a new role at the system level does not in itself make this happen, it can be argued that such a position in the system is necessary to *allow* it to happen. It is a combination of the character of the worker, the values, principles and experience she brings to the work, and the position in the interstices of the system that makes possible this bridging and connecting work.

The following passages from the interview with the System Service Coordinator illustrates this point.

> …(F)or every family it's a different thing. The complexity often is that it touches on everything. So it might be a child protection issue, but when you sort of take a look at it, it is often poverty, there is always a systems issue connecting with the Ontario Works and all of those very difficult things, and the mazes that people have to go through. That wears people down immediately. So what happens is, they get worn down, they can't even fight that system of getting through and understanding it, so then they become sort of labeled as, you know, not such a great family. You know, they can't get it together….(T)hey are labeled…and it could be whether its Ontario Works or Special Services at Home, it doesn't matter what the service is. If they are not following through, if they are not getting their paper work in, they are not making those calls, they are not doing that stuff, then they obviously don't want our service.
>
> …The other thing I want to say is that a lot of service providers who have been working with these multi-complex families, they are good people, and they are doing the best they can. So it's not about they are not getting service. It's not about that. And it's not even about even being ineffective at times. It's just because it gets so big and so complex, and the way of their life is complex. The layers become complex in terms of their relationship with other service providers become complex, and it becomes sometimes spinning wheels because information is shared in little bits and pieces all over the place, and then everybody feels overwhelmed. Everybody feels overwhelmed, not just the family but the service providers and the people that are part of their life, and then it becomes a "Holy mackerel, what is all this!?"

- **The System Service Coordinator is mandated to develop knowledge of, and is skilled in cultivating a host of community resources.**

Related to the dedicated character of the role, a large part of the role as System Service Coordinator is getting to know the broad spectrum of social services available in the community. As well, the System Service Coordinator carries the mandate and possesses the skill to cultivate a wide range of informal community supports. These advantages are illustrated by the following comment by one of the PHNs.

> For me, one of the biggest things I think is that I really never knew the community social service sector, so I don't know all they have that's available for these clients. So when it is looking at how to look at what's there, I didn't actually quite know where to begin. So [the System Service Coordinator] knows that system so well that she just goes in, she knows the key people, she picks their brains, they sort of sort it out, she gets them pulled in. It's quite amazing, where I would have probably taken a long period of time to know who to contact, plus it takes a lot of time. She just can do it so quickly and pull them together, and it's wonderful.

Though not part of the original evaluation plan, the System Service Coordinator discovered a number gaps in services as she enacted her responsibilities. A list of gaps in service is presented as Appendix J to this report.

- **System service coordination conveys *mentorship* and *capacity-building* effects.**

The role of System Service Coordinator is designed to be a temporary role. The System Service Coordinator takes over the coordinator role from the designated inter-agency or agency level coordinator only until she is able to assist the multi-complex family in developing empowering community plans and a system of social supports. As part of this model, there is an ongoing connection between the System Service Coordinator and other service providers, including the designated inter-agency or agency-level coordinator.

A notable theme that emerged the adminstrative partners focus group was how the System Service Coordinator ended up serving a mentoring function with PHNs with whom she worked.

> Just working with (the System Service Coordinator) enhanced the nurses' sort of sense of where they could go with actually doing service coordination for families. They saw it as a positive thing, although I know we had talked at this table in the past that we weren't sure whether or not some of the nurses would feel that was maybe doing their role. But in fact it ended up being very positive and the nurses grew from her and learned a lot more about what they could actually do around service coordination. So it was really sort of a mentoring kind of thing, I thought.

In addition to the mentorship that the System Service Coordinator was able to provide for individual nurses, one of the administrative partners suggested that the skill level and experience developed by the System Service Coordinator could be transferred more broadly throughout the system of children's services, thus having wider system-level impacts.

> Partner 1: [The System Service Coordinator has]...a real scope of skills that has been very beneficial, not only on an individual client service coordination level but on a broader level as well. I think that in some ways, some of her skills may be under-utilized, or we might leverage her skills a little bit differently to use them in the communities to help with service coordination at a system level. And there is an advantage, I think, for some counties, because she is an outsider, not funded by HBHC. I think that brings at least four counties some benefits, not perceived as being self-serving.
>
> Partner 2: Yes, some of the pieces that she would be able to help facilitate at our Children's Services Planning Committee level for the county, which she hasn't had a chance to do. Really, it's been providing information around the project. It hasn't been working with those agencies to move forward on some of these other goals, and I think that [the System Service Coordinator] could be an asset in that facilitation role.

Conclusions

In summary, the role of System Service Coordinator improved access to the system of prevention, early intervention and informal support in the following ways:

- Reduced fragmentation and gaps in services to multi-complex families because of a greater capacity to identify and bring together previously untapped or unconnected services and resources.
- Increased integration between families, informal supports and formal service

providers through facilitating the collaborative development community action plans.

- Increased the breadth and level of services available to families.

It is argued that these improved system-level outcomes may be attributed to key advantages that are conveyed by the position or location of the role within the overall system. The System Service Coordinator:

- Occupies a position in the system (autonomous, dedicated role) that makes possible greater potential for bridging and connecting work
- Is mandated to develop knowledge of, and is skilled in cultivating a host of community resources
- Is in a position to increase the capacity of PHNs and other service providers by providing informal mentorship as well as through formal training opportunities

Feasibility of One Coordinator Serving Five Counties

Is the model of *one coordinator serving five counties* adequate, or should there be separate service coordinators in each county?

