Review of School Health Support Services

Final Report

July, 2010

Table of contents

Glossary of Terms ii
Executive Summary 1
1. Background and Introduction 14
 1.1. Program Background 14
 1.2. Project Scope and Objectives 15
 1.3. Overview of the Report 16
2. Methodology and Approach 17
 2.1. Overview of Methodology and Approach 17
 2.2. Evaluation Framework 18
 2.3. Highlights of the Review Approach 19
3. Program Profile 24
 3.1. Introduction 24
 3.2. Population Served by SHSS 25
 3.3. SHSS Service Volumes and Individuals Served 26
 3.4. SHSS Wait Times 29
 3.5. SHSS Expenditures 32
4. Introduction to Findings and Recommendations 34
5. Mandate and Accountability 35
 5.1. Current State Findings 35
 5.2. Recommendations 39
6. Access and Equity 43
 6.1. Current State Findings 43
 6.1.1. Strengths 43
 6.2. Recommendations 51
7. Coordination 56
 7.1. Current State Findings 56
 7.2. Recommendations 66
8. Quality 70
 8.1. Current State Findings 70
 8.2. Recommendations 75
9. Moving Forward 79
Appendices 83
Appendix A – External Scan Bibliography 84
Appendix B – List of CCAC/LHIN Communities 88

Glossary of Terms

Term	Description
CCAC	Community Care Access Centre
Consultative Therapy	Service model in which the therapist shares knowledge, resources and expertise to enable others to make changes in their roles, programs, environments to improve child participation
CTC	Children's Treatment Centre
Direct Therapy	Service model that involves individually designed “hands on” intervention carried out by the therapist with the child. Focus is on meeting identified needs through specialized therapeutic strategies and techniques.
DSB or Board	District School Board
EDU	Ministry of Education
GMFCS	Gross Motor Function Classification System
ICF	International Classification of Functioning
IEP	Individual Educational Plan
IPRC	Identification, Placement and Review Committee
LHIN	Local Health Integration Network
MCYS	Ministry of Children and Youth Services
MOHLTC	Ministry of Health and Long-Term Care
MPOC	Measure of Processes of Care
OACCAC	Ontario Association of Community Care Access Centres
OACRS	Ontario Association of Children's Rehabilitation Services
OT	Occupational Therapy
OTN	Ontario Telemedicine Network
PPM	Policy and Program Memorandum
PT	Physiotherapy
RAI	Resident Assessment Instrument
SHSS	School Health Support Services
SLP	Speech Language Pathology
Tri-Ministry Review Team	SHSS Review Team with representatives from the three ministries: MOHLTC, EDU, and MCYS. This team provided overall direction for executing the SHSS Review.

Executive Summary

Program and Review Background

School Health Support Services (SHSS) were initiated in 1984 with the intent of ensuring that no school-aged child would be denied access to education because of special health support needs during school hours. Today, SHSS are provided to children and youth in publicly-funded and private schools, and to children and youth who are being home-schooled. Services provided through the program are provided by a range of professionals, including nursing, physiotherapy, occupational therapy, speech-language pathology and dietetics. The nature of services provided within the program include direct therapy and nursing services, consultative services (e.g. the training of educators and families), and the provision of related medical supplies, dressings and treatment equipment. SHSS also include personal support services such as personal hygiene activities and routine personal activities of living for children and youth in private schools and being home-schooled, which in the publicly-funded school system are provided by educators in the classroom.

Since the inception of SHSS, the Community Care Access Centres (CCACs), and their predecessor Home Care Programs, have had the mandate for the delivery of SHSS. CCACs are funded by the Local Health Integration Networks (LHINs) through the Ministry of Health and Long-Term Care (MOHLTC) for the SHSS program as part of their base operating budget. In their role, the CCACs administer the SHSS program and typically use contracted providers to deliver services in schools; however some CCACs provide SHSS directly through their own employees.

The SHSS program is currently regulated under the *Home Care and Community Services Act, 1994* and Regulation 386/99. In addition, Ministry of Education (EDU) policy, and inter-ministerial agreements also provide direction to the program. Specifically, EDU Policy and Program Memorandum No. 81 (PPM81) addresses the "Provision of Health Support Services in School Settings", guiding the delivery of school health support services and personal care for students with special needs in publicly-funded schools, and defines the division of services between school boards and community agencies funded by MOHLTC.

In 2004, the MOHLTC commissioned an independent review, led by the Honourable Elinor Caplan, of the competitive bidding process used by CCACs. In Caplan's report, *Realizing the Potential of Home Care, Competing for Excellence by Rewarding Results*, the review identified 70 recommendations to improve the quality of services in the community, strengthen the workforce and improve the procurement process. Specifically, 13 recommendations identified the need to clarify the roles and responsibilities of the CCACs, its partners and other organizations involved in the provision of services in the community. One of these recommendations suggested the Ministry of Children and Youth Services to "*conduct a review of the School Health Support Services program currently funded by the MOHLTC and delivered by the CCACs to develop a long-term strategy for both the coordination of services to children and youth in schools and the funding of these services.*" It was also suggested that the MOHLTC, EDU and MCYS, as well as agencies currently delivering school health support services, be involved in the review.

The government's May 2006 response to the report stated that: "*The ministry [MOHLTC] accepts and will support a joint review - with MCYS - of the School Health Support Services Program and determine how these services should be funded and coordinated.*" As an initial step, the MOHLTC identified the need to first understand the underlying issues within the current SHSS program, and to identify opportunities to improve them. By conducting a review focused on obtaining a comprehensive understanding of the current delivery of the program, the government will then be in better position to make decisions pertaining to SHSS policy direction, funding and program mandate.

In follow-up to the May 2006 response, the MOHLTC initiated a public procurement process to conduct the review of the School Health Support Services in the summer of 2009, and Deloitte Inc. (Deloitte) was selected as the successful vendor. Starting in the fall of 2009, the SHSS Review was led by a collaborative team of the MOHLTC, EDU and MCYS (Tri-Ministry Review Team), supported by Deloitte.

Review Scope and Objectives

The purpose of the SHSS Review was to identify strengths and weaknesses of the program at the provincial and local level. The Review had three areas of focus for evaluation:

1. Access and Equity
2. Coordination
3. Quality

Across these areas, the Review had the following objectives:

- Assess whether clients are able to access and are receiving high quality SHSS;
- Identify the strengths and weaknesses of the program's delivery and any areas in which it can be improved;
- Identify whether the strengths are aligned with the program's mandate;
- Investigate whether current client care models utilized by service provider agencies are consistent with research evidence and best practices; and
- Consider how SHSS can best serve students and their families; and whether proposed changes will benefit the students who use the services.

Through this evaluation, the Review identified strengths, weaknesses and opportunities for improvement for the SHSS program.

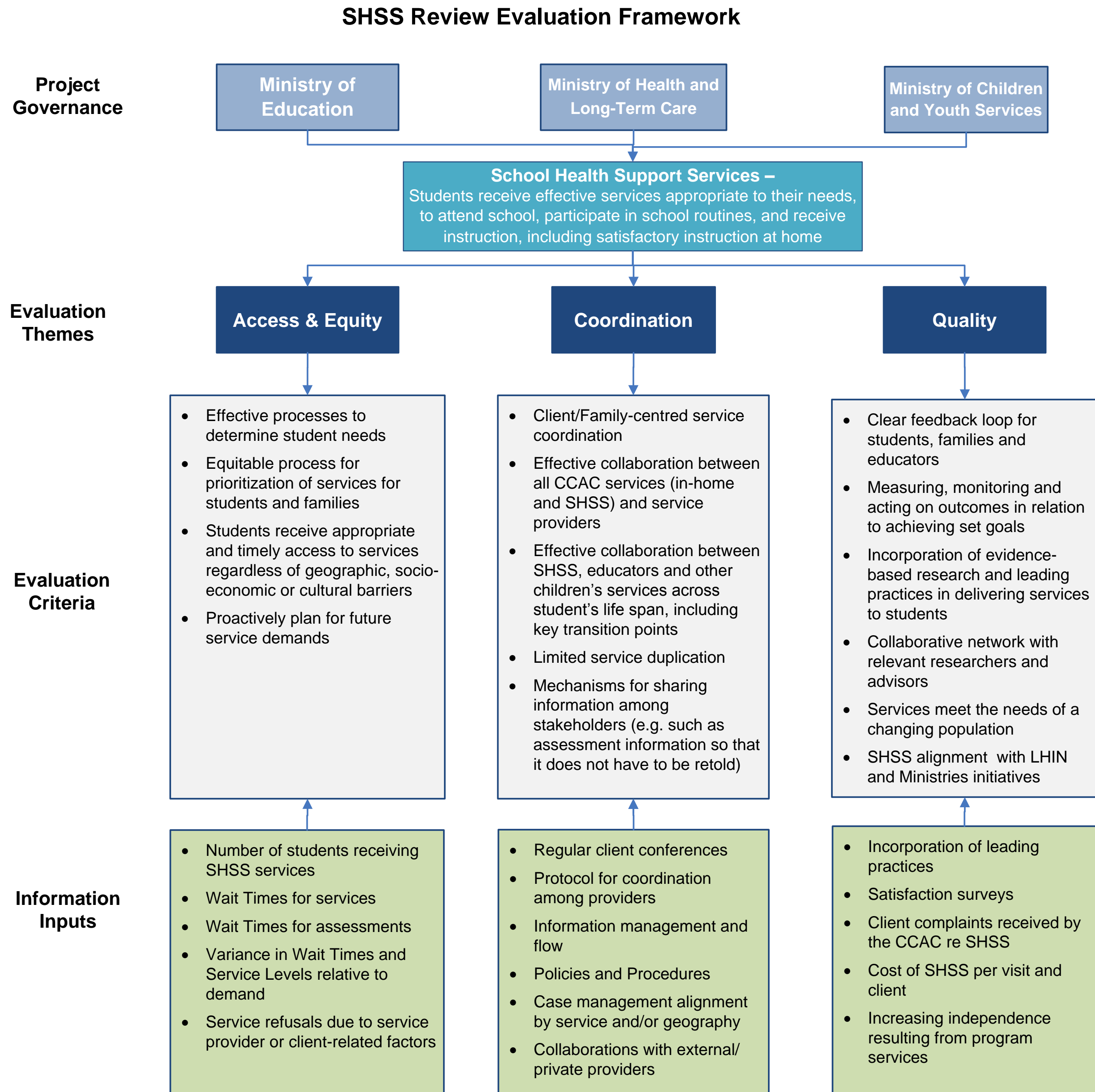
There are specific items that were not part of the Review, and were considered formally out-of-scope:

- The process to select service provider agencies and individual service providers;
- CCAC medical supplies and equipment policies;
- Expansion of SHSS through the addition of non-health supports/services beyond those currently included in SHSS;
- Assessment of funding and coordination authority, funding methodology and sustainability for SHSS; and
- Legislation, regulations, and policies governing the provision of SHSS.

Although insights were gained from stakeholders throughout the Review regarding both in-scope and out-of-scope items, this report focuses primarily on the in-scope objectives. It is anticipated that the key findings and recommendations related to the in-scope objectives of the Review will inform the future direction of the program.

Review Approach and Methodology

A comprehensive process was undertaken to review the SHSS program, from November 2009 to July 2010. An evaluation framework was developed early in the Review, which guided stakeholder consultations, analysis and the overall program assessment across the Review's three areas of focus: Access and Equity, Coordination and Quality.



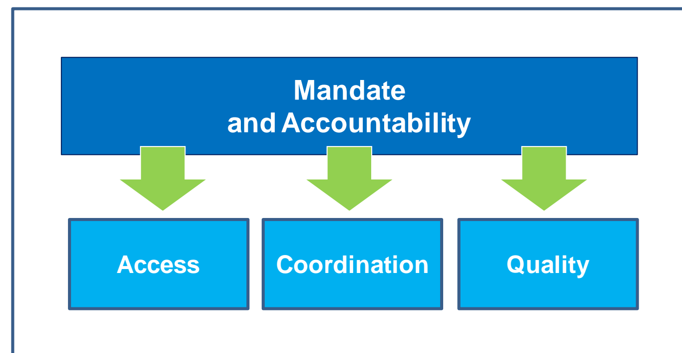
A number of activities were completed to gather the required information for the Review, including:

- A review of the provincial and local documentation and data trends (noted as the program profile)
- Consultations with provincial and local area stakeholders
- An external scan of leading practices
- A provincial-wide public survey that received 1,345 responses from families and stakeholders from across the sectors and geographies.

Findings and Recommendations

Building on the methodology outlined for the Review, a summary of findings and recommendations are presented across the Review's core evaluation areas of Access and Equity, Coordination and Quality.

In addition to these evaluation themes, stakeholder consultations clearly highlighted the need for improved clarity of the SHSS program's overarching mandate, scope and accountability, and the negative impact that the current lack of clarity has on Access and Equity, Coordination and Quality in the program. As a result, the findings and recommendations presented for the SHSS Review have been expanded to include Mandate and Accountability as a fourth area of reporting:



For each area of reporting, SHSS program strengths, challenges, leading practices from the field and research, and recommendations are presented. The proposed outcomes from implementing the recommendations are also identified.

Mandate and Accountability

The profiles of children attending school have changed over the years since the inception of the SHSS program in 1984. Emerging health trends and the growing complexity of their health support needs result in increasing service demands to support children in the classroom. It is important for a program mandate to evolve in parallel to meet these health support demands as well as to avoid the emergence of differing interpretations of the mandate. Having a consistent understanding of the program mandate will help to establish the roles and responsibilities of all stakeholders involved in the delivery of SHSS.

Strengths

There is a broad consensus among different stakeholders across the province that the SHSS program is a beneficial support service delivered to children. It is perceived that most children receiving these support services make progress in achieving their individual goals, and the program assists in increasing access to education.

Across the local areas engaged in the Review, the presence of specialized service providers involved in delivering the program was consistently identified. Stakeholders confirm that these providers possess specialized expertise to support the rehabilitation needs of children, and that the use of these resources for SHSS promotes the achievement of holistic goals that guide children's overall development.

Challenges

Challenges within the Mandate and Accountability for the SHSS program were identified across several key areas, including:

- Interpretations of the SHSS Program Mandate
- Interpretations of the SHSS Program Scope
- Delivery of Speech Language Pathology services
- Alignment of SHSS with Health System Priorities and Other Sectors
- Alignment with Leading Practices

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Interpretations of the SHSS Program Mandate

Differing philosophies exist among stakeholders on the supports that are required for children to participate in school, ranging from finite, concrete health goals to the facilitation of a child's developmental goals across life stages. As a result of various interpretations of the program mandate, variability exists in applying SHSS eligibility criteria across children's cases, which may lead to inequity across populations. Moreover, the program's philosophy of defining the scope of children's health support needs in school is driving a large proportion of the variability in access to the program across the province. Without a program mandate that is clearly understood by stakeholders, it is difficult to fully define accountability, roles and responsibilities for the SHSS program.

Interpretations of the SHSS Program Scope

Over the years, the demographic profile of children and youth participating in the classroom environment has evolved. The younger population with chronic conditions now lives longer and can join in more activities with appropriate assistance. Consequently, health support services have increased to attempt to meet this evolving demand; however, many stakeholders feel that the services offered are still insufficient to meet the needs of children enrolled in schools today.

Related to service scope, the majority of stakeholders feel that the current legislation and policies governing SHSS are outdated, and do not meet the current needs of students. Specifically, stakeholders express concern that existing policies, notably PPM 81, are narrow in scope and perceived to be designed for students with medical needs (e.g. injection of medication, catheterization, stoma care, postural drainage, suctioning and tube feeding), instead of supporting a child's broader health and developmental needs. Because of varied interpretation of the program mandate, different interpretations of existing policies have also occurred, resulting in some local areas providing a broader set of services to students than others. This results in some program inequity across the province

Delivery of Speech Language Pathology Services

The SHSS mandate is supplemented by the Interministerial Guidelines for the Provision of Speech and Language Services. These guidelines outline the responsibilities of Ontario's Ministries of Education and Health and Long-Term Care regarding the delivery of speech and language services. Through these guidelines, children requiring SLP services receive language support from the Board SLP, and speech support from the SHSS SLP. This results in fragmented service delivery for the child and family, and stakeholders note challenges in service coordination. Specifically, a number of stakeholders report that the collaboration between the Board and SHSS SLP groups is limited, and that this impacts the coordination of appropriate services for the student who requires both supports.

Alignment of SHSS with Health System Priorities and Other Sectors

Consultations at the provincial and local level identified challenges to the SHSS program that occur through the limited alignment between health, education and children and youth sector priorities. In some local areas, there appears to be good collaboration across the sectors, to enable a shared prioritization of services for children and their families; but in many areas this collaborative prioritization is limited.

For example, despite the decreasing population of the demographic under 19 years of age, a number of CCACs have chosen to focus efforts on children's services, as it is recognized that children requiring health supports will impact the health system as adults, if health issues are not supported early. However, the majority of stakeholders report that because the province's health strategy is focused on larger system transformation initiatives, such as reducing emergency room wait times and enabling individuals to age at home, the SHSS program receives limited priority for funding, management or service delivery in most local areas.

Stakeholders note that the different SHSS priorities across the province are also exacerbated by the different boundaries for service delivery across the health, education and children and youth sectors. This results in a heightened requirement for collaboration for the program.

Alignment with Leading Practices

Leading practices identify the need to focus on holistic goals for the child and family, to have clear eligibility parameters that inform program definition, and to have structured formal models of collaboration between different stakeholders to ensure effective child and family-centred care.

Recommendations

As noted in the findings, varied interpretations of the SHSS program's mandate and different philosophies on the program's objectives exist across the province. Because the program has not formally been reviewed since its inception, it is critical to understand the overarching SHSS mandate and models employed across the province.

Based on the findings from the review, the following recommendations are identified related to the mandate and accountability of the SHSS program. Supporting sub-recommendations and detailed considerations are provided for each recommendation in the main report:

Recommendation 1: Clarify the scope of services delivered under the mandate of the SHSS program

Recommendation 2: Under the SHSS mandate, enhance cross-sector collaboration to deliver SHSS that optimizes expertise and resources

It is anticipated that implementation of these recommendations will establish a common understanding of SHSS program, roles and responsibilities, optimize the delivery of speech and language resources, and improve consistency in service delivery across the province.

Access and Equity

Maintaining appropriate and equitable access to SHSS is critical to program integrity, as with any health or social service. For the SHSS program, variability in interpretation of the program mandate, approach to prioritization of different children's needs and availability of resources all impact access at the local level. Findings from across the provincial and local area consultations consistently identify that although efforts are made to improve access to SHSS, access varies across the province, based on geography, school setting, functional needs of the child, and cultural and linguistic needs. Further, stakeholders identify concerns with program access and equity with respect to both the different scope of SHSS available in difference communities, and the varying wait times for services across the province. As one of the core areas for the Review, improving access and equity to the SHSS program is an important driver of overall program improvement.

Strengths

The majority of stakeholders agree that children who require high physical supports receive SHSS in a timely manner. As a result, many stakeholders report that providers and educators work effectively in ensuring an individual's physical and health-related safety needs are met in the classroom environment.

To support equitable access and optimize existing resources, CCAC case managers/care coordinators typically apply prioritization tools to guide the triaging of children with support needs to best serve those most in need based on urgency and intensity of services required. There is variation in the development and alignment of these tools across the province, but where they exist, these guidelines support objective and equitable guidance to the allocation of finite SHSS resources across the children needing service.

Stakeholders acknowledge the financial and human resource limitations within their respective communities, and a number of areas have implemented innovative models to address potential access inequities that occur as a result of these constraints. Examples of alternate service models include:

- Using Ontario Telemedicine Network (OTN) to facilitate communication and education between a service provider in a city and another individual residing in a remote town
- Offering group clinics, in which a number of students receive services at the same time while optimizing the use of resources
- Expanding the pool of resources that deliver SHSS (e.g. using Therapy Assistants, such as Rehabilitation Aides or Communication Disorder Assistants, to implement an individual's service care plan.)

These alternate models help to enable appropriate and timely access, regardless of geographic, socio-economic or cultural barriers.

Challenges

Challenges within Access to the SHSS program were identified across the following key areas:

- Different access tools and criteria
- Wait times and population-specific access
- Service Delivery Models
- Collaborative planning across sectors
- Awareness of the SHSS program
- Alignment with Leading Practices

Different Access Tools and Criteria

As a result of varied interpretations of the SHSS program mandate, local areas across the province utilize different criteria, guidelines and tools to deliver SHSS. For example, field consultations revealed there is variation in the age and/or grade level in which children are referred to SHSS, which further varies by discipline/service required. Examples of program inequity include the scope of support needs that are considered eligible within the SHSS program, differences in the defined visit allocation guidelines, and the types of goals set to enable children to participate in the education curriculum.

While stakeholders use guidelines and tools to delineate priority cases, they are not standardized across the province. This lack of a consistent set of guidelines and tools results in variability in access to SHSS, and potentially impacts the overall progress of children's ability to participate in the education curriculum.