Evidence presented earlier strongly supports the conclusion that the role of System Service Coordinator for multi-complex families is very time-consuming. As reported above (see Table 3 on page 15) the average time required to serve one family during the pilot was estimated at 2.1 hours per case per week. Approximately 15% of that time was devoted to travel.

It is clear from the data gathered for this evaluation that it was very, very taxing for the System Service Coordinator to perform the role across the five counties. At the point at which the System Service Coordinator was carrying an active caseload of 22 families, a number of PHNs expressed concern based on their perceptions of how taxing the role was on the coordinator.

> PHN 1: I think that she is really fragmented. I think that she is just zipping here and zipping there. And you hear her voice mail when you phone in, "Well I'm in Perth, then I'm in Elgin, then I'm in Oxford." You know, she's just so many places. And I know that when we've done some meetings together, she is coming from Perth and she thought that it was going to take her this long. Well it took another twenty minutes longer. So it's just the coordination of her time and all that. I think she is really quite fragmented.
>
> PHN 2: I am curious to know the number of hours that she actually put in. Sometimes she meets with families in the evenings. She has things on holiday weekends. How does she get reimbursed for that?
>
> PHN 3: That's right. I know I got a voice mail today and she left, I think, at eight o'clock last night or something.

By all accounts, the woman who performed the role during the pilot phase is an extremely dedicated, high energy, highly skilled individual. By her own account, continuing to perform the role as she had been would be difficult to sustain.

> I could keep on doing this for awhile, but what happens a year from now, because it is such high-level energy for each and every family to do it justice. And everybody's energy level is different. So if you had someone else to do this job you don't know how much energy they could put into this….I mean realistically, I think it would be a set-up for someone else, and I think that would be unfair.

How should the role be deployed, assuming a five-county catchment area, and - if funding were to be made available - a maximum of one full-time equivalent (FTE)? This question occupied the greatest portion of time in the focus group with the administrative partners.

In their discussion, the administrative partners recognized that certain key principles informing the enactment of the role (i.e., relationship-centredness and family-focus) resulted in the System Service Coordinator organizing her travel and appointment scheduled to suit what she perceived as families' best interests, versus considerations of administrative efficiency.

The partners recognized this as a legitimate dilemma. The best solution it was felt would be two *dedicated* FTEs to cover the catchement area. However, it was also concluded that that level of funding would almost certainly not be available.

Consequently, the dilemma was framed in terms of the following two options:

1. Continue to deploy the FTE as one "dedicated" full-time System Service Coordinator serving five counties.

2. Split the FTE between (probably) two CSCN coordinators, who will also have other HBHC-related responsibilities.

The advantages and disadvantages of these two options as discussed are be summarized in Table 4.

Table 4: Advantages / Disadvantages of Two Options for Deploying System Service Coordinator FTE

Option	Advantages	Disadvantages / Challenges to Overcome
Dedicated FTE	• Efficiencies gained from one person developing and knowing job well • Advantages of having a highly skilled individual fully engaged in dedicated role	• Inefficiencies of time and cost related to travel • Strong concerns were expressed regarding the burden on the System Service Coordinator of being isolated and without peer support in her role
Shared FTE	• Time and cost savings in cutting down travel • Sense of peer support and being part of a team	• "Dilution" of the role (workers have to balance system service coordination with other duties)

After considerable discussion, the consensus of opinion was that the advantages of deploying the FTE as a one dedicated worker outweighed the disadvantages, and that training and administrative support could be provided to mitigate the disadvantages. Particularly it was concluded that ways could be found to support the worker around organizing travel time and meeting schedules. It was decided that the final recommendation on this question should be come through a deliberation process that would include the System Service Coordinator and other partners not present during the first focus group.

A second focus group reconsidered the dilemma and options as presented above. It was concluded that the problem of isolation in the role had diminished over time as the System Service Coordinator built networks among service providers in the various areas. It was also agreed that the problems associated with travel time could be mitigated, and that a plan would be developed to support and guide the worker in carrying out the role accordingly.

The recommendation that the role deployed as one dedicated FTE was endorsed.

Conclusions

- Carrying out the role of System Service Coordinator across the five-county catchment area was extremely time-consuming and taxing on a person who by all accounts is a very dedicated, high energy, highly skilled worker.

- One key dilemma has to do with how to efficiently cover such a large geographic area, while honouring the key principles of being relationship-centred and family focused in terms of scheduling and conducting community meetings and other tasks associated with the role.

- The best solution would be two dedicated FTEs to cover such an area, however it was concluded that this option was not feasible.

- Given available resources, two feasible options were identified, each with advantages and disadvantages: split the FTE between two workers to realize administrative efficiencies, or deploy the role as a dedicated FTE, and find ways to mitigate the disadvantages associated with travel time.

- The collective judgement of the administrative partners and the System Service Coordinator was that the dedicated FTE option was more desirable.

Recommendations

The administrative partners met in November 2001 to discuss the findings presented in this report. The following recommendations were made:

1. That one full-time equivalent System Service Coordinator position be funded on an annual basis serving multi-complex families in HBHC in Elgin-St. Thomas, Huron County, Middlesex-London, Oxford and Perth Counties.

2. That the full-time equivalent position be undertaken by one worker and deployed in manner which reduces travel time and associated costs.

3. That a resource consultant role to enhance community capacity be enacted as part of the role of System Service Coordinator.