Wait Times and Population-Specific Access

Two prominent themes that emerged from the program profile and stakeholder consultations revolved around wait times and different populations' access to SHSS. Wait times were found to vary across areas and stakeholders were generally dissatisfied with the wait for service, particularly for children who are categorized as lower priority relative to other children's needs. With respect to different populations who utilize SHSS, stakeholders identify that wait times and access issues can be exacerbated for select subpopulations, for which there is widespread consensus that effective strategies are needed to address existing barriers. Examples of the subpopulations impacted by the variation in SHSS delivery:

- Children with chronic conditions that require long-term support and episodic SHSS
- Francophone students
- Families that speak English as a second language
- Aboriginal communities
- Individuals living in rural, remote and northern communities

Population-based access to SHSS varies further by school type and geography. Current policy provides dedicated funding for children with support needs attending independent or private schools. While the intent of this funding was to ensure appropriate access for students seeking education outside the public school system, children enrolled in private schools encounter shorter wait times than their counterparts in public schools across the province. From a geographic perspective, due to the different interpretations of the program's mandate, SHSS service models differ by CCAC boundaries, creating variability in the services that can be accessed depending on the geographic location of the school. In addition to creating provincial variation, this causes variation of service delivery within school boards since some services are delivered within multiple CCAC boundaries.

Service Delivery Models

The majority of SHSS is delivered in a consultative model, in which collaboration between the provider, educator and family is needed so that ongoing support to the child is provided in between therapy sessions with the provider. There are challenges in developing collaborative relationships between providers and educators. In addition to the service delivery model challenges related to provider-educator collaboration, the model of SHSS being delivered one-on-one within the traditional school setting and school year are also limitations that raise concerns by stakeholders.

Wait Times and Population-Specific Access

As the needs of the population evolve and resourcing models within the health, education and children and youth services sectors change, there is a need to regularly examine and refine the way in which services are delivered, although there is limited evidence of this from provincial or local area consultations. Because of the different sectors involved in providing school health support services and varied degree of coordination between sectors, stakeholders may be unaware of the true impact of changing policies or practices in a given sector on another. Currently, stakeholders report a perception that significant practice changes are typically communicated, but that collaboration and joint planning to manage related impacts does not consistently occur.

Awareness of the SHSS Program

Finally, access to the SHSS program is further impacted by inconsistent awareness that the program exists. This was specifically noted by a large of proportion of families and educators:

- Families expressed confusion in navigating through the services offered by the various sectors to understand the services that can be accessed to support their child.
- Educators expressed concern and uncertainty about the most appropriate referral process, and how to manage referrals when their students are served by more than one CCAC.

Alignment with Leading Practice

As noted in the leading practices section of the report, some areas have implemented approaches to improve program access, utilize tools that guide prioritization and scope, and enhance awareness of the program, but these examples are not consistently implemented across the province.

Recommendations

Based on the findings, improved access and equity for the SHSS program can be achieved through implementation of consistent standards and tools across the province, deploying alternate service models to meet varied needs, increasing the awareness of the SHSS program overall, and improving comprehensive program planning to better facilitate a cross-sector response to meet service demands.

The following proposed recommendations will address the access challenges regularly encountered by stakeholders involved in the SHSS model. Supporting sub-recommendations and detailed considerations are provided for each recommendation in the main report:

Recommendation 3: Develop access guidelines and tools to guide service delivery

Recommendation 4: Develop formal forums and processes for proactive service planning

Recommendation 5: Establish alternative models of service delivery across the province to improve access and wait times

Recommendation 6: Increase awareness of the SHSS program provincially and locally

It is anticipated that implementation of these recommendations will establish a common set of tools to guide program access and service delivery, optimize the models of service delivery, improve cross-sector collaborative planning for the needs of local area children, and enhance awareness of the SHSS program.

Coordination

Considering the broad services available for children with special needs, coordination is often complicated, as there are multiple entry points into the health, education and children and youth services systems, and multiple services available. Families often access children’s services through multiple programs that are often funded by different ministries, which impacts coordination efforts by all stakeholders. Communication and collaboration is required across the multiple stakeholder groups – children/families, case managers/care coordinators, educators, SHSS service providers, CTCs and broader service providers – to achieve the benefits of effective coordination and to enable child and family centred-care.

Strengths

Coordination within the SHSS program and with other services that support children is effective in a number of areas of the province. Examples exist of strong communication and collaboration between stakeholders, involvement of families in planning services for their children, and transitioning children between programs or schools.

For families, stakeholders note several strengths with regards to communication and coordination:

- In some areas of the province, SHSS communication guidelines exist to inform families of the program and the details of their child's service plan.
- Families are generally involved in a discussion regarding their child's SHSS plan.
- In some areas, families have the opportunity to provide more comprehensive input on the development of their child's service plan for SHSS, in collaboration with case managers/care coordinators, educators and providers at case conferences.
- Many parents reported that they receive timely, comprehensive information about their child's progress, noting that provider reports give valuable updates on their child's therapy progress.

There are also processes in place for joint collaboration between case managers/care coordinators and service providers to ensure children's support needs are met:

- In the majority of areas, educators, service providers and CCACs connect through different mechanisms at the beginning or end of each school year to understand and plan for anticipated support needs of students enrolled in the SHSS program.
- The CCACs use this information, as well as data forwarded from pre-school programs for students entering school full-time, to inform provider agencies of the approximate service volumes for the upcoming school year.
- Further, a number of early education providers and educators report they incorporate information sharing processes to support a streamlined transition for children between pre-school and school.

Stakeholders reported transfers of students from one school to another within the same CCAC are relatively seamless and smooth.

- In some areas, inter-CCAC transfer processes have been developed, which enables seamless transitions as clients transfer from one CCAC jurisdiction to another.
- In most areas, school boards, CTCs and other community programs meet to proactively plan for students transitioning out of the school system into adulthood, by conducting conferences with the families and stakeholders several years before the transition occurs.

Challenges

Challenges in Coordination of the SHSS program were identified across the following key areas:

- Coordination with families
- Coordination with schools and educators
- Case management
- Transition processes
- Alignment with Leading Practices

Coordination with Families

There is variability on the level and the frequency of coordination that occurs for SHSS among stakeholders. Due to the lack of dedicated time and avenues for information exchange, coordination processes are inconsistent. Although some CCACs and providers emphasize that family engagement improves SHSS outcomes for their children, they often encounter challenges in determining optimal methods to reach parents. Coordination can be complicated for children whose services extend beyond SHSS. A proportion of children may have different providers in school and at home. In these areas, the

multiple providers supporting a child typically have limited communication with one another, which could negatively impact the continuity of care if the child's goals are not aligned.

Consultations revealed a large proportion of parents are overwhelmed with the number of individuals involved in the SHSS processes and unsure of the respective scope of responsibilities. As a result, parents feel they must regularly invest time and effort to reach out to the SHSS network to understand their child's progress and plan, and ensure they receive the right information from the right person.

As there are varied mechanisms for communicating with parents, it is challenging to ensure consistent messages are conveyed. Similarly, due to the wide interpretations of the SHSS mandate, families do not fully understand the goals and objectives of SHSS, the corresponding services provided, the program's purpose in supporting their child's broader development, and the role of the program within the broader network of children's programs available in the community.

Coordination with Schools and Educators

Staffing resources vary across Boards and schools, which complicate coordination among the SHSS program and educators. Some Boards do not employ in-house SLPs to address minor speech and all language needs, which impact the scope of activities of other SHSS stakeholders to meet this service demand. Children attending private schools need to seek language service outside of the education system, since most private schools do not employ their own SLPs.

Challenges also exist in developing collaborative relationships between providers and educators, as providers perceive that they are not part of school culture. Some providers, particularly therapists, feel they have limited time with educators to develop collaborative relationships. Therapists are generally in school to provide service to children, mostly outside of the classroom setting. Also, there are competing education priorities that are perceived to supersede the ability to foster relationships with educators, as therapists are not consistently present or available in classroom.

Case Management

Although CCACs promote the use of standardized, assessment and reporting tools, providers and educators perceive that these guidelines do not accurately capture assessment and treatment strategies. Providers reported CCAC templates are not "user-friendly" for SHSS, and that they are more appropriate for adult services. Providers feel required to complete multiple reports to ensure effective communication with educators and families. Service providers reported that they attempt to engage parents as much as possible, but variability exists in the ability to use a variety of communication channels.

While a proportion of CCACs facilitate case conferences at the onset of service plan initiation, there are consistent challenges with conducting these case conferences, which include organizing an optimal time when everyone can attend and using an allocated client visit to participate in the conference.

Stakeholders reported variability in the effectiveness and value of the current case management structure, however, as the approach and processes requires the same case management and provider resource effort, regardless of the intensity or duration of an individual's needs. While it is reported that some case managers/care coordinators regularly connect with parents, other families reported that they are unfamiliar or unaware of their assigned CCAC case manager/care coordinator or the appropriate circumstances in which to contact them. Also, some stakeholders perceive that the current case management model may not be appropriate for all cases, particularly for children with finite, "single-service" needs, as they require less intense services to enable access to the SHSS program.

Transition Processes

While most areas conduct planning meetings to support transitions between key life stages or across school/LHIN boundaries, the effectiveness of these mechanisms differs across Ontario. The inconsistency in proactive information sharing or lack of standardized transfer policies potentially results in delays to accessing the right support service.

Alignment with Leading Practices

Leading practice research examines several improvements for service coordination, including the integration of a key worker model, knowledge transfer, and skills and capacity development.

Recommendations

Effective coordination is needed for SHSS to link children and their families with the services they require, integrating services and resources, avoiding service duplication and unnecessary costs, and ensuring smooth transitions from one service to another. For effective coordination to occur, structures, tools and processes to facilitate communication and collaboration are required across multiple stakeholder groups.

Based on the findings from the review, the following recommendations are identified related to the coordination of the SHSS program. Supporting sub-recommendations and detailed considerations are provided for each recommendation in the main report:

Recommendation 7: Develop and implement common guidelines to achieve a “shared care and service plan” for each child that engages appropriate stakeholder groups

Recommendation 8: Assess effectiveness of case management services across all student population types to determine appropriate case management models to deploy

Recommendation 9: Develop common protocols for SHSS transition processes across a child’s life stages and across organizations

Recommendation 10: Establish navigation support to assist families in better understanding and navigating the services available for children requiring SHSS

Recommendation 11: Assess, develop and implement mechanisms required to enhance knowledge transfer among stakeholders in service delivery

It is anticipated that implementation of these recommendations will improve care coordination for children and families, facilitate smoother transitions between SHSS and other programs, optimize case management processes, and enhance collaboration across sectors.

Quality

Continuous quality improvement and integration of leading practices are critical to building quality within the SHSS program. Mechanisms for seeking, sharing, understanding and implementing outcomes, performance management and leading practices need to be in place so that they can be incorporated into the program for ongoing improvement. The review of program performance may include indicators such as child health outcomes, utilization metrics or stakeholder satisfaction and feedback. Ongoing monitoring of the SHSS program can inform planning processes, as organizations build their understanding of appropriate resourcing and capacity required for program delivery, to assist in designing an optimal service model that maintains quality support for the child. Effective professional development is also required for stakeholders to understand and buy-in as leading practices evolve for the SHSS program.

Strengths

Across the province, stakeholders identified strengths across the dimensions of program quality. Although not consistent in all areas of the province, examples were identified of quality service delivery, coordination and application of leading practices.

Overall, there is general agreement that the SHSS program achieves its overall intent and provides effective support in assisting children to access education.

- In several local areas, stakeholders report that the goals and activities of a child’s given plan are clearly documented in the individual service plan.
- Case managers/care coordinators, service providers, educators, and parents are aware of the goals and interventions related to a child’s needs, and of the child’s progress toward these goals.
- CCACs, educators and providers acknowledge parents as key partners in successfully supporting children to enhance their functional abilities, thus a family-centred approach is critical to maintain when structuring relevant services.

Examples were also identified of the program's continued evolution to meet child and family needs:

- Although the program is intended to deliver support services during the school year, a number of CCACs, providers and educators recognize the benefits of continuing support during the summer months to minimize regression and promote concrete skills within the child, to increase the likelihood of success in the classroom.
- The types of health support services delivered in schools have changed significantly and the roles providing these services have also shifted to try to meet the needs of the current population. Nurses, therapists and educators are part of a cross-disciplinary team that actively provide and support SHSS for these students with higher acuity needs.
- Generally, service providers and the CCACs utilize various mechanisms or avenues to maintain their knowledge of leading practices within children's health services and emerging trends.

Challenges

Challenges in Coordination of the SHSS program were identified across the following key areas:

- Establishing a Child's SHSS Goals
- Program Outcomes and Evidence-Based Practice
- Knowledge Transfer
- Use of Technology
- Program Feedback
- Alignment with Leading Practices

Establishing a Child's SHSS Goals

As a result of the contrasting interpretations of the program mandate, it is evident that the types of SHSS goals for students vary across regions, which results in inequities regarding the magnitude and types of services provided to children. Moreover, the goals and evaluation outcomes currently used in a child's service plan may not accurately align with their functional needs or health issues, as they are generally focused on targeted goals for improvement rather than on the child and family's broader holistic needs.

Program Outcomes and Evidence-Based Practice

Currently, consistent quality outcome indicators for the SHSS program across the province do not exist; this impacts the ability to regularly monitor services and inform the Ministries of overall program performance. While service providers and CCACs track a child's achievement of SHSS goals as set out in the service plan, there are limited indicators monitored to provide insights on the effectiveness of service delivery. In addition, the intensity of support services required for a given child cannot be determined in a consistent manner relative to other children, as the SHSS program does not incorporate assessment tools to monitor this dimension of service delivery and allocation. Without this type of information, it is challenging to understand the collective levels of service appropriate to meet SHSS demand or to project future service needs for local area populations.

With respect to how research and leading practice informs SHSS program quality, in general, there is a lack of a formal, integrated mechanism to conduct trial initiatives and research. As a result, it is challenging to develop and promote awareness among colleagues of the research underway to address common issues in delivering SHSS.

Knowledge Transfer

Some providers revealed challenges in sharing their knowledge with educators and parents to enable a consultative model of service delivery, as educators may not possess required specialized training relevant to a child's SHSS needs. Educators and parents also note concern that the activities they are requested to support through the SHSS program are outside their own skill sets. Across the province, educators and parents report variable understanding of SHSS recommendations and are, at times, reluctant or feel ill-equipped to carry out the activities instructed by the therapists.

Use of Technology

Technology advances, such as assistive communication devices, have better enabled children to participate in the classroom in a more fulsome manner. However, it is perceived that there is inconsistency among educators as to their abilities in utilizing these supports effectively.

Program Feedback

Although the CCAC provides families with information on communication options and feedback mechanisms upon admission to the program, it is perceived that this information is not consistently retained by parents. It was reported that a proportion of parents are hesitant to raise concerns around the management of their child's case or the performance of a given individual involved, as they are concerned about repercussions to their actions and that the health support services provided would be impacted.

Alignment with Leading Practices

Leading practice research examines several improvements for identifying program outcomes through consistent measurement and tools, developing and applying evidence-based practice, and for implementing effective knowledge transfer processes between stakeholders.

Recommendations

An enhanced focus on quality is needed through several dimensions of the SHSS program to support improved access, equity, coordination and program management. Based on the findings from the review, the following recommendations are identified related to the quality of the SHSS program. Supporting sub-recommendations and detailed considerations are provided for each recommendation in the main report:

Recommendation 12: Assess SHSS program outcomes in achieving its mandate, with defined indicators and measurement processes

Recommendation 13: Establish a provincial mechanism that objectively reviews SHSS models and clinical leading practices on an ongoing basis, and integrates results into the program

Recommendation 14: Establish tools to determine weighting or required intensity of services for SHSS

Recommendation 15: Establish initial and ongoing SHSS professional development requirements for stakeholders

It is anticipated that implementation of these recommendations will improve quality of services for children and families by enhancing accountability, promoting child and family-centred goals and outcomes, implementing proactive program planning, incorporating leading practices, and facilitating knowledge exchange and capacity building.

Moving Forward

This School Health Support Services Review aims to build on the successes of the program since its inception over 25 years ago, address some of its challenges, and support the province in a critical first step toward improving the program. The findings and recommendations of this Review outline steps toward change to improve the program, align services across sectors and with other programs, and enable SHSS to better serve children and families.

Given the many stakeholders involved in the SHSS program across Ontario, the recommendations coming from this Review will require a collaborative commitment and effort across all relevant sectors, involving stakeholders at both the provincial and local levels. Leadership and commitment are needed from both levels for the different recommendations, to ensure that strategies implemented are effective and sustainable, and ultimately lead to enhance SHSS throughout the province.

1. Background and Introduction

1.1. Program Background

School Health Support Services (SHSS) were initiated in 1984 with the intent of ensuring that no school-aged child would be denied access to education because of special health support needs during school hours. Today, SHSS are provided to children and youth in publicly-funded and private schools, and to children and youth who are being home-schooled. Services provided through the program are provided by a range of professionals, including nursing, physiotherapy, occupational therapy, speech-language pathology and dietetics. The nature of services provided within the program include direct therapy and nursing services, consultative services (e.g. the training of educators and families), and the provision of related medical supplies, dressings and treatment equipment. SHSS also include personal support services such as personal hygiene activities and routine personal activities of living for children and youth in private schools and being home-schooled, which in the publicly-funded school system are provided by educators in the classroom.

Since the inception of SHSS, the Community Care Access Centres (CCACs), and their predecessor Home Care Programs, have had the mandate for the delivery of SHSS. CCACs are funded by the Local Health Integration Networks (LHINs) through the Ministry of Health and Long-Term Care (MOHLTC) for the SHSS program as part of their base operating budget. In their role, the CCACs administer the SHSS program and typically use contracted providers to deliver services in schools; however, some CCACs provide SHSS directly through their own employees

The SHSS program is currently regulated under the *Home Care and Community Services Act, 1994* and Regulation 386/99. In addition, policy by the Ministry of Education (EDU), and inter-ministerial agreements also provide direction to the program. Specifically, EDU Policy and Program Memorandum No. 81 (PPM81) addresses the “Provision of Health Support Services in School Settings”, guiding the delivery of school health support services and personal care for students with special needs in publicly-funded schools, and defines the division of services between school boards and community agencies funded by MOHLTC and Ministry of Community and Social Services (MCSS). Since the original development of PPM81, related services have transferred from MCSS the MCYS. The interministerial agreement aims to fulfil Ontario Government's commitment to ensure that all students with special needs receive the support services required to benefit from an educational program.

In 1985, the Model for the Provision of School Health Support Services was developed between the MOHLTC, EDU and MCSS to clarify the appropriate delegation of routine activities from health providers to educators, specifically for catheterization and suctioning. In the same year, Interministerial Guidelines for the Provision of Speech and Language Services (SLP) were also developed between the MOHLTC, EDU and MCSS to clarify responsibilities for speech and language services in schools. These guidelines were reviewed and revised in 1988 to assist in decision making at the local level and determine respective roles in the provision of services in schools. The speech and language guidelines assign individual and shared responsibilities to the health and education systems, describe a mechanism for resolving differences in interpretation and set out a requirement for an annual review mechanism by an interministerial committee.

Given the policy and service delivery environments of the SHSS program, a number of stakeholders across the health, education and children and youth sectors are involved in the program’s governance, design, evaluation and delivery.

1.2. Project Scope and Objectives

1.2.1. Background of Review

In 2004, the MOHLTC commissioned an independent review, led by the Honourable Elinor Caplan, of the competitive bidding process used by CCACs. In Caplan's report, *Realizing the Potential of Home Care, Competing for Excellence by Rewarding Results*, the review identified 70 recommendations to improve the quality of services in the community, strengthen the workforce and improve the procurement process. Specifically, 13 recommendations identified the need to clarify the roles and responsibilities of the CCACs, its partners and other organizations involved in the provision of services in the community. One of these recommendations suggested the Ministry of Children and Youth Services (MCYS) "*conduct a review of the School Health Support Services program currently funded by the MOHLTC and delivered by the CCACs to develop a long-term strategy for both the coordination of services to children and youth in schools and the funding of these services.*" It was also suggested that the MOHLTC, EDU and MCYS, as well as agencies currently delivering SHSS, be involved in the review.

Specific insights from the Caplan review indicated the provision of services through the SHSS program was fragmented and lacked coordination. Issues related to service fragmentation were influenced largely around waitlists to obtain services, such as lengthy waits for the assessment and approval of services. In her findings, Caplan reported that there was no central location for families to access the services they need for their children. This was particularly difficult for families of children who require multiple services, since they were delivered through a number of different agencies and were part of different programs. Caplan's findings were that families often accessed children services from multiple programs that were funded by different ministries, further contributing to the lack of service coordination. Further, the varied geographic distribution of both resources and students, located across rural and urban areas, and in northern and southern Ontario, added another layer of complexity in providing timely access to appropriate support services to students in need. From the findings in the Caplan report, the province identified the need for an accessible, equitable, coordinated system that delivers quality health services to children to support their health and development and creates better outcomes for them in the future.

The government's May 2006 response to the report stated that: "*The ministry [MOHLTC] accepts and will support a joint review - with MCYS - of the School Health Support Services Program and determine how these services should be funded and coordinated*." As an initial step, the MOHLTC identified the need to first understand the underlying issues within the current SHSS program, and to identify opportunities to improve them. By conducting a review focused on obtaining a comprehensive understanding of the current delivery of the program, the government will then be in better position to make decisions pertaining to SHSS policy direction, funding and program mandate.

In follow-up to the May 2006 response, the MOHLTC initiated a public procurement process to conduct the review of the School Health Support Services in the summer of 2009, and Deloitte Inc. (Deloitte) was selected as the successful vendor. Starting in the fall of 2009, the SHSS Review was led by a collaborative team of the MOHLTC, EDU and MCYS (Tri-Ministry Review Team), supported by Deloitte.

1.2.2. Purpose of Review

The purpose of the SHSS Review was to identify strengths and weaknesses of the program at the provincial and local level. The Review had three areas of focus for evaluation:

1. Access and Equity
2. Coordination
3. Quality

Across these areas, the Review had the following objectives:

- Assess whether clients are able to access and are receiving high quality SHSS;
- Identify the strengths and weaknesses of the program's delivery and any areas in which it can be improved;
- Identify whether the strengths are aligned with the program's mandate;
- Investigate whether current client care models utilized by service provider agencies are consistent with research evidence and best practices; and
- Consider how SHSS can best serve students and their families; and whether proposed changes will benefit the students who use the services.

Through this evaluation, the Review identified strengths, weaknesses and opportunities for improvement for the SHSS program.

There are specific items that were not part of the Review, and were considered formally out-of-scope:

- The process to select service provider agencies and individual service providers;
- CCAC medical supplies and equipment policies;
- Expansion of SHSS through the addition of non-health supports/services beyond those currently included in SHSS;
- Assessment of funding and coordination authority, funding methodology and sustainability for SHSS; and
- Legislation, regulations, and policies governing the provision of SHSS.

Although insights were gained from stakeholders throughout the Review regarding both in-scope and out-of-scope items, this report focuses primarily on the in-scope objectives. It is anticipated that the key findings and recommendations related to the in-scope objectives of the Review will inform the future direction of the program.

1.3. Overview of the Report

This report summarizes the results of the SHSS Review. The objective of this report and recommendations is to identify strengths, weaknesses and opportunities for improvement for the SHSS program. The remainder of this report is organized as follows:

- **Overview of Methodology and Approach** – Provides a description of the activities undertaken to collect the information required to conduct the SHSS Review

- **Program Profile** – Provides a summary of provincial level data, with some insights on the current state of operations of the SHSS program

- **Overview of Findings and Recommendations** – Describes the format of the subsequent sections that detail the findings and recommendations of the review.

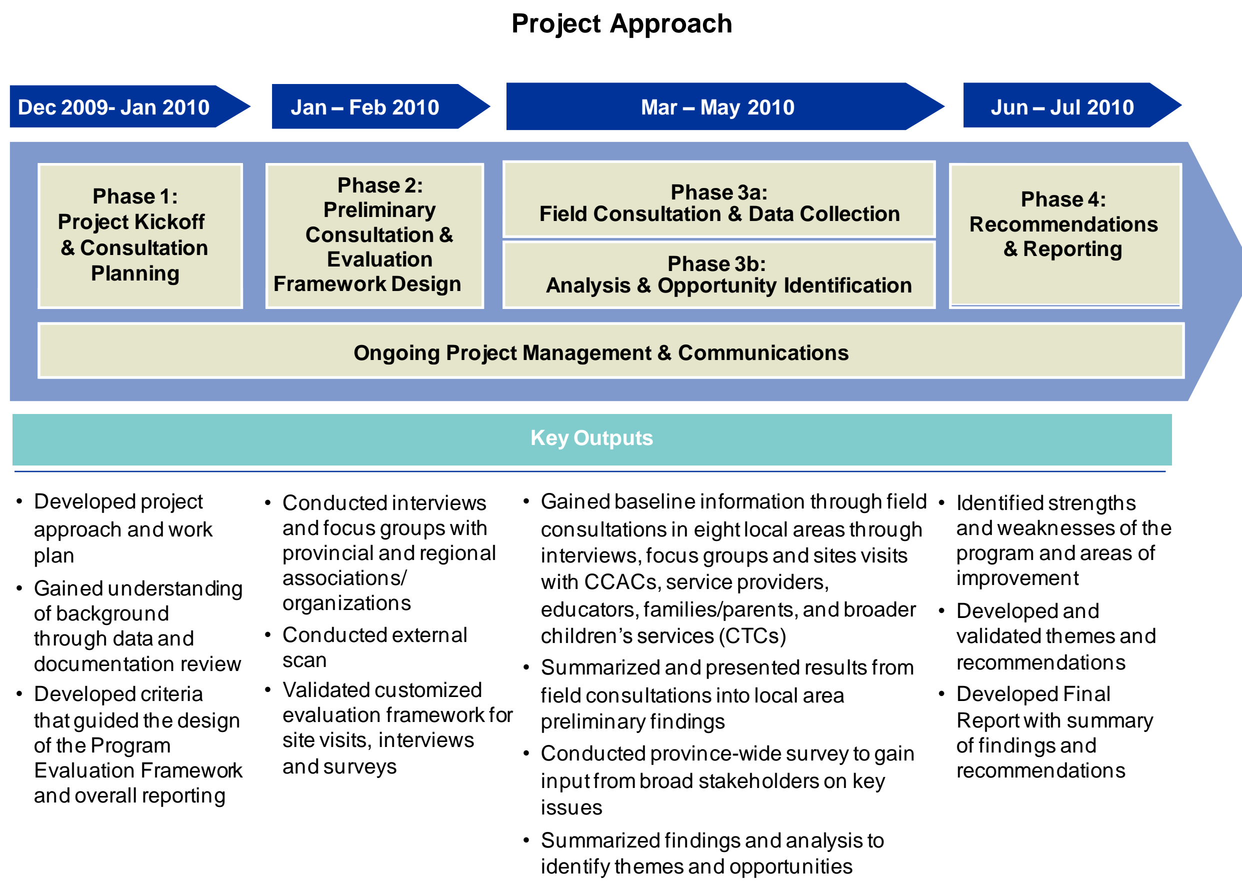
- **Moving Forward** – Presents concluding perspectives on the program and a summarized list of recommendations and intended outcomes, for ease of reference.

2. Methodology and Approach

2.1. Overview of Methodology and Approach

The SHSS Review was initiated in November 2009 and was completed in July 2010. A four-phased approach was applied to meet the objectives and timeline of the Review, as depicted in the project approach diagram below.

Project Approach



As outlined in the project approach above, to understand the strengths, weakness and opportunities for improvement in the SHSS program, stakeholder consultations were conducted at a provincial and local level, an external scan of leading practices was completed, and a province-wide survey was also conducted to gather broad stakeholder input. The program review was guided by an evaluation framework, which provided structured evaluation criteria used to ensure a consistent and comprehensive approach throughout the review.

An overview of the evaluation framework and key inputs to the review is provided in the following sections.

2.2. Evaluation Framework

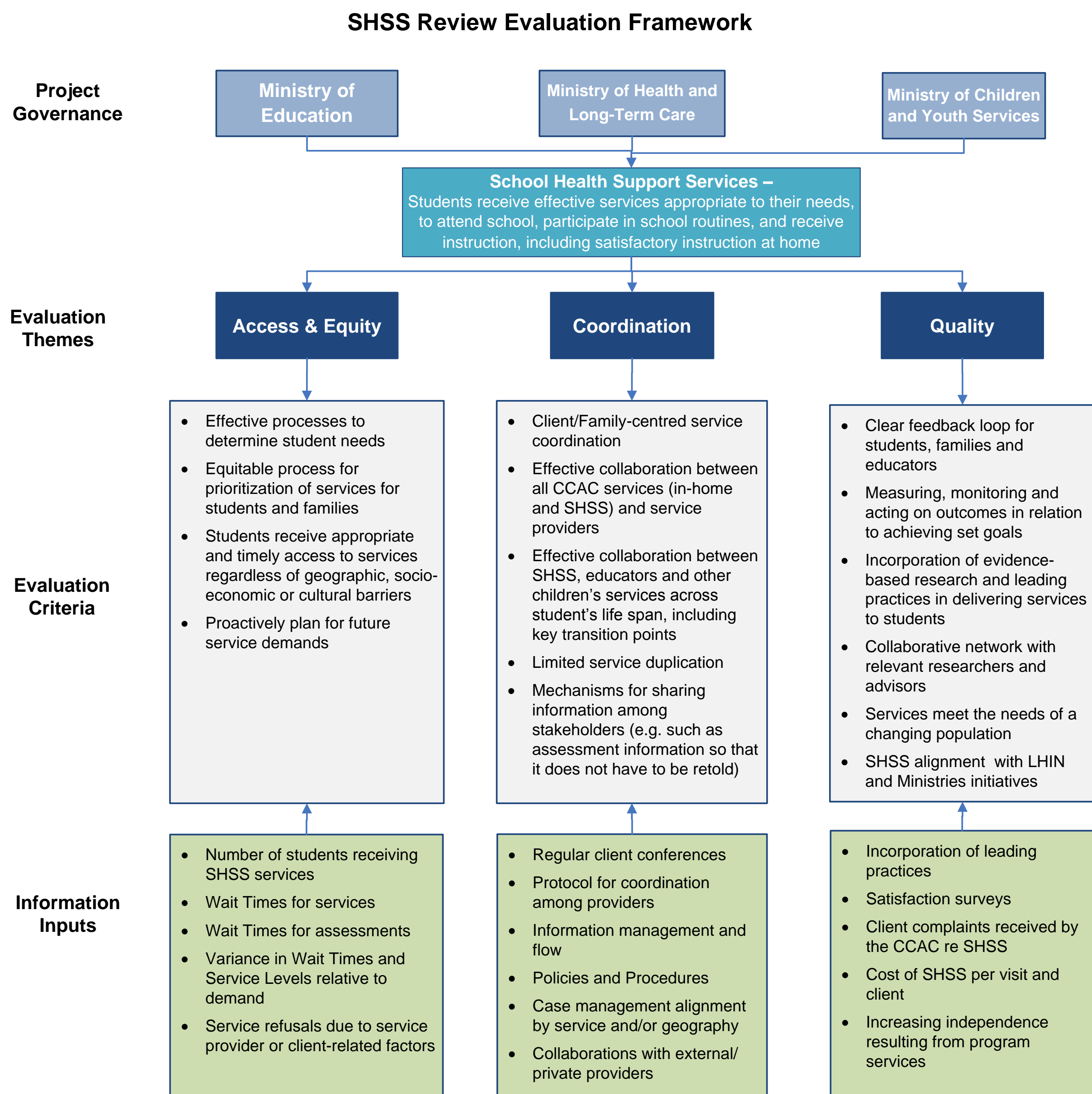
To guide the successful completion of the SHSS Review, a comprehensive program evaluation framework was applied that assessed the strengths and weaknesses of SHSS related to the three core themes of the Review:

1. Access and Equity
2. Coordination
3. Quality

Under each of the themes, evaluation criteria were specified to examine key components of the program. Supporting each set of evaluation criteria, lines of inquiry were established to guide stakeholder consultations, and key information inputs were gathered at the provincial and local levels.

The following diagram outlines the evaluation framework used for the SHSS Review.

SHSS Review Evaluation Framework



The evaluation framework shaped the structure of consultations during all phases of the Review. Findings and insights gained during Phase 2 consultations validated the evaluation framework, and informed the subsequent phases of the SHSS Review. This validated framework then formed the structure of the interviews, focus groups and site visits that were conducted during the Phase 3 field consultations. The framework also served as the foundation for the questions developed for a province-wide survey that was conducted during in the April-May period of Phase 3.

2.3. Highlights of the Review Approach

The remainder of this section details the activities of each phase of the SHSS Review that were conducted to meet the Review's identified objectives.

2.3.1. Provincial Stakeholder Insights and External Scan

To provide early insights into the SHSS program, a series of preliminary consultations with provincial stakeholders and an external scan of leading practices for SHSS were conducted. These activities helped to refine the evaluation framework defined above, and served to form a preliminary baseline on the SHSS program regarding strengths, weaknesses and opportunities across the three evaluation themes of Access and Equity, Coordination and Quality.

Preliminary Consultations

A number of interviews and focus groups were conducted with representation from the three Ministries, CCACs, CTCs, Public Health, associations, networks, community representatives, providers and LHIN teams. Consultations were structured around the evaluation framework. A full list of the organizations that participated as part of the consultations is provided below and on the following page.

- Alliance of Professional Associations for Community-Based Therapy Services
- CanChild Centre for Disability Research
- Children's Treatment Network of Simcoe-York
- Early Learning and Childhood Development Branch, MCYS
- Hospital for Sick Children
- Local Health Integration Network Collaborative
- McMaster Children's Hospital (Pediatric Orthopedic Surgeon)
- Minister of Education's Advisory Council on Special Education (MACSE)
- Ministry of Children and Youth Services
- Ministry of Education Regional Office Leads
- Ministry of Health and Long-Term Care
- Niagara Peninsula Children's Treatment Centre
- Ontario Alliance of Christian Schools (OACS)
- Ontario Association of Children's Rehabilitation Centres (OACRS)
- Ontario Association of Community Care Access Centres (OACCAC)
- Ontario Association of Speech-Language Pathologists and Audiologists (OSLA)
- Ontario Community Support Association (OCSA)
- Ontario Federation of Independent Schools (OFIS)
- Ontario Home Care Association
- Ontario Physiotherapy Association
- Ontario Society of Occupational Therapists
- Saint Elizabeth Health Care
- Thames Valley Children's Treatment Centre
- University of Toronto, Department of Paediatrics (Clinician-Specialist)

- **Specific Disability/Health Related Organization and Family Associations:** *Autism Ontario, Down Syndrome Association of Ontario, Learning Disabilities of Ontario, Ontario Association for Families of Children with Communication Disorders, Ontario Brain Injury Association, Toronto Family Network, Tourette Syndrome Association of Ontario*

- **Pre-school service providers:** *Brant Preschool Speech and Language ("Talking Tots"), Durham Preschool Speech and Language (Grandview Children's Centre), Kent Preschool Speech and Language, Lambton Preschool Language ("SoundStart"), Niagara Pre-School Language, One Kids Place, Thames Valley Preschool Speech and Language, Waterloo Pre-School Language*

As a follow-up to these consultations, the following organization provided submissions a written account of their perspectives on the SHSS in relation to the three evaluation themes:

- Down Syndrome Association of Ontario
- Ontario Alliance of Christian Schools
- Ontario Association of Children's Rehabilitation Centres
- Ontario Association of Community Care Access Centres
- Ontario Home Care Association
- Ontario Public School Boards' Association
- Ontario Secondary School Teacher's Federation
- Windsor Regional District School Board

External Scan

Early in the planning for the SHSS Review, it was deemed critical to establish a solid base of evidence and knowledge of leading practices against which current service delivery in organizations across the province could be compared throughout the Review. To address this need, a global literature search and consultations with academic field experts were conducted to gain insights on leading practice in delivery and organization of SHSS for students and their families. The external scan focused on both challenges and leading practices identified through a literature review and consultations with academic field experts (e.g. CanChild Centre for Disability Research). Further details regarding the external scan are contained in the Technical Appendix and a Bibliography is provided in Appendix A.

The findings of the external scan are organized based on the preliminary evaluation framework for the SHSS Review, specifically related to the evaluation goals and objectives across the three themes of Access and Equity, Coordination and Quality. Important to note is that the breadth, depth and type of information available in the literature varied due to the different levels of research and publication conducted across the different SHSS areas. As a result, the information gathered through the external scan was not consistently robust across the three evaluation themes. Given the limited research targeted directly towards SHSS, research related to pediatric rehabilitation outside the school environment was also included to provide additional insights where relevant.

From the insights gathered through the external scan, a number of leading practice service delivery models and practices were identified. These leading practices were referenced throughout the field consultations described in the following section, and are highlighted in the findings and recommendations sections of this report.

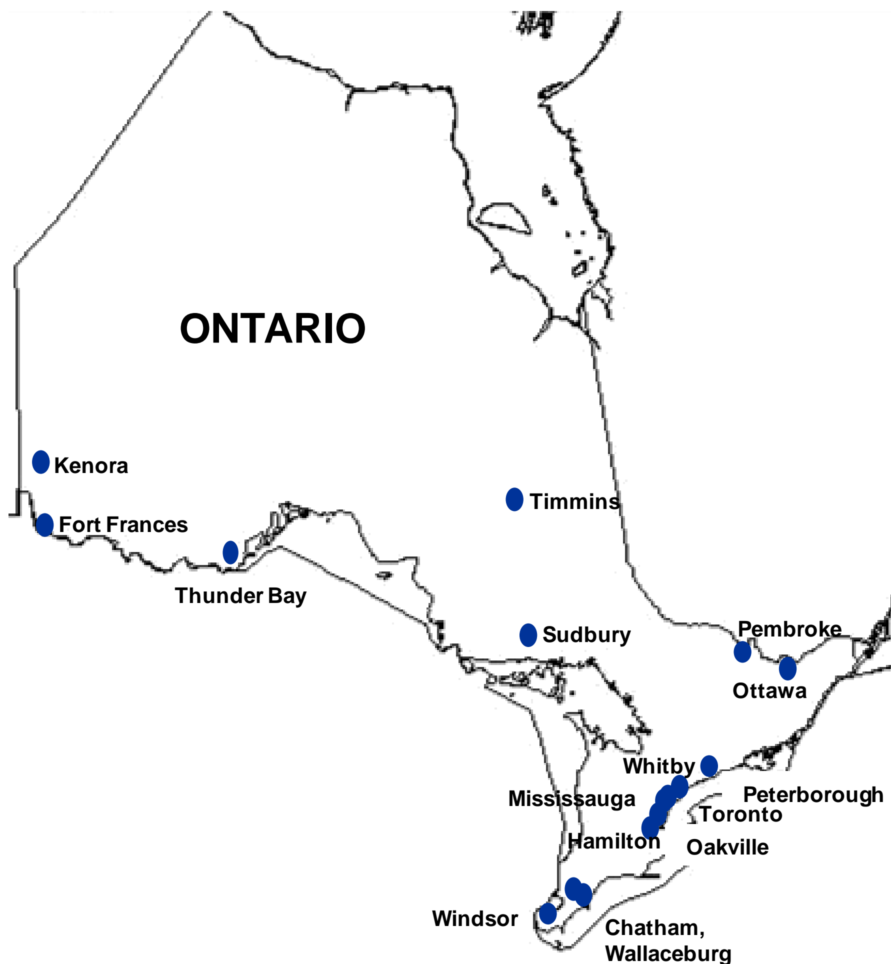
2.3.2. Local Area Field Consultations

Building on the preliminary insights gathered through the provincial stakeholder consultations and external scan, local area field consultations were conducted in eight geographic areas across the province. In the field consultations, the Review team conducted in-depth consultations and assessment with local CCACs, service providers, educators, CTCs, broader children's services and families.

It was determined early in the Review that it would not be possible to visit all areas and communities across the province. As a result, the eight areas selected for the field consultations were determined by the Tri-Ministry team, informed by a number of project planning discussions with the full Review team, and guided by the following factors designed so that the Review was able to effectively gain an overall provincial perspective of the SHSS program:

- Demographic composition and distribution of school-aged population
- Urban/rural geography and distribution across the province
- Availability of services and service delivery models
- Awareness of issues related to the program

A map of the communities within Ontario in which the local field consultations were conducted is presented below.



An overview of the organizations and groups consulted with in each of the eight local areas reviewed is provided in the table on the following page.