4. That the partners meet on a quarterly basis to monitor, direct and support the initiative.

5. That the results of this evaluation be disseminated to the Ministry of Community and Social Services, South West Regional Office, the Integrated Services for Children Division, Healthy Babies Healthy Children, all HBHC programs across Ontario, participating counties children's services' planning committees and through other networking and educational opportunities.

Conclusions

Service Coordination is an integral part of working with families who are experiencing barriers to service. In most agencies and programs, it is generally being implemented as an add-on role of the service provider. *The System Service Coordination Pilot Project* investigated the question of whether a *dedicated, third party service coordinator* would provide significant gains for selected families by enhancing their functioning and well being. Significant gains were also anticipated for the service system because of reduced demand for more costly, intrusive downstream interventions in the future.

This pilot demonstrated that s*ystem service coordination* was effective for families and providers alike. Families perceived a high degree of influence over their care – a determinant of health – and thought the plan would make a difference to their families. Families experienced enhanced community integration demonstrated by increased involvement of informal supports. PHNs increased the amount of time they were able to provide professional nursing services to families and benefited from mentoring by the *System Service Coordinator* in a team approach.

Service coordination was demonstrated to take time. The role of the *System Service Coordinator* was enacted as seven sets of overlapping activities. A number of invisible tasks were highlighted as being essential to the role and thus to outcomes for families. These activities, to a degree, also apply to i*nteragency service coordination* where the designated service coordinator is also a service provider.

The positive results of this pilot project are thought to be causally related to the autonomous, dedicated nature of the *System Service Coordinator* position.

While it cannot be stated on the basis of this study that this type of early intervention will prevent more costly intervention in the future, the nature of the challenges faced by multi-complex families are consistent with those of families that often require more costly and intrusive types of downstream interventions from the community social service system.

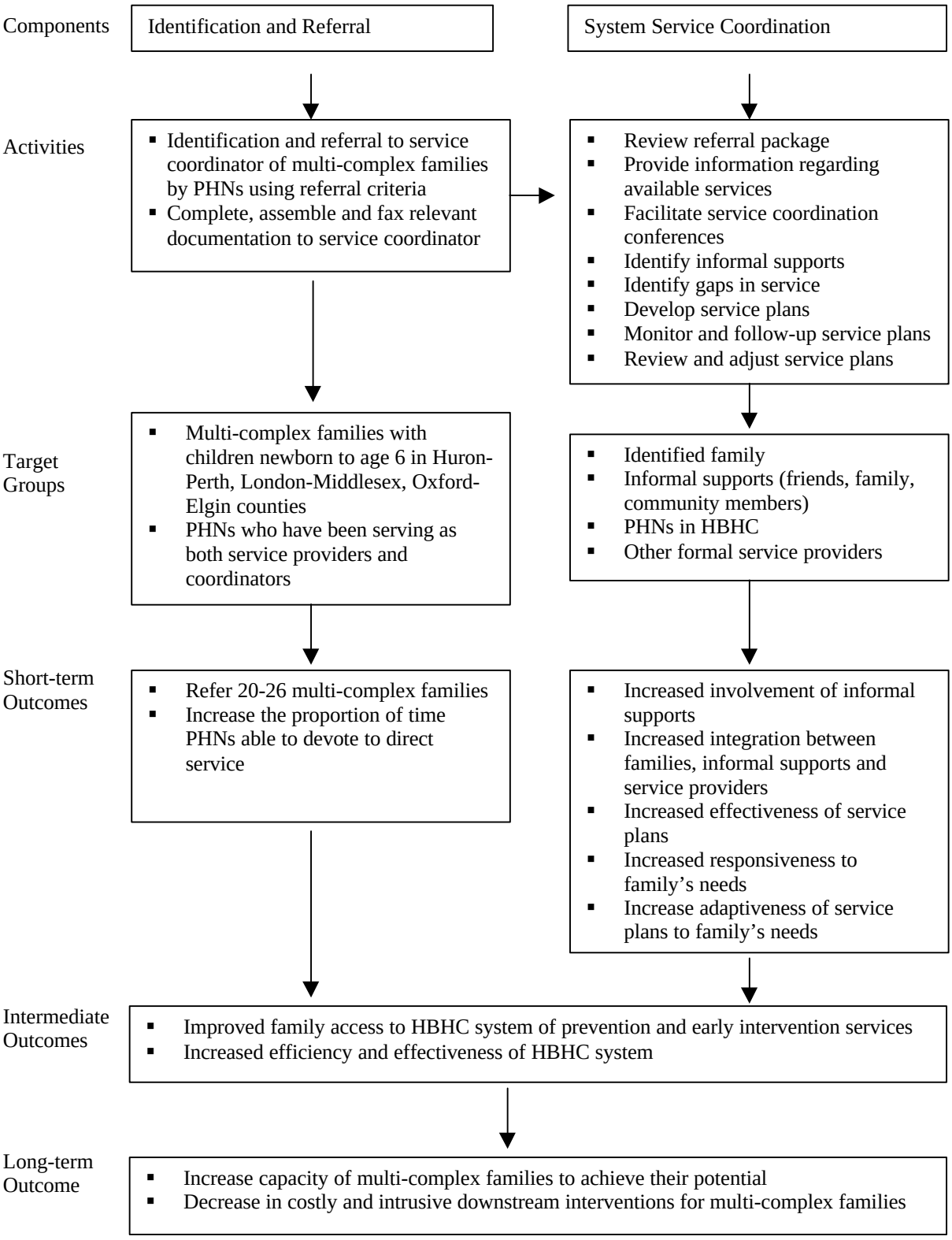
A significant limitation of this study is that the data analyzed was collected after only four to six months of operation. The findings reported here are extremely useful for purposes of formative evaluation, but suggest only the most immediate outcomes on the social service system and the limited number of families served during the pilot.