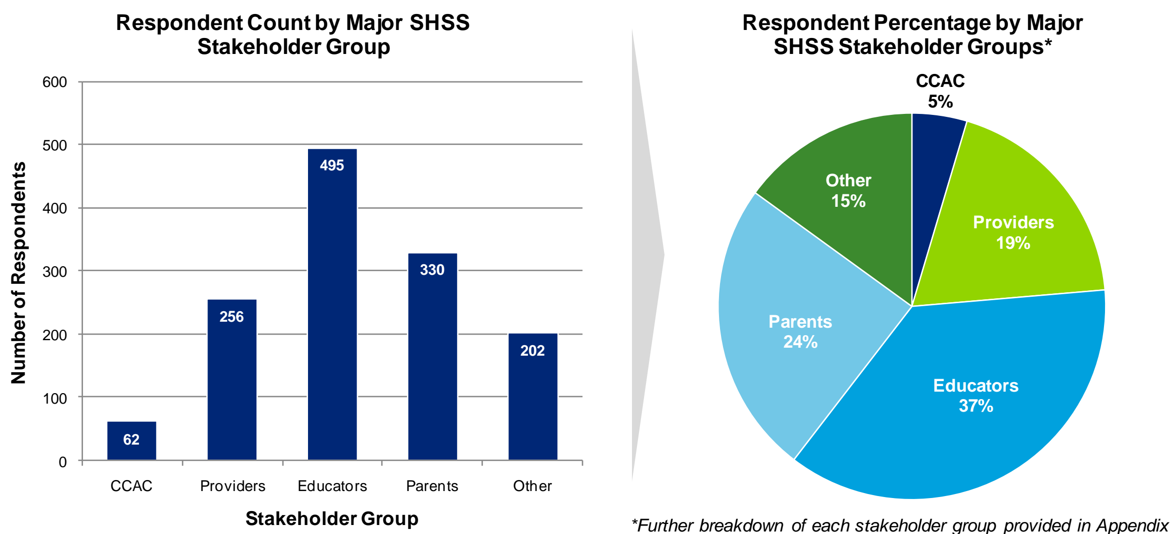
Areas Reviewed	Communities	Site Consultations
Central East	Whitby, Peterborough	• Families • Central East CCAC and Providers • Educators: Durham DSB, Kawartha Pine Ridge DSB, Peterborough Victoria Northumberland and Clarington Catholic DSB, Private Schools, • CTCs: Five Counties Children's Centre, Grandview
East	Ottawa, Pembroke	• Families • Champlain CCAC and Providers • Educators: Renfrew County DSB, Ottawa Catholic DSB, Conseil scolaire de district de l'Est de l'Ontario, Private Schools • CTCs: Ottawa CTC
Hamilton	Hamilton	• Families • Hamilton Niagara Haldimand Brant CCAC and Providers • Educators: Hamilton Wentworth DSB, Private Schools • CTCs: Hamilton Health Sciences Centre CTC
Mississauga Halton	Mississauga, Oakville	• Families • Mississauga Halton CCAC and Providers • Educators: Halton DSB, Dufferin-Peel Catholic DSB, Private Schools • CTCs: ErinoakKids
North East	Sudbury, Timmins	• Families • North East CCAC and Providers • Educators: Ontario North East DSB, Sudbury Catholic DSB, Conseil scolaire de district catholique du Nouvel-Ontario, Private Schools • CTCs: Sudbury Regional Hospital CTC, One Kid's Place CTC
North West	Thunder Bay, Fort Frances, Kenora	• Families • North West CCAC and Providers • Educators: Rainy River DSB, Thunder Bay Catholic DSB, Kenora Catholic DSB, Private Schools • CTCs: George Jeffrey CTC
Toronto	Toronto	• Families • Toronto Central CCAC and Providers • Educators: Toronto DSB, Toronto Catholic DSB, Conseil scolaire de district catholique Centre-Sud, Private Schools • CTCs: Bloorview Kids Rehab
West	Chatham, Wallaceburg, Windsor	• Families • Erie St. Clair CCAC and Providers • Educators: Lambton Kent DSB, Windsor-Essex Catholic DSB, St. Clair Catholic DSB, Private Schools • CTCs: Children's Treatment Centre of Chatham-Kent, John McGivney Children's Centre, Pathways CTC

2.3.3. Province-Wide Survey

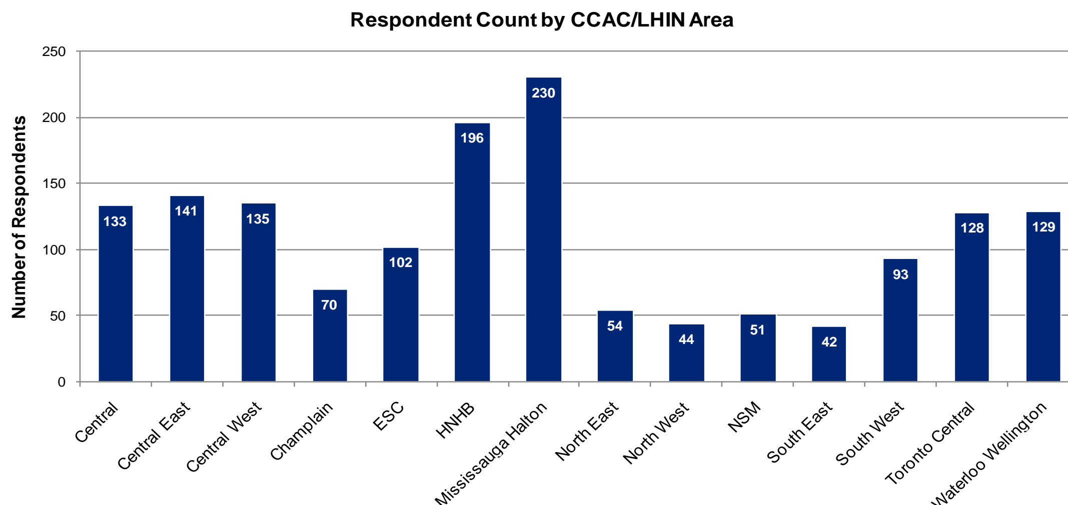
As part of the SHSS Review, a province-wide survey of over 60 questions was conducted to gather additional stakeholder input from the broad set of SHSS stakeholders across the health, education, children and youth services sectors, and from parents and families. This survey was offered in parallel to the provincial stakeholder and local area field consultations described previously, and was open to all Ontarians. The survey was primarily conducted online, in both English and French; however, only 1% of respondents accessed the French survey. To enhance access to the survey, paper copies were also made available but no requests were made for the survey in this form.

The survey was open for input from April 22 to May 24, 2010 and was made available on the MOHLTC's website for the SHSS Review. The survey was also widely distributed through the network of SHSS stakeholders involved in the Review, across health, education, children's services and parent/family organizations.

A total of 1,345 responses were received, across a mix of stakeholder groups and geographies, as depicted in the charts below. Additional details from the findings of the survey are noted throughout the Current State Findings in the next section of this report.



The geographic profile of survey respondents is presented below, organized alphabetically by CCAC geographic region, and demonstrates the broad geographic distribution of responses received for the survey. A description of the communities within each CCAC/LHIN Area is provided in the Appendix B.



3. Program Profile

3.1. Introduction

At the start of the Review, an initial program profile was developed to provide insight into the current state of the population, services and financial position of the SHSS program. This profile was enhanced throughout the Review, and a summary is presented below to provide a general orientation to the SHSS program. Information presented was collected through three primary sources:

- Ontario Association of Community Care Access Centres
- Ministry of Health and Long-Term Care
- CCACs involved in the eight local area field consultations of the Review

In reviewing this summary program profile, the following characteristics about the available program data are important to understand:

- Key SHSS indicators are tracked primarily through the CCACs, as procured service providers report relevant information as part of their contract requirement.
- In addition, referrals to the SHSS program from educators and other stakeholders are tracked through the same database.
- While high-level data can be analyzed, the organization alignment efforts underway across all CCACs revealed that historical data tracking differs across the previous sites, and a true reflection of SHSS activity can only be obtained for the most recent fiscal years (2007/08 to 2009/10).

As a result, limited historical comparisons before 2007/08 can be conducted across the province relative to utilization, program and individual outcomes, and comprehensive service demand by children.

This program profile presents the information available for the SHSS program, focusing on four key areas:

- Population served by the SHSS program
- SHSS service volumes and individuals served
- SHSS wait times
- SHSS program expenditures

3.2. Population Served by SHSS

Based on its mandate, the SHSS program primarily serves children and youths 19 years of age and below. The less than 19 years population represents approximately 24.5% of the provincial population (3,136,031), ranging from 22% to 26% in each CCAC area across the province. On average, 2.1% of this less than 19 years population (65,473) accessed SHSS across Ontario.

The table below presents the population and proportion served by the SHSS program by each of the CCAC/LHIN areas.

CCAC / LHIN	Total Population	≤19 years of Total Population	% of ≤19 years population receiving SHSS
Central	1,640,512	24.3%	1.5%
Central East	1,494,364	23.9%	2.4%
Central West	779,481	26.4%	2.3%
Champlain	1,193,083	23.6%	2.1%
Erie St. Clair	645,636	24.6%	1.8%
Hamilton Niagara Haldimand Brant	1,376,923	23.9%	2.3%
Mississauga Halton	1,140,162	26.5%	2.0%
North East	565,736	22.6%	1.5%
North West	235,329	25.3%	7.1%
North Simcoe Muskoka	431,214	24.7%	1.9%
South East	482,940	22.4%	2.9%
South West	936,578	24.3%	2.6%
Toronto Central	1,168,185	22.0%	1.3%
Waterloo Wellington	713,718	25.3%	1.8%
Ontario	**12,803,861**	**24.5%**	**2.1%**

Source: Statistics Canada, 2006 Census projections and OACCAC 2008/09 data

The table above illustrates wide variation across the CCACs/LHINs with regards to the proportion of services delivered to the school-aged population. For example:

- Areas such as the Central East and Hamilton Niagara Haldimand Brant LHINs are below the provincial average with regards to the proportion of children and youth relative to their total population (both 24%), yet their CCACs service a higher proportion of the population with SHSS relative to other areas (2.4% and 2.3%, respectively).
- Conversely, the Mississauga Halton LHIN has the largest proportion of individuals less than 19 years of age in their catchment area (26%), but the CCAC is below the provincial proportional average in providing SHSS to this population (2%).

These variations in population served present a current state snapshot within each CCAC area, but do not give insight into the appropriateness of population served relative to service demand.

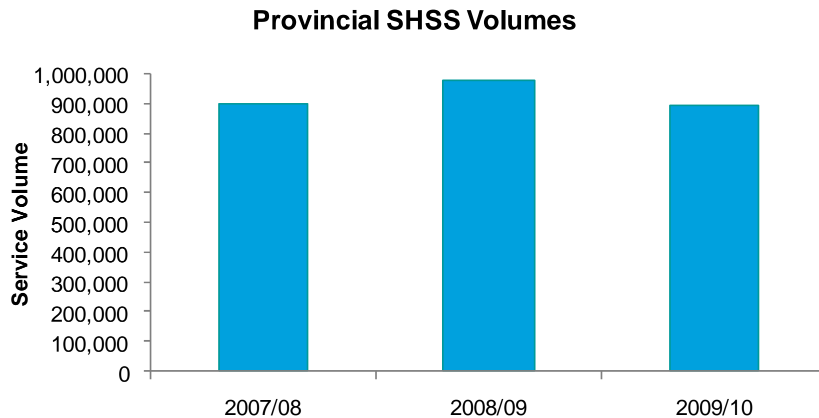
Overall, children and youth receiving SHSS across the province represent a relatively small proportion of the population (2.1%). Further, population projections anticipate that the population aged 19 years or less is declining in Ontario, which is aligned with declining enrollment in schools, suggesting the need for a more comprehensive understanding of changing population demand for SHSS. A full understanding of service demand and effective forecasting is needed to better assess the extent to which the SHSS program is meeting Ontario's changing children and youth population.

3.3. SHSS Service Volumes and Individuals Served

In 2008/09, the SHSS program delivered close to 1,000,000 units of service across the province. According to 2008/09 data, the vast majority of service volumes are delivered in the public school setting (97%), while the remaining proportion of services are delivery in private school or home school settings.

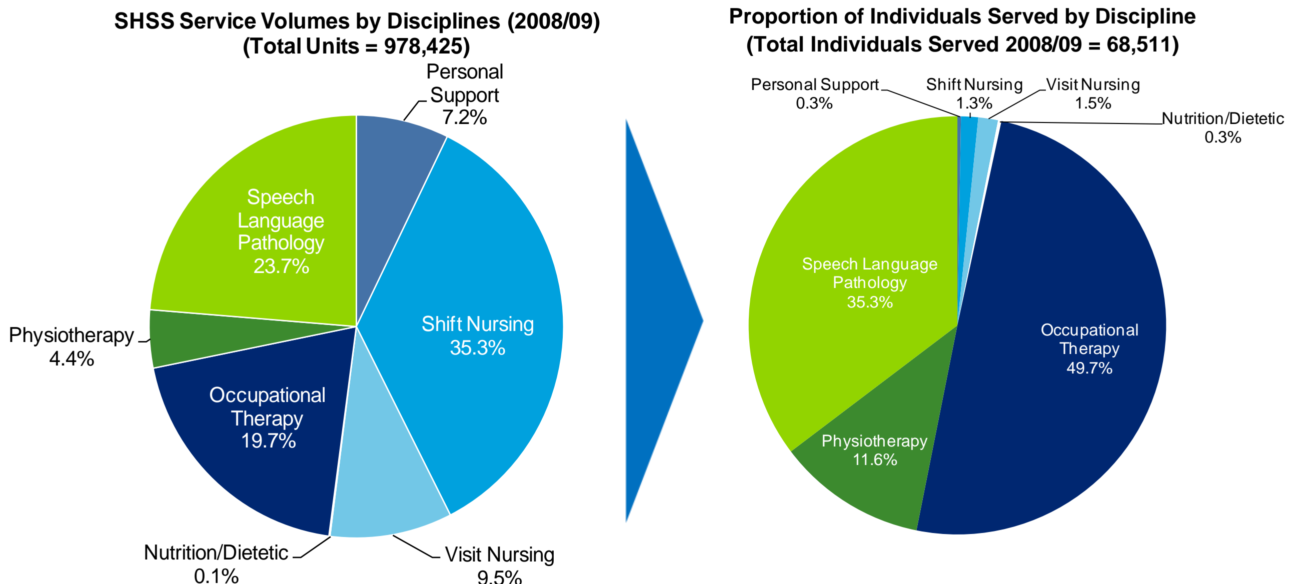
Overall Service Volumes

From 2007/08 to 2008/09, SHSS volumes increased by 9%, however service volumes in 2009/10 decreased back to 2007/08 levels, as presented in the chart below.



Source Data: OACCAC
FY2009/10 volumes have been projected based on data trend and do not represent actual volumes. With migration to CHRIS, the CCACs have noted potential data quality issues exist with the data trends.

Over this 2007/08 to 2009/10 period, the proportion of service volumes delivered and individuals served by professional discipline were both relatively constant. As presented in the charts below, nursing represents the largest volume of services by discipline (45%), however represents only a small % of individuals served by the SHSS program (<3%). In contrast, occupational therapy serves the greatest proportion of SHSS clients (~50%), yet only represents 20% of total SHSS volumes. For greater data accuracy, the charts below present 2008/09 data as it represents a full-year of data, as opposed to 2009/10 in which data was only available for the first three quarters at the time of this report.

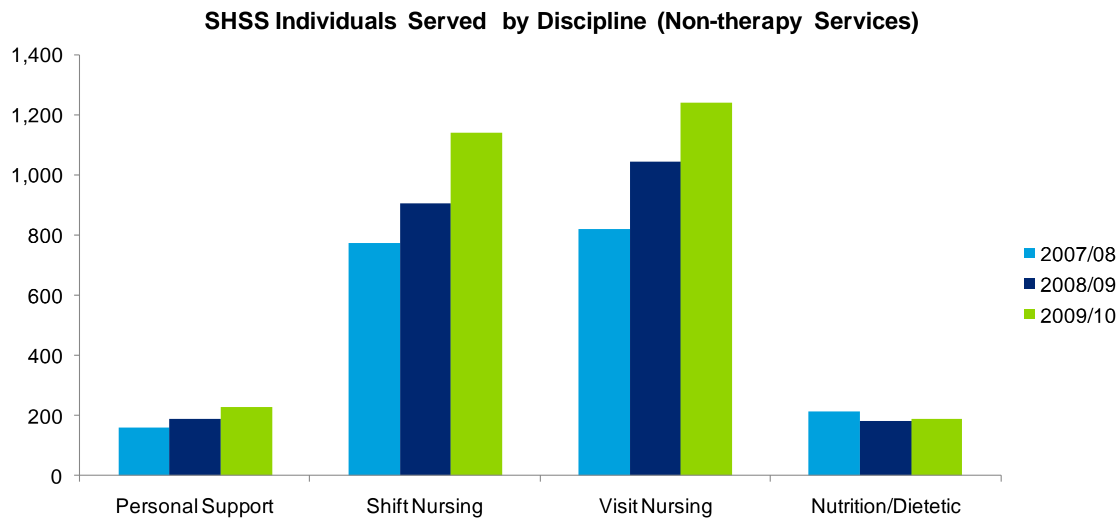


Source Data: OACCAC, 2008/09

Understanding the Individuals Served by the SHSS Program

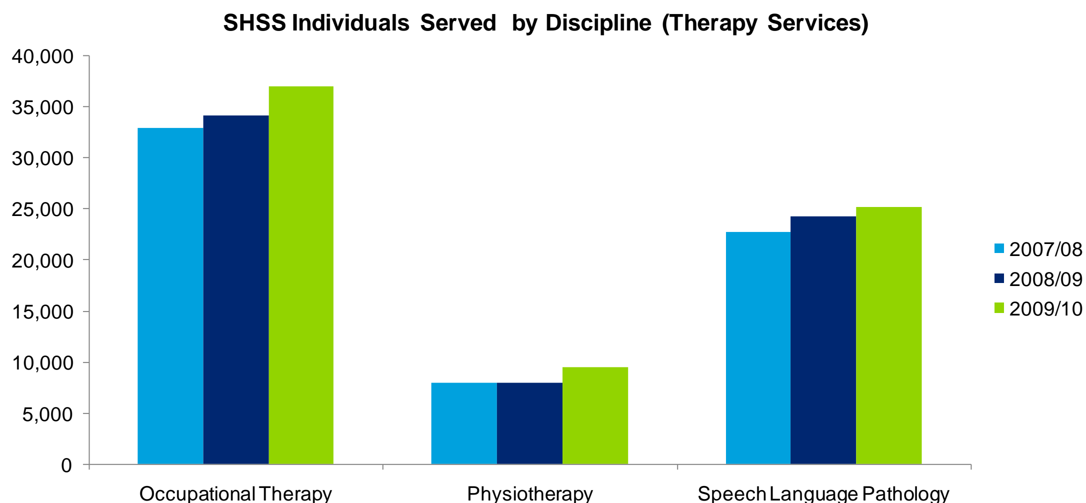
From 2007/08 to 2009/10 (as projected based on volumes for the first three quarters of the year), the increase in the number of individuals served by SHSS across all disciplines is 12%.

Although a relatively small volume of individuals receive personal support and nursing services, these services had the highest increases in the number of individuals served during the same time period (42% for Personal Support, 47% for Shift Nursing, and 51% for Visit Nursing). Nutrition/Dietetics was the only SHSS discipline that had a decrease in the number of individuals served (12% decrease). These trends are presented in the figure below.



Source Data: OACCAC.
FY2009/10 volumes have been projected based on data trend and do not represent actual volumes. With migration to CHRIS, the CCACs have noted potential data quality issues exist with the data trends.

The therapy services had higher numbers of individuals served over the three years, presented at a comparable scale in a separate chart below. Although these disciplines had a smaller percentage increase of individuals receiving services than the other disciplines, these increases constituted a larger total number of individuals. From 2007/08 to 2009/10, the increases in the number of individuals receiving Occupational Therapy, Physiotherapy, and Speech Language Pathology services were 12%, 19% and 11%, respectively.



Source Data: OACCAC
FY2009/10 volumes have been projected based on data trend and do not represent actual volumes. With migration to CHRIS, the CCACs have noted potential data quality issues exist with the data trends.

Intensity of Services

As suggested by the differences in total service volumes and number of individuals served by discipline, provincial data suggests that a small number of children receive multiple nursing services over the course of the year, in contrast to a large number of children who receive fewer therapy services over the course of the year. Further analysis of the service volumes per individual receiving SHSS supports this finding, as presented in the table below:

- The intensity of service volumes per individual is much greater for Personal Support and Nursing services than for the therapy services. Personal Support and Nursing services are typically provided to individuals on an ongoing basis, which accounts for the higher volumes per individual.
- Therapy services are typically provided in service blocks for each individual on service. Thus, a finite number of visits are provided to each individual within a year, which accounts for the low volumes of service per individual.

Service Discipline (units)	Units of Service per Individual Served (2008/09)
Personal Support (hours)	373
Shift Nursing (hours)	381
Visit Nursing (visits)	89
Nutrition/Dietetic (visits)	4
Occupational Therapy (visits)	6
Physiotherapy (visits)	5
Speech Language Pathology (visits)	10

Source Data: OACCAC

Note: the units of service volume for Personal Support and Shift Nursing are hours, while for all other services the units are by visits. From consultations, a visit was estimated to average an hour in length. With this assumption, the data presented above are comparable across the service disciplines as an indicator of the units of service per individual served.

What is not known from the analysis above is the number of children with complex needs who may be receiving both nursing and therapy services, or who are receiving multiple therapies. At a provincial level, data is not collected to support this further analysis, nor is it consistently tracked across CCACs.

Data collected from the field consultations in Phase 3, however, does provide some additional insight. Across the eight CCACs involved in field consultations, five track individuals receiving multiple or single services from the SHSS program. From this field-level data, it is observed that the majority of students in receiving SHSS are receiving a single service, as presented in the table below

CCAC	Approximate Percentage of Individuals Receiving Single Services from the SHSS Program
Champlain	75%
Hamilton Niagara Haldimand Brant	90%
Mississauga Halton	80%
North West	85%
Toronto Central	90%

Source Data: Gathered from the databases of each individual CCAC

Across the five CCACs included in the table above, a total of 84% of children served by the local area SHSS programs are receiving a single service, and 16% are receiving multiple services. The sample of CCACs above represents approximately 36% of the individuals that receive SHSS across the province, and suggests that the majority of individuals served by the SHSS program are receiving a single service.

As the indicator of how many and what type of services are being received by each individual is not consistently tracked at the provincial or local levels, an exact number or set of conclusions cannot be reached from this high-level data. When combined with earlier findings, including data indicating that the majority of individuals served by SHSS are receiving therapy services (96%), however, the following likely characteristics of individuals served by the SHSS program can be surmised:

- The majority of services delivered through SHSS are for children receiving single therapy services. Based on the sample above, it is estimated that 80% of children receiving SHSS across the province are receiving single therapy services. This estimation is aligned with findings by the OACCAC in its submission for the SHSS Review, which identified that this group of children represents 70 to 80% of the SHSS population served through CCACs.
- For the 16% of children who receive more than one service, it is likely that many receive more than one therapy service, and that many who receive nursing services also receive therapy service.

It is important to note that these summary characteristics are based on the current services delivered to individuals by the SHSS program, and do not necessarily represent the full set of services needed by individuals. Further investigation and data collection will be required by the SHSS program at the provincial and local levels to fully assess the characteristics of individuals being served by the program.

3.4. SHSS Wait Times

The SHSS program tracks the number of individuals waiting for the program across the province, but the wait time for each individual to receive service is available at the local level only. As a result, this program profile presents a summary of SHSS wait times for the eight local areas involved in the Phase 3 field consultations, and then separately presents province-wide data on the number of individuals waiting for service. A comparison between the wait times of public and private school students is also presented.

Program Wait Times

At the local level, CCACs collect and report on wait times using different approaches, for example:

- By professional discipline
- By functional need or diagnosis
- By school type
- Wait time between referral and assessment
- Wait time between assessment and first service
- Number of clients waiting for service

Across the CCACs involved in the Phase 3 local area field consultations, the following was observed:

- Children with complex multiple service needs typically have no or short wait lists
- Private school students typically have no wait or shorter waits for service
- The wait time between referral and assessment ranges from 30 – 90 days across the CCACs

The range of wait times from assessment to first service by service discipline varied significantly across the eight CCACs that participated in the local area field consultations, a summary of which is presented in the table on the following page.

Discipline	Approximate Range in SHSS Wait Time Across Local Area CCACs
Nursing	0 – 60 days
Occupational Therapy	30 – 350 days
Speech Language Pathology	40 – 500 days
Physiotherapy	15 – 650 days

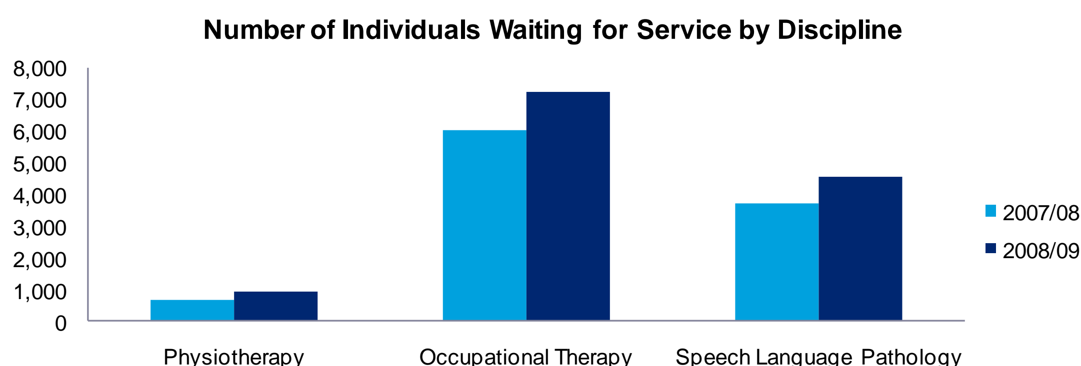
Source Data: Gathered from the databases of each individual CCAC

Number of Individuals Waiting for Service

From 2007/08 to 2008/09, the number of individuals waiting for SHSS in the province increased across the therapy services, as noted in the chart below. This increase in the therapy waitlist is aligned with a corresponding increase in therapy wait times.

The number of individuals waiting for nursing and nutrition services was less than 100 across Ontario in both 2007/08 and 2008/09, reflecting quick service for individuals requiring nursing services, which was consistent with stakeholder reports across the Phase 2 and Phase 3 field consultations. Because the number of individuals waiting for nursing and nutrition services is low, they are not presented in the chart below.

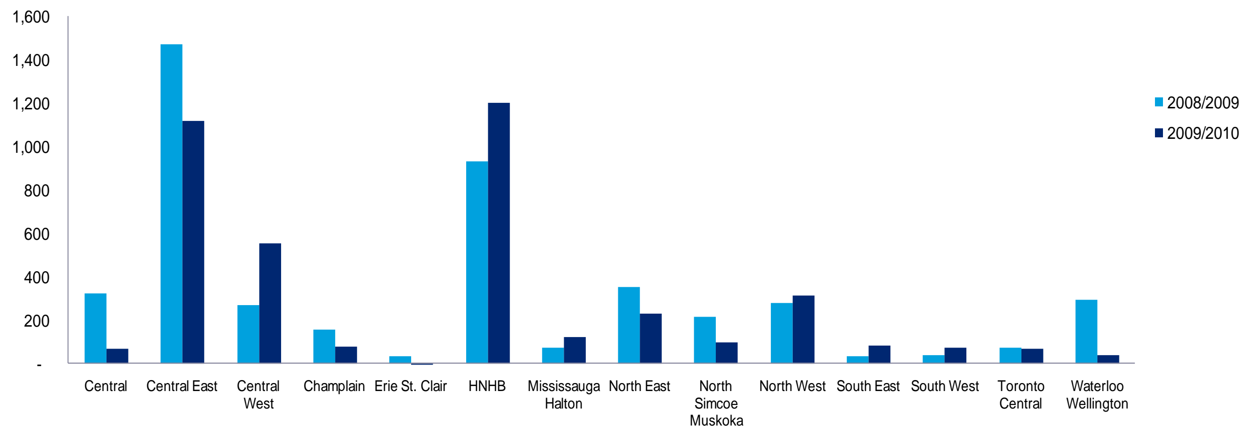
Number of Individuals Waiting for Service by Discipline



Source: Final 2008/09 Comparative Reports and extraction from the Ontario Healthcare Financial and Statistical database (OHFS)

Note: the data system that provides the information charted above collects the number of individuals waiting for each specific service at year-end, but does not collect the number of discrete students waiting for school services. The number of individuals waiting for each service cannot be totalled and/or interpreted as a total number of individuals waiting for service since individuals may be waiting for more than one service. Furthermore, because the data is taken at a point-in-time at year-end, the tally of individuals waiting for services over the course of the year is not represented in this data.

Additional provincial data is captured to track the number of clients waiting for speech language pathology services across the CCACs, through which full-year data for 2009/10 was available for the Review. In contrast to the trend between 2007/08 to 2008/09, a decrease in the number of children waiting for speech language pathology services is observed in 2009/10. Across the province there was an 11% decrease in the number of individuals waiting for these services from 2008/09 to 2009/10. The total number of individuals waiting for these services in 2009/10 (4,066) is, however, still 9% higher than 2007/08 levels (3,715). A comparison between 2008/09 and 2009/10 by CCAC area is presented on the following page.



Source: Final 2008/09 and 2009/10 Comparative Reports and extraction from the Ontario Healthcare Financial and Statistical database (OHFS)

Note: the data system that provides the information charted above, and in the table below, collects the number of individuals waiting for each specific service at year-end, but does not collect the number of discrete students waiting for school services. The number of individuals waiting for each service cannot be totalled and/or interpreted as a total number of individuals waiting for service since individuals may be waiting for more than one service. Furthermore, because the data is taken at a point-in-time at year-end, the tally of individuals waiting for services over the course of the year is not represented in this data.

Comparing Public and Private School Wait Times

Given the different funding available for children requiring SHSS who attend private and public schools, a further comparison of the wait times and number of individuals waiting for service was conducted. Public schools are considered to be all public and catholic schools, both English and French, for the purpose of this comparison. It is important to note that students attending private schools or who are home schooled represent approximately 6% of the total student population in Ontario, based on published data from the Ministry of Education, OFIS and OACS.

The table below presents the wait time data for 2008/09 for private schools and public schools. Based on the data below, the proportion of private (4.2%) and public school (95.8%) students waiting for SHSS are relatively aligned with their respective proportions in the total provincial student, explaining in part the lower number of private school students waiting for service. By comparison, private school students typically have shorter wait times for service than public school students, across all disciplines.

Service Type by Discipline	Individuals waiting for service (2008/09)		Average number of days waited for initiation of service (2008/09)	
	Private	Public	Private	Public
Visiting Nursing	0	46	26	70
Shift Nursing	0	11	8	83
Nutrition/Dietetic	0	13	0	72
Physiotherapy	46	870	110	219
Occupational Therapy	268	6,933	42	151
Speech Language Pathology	224	4,329	31	121
Personal Services (private/home only)	3	Not Applicable	217	Not Applicable

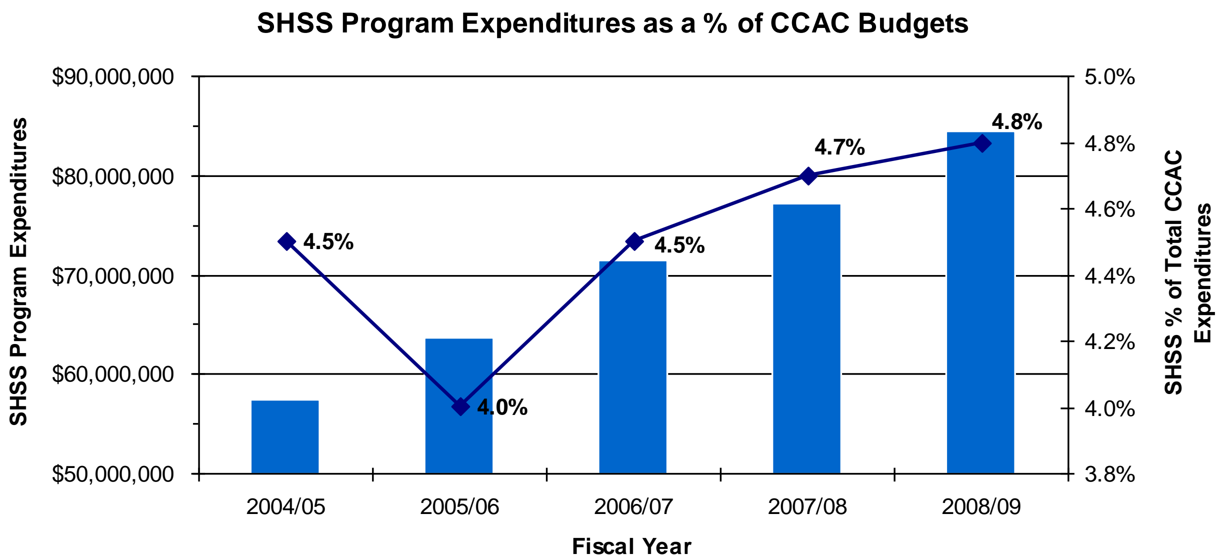
Source: Final 2008/09 Comparative Reports and extraction from the Ontario Healthcare Financial and Statistical database (OHFS)

3.5. SHSS Expenditures

The majority of the SHSS program is funded through the base operating budget of the CCACs, with no dedicated funding envelope, however expenditures are tracked separately. As discussed further below, dedicated funding does exist for children attending private schools who require SHSS.

Overall Program Expenditures

At the time of the Review's analysis, 2009/10 financial data was not yet available due to the timing of the fiscal year, and so analysis of 2008/09 financial data was conducted. Program expenditures for SHSS in 2008/09 were approximately $84M, from a total budget for all CCAC services for all ages of $1.761B (4.8%). This compares with SHSS expenditures of $77M in 2007/08, from a total budget for all CCAC services for all ages of $1.629B (4.7%). This slight increase in budget between years is indicative of a trend of increases over the previous years, as shown in the chart below.



Source: OHFS database for 2004/05, 2005/06, 2006/07, 2007/08 and 2008/09.

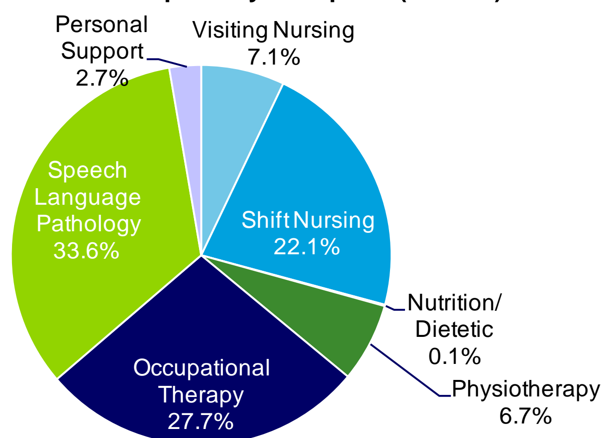
Stakeholders report budget reductions to the SHSS program in 2009/10, however, which aligns with a shift to lower service volumes presented earlier. As a result, it is anticipated that the 2009/10 spending on the SHSS program will be lower relative to the 2008/09 year, reversing previously observed trends.

Program Expenditures by Discipline

In examining SHSS expenditures for 2008/09 with respect to the services provided, Speech Language Pathology, Nursing and Occupational Therapy are noted to be the largest areas of SHSS program spending. Physiotherapy, Nutrition/Dietetics, and Personal Support constitute the lowest proportion of expenditures. These spending patterns align with the service volumes proportions across the disciplines presented earlier.

SHSS program expenditures by discipline for 2008/09 are presented in the chart on the following page.

Proportion of SHSS Spend by Discipline (2008/09)



Source: Final 2008/09 Comparative Reports and extraction from the Ontario Healthcare Financial and Statistical database (OHFS)

SHSS Expenditures across Public and Private School Settings

As demonstrated in the following table, SHSS expenditures are distributed across public and private/home school students. Although the MOHLTC does not provide a discrete funding envelope for SHSS, there is dedicated funding for the provision of SHSS for children attending private schools or receiving home schooling. Currently, the SHSS program spends approximately $6.0M, excluding overhead expenses, to serve students attending private schools or receiving home schooling. Additional funding is available to address the needs of new or existing students attending private schools or receiving home schooling who require SHSS.

The proportion of public (92.5%) versus private/home school (7.5%) spending on SHSS is relatively aligned with the proportion of public versus private/home school students in the province; however due to a lack of data in the SHSS program, an assessment of the alignment of SHSS needs of students in the different school settings to proportional spending is not available.

Service type	Direct Client Service Expenses ($) 2008/09			Estimated Overhead expenses ($) 2008/09	Total direct client and overhead expenses ($) 2008/09
	Private/ Home school	Public school	Total		
Visiting Nursing	$111,916	$5,293,309	$5,405,225	$554,668	$5,959,893
Shift Nursing	$217,995	$16,665,552	$16,883,547	$1,678,137	$18,561,684
Nutrition/Dietetic	$226	$88,686	$88,912	$8,449	$97,361
Physiotherapy	$164,167	$4,915,782	$5,079,949	$547,758	$5,627,707
Occupational Therapy	$1,377,129	$19,693,721	$21,070,850	$2,211,819	$23,282,669
Speech Language Pathology	$1,765,291	$23,778,656	$25,543,947	$2,678,526	$28,222,473
Personal Support	$2,068,147	$0	$2,068,147	$198,986	$2,267,133
Total	**$5,704,871**	**$70,435,706**	**$76,140,577**	**$7,878,343**	**$84,018,920**

Source: Final 2008/09 Comparative Reports and extraction from the Ontario Healthcare Financial and Statistical database (OHFS)

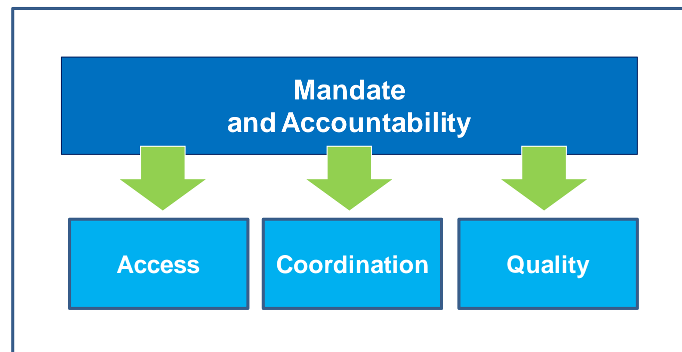
4. Introduction to Findings and Recommendations

Building on the methodology outlined for the Review, the following four key inputs form the basis of the current state findings and recommendations for the SHSS program:

- SHSS program profile trends
- Provincial and local area consultations
- Province-wide stakeholder survey
- Leading practices emerging from the global external scan and local area practices

The Review's evaluation framework, described in Section 2.2 of this report, is used to summarize the findings and recommendations from these inputs across the Review's three core evaluation themes of Access and Equity, Coordination and Quality.

In addition to these evaluation themes, stakeholder consultations clearly highlighted the need for improved clarity of the SHSS program's overarching mandate, scope and accountability, and the negative impact that the current lack of clarity has on Access and Equity, Coordination and Quality in the program. As a result, the findings and recommendations presented for the SHSS Review have been expanded to include Mandate and Accountability as a fourth area of reporting:



For each area of reporting, findings and recommendations are reported in the following structure:

- **Strengths** – Present positive findings that align with the respective evaluation goals and objectives
- **Challenges** – Present areas where the SHSS program does not fully meet the goals or objectives articulated in the Review's evaluation framework, suggesting opportunities for improvement
- **Field and Research-based Leading Practices** – Present relevant leading practices from the various communities across the province and evidence-based research that align with the respective areas of focus. These leading practices offer insights that assist in shaping the Review's recommendations to enhance the SHSS program overall.
- **Recommendations and Outcomes** - Present the recommendations to improve the SHSS program across the province, and proposed outcomes that are envisioned if the recommendations are implemented.

The findings and recommendations for the SHSS Review are presented in the following sections of the report, in the order of Mandate and Accountability, Access and Equity, Coordination and Quality. A summary of the SHSS program recommendations and proposed outcomes is also summarized in the Moving Forward section of the report.

5. Mandate and Accountability

The profiles of children attending school have changed over the years since the inception of the SHSS program in 1984. Emerging health trends and the growing complexity of their health support needs result in increasing service demands to support children in the classroom. It is important for a program mandate to evolve in parallel to meet these health support demands as well as to avoid the emergence of differing interpretations of the mandate. Having a consistent understanding of the program mandate will help to establish the roles and responsibilities of all stakeholders involved in the delivery of SHSS.

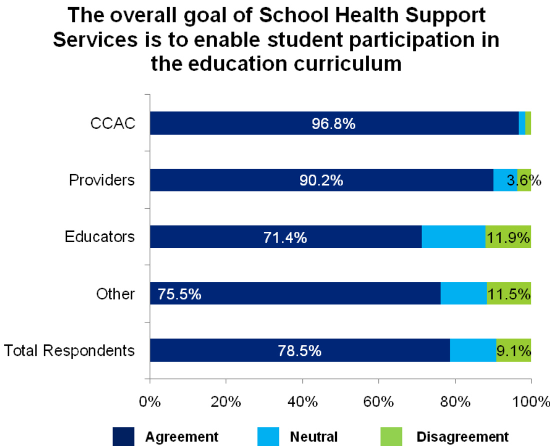
5.1. Current State Findings

5.1.1. Strengths

Overall Positive Outcomes

There is a broad consensus among different stakeholders across the province that the SHSS program is a beneficial support service delivered to children. It is perceived that most children receiving these support services make progress in achieving their individual goals, and that the program assists in increasing access to education - physically, socially, or mentally.

According to the province-wide survey results, illustrated on the right, there was consistent agreement across the stakeholder groups that the overall goal of SHSS is to enable student participation in the education curriculum. Overall, 79% of respondents indicated agreement that this was the goal of SHSS. In the CCAC and provider groups, a higher proportion of respondents indicated agreement compared to the other groups, respectively 97% and 90%.



Specialized Resources

Across the local areas engaged in the Review, the presence of specialized service providers involved in delivering the program was consistently identified. Stakeholders confirm that these providers possess specialized expertise to support the rehabilitation needs of children, and that the use of these resources for SHSS promotes the achievement of holistic goals that guide children's overall development.

5.1.2. Challenges

Varied Interpretation of the SHSS Program Mandate

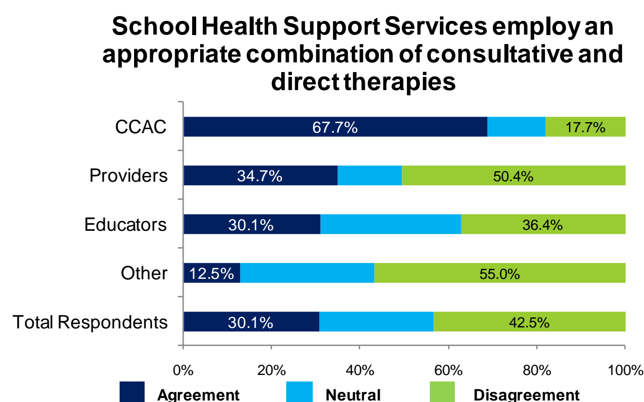
The alignment of the CCACs with the LHIN boundaries has resulted in efforts towards standardization, but there is variation in interpreting the SHSS program mandate, objectives and associated goals. Differing philosophies exist among stakeholders on the supports that are required for children to participate in the education curriculum, ranging from finite, concrete health goals to the facilitation of a child's developmental goals across life stages. Further, different interpretations exist among stakeholders about the extent of participation or engagement in the education curriculum intended by the SHSS program.

Examples of stakeholder perceptions of the mandate are included in the table on the following page.

Perceptions of Mandate	Implications
Enabling children to have access to the school curriculum	Perspectives vary from only facilitating the student's physical presence in the classroom, to enabling a student's ability to fully participate in all education activities to the same degree as peers
Enable integration for all children in daily school life, regardless of mental or physical challenges/disabilities	A proportion of stakeholders perceive a student has the right to the necessary supports to participate in school environment of choice, regardless of his/her student's challenges or disabilities,
Optimize children's educational experience	SHSS includes supporting children beyond their current physical needs, but extends to their overall developmental needs
Promote independence and support children to participate in all social and daily living aspects to fulfill the role of a student	School curriculum scope includes, not only academic subjects but, all aspects of physical and social interaction, such as physical education classes

As a result of various interpretations of the program mandate, variability exists in applying SHSS eligibility criteria across children's cases, which may lead to inequity across populations. Stakeholder consultations across sectors reiterated the different interpretations of the SHSS program mandate. Moreover, the program's philosophy of defining the scope of children's health support needs in school is driving a large proportion of the variability in access to the program across the province.