Further study is necessary to determine the longer-term impact on families, service providers and the service system. An approach that would provide more definitive evidence of longer-term impacts would be a *multiple time series* evaluation design. One would compare intermediate and longer-term outcomes on key objectives of the program between two or more settings - one of which would be employing system service coordination - over time. Each setting would be closely matched in terms of relevant characteristics of families being served as well as other key demographic factors. Careful consideration would need to be given to determining appropriate outcomes and indicators. Outcomes that might be measured include the following:
<u>At The Service System Level:</u> output of PHNs in delivering nursing services, increase in skill level of service providers functioning as service coordinators at the agency and interagency levels, and reduction in frequency and costs associated with more intrusive interventions (e.g., child apprehension).
<u>At The Family Level:</u> indicators of enhanced family functioning, indicators of family well-being, and indicators of frequency and intrusiveness of interventions.

Appendices

Appendix A

Logic Model : System Service Coordination Pilot Project



Appendix B

Referral Criteria, Process and Forms

System Service Coordination
Pilot Project

Referral Criteria…

The Public Health Nurse will use judgement based on one or more of the following criteria:

1. The family has multi-complex needs that cross many life domains (i.e. residence, family, social, behavioral/emotional/psychological, educational/vocational, safety, legal and health) and/ service sector (health, education, social services).

2. The family's need for service coordination compromises the provision of a direct professional service or role (i.e. nursing, O.T., P.T., infant development).

3. The coordination of services across agencies is having limited success in meeting the family's needs.

Referral Process…

The following information will be faxed to the CSCN Service Coordinator:

- Completed Referral Form
- Copy of HBHC Family Assessment
- Copy of Family Service Plan, if applicable
- Copy of signed consent form

About Documentation…

Documentation should not have to be duplicated. For example, if the recent family assessment is completed, the referral form may not be necessary. However, if the family assessment was completed more than 3 months ago, the referral form can be used to update relevant family information.

Request for

Healthy Babies / Healthy Children System Service Coordination

A.	**Identifying Information** **Family Name:**	
	Address:	Phone:
	Members:	DOB:
		DOB:
		DOB:
		DOB:

B.	Referral Source	
	Other Services Involved:	
		Phone:
		Phone:
		Phone:

C. Reason for Referral Indicate #1, #2, #3 Referral Criteria or a combination of all three)

Additional Information:

D. Summary of Strengths:

E. Summary of Needs:

F. Components of Current Service Plan

G.	Summary of Service/Support *Options Explored/Used to Date:*	
	Options	Outcomes:

Signature: **Date of Referral:**

Appendix C

Tracking Form

Multi-Complex Families Identified and Referred

PHN Name:	
County:	

For the Month of:

- ❑ March
- ❑ April
- ❑ May
- ❑ June

(CHECK ONE)

How many families did you **IDENTIFY** this month (following consultation with coordinator) that met the criteria for multi-complex HBHC families?

☐ (Write the number of families identified in the box)

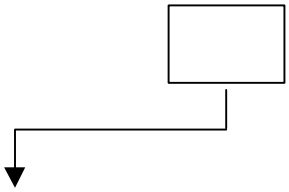
How many of these families did you REFER this month to (the System Service Coordinator)?

☐ (Write the number of families referred in the box)

Have any of the families you have identified **DECLINED OR REFUSED** to take part in system service coordination?

❑ No → You're done. Thank you for completing this questionnaire!

❑ Yes → If yes, how many clients declined or refused?



(Write the number of families referred in the box)

Please briefly state the reason for decline or refusal for each instance

_____

_____

_____

PLEASE SUBMIT THIS FORM TO PROGRAM MANAGER ON THE THIRD BUSINESS DAY OF THE MONTH. FORMS WILL BE FORWARDED TO PROJECT EVALUATOR BY THE FIFTH BUSINESS DAY OF THE MONTH.

THANKS FOR YOUR COOPERATION

Appendix D

Basis for Estimates in Case/Time Analysis

The case/time analysis reported on page 15 of the report is based on data tracked by the system service coordinator, and calculations made according to certain estimates and assumptions.

In Table 5, the information reported in column two (headed "Reported Time Spent and/or Frequency of Activities") are the tracking data reported by the system service coordinator. The information presented in column three (headed "Basis of Estimate") are the assumptions and/or estimates upon which calculations were made to derive the case/time ratios reported under "Tracking Coordination Activities Through Activity Log" of the report.

Additional assumptions and calculations had to be made to derive an estimate of how much time was spent making phone calls. This information is reported in Table 6 below.

Table 5: Basis for Activity/Time Analysis Estimates (1 March – 15 June)

Activity	Reported Time Spent and/or Frequency of Activities	Basis of Estimate
Consultations with PHNs and FHVs	27 consults with 14 different PHNs	# of consults tracked; estimated average of 60 min./consult
Home Visits	48 visits @ average of 2 hours each	# of visits tracked; estimated time per visit
Phone calls	700	664 calls tracked, coordinator made many more calls that were not tracked. Further calculation to arrive at estimate of hours/case, see Table A2.2.
Research Time	75 hours (5 hrs week)	Estimated 5 hour/week
Community Meetings		Estimate 1/week @ 2hr/meeting * 15 weeks
Preparation Time for Conferences	46 hours	At least 23 conferences were held; estimated average preparaton time/conference @ 2 hours
Community/Family Conferences	23 meetings. Approx. 69 hours	Estimated average of 3 hours/conference
Writing, Editing and Distributing Plans	39 hours	13 plans completed; estimated 3 hours/plan
Number of Plans	13 complete; 7 plans in process	Tracked
Kilometers traveled	Feb: 2700; March-May: 4617; Total KM: 7317	Tracked
Travel time	104 hours	Estimate based on 7317 km tracked, average speed at of 70 km/h

Table 6: Basis of Estimate for Hours Spent on Phone Calls Per Case

Coordinator's Categorization Of Typical Length Of Calls	Coordinator's Estimate Of Distribution Of Calls Per Category	Estimated # Of Calls In Each Category	Assumed Average Length Per Call	Estimated Total Minutes Of Calls Per Category	
30 secs to 1 min	30%	210 calls	1 min.	210.0	
15-20 minutes	50%	350 calls	15 min.	5250.0	
30 min. to an hour	20%	140 calls	45 min.	6300.0	
Total minutes over 15 weeks				11760.0	
Total hours over 15 weeks					196.0
Hours/case over 15 weeks (total hours/22 cases)					**8.9**

Appendix E

Focus Group Questions

Public Health Nurses Working With Multi-Complex Families
13 June, 2001

Opening

1. I'd like to go around the table and ask each person to say your name, which health unit you work with, how long you been there, and how long you've been working in the Healthy Babies Health Children Program.

Introduction

2. From your perspective, what are some of the key challenges involved in working with "multi-complex families"?

Impact of System Service Coordination on Service Delivery

3. From what you have been able to observe, how has service delivery changed as a result of employing this model? Be as specific as possible. Give examples.

   Probe: Has the model increased the proportion of time PHNs were able to devote to direct service?

4. Has this model improved your ability to deliver service? If so, describe how. Be as specific as possible. Give examples.

5. If not, why not? What problems or obstacles do you still encounter in trying to deliver the best possible service?

Service Deliverer's Assessment of Impact on Multi-Complex Families

6. From what you have been able to observe, what has been the impact of the system service coordination model on the "multi-complex" families you have worked with? Give examples.

There are a number of specific aspects we are interested in assessing. Please comment on how the model has affected:

7. Involvement of informal supports?

8. Level of integration between families, informal supports and service providers?

9. Effectiveness of service plans?

10. Responsiveness of system to families needs?

11. Adaptability of service plan to changes or developments in the family's needs?

Ending

12. What one suggestion would you make to improve the model of system service coordination?

13. Would you recommend this model be implemented on a wider scale? Why or why not?

14. Any final comments?

Appendix F

Questionnaire to be Administered by PHNs
to Families Participating in System Service Coordination

Introducing the Questionnaire: (To be read or closely paraphrased):

I have a few questions about what it was like for your family to have a worker like (the System Service Coordinator) helping you. (Coordinator's name)'s job is called "service coordinator". A service coordinator is someone whose *only job is to help families with a lot of issues sort things out and make the best possible plan to get the kind of help they need.*

Keep in mind that these questions are not so much about (Coordinator's name) *as a person,* but more about out how much difference it makes to have *a special worker involved with families whose only job is to help sort things out.*

Please answer the following questions as honestly as you can. Your name will not be put with your answers. (Coordinator's name) will not know what you said.

I am going to read a few short statements, and ask you to say how much you agree or disagree with each statement. For each statement you'll have five choices. You can say you**…**

Strongly agree, or *Agree*, or *Neither agree nor disagree*, or *Disagree*, or *Strongly disagree*.

Try to pick the ONE that BEST matches what you think. You don't have to remember these choices, I'll give them to you again as I read the questions.

After I ask the agree/disagree questions, you'll have a chance to say anything you want in your own words.

OK? Do you have any questions?

Let's begin.

To what extent do you agree or disagree with the following statements?

1. I **FELT COMFORTABLE** WITH "A THIRD PARTY" OR OUTSIDE PERSON HELPING SORT THINGS OUT AND MAKE PLANS. Would you say you:

Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly Disagree**
1	2	3	4	5

(CIRCLE THE NUMBER CORRESPONDING TO THE ANSWER GIVEN)

2. MY **VOICE WAS HEARD** AND MY IDEAS WERE LISTENED TO IN DISCUSSING MY FAMILY'S NEEDS. Would you say you:

Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly Disagree**
1	2	3	4	5

3. I **HAD INFLUENCE** OVER THE PLAN THAT WAS MADE FOR MY FAMILY. Would you say you:

Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly Disagree**
1	2	3	4	5

4. SOME DEFINITE **ACTION STEPS HAVE BEEN TAKEN** BASED ON THE PLAN WE MADE. Would you say you:

Strongly agree	**Agree**	**Neither agree nor disagree**	**Disagree**	**Strongly Disagree**
1	2	3	4	5

5. WERE THERE ANY NEW OR DIFFERENT PEOPLE WHO BECAME INVOLVED IN HELPING YOUR FAMILY AS A RESULT OF DIANE'S WORK? FOR EXAMPLE, FRIENDS, RELATIVES, PEOPLE YOU KNOW FROM CHURCH OR ANYWHERE ELSE IN THE IN THE COMMUNITY?

☐ Yes ☐ No ⟶ Go on to Number 6

What kind of people and how were they asked to help?