An example of varied interpretations of the program mandate is the use of consultative and direct therapy. According to the survey results, depicted in the graph on the right, there is varied agreement that SHSS employs an appropriate combination of consultative and direct therapies across the stakeholder groups. The CCAC respondents had the highest proportion of respondents indicating agreement that the combination of the two approaches is appropriate (68%). All other stakeholder groups had lower proportions of respondents indicating agreement (less than 35%). During field consultations, it became evident in some local areas that there was a divide among stakeholder groups on the appropriate balance of delivering service through consultative and direct approaches. Many educators and parents felt that direct service should be delivered through the program. Across the province, CCAC representatives consistently support service delivery models that utilized consultative approaches to treat a child by transferring knowledge to a child's support network.



Variability across and within different stakeholder groups regarding the governing accountability and directives of the SHSS program versus other provincial children's service programs is also evident across Ontario. Representatives from the CCAC, service provider agencies and education work collaboratively in several local areas to refine the SHSS program within the broader community network of children's and health services. However, the majority of areas face regular challenges in reaching consensus on the model that will best deliver the program to meet the needs of children in their local area.

Without a program mandate that is clearly understood by stakeholders, it is difficult to fully define accountability, roles and responsibilities for the SHSS program. Given the varied interpretation of the program mandate, roles and responsibilities of the program vary throughout the province. The overlapping involvement of the various sectors and stakeholders, and different models that have emerged in local areas due to historical relationships, further blur the lines of accountabilities for the SHSS program today.

Varied Interpretation of SHSS Scope of Services

Over the years, the demographic profile of children and youth participating in the classroom environment has evolved. The younger population with chronic conditions now lives longer and can join in more activities with appropriate assistance. Consequently, SHSS have increased in attempt to meet this evolving demand; however many stakeholders feel that the services offered are still insufficient to meet the needs of children enrolled in schools today. Consultations and interviews revealed that students require a number of additional supports to increase their ability to access education, such as:

- Diabetes management
- Sensory support
- Autism and other behavioural conditions
- Mental health
- Transportation to school

At the local level, the SHSS program varies in the extent to which it provides service for these additional services. In some areas, SHSS delivery has informally expanded to include some or all of these services, and to be delivered beyond the school environment. For example, support services are delivered to students during transportation to school. Among the stakeholder groups, there is a lack of clarity on whether these additional supports should be provided through SHSS or other programs.

In many larger communities, these additional support services can be accessed through other programs or third-party providers, however challenges are faced by children seeking these services:

- Third-party providers do not always gain consent to work with children in the school environment given school policy and required capacity to monitor all external individuals that enter school grounds to maintain the safety and security of a school's full student population.
- In addition, these third-party providers do not exist in all rural and remote areas. In these cases, the SHSS program will in some cases assume responsibility for the provision of these types of services to ensure children can be effectively followed.

Additional concerns were raised about SHSS scope with respect to services not being delivered to students attending Section 23 schools. Currently, these students are not eligible for SHSS, which is based on historical policy, in which these students had access to other support services within Section 23 schools. At the time of the program's creation, the SHSS program was perceived to duplicate these services, and so was not offered in Section 23 schools. As the Section 23 model has evolved, some Section 23 students are now reverse-integrated into public school classrooms (i.e. they are in regular public classrooms for part of their day, and in Section 23 classrooms for part of their day), but are still not eligible for SHSS. Further, education stakeholders expressed concern that the support services available in Section 23 schools are limited, noting a need to expand the scope of SHSS to include Section 23 students.

In general, these differences in service scope and limitations contribute to the variation of service models observed in the SHSS program across the province.

Need to Review Governing Legislation, Regulation and Policy

Stakeholder understanding of the broader legislative/regulatory framework governing the SHSS program is varied across the province, with most stakeholders being familiar primarily with the specific policies that support the program. Specifically, stakeholders express concern that existing policies, notably PPM 81, are narrow in scope and perceived to be designed for students with medical needs (e.g. injection of medication, catheterization, stoma care, postural drainage, suctioning and tube feeding), instead of supporting a child's broader health and development needs.

Overall, the majority of stakeholders stated that the current legislation and policies governing SHSS are outdated and do not meet the current needs of students. Because of varied interpretation of the program mandate, different interpretations of existing policies have also occurred, resulting in some local area providing a broader set of services to students than others, as noted above. This results in some program inequity across the province.

Many stakeholders feel that there are a broader set of needs that should be addressed through SHSS to support student access to education. Given existing issues around program interpretation, the evolving education and health environments and student populations, stakeholders state that PPM81 and the broader legislative, regulatory and policy framework for the SHSS program need to be revised to achieve three objectives:

- To provide greater clarity on the program's mandate and accountability for its delivery
- To achieve agreement on the scope of services offered through SHSS and populations that are eligible for service
- To expand the program's scope beyond a medical model to focus more on a child's broader holistic goals

Policies related to the transition between pre-school and school were also noted by stakeholders as requiring further revision, and will be discussed in the Coordination section of this report.

Divide Between Speech and Language Pathology Services

The SHSS mandate is supplemented by the Interministerial Guidelines for the Provision of Speech and Language Services. These guidelines outline the accountabilities of Ontario's ministries of education and health regarding the delivery of these services. Through these guidelines, children requiring SLP services receive language support from the Board SLP, and speech support from the SHSS SLP. This results in fragmented service delivery for the child and family, and stakeholders note challenges in service coordination. Specifically, a number of stakeholders report that the collaboration between the Board and SHSS SLP groups is limited, and that this impacts the coordination of appropriate services for the student who requires both supports.

There is a perception that multiple assessments are conducted and these findings are not shared among the cross-disciplinary team particularly when a student requires speech services in public schools. In general, the Board SLP assesses a child's speech abilities and submits a referral for SHSS to the CCAC. The case managers/care coordinators are still required to interview the child's parents to gain consent and determine eligibility for the program. Upon admission to the program, an SHSS SLP conducts a subsequent assessment, which often includes a similar assessment approach conducted by the Board SLP.

Therapists report that they are required to conduct their own assessments, as bound by their respective regulatory college standards. However, as families and educators are not largely aware of these standards, it is perceived to be a duplication of service, which potentially delays access to receiving health supports in school. While it is necessary to re-assess the needs for service if children have been on the wait list for a period of time, a proportion of stakeholders perceive that SHSS and Board therapists should be in the same circle of care, which would reduce the need for multiple, lengthy assessments.

Throughout the provincial and local area consultations, the majority of stakeholders consistently identified the need to address this divide between speech and language by consolidating the service into a single speech language pathology service for children in schools.

Limited Alignment of SHSS with Health System Priorities and Other Sectors

Consultations at the provincial and local level identified challenges to the SHSS program that occur through the limited alignment between health, education and children and youth sector priorities. In some local areas, there appears to be good collaboration across the sectors, to enable a shared prioritization of services for children and their families; but in many areas this collaborative prioritization is limited.

For example, despite the decreasing population of the demographic under 19 years of age, a number of CCACs have chosen to focus efforts on children's services, as it is recognized that children requiring health supports will impact the health system as adults, if health issues are not supported early. However, the majority of stakeholders report that because the province's health strategy is focused on larger system transformation initiatives, such as reducing emergency room wait times and enabling individuals to age at home, the SHSS program receives limited priority for funding, management or service delivery in most local areas.

Stakeholders note that the different SHSS priorities across the province are also exacerbated by the different boundaries for service delivery across the health, education and children and youth sectors. This results in a heightened requirement for collaboration for the program. As new provincial strategies emerge, stakeholders recognize the need to improve this collaboration. For example, the government's plan to strengthen education in Ontario will be achieved through strategies such as the development of the *Best Start* Child and Family Centre concept, and the implementation of the Full Day Early Learning Kindergarten Program, where full-day learning is offered for 4- and 5-year-olds. This initiative is intended to promote a strong start for children early in life to increase the likelihood of success as they develop. Nearly all stakeholders acknowledge that this shift in education will likely have significant impacts to the SHSS program.

5.1.3. Leading Practices from the Field and Research

The following leading practices from the field and from research present options to explore as additional considerations to enhance the mandate of the SHSS program:

Leading Practice from the Field:

- **Holistic Services –** The Children's Treatment Network of Simcoe York (CTN) has developed a comprehensive network that integrates services across Ministries and sectors to provide timely, effective service to children with complex support needs. The focus of the model is to enable the right providers to deliver the right services to meet a child's functional support needs and family support needs, in a coordinated manner. The CTN model is unique in its success within the SHSS program, as it is supported by a cross-section of over 50 network partners whose partnerships are governed by contracts, charters, common principles and other enablers.
- **Defining Transition Processes –** In the Central East area, a number of stakeholders used a joint memorandum of understanding as a type of shared charter, to establish a common understanding, set of roles and responsibilities and monitoring mechanisms to improve local service delivery, which serves to augment existing provincial policies. The Central East example is focused on the transition between the pre-school speech and language program and the SHSS program, and demonstrates a cross-sector model to improving program coordination, efficiency and child and family experience through a structured approach.

Research-based Leading Practices:

- **International Eligibility Standards** - Holistic goals are necessary to ensure that all perspectives of a child's functioning and health are addressed. The WHO's International Classification of Functioning, Disability and Health (ICF) Model describes disability in terms of body functions/structures, activities and participation while identifying personal/environmental factors that can facilitate comprehensive goal setting and collaboration. As the model addresses needs on the basis of disabilities, rather than disorders, this may impact the prioritization approach in providing health support needs to children in school.

5.2. Recommendations

As noted in the findings, varied interpretations of the program's mandate and different philosophies on the program's objectives exist across the province. As a result, CCACs, educators, CTCs, providers and parents have differing perspectives about the nature and type of services that are, or should be, provided through the program. Across the local areas reviewed, the program fulfills different purposes through varying roles and responsibilities. This is further complicated by the diverse service models utilized in different areas of the province across the health, education and children and youth services sectors.

Because the program has not formally been reviewed since inception, it is critical to understand the overarching SHSS mandate and the models employed across the province to achieve the governing objective of providing SHSS to enable children to access education. Based on the findings from the review, the following recommendations are identified related to the mandate and accountability of the SHSS program:

Recommendation 1: Clarify the scope of services delivered under the mandate of the SHSS program

Clarification of the SHSS program will improve program governance, management and planning, stakeholder understanding of services provided, as well as coordination of services with other health, education and children's services. A shared understanding of the objectives and scope of services offered through the SHSS program mandate can facilitate consistent program accountability and outcomes. With this foundation, local area stakeholders can articulate defined roles, responsibilities and expected outcomes in their communities to align with provincial mandate expectations.

Proposed Outcomes:

Implementation of this recommendation will achieve positive outcomes, such as:

- Establishment of a common understanding of SHSS program purpose and objectives across stakeholders for more consistency in service delivery across the province
- Clarification of roles, responsibilities and accountabilities across stakeholders to deliver SHSS
- Optimal use of speech and language resources that are coordinated to meet the needs of children requiring them
- Alignment of legislation, regulation and policy required to support the program mandate and scope of services delivered

Recommendation Description:

Clarification of the SHSS program scope requires the establishment of a common understanding of the program's mandate, which should be achieved through the following sub-recommendations:

1.1. Establish the objectives, scope and intended outcomes of SHSS

- While revisions to governing legislation and policies were not formally part of this SHSS Review, the lack of clarity and and consensus among stakeholders as to the breadth and depth of SHSS impacts services delivered across the province. To assist in clarifying the scope, the Ministries should consider establishing a working group that re-examines the program mandate and scope of services across sectors, with consideration of key points of coordination or integration with other health and children's services.
- Specifically, the Ministries need to consider the following themes in clarifying the SHSS program mandate:
  - Identify the overarching objectives of the SHSS program. Through provincial and local consultations, stakeholders identified a range of potential program objectives that should be considered in clarifying the overarching SHSS mandate:
    - SHSS enables children to physically attend school
    - SHSS facilitates children to access the educational curriculum and participate in all activities
    - SHSS supports children to meet their developmental milestones across all lifestages
    - SHSS is well-coordinated into the broader network of children's health support services

  - Clarify the program's role within the context of other health, education and children's services
  - Assess the achievement of the program's mandate within a broader economic and service context of children's life-long needs
  - Direct the program's integration and coordination within the network of children's services to ensure holistic goals area consistently targeted
- In light of the children's services available in communities, there are a number of key considerations for the Ministry to explore in defining the scope of services to be provided under the umbrella of SHSS (e.g. support for diabetes management related to insulin monitoring, administration and snack management; provision of sensory services; support for austism and other behavioural needs; support to Section 23 students; and support for mental health needs).

1.2. Develop a consolidated approach to deliver both speech and language services

- Re-examine the current model to better optimize resources to enhance service delivery for children requiring speech and/or language support services
- Review relevant policies, such as the Interministerial Guidelines for the Provision of Speech and Language Services, to align with revised delivery model

1.3. Align relevant legislation, regulation and policy with the agreed mandate, accountability and scope of services; this will need to include a review of PPM 81

1.4. Execute a communication strategy to provide clarity on the SHSS program mandate, objectives, scope of services, and roles and responsibilities to stakeholders across the province; this will need to include ongoing communication mechanisms that continue to provide an understanding of the SHSS program mandate

Recommendation 2: Under the SHSS mandate, enhance cross-sector collaboration to deliver SHSS that optimizes expertise and resources

Building on the previous recommendation regarding program mandate, a common understanding of the program's mandate, philosophy and scope of services provided can be facilitated through effective collaboration structures and guidelines of engagement. These include creating shared mechanisms across the sectors involved that guide the planning, coordination, delivery and evaluation of services. The recommendation will inform decision makers to determine optimal delivery of the program within the resources available.

Proposed Outcomes:

The actions associated with this recommendation will achieve the following outcomes:

- Assist in establishing a common understanding of the SHSS program
- Facilitate working relationships, service delivery, planning and coordination among local area stakeholders
- Define program accountability, roles and responsibilities and performance expectations that relate to child and family focused outcomes
- Promote innovative service delivery models that optimize the use of available resources

Recommendation Description:

The execution of the proposed sub-recommendations can assist in facilitating the implementation of shared charters and principles:

2.1. Develop or leverage existing cross-sectoral provincial mechanisms to optimize SHSS and broader system capacity, focused on collaborative planning, policy development and program monitoring

- The provincial mechanism will be charged with on-going planning and monitoring, and would be the vehicle for supporting Recommendations 4 and 12 under the subsequent Access and Equity and Quality sections, respectively

2.2. Enable collaboration across stakeholder groups through standardized structures and guidelines

- Develop shared charters or joint structures for each local area to outline roles and responsibilities
- To enable local flexibility, establish local cross-sectoral working groups to tailor and implement provincial solutions
- Facilitate joint relationships that are needed for effective SHSS delivery with embedded accountabilities at the provincial level, and across agencies
- Examine local funding structures to enable flexibility and coordination across structures to meet local resource needs

2.3. Develop shared principles among stakeholders to foster collaboration and dialogue on the delivery of SHSS; the table below provides examples of relevant principles for the Ministries to explore:

Considerations	Description
Performance and Accountability	• Shared understanding of performance expectations within stakeholder groups
Flexibility	• Shared understanding and enablement of human resources and funding flexibility across sectors to deliver effective health support services to children in schools
Focus on Child Outcomes	• Shared philosophy and standardized guidelines that promote positive child and family focused outcomes resulting from SHSS

6. Access and Equity

Maintaining appropriate and equitable access to SHSS is critical to program integrity, as with any health or social service. For the SHSS program, variability in interpretation of the program mandate, approach to prioritization of different children's needs and availability of resources all impact access at the local level. Findings from across the provincial and local area consultations consistently identify that although efforts are made to improve access to SHSS, access varies across the province, based on geography, school setting, functional needs of the child, and cultural and linguistic needs. Further, stakeholders identify concerns with program access and equity with respect to both the different scope of SHSS available in difference communities, and the varying wait times for services across the province. As one of the core areas for the Review, improving access and equity to the SHSS program is an important driver of overall program improvement.

6.1. Current State Findings

6.1.1. Strengths

Development of Prioritization Tools

In general, CCAC case managers/care coordinators apply prioritization guidelines and supporting tools to enable the triaging of children with SHSS needs to best serve those most in need based on urgency and intensity of services required. There is variation in the development and alignment of these guidelines and tools across the province, but many of the local areas reviewed have guidelines and tools that are used consistently for the children served by the SHSS program in their catchment area. In several areas, prioritization guidelines and tools have been developed through collaboration between the CCAC and service providers, resulting in a set of guidelines and tools that provide objective and equitable direction to the allocation of finite SHSS resources across the children needing service.

Alternate Models to Ensure Appropriate and Timely Access, Regardless of Geographic, Socio-economic or Cultural Barriers

Stakeholders acknowledge the financial and human resource limitations of their respective communities and a number of areas have implemented innovative models to address potential access inequities that occur as a result of these constraints. For example:

- A proportion of stakeholder groups in northern Ontario leverage technology, such as the Ontario Telemedicine Network (OTN), to facilitate communication and education between a service provider in a city and another individual residing in a remote town. This technology-enabled process supports timely access to a specialist while bridging long distances to deliver services and reduce provider or family travel.
- Other areas have implemented non-regulated health professionals to complement the services provided by clinicians who may be in finite supply (i.e. using Therapy Assistants, such as Rehabilitation Aides or Communication Disorder Assistants, to implement an individual's service care plan). This model enables the clinician to meet the breadth of service demands across a given region, while still addressing the complexity of an individual's support needs.
- Another model that helps to increase access to service includes offering group clinics, in which a number of students receive services at the same time while optimizing the use of resources. These clinics help to manage wait times for students to receive services while optimizing the use of resources. In the Niagara area, groups SLP clinics are offered to students. Since the program is offered after-school, therapists and families have the opportunity to connect directly regarding the child's service plan.

In light of the number of children waiting for services, in some areas, the CCAC and service providers work jointly to develop strategies to enhance SHSS delivery. As described previously, a broad range of

support needs required by students may be best served through several approaches. In some areas, the CCAC and service providers conduct screening clinics to re-evaluate individuals on the following:

- Decline in function and require SHSS urgently
- Meet eligibility criteria, yet deemed appropriate to continue waiting for SHSS. These individuals may be provided with strategies or basic therapies to practice with family at home to reduce the risk of declining function
- Are deemed appropriate to be discharged from service, as function has improved and they no longer meet eligibility criteria

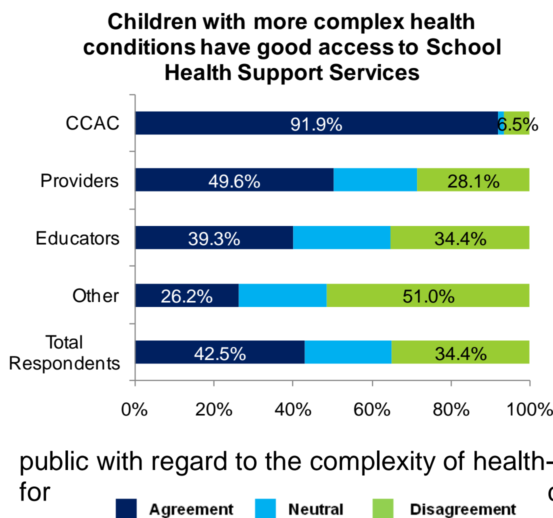
This approach ensures specialized providers are part of the decision-making to determine appropriateness of care and ensure resources are used effectively.

Regardless of the innovative model applied, it was reported that the collaboration between key stakeholders is critical for these alternate models to be implemented successfully.

Safety Assurance for Complex Support Needs

A proportion of children in the school environment have highly complex needs. As they have often been involved with the CCAC since birth, the eligibility for services is clear and stakeholders identify these students early as requiring relevant SHSS when they reach school age. Early identification and intervention is critical for these children, as they may require a higher intensity of services from a cross-section of providers.

Stakeholders consistently identify that these children receive appropriate service through the SHSS program quickly, with minimal wait times. As a result, many stakeholders report that providers and educators work effectively in ensuring an individual's physical and health-related safety needs are met in the classroom environment. Interviews and focus groups revealed that children enrolled in specialized developmental classes receive dedicated, competent support through a multi-disciplinary team.

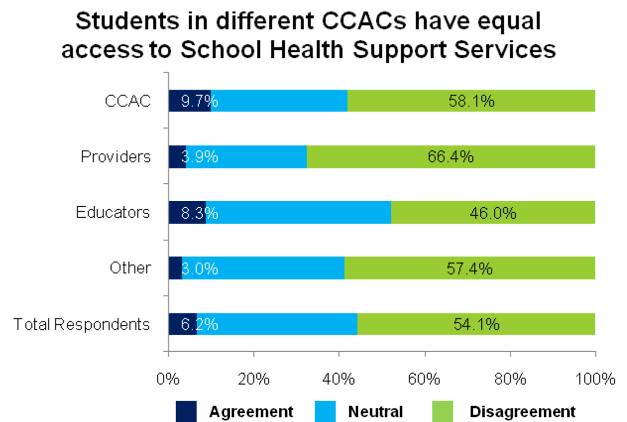


As seen by the survey results presented on the left, the majority of CCAC respondents (92%) support this view that children with complex health conditions have good access to SHSS. Educators and parents showed higher levels of neutrality or disagreement, however.

Field consultations revealed that these contrasting views may be due, in part, to the different program interpretations and policies noted earlier, and the different perspectives of clinicians and the general public with regard to the complexity of health-related needs of children, such as the support required for children with stable diabetes.

In some areas, diabetes management related to insulin monitoring, administration and snack management is supported by the SHSS program through nursing services. In other areas diabetes management is not supported by SHSS because it is considered to be an activity of daily living that does not require nursing supervision by some CCACs. Because educators often report that they do not feel comfortable providing insulin monitoring support for children with stable diabetes, this can be seen as a need for which the SHSS program is not providing sufficient access.