_____

_____

_____

6. Do you have any comments you would like to make about the job *of service coordinator*, how it has affected your family, or about this questionnaire?

(Take down what is said in respondent's own words, and check it back with them to make sure you got down what they meant to say.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

THANK YOU VERY MUCH FOR ANSWERING THESE QUESTIONS.

Appendix G

Respondents' Final Comments

The Public Health Nurses who administered the family questionnaire were instructed to ask the following question of respondents.

"Do you have any comments you would like to make about the job of *system service coordinator*, (or) how it has affected your family…?"

The nurses were instructed to take down what was said in the respondent's own words, and check it back with them to make sure the respondent's meaning was captured accurately. Eleven of the fourteen people who responded to the questionnaire made comments. Comments were transcribed verbatim from the questionnaire and are presented below.

- Great at what she does
- She has done me a lot of good
- She gave another opinion on things
- It has changed things so much at home

- I've only been with Diane two times. After seeing her more I would be able to give more specific and better answers to the questionnaire. I want to continue with her because I think it can help me.

- She does a good job.

- Glad to have met and looking forward to working with her more

---

- Before she came in it was chaos – a lot easier setting up meetings, have appointments more organized
- Has worked with community i.e., VON. to help get service,
- Easier don't pay but cheque remains same

- Sometimes not sure what more can be done – so not sure what to ask her, she always says just call
- Children benefit from her meeting with the school
- Son benefiting from having someone walking him to school – new person in his life

---

- She is friendly, listens, tries to help me out, likes my babies

---

- Nice, friendly
- Sounds good about her plan, hoping it turns out. People haven't followed through before when they said they would so being careful, not getting hopes up
- Diane has had 1 HV/ 1 follow-up phone call re: meeting that is planned

---

- Diane has made a huge difference in my life she has given me the confidence to advocate for my child and my family
- That my opinion and the needs of my family are priority. I still have difficulty with some agencies at times, but I feel it can better address my needs to them now. I feel I am listened to more, and am given some of the respect I deserve. In essence "I found my backbone". I was very nervous about dealing with "another" agency but am grateful I consented to speaking with Diane

---

- Pretty understanding
- Good at what she does

- Helped coordinating agencies organize a plan
- Things in order
- Court papers – action
- Written plan
- Family reunited
- Referral and steps to reunite family seemed to be on hold prior to involvement – movement after

Appendix H

Description of Activities Comprising the Role of System Service Coordination, with Excerpts from Narrative Account of Process by System Service Coordinator

1. Initial Consultation(s) with Public Health Nurse(s)

- Receive initial referral call from PHN; obtain overview of the family's situation
- Review/assess what services and supports have been tried to date
- Assess concerns of both family and service providers
- In some cases, contact outside (non-referring) PHN and/or Family Home Visitors for case consultation (without identifying family)

2. Initial home visits: "breaking the ice" and identifying and developing immediate "mini-plans" to address the most pressing solvable problem

- Set up and conduct initial meeting with family
- May or may not happen with referring PHN depending on perceived advantages
- Purpose: "breaking the ice," getting to know family, establishing trust
- Work toward posing question: "how can I help?"
- Assess most pressing concrete needs or problems
- Create an immediate "practical little plan" to address most pressing concrete needs or problems
- Takes anywhere from 1 to 4 hours

> (I)nitially the first thing, is to meet the family. Several families…said to me what really works good is having a PHN go with you, because that is their first connection, so that is breaking the ice. So breaking the ice sometimes takes a little bit of time, maybe one or two visits. And we start to get things kind of captured. I usually write up the notes initially about whatever happened so that there is a record of what was talked about, even then. That's the first thing. The next thing is to sort of figure out what needs to happen. And sometimes I meet with the family without even anybody there because again, that is that relationship building that needs to happen. There has to be that trust. So I often do that. Not always, it just depends on the family.
>
> … "What would be helpful?" That is usually the question. It's not about "this is what I think needs to happen." It's "what would be helpful for you today?" So we start with that, because sometimes it's the very practical things, not the dreaming and the white picket fence. We want to get to that, we want to look at life dreams, but sometimes the very practical things that need to happen right now need to be addressed in order to bring the stress level down.

3. Follow-Up on Immediate Mini-Plans

- May involve setting up meetings, e.g., with school officials
- May involve encouraging and supporting family member in taking action to rectify a problem (e.g., restoring natural gas service for home and water heating)
- May involve finding resources to address an immediate material need
- A crucial part of the process of building trust with family ("action builds trust")

The system service coordinator related a story of one of the mom's she was working with whose hydro had been disconnected. She had been boiling water on the stove to bath her children.

> …(S)he would love to get a new job, she would love to do all these things. Yet, really it was about the hook-up. So it's getting the consent form and talking to the manager at Union Energy and talking about what can we do in order to get an understanding. So sometimes it's those very practical things that need to be worked through and then create a little plan around how are we going to help you to get hooked back up, because without heat in the winter we're in trouble, so let's deal with the food and shelter….You know, sometimes [it's] Maslow's hierarchy; we can't get to the most important things, the love and feeling good about stuff, if you can't deal with the most basic things in life…. you can't put the cart before the horse sometimes….
>
> [Another example would be] …coordinating meetings with schools…where the family really feels they have had a history with educators and so feel intimidated, scared, do not have any resources or support to walk into that school to figure out how it's going to work out for their child going to school. So that has been a huge piece. Sometimes it's that sort of concrete coordination…. (A)ction builds trust. So sometimes by just saying I can do that little piece builds the trust with the family and they say "Oh that was very helpful."