6.1.2. Challenges



Lack of Standardized Provincial Guidelines and Tools

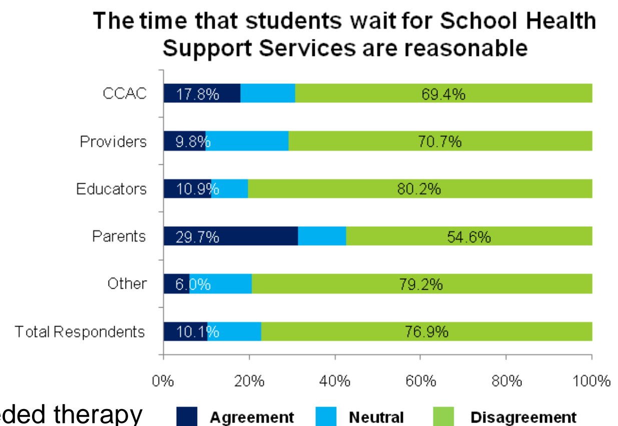
As a result of varied interpretations of the SHSS program mandate, local areas across the province utilize different criteria, guidelines and tools to deliver SHSS. The graph on the right depicts the survey participant responses regarding the equity of access to services delivered in different areas. All stakeholder groups revealed strong levels of neutrality and disagreement with regards to the equity of SHSS experienced among CCACs, which is driven in part by different guidelines and standards in place across the province, as noted further in the field consultation findings below.

While CCACs and service providers have started to develop relevant tools to guide practice, local areas are in various stages of implementation; thus, case managers/care coordinators may still utilize different policies though they operate within the same CCAC boundaries. This results in several points of variation in the SHSS program today, which impacts access and equity:

- Although a number of CCACs and service providers leverage tools previously developed in other CCACs, it is evident that the majority of areas apply different policies, documentation forms and tools in the SHSS program, which assists in driving inequitable access across communities.
- Examples of program inequity include the scope of support needs that are considered eligible within the SHSS program, differences in the defined visit allocation guidelines appropriate to meet an individual's needs, and the types of goals set for the child to address issues and challenges for participating in the education curriculum.
- In addition, field consultations revealed there is variation in the age and/or grade level in which children are referred to SHSS across the local areas reviewed, which further varies by discipline/service required.

While stakeholders use guidelines and tools to delineate priority cases, they are not standardized across the province. This lack of a consistent set of guidelines and tools results in variability in access to SHSS, and potentially impacts the overall progress of children's ability to participate in the education curriculum. Further, stakeholders report that when children transition to other regions, they often fall under different priority scales, though their support needs do not change, which can impact the level, timeliness and scope of services received; this results in varying equity of receiving services through the SHSS program across the province.

Wait List Management



A prominent theme that emerged from the quantitative and qualitative analyses revolves around wait times to access SHSS. Wait times were found to vary across areas and stakeholders were generally dissatisfied with the wait for service, particularly for children who are categorized as lower priority relative to other children's needs. As demonstrated in the chart to the right, survey findings demonstrates overall stakeholder dissatisfaction with the length of time encountered to access SHSS. The survey findings revealed that 77% of respondents disagreed that wait times are reasonable, and felt that wait times impact the ability to assist children in accessing the needed therapy in a timely manner. Issues around wait times were also one of the primary concerns raised by stakeholders participating in the field consultations, and gathered from survey respondent commentary.

Examining SHSS wait times further, data and consultation findings indicate that wide variability exists among local areas, as well as by service need, in the wait times to access SHSS. As previously shown in the Program Profile, the table on the right demonstrates the range of wait times across SHSS disciplines. As this information is collected at the local level, and not reported provincially, these findings represent the timeframes that align with only the eight areas of the province involved in the local area field consultations. It is important to note that depending on the timing of admission onto the wait list, these days include the summer months when children are not enrolled in school. Regardless, in a number of areas, wait times can extend to two years after referral to the program.

Discipline	Approximate Wait Time Range (days)
Nursing	0 – 60 days
SLP	40 – 500 days
OT	30 – 350 days
PT	15 – 650 days

As the SHSS program and role of the CCACs evolved, the CCACs were mandated with the primary responsibility for coordinating services and managing prioritization of children on the SHSS wait list. In this evolved model, in the majority of areas, the CCAC does not provide direct SHSS to students. This model permits the CCAC to monitor equitable access to service by coordinating providers and children with SHSS needs. Stakeholders report, however, that because provider agencies typically do not have access to comprehensive wait list information (e.g. complexity of support needs, geographic location), this model poses a challenge to proactively plan for deployment of appropriate resources, while optimizing efficiencies and quality of care. In some areas, providers and the CCAC share wait lists and actively collaborate on wait list management; however this is not a consistent practice across the province. As a result, there is a general perception that the lack of transparency between the CCAC and providers in some areas reduces opportunities to collaboratively work together to reduce wait times for SHSS.

Additionally, there appears to be limited monitoring of children's needs while waiting for service. Therefore, an individual's functional abilities or health issues may deteriorate, which could potentially impact the child's path to improve if therapy is not started prior to a functional decline. Conversely, where a child's functional needs are developmental in nature, they may improve as the child ages on a wait list, such that support services are no longer required. If on-going monitoring of a child's status does not occur, CCAC and provider stakeholders will continue to wait list the student for service though he/she is no longer eligible for services, which delays access to SHSS for other students waiting for services.

Although the CCAC asks families and educators to notify CCAC case manager/care coordinator of a child's change in functional status, this monitoring process is not consistently followed. Further challenging this monitoring issue, a proportion of providers perceive that educators and families do not have the specialized assessment skills to accurately identify potentially critical changes, which limits the effectiveness of non-health professionals in this monitoring role.

Unique Populations and Communities

The majority of stakeholders agree that there are several defined subpopulations that utilize SHSS, but the current model inhibits timely access to services for all groups. While efforts have been made to address potential barriers, there is widespread consensus that there are opportunities to explore effective strategies to address them. Examples of the subpopulations impacted by the variation in SHSS delivery are highlighted below.

Children with Chronic Episodic Needs

The incidence of chronic disease management is increasing across demographics and also extends to the school-aged population. A proportion of children with chronic conditions may require long-term support, yet their needs also require episodic SHSS in alignment with their development needs. As a result, this population may require less intensive services interspersed throughout their life stages ("chronic episodic needs"). In the majority of areas, these needs do not align well with the respective visit allocation protocols. While it is acknowledged that children with these intermittent needs require health support services, this population may encounter multiple wait times to access services, despite being identified early in their development.

Cultural and Linguistic Needs

The cultural and linguistic diversity of the population is evident across numerous areas in Ontario. Overall, a number of strategies have been implemented to better address the unique language needs of children and their families. However, stakeholders report that these services are insufficient in effectively addressing children's support needs. Specifically, stakeholders identify concerns in accessing services that are culturally and linguistically attuned for children and families who are Francophone, who speak English as a second language, and who are Aboriginal.

Provider agencies recruit Francophone and French-speaking therapists to deliver services in the French language. Despite the fact that Anglophone and Francophone students are maintained on the same wait list to promote equity, a proportion of educators and families report that Francophone practitioners are better suited to provide therapy services, particularly in speech-related services. Although French-speaking Speech Language Pathologists (SLPs) meet language proficiency standards, for complex pronunciation and speech needs, it was perceived by a proportion of stakeholders that Francophone students may receive more effective services from a Francophone provider. As a result, students may encounter wait times to access these specialized services, if relevant.

For families that speak English as a second language, parents, educators and service providers report that they encounter difficulties in understanding the scope and objectives of SHSS, and the process to access and wait for services. Families and educators report that this lack of comprehensive knowledge can potentially reduce the likelihood for these children to receive SHSS. The benefits of the program may not be fully articulated to or understood by these families, which may result in them not providing consent for SHSS nor playing active roles in supporting their children with their SHSS health-related needs at home.

The Aboriginal population is reported by stakeholders to experience general barriers to accessing SHSS, especially in rural and remote communities. CCACs, providers and educators are cognizant of the unique characteristics of the Aboriginal communities regarding health-related support services; however, in some regions, these children ultimately receive less SHSS (i.e. fewer visits) relative to others living in the same area. While the data is not available to support this discrepancy in service access, there is a perception that this is more pronounced in rural and remote areas. Further, for Aboriginal communities in rural and remote areas, it is perceived that there is confusion as to the federal mandate to support health needs in concert with the expected services offered by the SHSS program, particularly with remote communities and on-reserve schools.

Rural, Remote and Northern Communities

In a number of areas in Ontario, population distribution is widespread and the finite human resources that provide health services face challenges in offering equitable services for individuals living in rural, remote and northern communities. Providers may travel long distances to work with students, which limits their ability to connect with multiple children within a given day. Consequently, travel logistics impact overall wait times for students to access SHSS. A number of areas use alternate service models to provide these support services. However, as a result of their intermittent visits, children, families and educators do not receive similar access to specialized professionals as those that live in urban centres. In the North, specific programs, such as the Integrated Services for Northern Children (ISNC), offer dedicated funding to meet the needs of children and families in northern communities. However, there appears to be a lack of clarity on roles and responsibilities of the organizations providing these services versus the mandate of the SHSS program.

Limitations of Service Delivery Models

As noted previously, the majority of SHSS is delivered in a consultative model, in which collaboration between the provider, educator and family is needed so that ongoing support to the child is provided in between therapy sessions with the provider. There are challenges in developing collaborative relationships between providers and educators, however, including:

- Provider perspectives
  - Providers perceive that they are not part of school culture.

  - A proportion of providers perceive that educators do not set aside sufficient time to learn effective SHSS strategies or to carry out recommendations with their students.
- Educator perspectives
  - Educators perceive that most providers utilize the “pull-out” approach (i.e. when children are taken out of the classroom to receive SHSS) with students, where therapists work with children outside the classroom setting.
  - This approach limits effective knowledge transfer and sustainability of strategies with educators upon completion of the child’s service plan.
  - In addition, a therapist visit may not coincide with the scheduled breaks within the school day, and educators perceive service providers do not consider the education timetable when scheduling sessions.
  - Supporting these consultation findings, a minority (22%) of educators responding to the provincial survey indicated agreement that SHSS in the classroom are well coordinated with the curriculum and other activities.

In addition to the service delivery model challenges related to provider-educator collaboration, the model of SHSS being delivered one-on-one within the traditional school setting and school year are also limitations that raise concerns by stakeholders:

- Because SHSS are typically not offered during the summer, summer breaks are noted to cause gaps in services for students by stakeholders, and can result in functional decline for the child. Many stakeholders expressed the need to expand SHSS to provide services outside of the school setting and continuously throughout the year to facilitate access and maintain a child’s progress.
- In addition, a requirement in most areas for SHSS consultations between providers and families can be a barrier to access for working families to engage in their child’s therapy. This can limit the family’s involvement in their child’s ongoing support, which also limits the effectiveness of the consultative model. Stakeholders note that enabling evening sessions for families would support improved access and application of a consultative approach.
- A challenge to alternate service delivery models for SHSS to the traditional one-on-one approach is the current provider funding model. In the majority of areas, service providers are contracted based on a fee-for-service model for each child served within the school setting. This fee-for-service model limits the ability to alter the provision of services into alternative models that would meet the needs of specific populations. It also limits the ability to develop models that optimize the use of the resources available within local areas and across different sectors.

Service providers state that a more flexible funding and service delivery model would facilitate the development of innovative service delivery models that would best meet the needs of SHSS populations using the human, technology and infrastructure resources available throughout the school year.

Variable Equity between Schools

Current policy provides dedicated funding for children with support needs attending independent or private schools. While the intent of this funding was to ensure appropriate access for students seeking education outside the public school system, children enrolled in private schools encounter shorter wait times than children attending public schools across the province, as described in the Program Profile.

Access to SHSS also differs by geography. Due to the different interpretations of the program’s mandate and scope of services, SHSS service models differ by CCAC boundaries, resulting in variability in the services that can be accessed depending on the geographic location of the school, and in the wait times for service. In addition to creating provincial variation, this causes variation of service delivery within school boards since some fall within multiple CCAC boundaries. Further, boards offer different programs that complement SHSS, such as equipment funding and policies (e.g. Special Equipment Amount (SEA)), contributing to the varied support available to students in each local area. CTCs in different areas also offer different programs complementary to SHSS. As a result of the different resources available through schools and CTCs, service plans can differ in scope, skill mix and infrastructure supports depending on the school that a student attends. Stakeholders feel that the varied levels of understanding of the services offered among these multiple programs, and varied degrees of collaboration to integrate programs to

optimize resources has led to the different levels of access to SHSS that are available to children depending on the school that they attend.

Lack of Standardized Approach to Predict Future Needs and Resourcing

As the needs of the population evolve and resourcing models within the health, education and children and youth sectors change, there is a need to regularly examine and refine the way in which services are delivered, while maintaining quality standards of care. These changes occur at both the provincial and local levels. Because of the different sectors involved in providing school support services and varied degree of coordination between sectors, stakeholders may be unaware of the true impact of changing policies or practices in a given sector on another. Stakeholders reported examples such as changes to the education curriculum in relationship to cursive writing, and changes to the roles responsible for activities of daily living in the health sector, which impact the model for SHSS. Consultations suggest that historically, the CCAC, providers and educators were actively involved in joint decision-making and planning to manage the impact of changes across sectors. Currently, however, stakeholders report a perception that significant practice changes are typically communicated, but that collaboration and joint planning to manage related impacts does not consistently occur.

Although some forecasting studies have been completed by CanChild, there appears to be limited evidence of planning for future populations in the local areas. While a few areas annualize their volumes to understand next year's anticipated service need, in general, stakeholder groups do not apply a robust methodology to project future service demand in order to proactively plan for SHSS.

The CCACs have begun to use the Client Health and Related Information System (CHRIS) to track a number of indicators relative to each client, which can then be collated to better understand system needs in the community. However, CCACs are currently in various stages of implementation of the CHRIS tool, thus, it is difficult to develop a comprehensive understanding of SHSS utilization, future needs and the corresponding models to deliver support.

Limited Awareness of the SHSS Program

The SHSS program is delivered and communicated across the province through the health, education and children and youth sectors, and there are various mechanisms that communicate the services to different stakeholder audiences. Regardless, field consultations suggest that there is inconsistent awareness that the SHSS program exists. This was specifically noted by a large of proportion of families and educators:

- Families expressed confusion in navigating through the services offered by the various sectors to understand the services that can be accessed to support their child.
- Educators expressed concern and uncertainty about the most appropriate referral process, and how to manage referrals when their students are served by more than one CCAC.

As noted in the leading practices below, some areas have implemented approaches to improve awareness of the program, but this challenge of SHSS program awareness appears to be present in many areas of the province.

6.1.3. Leading Practices from the Field and Research

The following leading practices from the field and from research present options to explore as additional considerations to enhance access to the SHSS program:

Leading Practice from the Field:

- **Standardization Prioritization System –** In the East area, a standardized, widely used prioritization system has proven to be an effective way of categorizing the types of service demands required and management of the overall wait list. This system uses a four lettered

category system, which allows individual cases to be appropriately ranked and prioritized. This system assists in allowing case managers and service providers to decide collaboratively on the students taken off the wait list and plan when service openings become available.

- **After Hour Group Programs** – The Niagara area offers SLP clinics after school hours for moderate speech clients in a group setting (up to 3 per session), in an effort to expand access to services. This program has helped managed the waitlist and optimize resources by serving multiple students at a time while providing the opportunity for therapists to directly consult with families. There is some consideration underway to expand this program to other areas.
- **Scope of Practice -** The CCAC and providers in the North East area collaborated to develop an effective solution to address human resources and geography barriers. Providers work in a team model with Therapy Assistants, such as Rehabilitation Aides or Communication Disorder Assistants, to implement an individual's service care plan. While the regulated professional therapist is actively involved in assessment, development of the child's service care plan and evaluation, the therapy aide works directly with the client with guidance and direction from the regulated professional. Using therapy assistants in a consultative model enables the therapist to deliver services to a broader population, while maintaining quality service delivery through a team approach; individuals receive the right service from the right provider in a more timely manner.
- **Reducing Administration of Referrals –** In the Toronto Central area, a school board uploads referral forms on its website to be accessed by teachers in their classrooms; student information can be populated on forms from existing systems, which reduces administrative efforts.
- **Increasing SHSS Awareness – I**n the Toronto Central area, the CCAC, providers and educators realize the challenges in maintaining current information about the SHSS program. As a result, the CCAC and service providers have offered in-services to educators to better understand the umbrella of services under the SHSS program. In the Central East area, community, children and youth services organizations, education, public health units, pre-school programs and other health related organization collaboratively developed information materials that are intended to provide navigational support to families and educators to access services children require.
- **Single Point of Access** – In the North East and North West areas, community networks have been established to provide information and central access to all children's services outside of SHSS in the respective areas. Families, providers, educators and other stakeholders can acquire information on and be directed to appropriate children's services through these networks. Having a single point of access is identified by stakeholders as being effective in facilitating family and educator navigation to services.

Research-based Leading Practices:

- **Leveraging Technology** - Telehealth is used widely in several clinical programs to connect specialists with other health professionals and/or patients, to attempt to deliver quality care closer to home. For example, Dr. Deborah Theodoros, from the School of Health and Rehabilitation Sciences at the University of Queensland, reports telerehabilitation has the "capacity to optimize functional outcomes by facilitating generalization of treatment effects within the person's everyday environment" (Journal of Telemedicine and Telecare, 2008). The assessment of speech disorders in children through telerehabilitation has high levels of agreement with face to face assessments. Substantial improvements in communication have been reported by parents and clinicians in children receiving teletherapy in homes. Preliminary efforts have utilized the technology to deliver services via videoconferencing and through interactive computer-based therapy activities.

- **Key Worker Model** – A Key Worker model of service delivery involves a single point of contact that guides and supports families. Research suggests that this model enables improved family navigation, understanding of programs available, and support to a child's needs. According to CanChild Centre for Disability Research, benefits of the Key Worker Model include:
  - Increased parental engagement, empowerment and satisfaction with services
  - Increased navigability of the system by families and professionals
  - Better and quicker access to benefits, services and practical help

6.2. Recommendations

Based on the findings, improved access and equity for the SHSS program can be achieved through the implementation of consistent standards and tools across the province, deploying alternate service models to meet varied needs, increasing the awareness of the SHSS program overall, and improving comprehensive program planning to better facilitate a cross-sector response to meet service demands.

The following proposed recommendations will address the access and equity challenges regularly encountered by stakeholders involved in the SHSS model.

Recommendation 3: Develop access guidelines and tools to guide service delivery

Proposed Outcomes:

The incorporation of common access guidelines and tools can achieve the following results:

- Enable equity of SHSS program access across the province
- Guide planning and coordination efforts of the local areas
- Facilitate local areas to tailor provincial tools, assess the equity of access to services currently, and develop plans to improve access across various student populations

Recommendation Description:

The development of access guidelines and tools can be accomplished through the following:

3.1. Develop provincial access guidelines for the SHSS program

A number of categories must be considered to address the variability in service delivery across communities:

Category	Considerations to Mitigate Variability
Local Flexibility and Parameters Impacting Services	• Provincial access standards can be guidelines to enable local flexibility relevant to unique communities, which is related to: − Population needs in relation to SHSS − Number of support services required by students − Geography of the local areas
Language and Culture	• Incorporate consistent standards and resourcing to meet the needs of the Francophone population • Clarify the roles and accountabilities of various federal programs in delivering school health support to Aboriginal communities • Establish effective processes to support families where English is a Second Language, which may foster increased participation in supporting their children's SHSS goals
Functional Needs	• Incorporate standardized processes to address: − Episodic needs of children who require chronic, long-term support − Children with single-service support needs − Children with high, physical support needs

Category	Considerations to Mitigate Variability
Education Sector	• Address variability within Boards regarding SHSS-related standards, processes, and roles and responsibilities that is evident across schools – Standardize processes and knowledge for submitting SEA grants for required equipment to enhance student participation in the classroom • Clarify expectations among educators within Boards to limit potential variability that may arise with individual referral practices
Health Sector	• Address variability among CCACs regarding access criteria and eligibility • Clarify expected performance of CCAC case manager/care coordinator role to limit potential variability that may arise with individual practices
Children's Services Sector	• Address variability across CTCs regarding programs and services offered through SHSS • Address variability of support services delivered by CTCs that are complementary to the SHSS program • Determine service model for specialized services for areas where CTCs do not exist
Provincial Human Resources	• Examine cross-sector policies to enable improved access through better coordination and sharing of scarce resources across sectors • Align provincial human resource strategies to address access issues related to finite human resource availability

3.2. Assess, develop and implement common tools to support access guidelines, including:

- Common eligibility and discharge criteria
- Standardized referral and intake forms and processes
- Standardized consent forms and processes
- Common prioritization parameters
- Common assessment tool to be applied by all stakeholders
- Wait list management tools supported by improved cross-sector collaboration at the local level across providers, CCAC, educators, and CTCs in managing waitlists

3.3. Examine current policies and funding to address the inequities between children attending public and private schools in accessing SHSS

Recommendation 4: Develop formal forums and processes for proactive service planning

Proposed Outcomes:

The implementation of forums that are tasked with proactive planning of service delivery will:

- Enhance collaboration across sectors and SHSS stakeholders to meet the needs of the population
- Create mechanisms to share information across stakeholder groups to help inform program planning
- Determine how to addresses challenges of program planning among competing initiatives by aligning population needs and sector changes with resource capacity

Recommendation Description:

The establishment of formal forums and processes to proactively plan for SHSS can be facilitated through the following:

4.1. Promote regular collaboration – both locally and provincially – among the health, education, and children and youth services sectors, to determine optimal models and approaches required to best manage finite resources across sectors on an annual basis. Objectives of this collaboration should include:

- Determine impacts of evolving population service demands and environment on SHSS mandate including existing and changing legislation (e.g. Full Day Early Learning Kindergarten Program)
- Assess changes in education curriculum on SHSS requirements (e.g. decrease in cursive writing exercises in the classroom, shift to integrated classroom model)
- Assess changes in clinical practice on education curriculum (e.g. shift to consultative model, changes to nursing supports and delegation of responsibilities)
- Determine SHSS alignment with children's broader needs in order to support the needs of the evolving population
- Utilize CHRIS and other cross-sector data and information systems to inform program planning

Recommendation 5: Establish alternative models of service delivery across the province to improve access and wait times

Proposed Outcomes:

By implementing alternative models for SHSS, the program can achieve positive outcomes, such as:

- Enhancing optimization of finite resources with the introduction of alternate health professionals, which aligns with leading practice
- Increasing access to specialized expertise to better support children's needs in a timely manner

Recommendation Description:

Protocols to establish alternative service models that can be implemented across the province for SHSS can be developed through the following:

5.1 Develop forums, with identified experts, to develop alternative service models that address service access challenges and meet the unique needs of different communities.