4. Setting Up "Community Planning Meeting(s)"

- Identify and contact various formal service providers and informal supports currently involved with family
- Will often take form of a series of mini-meetings with different players to avoid intimidating or overwhelming family
- Examples: school, health/medical, settlement related (for newcomers)
- Much time spent on "creative digging" and "out of box" thinking to identify and involve additional formal, informal and non-conventional supports as needed (e.g., neighbours, friends, family members, church, community groups, service clubs, businesses, etc.)
- Convene a community meeting with all identified supports *if deemed appropriate* for family
- May "build up" support network slowly by adding service providers and/or informal supports over time as deemed appropriate for family (Some families never have full community planning meetings.)

The system service coordinator's initial approach was to try to identify a significant number of "supports" in a family's life to begin building a social support system around the family.

> Let's bring everybody together, after the first meeting…. I can bring all these people together and we will come up with a community plan…. (I brought)… together teachers, resource teachers, Public Health, Children's Mental Health, all these service providers that have been involved in their lives, … and it was just so overwhelming for the family. It was just horrendous. Like 20 people in a room telling you what you need to do in your life, not a good feeling. I mean they have all been parts of some piece of it, and it just felt like she had to "yes" to everything and thought it was all a great idea, and then walked out and said she wouldn't be able to do any of it because it was just too overwhelming, too much.
>
> …I thought there has to be different ways about going about coordinating planning that doesn't put people in a really uncomfortable situation. It may come to that point, but you don't do that first with folks.
>
> Then we broke it down to many meetings with different people, and what was manageable for her, what didn't feel comfortable, what would work. So there would be some times where there would just be a couple of people with the school, or there might be some people with Mental Health, and I was the link to all of those little groups of people in the meetings that basically were happening

around specific issues, so that I was the glue, but not necessarily everybody sitting around the table. That's too much.

5. Building the "Community Action Plan" and Facilitating the Emergence of a Community Support Network

- Convene and facilitate planning sessions in manner sensitive to family's particular situation
- Incorporate roles for formal and informal supports around family's needs in novel and creative ways
- Make the roles/tasks to be undertaken by various parties explicit
- Record minutes of community planning meetings
- Write up the plan(s) using a visual/graphic and family-focused format
- Distribute plans to various parties
- Community action plan becomes mechanism of accountability
- Coordinating various parties and writing up plans is very time consuming

And a big part of my role has been to assure all the minutes are done, writing up the plan, everybody getting copies…that is a huge piece of the job because that is the accountability that says this is a community plan, this is not just an agency plan. And the community plan speaks to everybody's role and what they are doing with and for that family. And when I say that it sometimes takes a lot of time to develop, it's because people don't need language to communicate, they need the visual. So a lot of plans have been visually plans, and that takes a lot of time because I do it all I actually have to come up with a design that works for a family.

There are several different models, different examples. One was just a safety plan, which was pictures and numbers. One was to help a mom stay on track because she couldn't keep her place in a neat and tidy fashion. One was a plan that was all the different service providers and what their roles were. One was a plan that was a pie shape and one was a picture and who to call when, so she was able to cross-reference with that.

The use of a "visual plan" format illustrates from another angle the application of the "family-centred" principle.

…(O)ften we write things that are designed for service providers, professionals. And you know, if a community plan is going to respond to the family and they are in the driver's seat, they need to be totally part of it. So it's always thinking… "What way would you understand it? So that this isn't about us, it's about what is helpful to you."

6. Monitoring and Following-up on Community Action Plans

- Some families require only modest support to get on track, require little follow-up, e.g., a phone call to assess effectiveness and appropriateness of plan
- For some families there is a need to periodically reconvene community support network to review and revise plan
- Plan is reworked and distributed to various parties

Once those little mini-meetings come together, I'm sometimes present, and I always ask "Do I need to be there?" I guess I keep asking that, not only to myself but also to the families. Am I necessary, when am I needed and when am I not needed. So it's always asking that question and going back to that internal question. Once that happens, then I am sometimes a contact, and basically action plans are derived from those mini-plans. Then I monitor, in a nutshell, how things are going. So I'm the link again. So that goes back to the billion phone calls sometimes that happen.

…(T)he word foundation is a good way of describing it because it is not about having a team in there forever. The foundation can be defined as the family is feeling okay, they are picking up the phone, …having other people in their lives that are not necessarily professional people, …feeling okay with the service providers that are there for them, who are responding and acting on things that they said they were going to do. So there was some accountability and monitoring….. (I)t is a diminishing role but knowing that if things got falling apart again that maybe there is a time to come back together. And that is the foundation. Sometimes a few of the bricks start falling a bit and then you need to come and jump back in just to bring it back together. So I think that, to me, is a bit of the foundation, and that families believe in themselves. And that takes time.

7. Disengagement Process (returning family to Inter-Agency Level Service Coordination)

- Formal protocol for disengagement ("closing the file") not yet developed
- Three categories of levels of involvement with families as of the end of October (after 8 months)
- Ongoing involvement (11 families)
- Currently minimal involvement (6 families)
- Involvement completed (11 families)
- With 8 out of 28 families served as of the end of October, only limited involvement was needed. Involvement appears to be concluded, but the door remains open if family needs support to get back on track.
- 20 of 28 families, require(d) "staged" disengagement, periodic follow-up to keep community support network functioning and intact
- Need to develop protocol for transferring responsibility for monitoring action plan and support network to designated interagency service coordinator
- Need protocol to signal need for re-engaging system service coordination

…(O)ne of the things that is very clear in my mind as System Service Coordinator, I am not involved in people's lives in that very, very, regular, concrete way. And that's the question I keep asking all the time, "Do I need to step away?" And what I need to do is to really support the system in responding differently, or responding to families, support the person that is really part of someone's life on a regular basis. That is my role, not to be the person. So if I can inspire and get things rolling in that way, great. But I need to keep asking that question, am I getting to involved, do I need to step away.

Appendix I

Informal Community Supports and Services Explored

The system service coordinator was asked to prepare of list of informal supports she had identified and attempted to integrate into families' community support networks. The list is presented below with minimal editing for readability.

- Invited mothers' families and friends to planning meetings as a routine strategy. Everyone had a part to play; one mother invited her grandparents, one family invited her sister, mother and close friend. Every family's situation is different. I would make the calls, if the mother didn't feel comfortable in asking for family and friends' involvement. Nine times out of ten people came and were very supportive in ways they felt comfortable with.
- Recruited high school students for babysitting (instead of formal funded respite).
- Neighbour accessed to provide childcare (instead of formal respite options).
- Requested support from Fanshawe College, Early Childhood Education students.
- Obtained a donation to pay for one-year membership at Child Reach.
- Tracked down a past foster mother (who lives in another community about 2 hours away) was willing to reconnect with one Mother to offer emotional support.
- Elicited clothing donations--safety gates, strollers, beds, air conditioner …lots of donations provided to families through connections in their community.
- Obtained financial support for a family of five to get their van back on the road through the United Way.
- Worked out a plan with a local auto repair shop to get family's van back on road.
- Hired a mother to tell her story to 45 resource consultants and managers across 5 counties…you could hear a pin drop!
- Provided 4 families with tickets to Jane Elliott ($20.00 per ticket) North America's most dynamic diversity trainer in North America. Every family who received a ticket came to this special event.
- Accessed funding to support a family move from one rural area to another rural area ~ 46kms one way.
- Contacted a tow trucker driver to help in the move.
- Connected a family to a neighbourhood daycare provider, thus avoiding having to arrange transportation to send their two year old 30 minutes across town to a funded daycare setting.
- Contacted a tutoring service to support one family's little boy.
- Contacted Ontario Hearing Society for resources.
- Barter System ~ creative way families can receive support while offering something they could do in return for someone else.
- Accessed Respite Network to obtain additional support for families in crisis.
- Accessed Memorial Boys and Girls Club for recreation, leisure and funding for families.
- Obtained donation from Lion Club in London to support one family.
- Obtained donation from Lions Club in Strathroy to support a rural family pick up their son who has autism from school every other day.
- Received donations from 2 Optimist Clubs in London to support one family.
- Obtained donations from Optimist Club in Ingersoll to support family expenses to Toronto in supporting their daughter who had a kidney transplant.
- Contacted a local jeweler who connected one family with more financial resources.
- Received funding from Salvation Army to support a mom with multiple challenges.
- Obtained resources from Ross McDonald School for the Blind.
- Invited a landlord to join one family's community team.
- Elicited offer of financial support from Lioness Clubs in London for one family.
- Elicited offer from Lioness Club in Tillsonburg for members to visit and provide informal support to one mother.
- Supported one mother's move to Sisters of St. Joseph's to avoid a family crisis.

- Connected children to school activities (informal ways to access family respite).
- Contacted the president of a soccer league to access subsidy for one family, and connected them to other families who were willing to provide transportation to and from the soccer fields.
- Connected one mother to a *Doula* (volunteer service to support mother through her birthing experience).
- Rotary Club provided funding for family.
- Contacted churches in Ingersoll and Stratford who offered space to have planning meetings.
- Invited members of peoples' churches to their planning meetings.
- Connected one mother to a nanny who came into their home to provide additional supports to her baby and two-year-old..
- Connected with several realtors from different community to pursue affordable housing options.
- Elicited offer of support from Native Community Housing Services to help one family with their housing needs.
- Arranged support from Credit Counseling Services to help one family with a rent to own option.
- Connected a mother with another mother whose daughter had also experienced kidney transplants. That mother is now part of the family/community team.
- Contacted 4 different IODE chapters in this region:
    - One chapter provided the funding for taxi fares for a mother with limited English Language skills, 3 sick children get to the hospital and to other specialist appointments.
    - One chapter provides practical things families need…clothing, household items like beds and washing machines etc…
    - One chapter had members willing to offer childcare so one single mother could have a break.
    - One chapter provided funds to one family to hire in-home supports.

Appendix J

Gaps in Services/Problems in Service Delivery

In the process of identifying and bringing to the table a full range of formal and informal services and supports, the system service coordinator generated a list of gaps. This list is presented below with minimal editing.

- *Affordable housing*, long waiting lists.
- Families whose *needs do not fall under a clearly defined social service* may fall between the cracks.
- *Services for rural families*; transportation burden. This includes both rural families and families who actually live in the city of London but are on the fringe of the city.
- *Insufficient income to meet basic needs*. Families on Ontario Works often experience significant poverty.
- *Language and literacy barriers* experienced by Ontario Works clients. Lots of information is sent to people who do not understand it, and their cheques are cut off when they do not respond.
- *Respite* for children who do not have a developmental delay and are not in need of protection.
- *Lack of consistency in service delivery* and approaches across this region in areas such as Child Welfare, Ontario Works, Childcare Subsidy, and Mental Health Services.