- Determine existing tools, structures and processes that are currently in place that can be leveraged to enhance service delivery
- Participate in information sharing processes to communicate successful service delivery models across the province
- Implement ongoing evaluation processes to assess service delivery model effectiveness that will be related to examining overall program performance

The following table outlines a sample of the leading practices and options.

Service Category	Description
Screening clinics	• To address the increasing volumes on the wait list, a number of CCACs and providers conduct periodic clinics to perform evaluations for students on the wait list to: – Discharge appropriate children who no longer require SHSS – Provide practical strategies for children and families to work on at home while waiting for services, where appropriate – Prioritize children whose support needs have increased to ensure services can be provided in a timely manner
Summer Programs	• Focus program and service delivery to address and maintain the functional needs of students beyond the school year: – Supports children to continue working through SHSS recommendations and limit potential regression of functional abilities during the summer months
After Hours Programs	• Conduct SHSS sessions with children after school hours to enable families to participate in visits with their child and SHSS provider, which can promote continuity of recommendations in the home
Combined Home Sessions	• Periodic joint visits among providers, as appropriate, are conducted in a child's home to address particularly challenging issues and promote family engagement in carrying out recommendations
Pull-Out versus Integrated Classroom Approach	• For appropriate children, incorporate SHSS visits within classrooms to promote knowledge transfer between providers and educators
Leveraging Technology	• Leverage technology, such as OTN, to facilitate communication between professionals or deliver services, as appropriate

5.2 Examine and implement an effective skill mix for professionals in delivering SHSS

- Examples include incorporation of Therapy Assistants/Aides or Communication Disorder Assistants in service delivery, where appropriate
- Skill mix changes should also consider the integration of professional therapy students nearing graduation, which also serve to increase the number of new professionals seeking to enter the SHSS field

Recommendation 6: Increase awareness of the SHSS program provincially and locally

Proposed Outcomes:

There is wide consensus among stakeholders of the opportunity to enhance awareness of the SHSS program and the benefits of providing health supports to children in the classroom. Proposed outcomes include:

- Increase ability for families, educators, and other stakeholders to identify and refer children to appropriate supports
- Offer relevant information to families in ways that resonate with them and enhance their understanding of the network of services available
- Reduce confusion for families in navigating the system through a single point of access

Recommendation Description:

Enhancing awareness of the SHSS program can be realized through the following strategies:

6.1. Develop enhanced communications and tools to increase awareness within schools and support broader navigation with community partners, which include examples such as:

- Brochures and other tools to provide SHSS program information to families and educators, within the context of broader children's services
- Implement web-based portals for ongoing communication among CCAC, providers, educators and families during service delivery
- Leverage or incorporate peer-to-peer mentoring networks for families to share relevant program information and broader community supports that intersect with SHSS
- Determine additional support requirements for families to ease their navigations of the system across health, education, and children and youth sectors, and implement strategies to support them, such as local family networks or on-line forums

6.2. At a local level, assess feasibility of implementing a single point of access for all children's services across services, which will include SHSS

7. Coordination

Considering the broad services available for children with special needs, coordination is often complicated, as there are multiple entry points into the health, education and children and youth services systems, and multiple services available. Families often access children's services through multiple programs that are often funded by different ministries, which impacts coordination efforts by all stakeholders. Communication and collaboration is required across the multiple stakeholder groups – children/families, case managers/care coordinators, educators, SHSS service providers, CTCs and broader service providers – to achieve the benefits of effective coordination and to enable child and family centred-care.

7.1. Current State Findings

7.1.1. Strengths

Multiple Communication Avenues and Mechanisms for Information Sharing

In some areas of the province, communication guidelines are available to assist in informing families about the SHSS program and the details of their child's service plan. These include sending a letter to parents to indicate the services their child will receive, sending notes to parents after each visit, and conducting case conferences for parents that include a child's service providers, case manager/care coordinator and educators. Throughout the province, families are generally involved in a discussion regarding their child's SHSS plan. Many parents reported that they receive timely, comprehensive information about their child's progress. In some areas, families have the opportunity to provide input on the development of their child's service plan for SHSS, in collaboration with case managers/care coordinators, educators and providers at case conferences. Parents stated provider reports give valuable updates on their child's therapy progress.

As their child receives services, families are informed of their child's progress through a variety of communication mechanisms, such as provider reports, communication books, or phone calls with the providers and/or case manager. In many areas, parents are also invited to attend sessions delivered in schools. Communications can also include recommendations or exercises that parents are encouraged to carry out with their child, to promote continuity of support at home.

The following are some examples of other information mechanisms noted to be effective by stakeholders in some areas of the province with regard to SHSS:

- Face-to-face case conferences with parents, services providers and educators have been implemented in some areas to enhance the understanding of the service plan, expectations, roles and responsibilities among those involved.
- In some areas, formal visits are arranged at each school with the principal (or designate) and the case manager/care coordinator at the start of the school year to review the provision of SHSS.
- To assist educators and families to understand the SHSS model, in some areas, CCACs provide schools with an SHSS resource manual.

Strong Communication Links for Children with Complex Needs

As identified earlier, stakeholders noted children with complex needs are reported to have timely access to SHSS. To facilitate this timely access, strong communication links among stakeholders exist to ensure the high physical support needs of children are met. Family engagement occurs consistently, given the increased requirement for coordination among providers, educators and case managers/care coordinators, and the frequency of service delivery. For many parents, they have established a strong relationship with the providers that deliver service to their children. These relationships are facilitated

when the same provider also delivers service in the home to the child. The majority of families connect directly with providers, which often enhances their understanding of SHSS service delivery and the various roles involved.

Effective Collaboration between CCACs and Service Providers

There are processes in place for joint collaboration between case managers/care coordinators and service providers to ensure that children's support needs are met. The following examples illustrate the effective collaboration mechanisms and guidelines that exist in local areas across the province:

- Overall, strong collaboration exists among SHSS, educators and other children's services for children with highly acute and/or high physical needs.
- Children that require both in-home and in-school CCAC service, due to the complexity of their support needs tend to have one case manager/care coordinator to oversee the two programs. Further, some children have a common service provider that delivers service in both environments. This model streamlines the number of individuals involved in a service plan and promotes effective coordination.
- In most areas, case managers/care coordinators and individual service providers are geographically assigned to schools, which promote the opportunity for these SHSS stakeholders to foster relationships with educators as there are fewer individuals to engage in this model.
- In some areas, case managers/care coordinators have opportunities to meet with their assigned schools on a more frequent basis to review the SHSS caseload and/or provide general information on SHSS and in-service programs on SHSS
- Regular collaboration through case conferencing among CCAC, providers and educators exist in some local areas, which promotes efforts to strengthen SHSS-related planning and goal setting. In some schools, case conferencing involves all of a child's providers, educators and parents in an effort to set goals, to participate in Individual Education Plans (IEP), and to communicate roles
- In a proportion of areas, CCAC and service providers connect regularly regarding SHSS to collaboratively address issues and plan solutions to deliver effective services, which assists stakeholders to define clear roles and responsibilities

Informed Transitions

In the majority of areas, educators, service providers and CCACs connect through different mechanisms at the beginning or end of each school year to understand and plan for the anticipated support needs of students enrolled in the SHSS program. The CCACs use this information, as well as data forwarded from pre-school programs for students entering school full-time, to inform provider agencies of the approximate service volumes for the upcoming school year.

In several areas across the province, families have access to children's support services during the pre-school stage of a child's life. Where a child's needs for developmental support services are identified at pre-school age, families are well-informed of the SHSS program and are well-positioned to navigate the health support system. Further, a number of early education providers and educators report that stakeholders incorporate information sharing processes for pre-school children to avoid delay of support services when transitioning to school. Therapists in several local areas report that they conduct joint visits to support these transition points, which can enhance knowledge sharing and maintain continuity of care.

For SLP services, normally a Board SLP assessment is required to determine eligibility for SHSS. As described in the Access section, to facilitate smoother transitions, some areas have enabled direct referrals from the pre-school speech and language program to SHSS. In other areas, where education Boards receive discharge reports from pre-school speech programs indicating further support service is required for a particular student, Boards will directly submit an application to the SHSS program without conducting a board assessment to minimize service duplication and increase timely access to service.

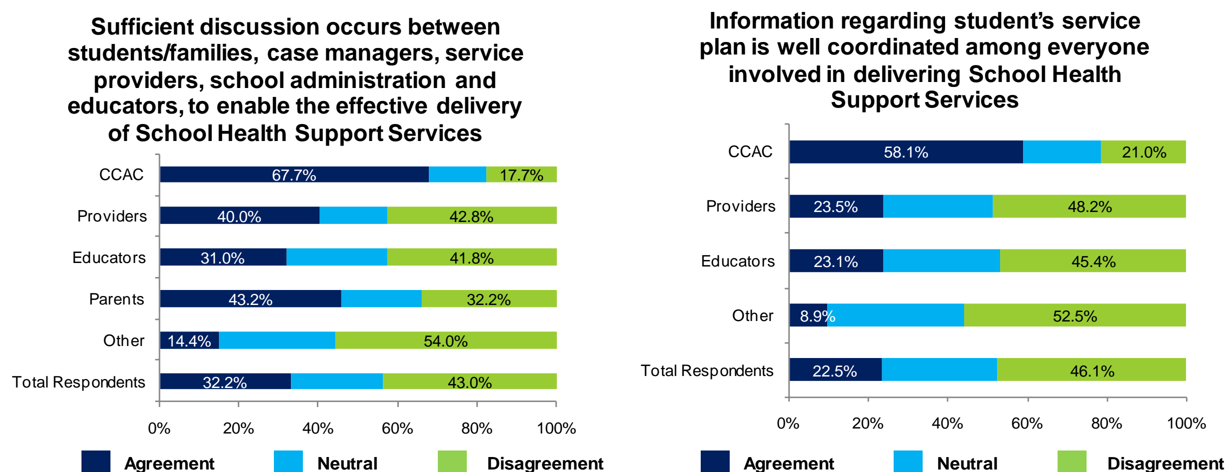
Stakeholders reported that transfers of students from one school to another within the same CCAC are relatively seamless and smooth. In some areas, inter-CCAC transfer processes have also been developed, which enables seamless transitions as clients transfer from one CCAC jurisdiction to another.

In most areas, school boards, CTCs and other community programs meet to proactively plan for students transitioning out of the school system into adulthood, by conducting conferences with the families and stakeholders several years before the transition occurs. These proactive sessions facilitate a cross-section of relevant stakeholders to collaborate and explore potential educational, vocational, or social opportunities for the young adult.

7.1.2. Challenges

Variable Stakeholder Collaboration

Results from the province-wide survey suggest that stakeholder groups other than CCACs do not perceive that sufficient discussion occurs across SHSS stakeholders for effective service delivery (32%). As demonstrated in the following charts, a minority of survey respondents (22%) indicated information regarding a child's SHSS service plan is well-coordinated across stakeholders. These findings are supported by perceptions gathered from consultations throughout the province, particularly related to the collaboration that occurs between SHSS providers and educators.



While coordination among parents, case managers/care coordinators, SHSS providers, educators and other children's service providers is encouraged throughout the province, there is variability on the level and the frequency of coordination that occurs. Due to the lack of dedicated time and avenues for information exchange, coordination processes are inconsistent across the local areas reviewed:

- For example, while some educators feel that they are adequately informed of when providers are on-site delivering service, others feel disconnected from the scheduling or consultative process, or that these processes are inconsistent among different providers.
- Further, a proportion of stakeholders state that the limited mechanisms available to facilitate coordination ultimately results in fragmented service delivery.

If accurate information regarding a child's current functional abilities is not shared among stakeholders in a timely manner, the child may not receive the appropriate SHSS required to address his or her needs.

Variable Stakeholder Collaboration – Families

During field consultations, parents and providers revealed that the extent of family engagement varies within local areas and across different communities in the province. Further, there are challenges in engaging parents, as service delivery occurs during school hours, which may not be optimal timeframes in which working families can participate. For many parents that work or are faced with other commitments during the day, it is difficult to schedule time to attend sessions or conferences during school hours. While some providers incorporate flexibility in their work day to connect with parents after-hours, this occurs largely on a case-by-case basis.

Although some CCACs and providers emphasize that family engagement improves SHSS outcomes for their children, they often encounter challenges in determining optimal methods to reach parents. A proportion of families reported that letters, phone calls, or care plans sent home are not sufficient to continue SHSS exercises in the home environment. Participation in service planning is further hampered for families who do not speak English. While translation services are available in the majority of areas, this service is not consistently utilized. Parents unable to attend SHSS sessions or who do not understand the information documented on their child's service plan often have more difficulty participating in their child's service delivery and understanding their role in facilitating their child's development.

Variable Stakeholder Collaboration – Services External to SHSS Program

Coordination can be complicated for children whose services extend beyond SHSS. A proportion of children may have different providers in school and at home. In these areas, multiple providers have limited communication with one another, which could negatively impact the continuity of care if the child's goals are not aligned. Although some CCACs attempt to manage the needs of support services across a child's home and school life, the breadth of providers and lack of coordinating infrastructure such as a shared record and service plan can limit seamless, effective coordination.

Variable Stakeholder Collaboration – Speech and Language Pathology Services

Staffing resources vary across school boards and schools, which complicate coordination among the SHSS program and educators. Some boards do not employ in-house SLPs to address minor speech and all language needs, which impacts the scope of activities of other SHSS stakeholders to meet this service demand. Children attending private schools need to seek language service outside of the education system, since most private schools do not employ their own SLPs. For boards that have SLPs, a proportion of stakeholders reported lack of coordination and collaboration regarding the development of goals and evaluation of outcomes with the SHSS SLPs. The variations in Board roles and CCAC SLP eligibility and service policies across local areas limit the ability to follow a standardized approach in coordinating services between the health and education sectors.

Lack of Standardized Documentation and Shared Record

Although CCACs promote the use of standardized, assessment and reporting tools, providers and educators perceive that these guidelines do not accurately capture assessments and treatment strategies. Providers reported CCAC templates are not "user-friendly" for SHSS and are perceived to be more appropriate for adult services. In many areas, parents and educators receive provider reports on triplicate paper forms, which are sometimes difficult to read as a carbon copy, and can be easily lost or misfiled.

Providers feel required to complete multiple reports to ensure effective communication with educators and families. Service providers reported that they attempt to engage parents as much as possible, but variability exists in the ability to use a variety of communication channels (e.g., variability among provider's use of email exchanges to share information, due to perceived privacy issues). Similarly, perceived added workload associated with required documentation impacts available time for a therapist to connect with children and families, and complete other responsibilities.

These challenges are further impacted by the lack of a consistent shared record and service plan available to service providers and families, in most areas of the province. Although some areas have proven successful in their use of paper-based communication books that serve as a communication log between providers, educators and families, a more comprehensive shared record and service plan is only observed in the electronic 'Single Plan of Care' tool used by the Children's Treatment Network of Simcoe York. This tool is discussed further in the leading practices section supporting these Coordination findings.

Inconsistent Case Conferencing

While a proportion of CCACs facilitate case conferences at the onset of service plan initiation, there are consistent challenges with conducting these case conferences, which include organizing an optimal time when everyone can attend and the requirement in most local areas to use an allocated client visit to

participate in the conference. Service providers are not allocated specific time for case conferences, which results in one less visit for direct intervention with the child. However, the CCAC guidelines state required communications are expected to be completed within the allocated visits and case managers/care coordinators perceive knowledge sharing for case conferences could be achieved through this approach, for appropriate cases.

Despite attempts by some CCACs to coordinate care among providers for students with medically complex or specialized rehabilitation needs, families report often needing to collaborate with multiple providers without sufficient assistance of central coordination. This is further complicated for the families of children who access children's services outside of SHSS, such as in-centre CTC programs or other third-party or in-home services.

Lack of Clarity of the Case Management Role

The support needs of children vary across populations, ranging from finite, short-term health support to chronic support across all life stages. Thus, children and families require varying degrees of assistance to access and coordinate services through the health system. SHSS case management services through the CCAC facilitate access to SHSS by conducting structured assessments, determining eligibility of service, and approving the service care plans that guide the goals and activities for each individual. Stakeholders reported variability in the effectiveness and value of the current case management structure, however, as the approach and processes require the same case management and provider resource effort, regardless of the intensity or duration of an individual's needs.

Despite some noted successes of case management in the SHSS program, variation exists throughout the province with regards to the activeness and availability of case managers/care coordinators. A proportion of stakeholders from the CCAC, provider agencies and schools perceive that the workload associated with the case management process is onerous and promotes duplication of services, which suggests that an opportunity exists to review the case management approach. It is perceived that case managers/care coordinators manage high caseloads, which limits their ability to provide effective navigation and coordination services to families. Only 37% of CCAC survey respondents indicated that SHSS case manager/care coordinator workload is appropriate. Providers perceive CCAC case managers/care coordinators are challenged to maintain the coordinator role; historically case managers/care coordinators were able to fulfill this role effectively, but stakeholders perceive that current financial constraints compel case managers/care coordinators to act more as "gatekeepers" or "service brokers" for the program today.

While it is reported that some case managers/care coordinators regularly connect with parents, other families reported that they are unfamiliar or unaware of their assigned CCAC case manager/care coordinator or the appropriate circumstances in which to contact them. Some parents reported that they primarily seek guidance and clarity from the providers supporting their children. A proportion of stakeholders perceive that the coordination responsibilities assumed by service providers is a duplication of service that is within the scope of case managers/care coordinators. Further, while coordination is not remunerated for providers within the current SHSS model, CCACs perceive that these activities are expected to be incorporated within an allocated visit. However, service providers reported that, depending on the complexity of the child's needs, these activities require significant time and effort. Also, some stakeholders perceive that the current case management model may not be appropriate for all cases, particularly for children with finite, "single-service" needs, as they require less intense services to enable access to the SHSS program.

Limited Relationship between Educators and Service Providers

As described in the Access section, challenges also exist in developing collaborative relationships between providers and educators, as providers perceive that they are not part of school culture. Some providers, particularly therapists, feel they have limited time with educators to develop collaborative relationships. Educators perceive that most therapists utilize the "pull-out" approach (i.e. when children are taken out of the classroom to receive SHSS) with students, where therapists work with children outside the classroom setting. This approach limits effective knowledge transfer and sustainability of strategies with educators upon completion of the child's service plan, and is counter to the education sector's direction toward more of an integrated classroom model. The limitations in the relationship between educators and service providers are reported to cause variability in the involvement of service

providers with the Identification, Placement and Review Committee (IPRC) in the Individual Education Plan (IEP) process. Consequently, this limits the ability to ensure SHSS goal alignment for a student with an IEP, where this would benefit the child.

Challenges also exist in developing collaborative relationships between providers and educators, as providers perceive that they are not part of school culture. Some providers, particularly therapists, feel they have limited time with educators to develop collaborative relationships. Therapists are generally in school to provide service to children, mostly outside of the classroom setting. While most local areas attempt to allocate providers to geographic areas, intended to foster greater team relationships between educators and providers, all stakeholders revealed widespread challenges in limiting the number of providers in a given school. This may lead to increasing wait lists and delay access to SHSS.

In addition, there are competing education priorities that are perceived to supersede the ability to foster relationships with educators, as therapists are not consistently present or available in classroom.

Varied Perceptions of Roles and Responsibilities

As noted, a proportion of stakeholders conduct case conferences at the initiation of a service plan and parents are invited to attend in order for all parties to understand the collective roles and responsibilities of the individuals involved in supporting a given child within the SHSS model. From the survey results, 68% of parent respondents indicated that they understood their roles and responsibilities in SHSS. Further, over half (57%) of parent respondents understood the roles and responsibilities of everyone else involved in SHSS. However, consultations revealed a large proportion of parents are overwhelmed with the number of individuals involved in the SHSS processes, and are unsure of the respective scope of responsibilities. As a result, parents feel they must regularly invest time and effort to reach out to the SHSS network to understand their child's progress and plan, and ensure they receive the right information from the right person.

The success of the consultative approach depends on the participation of other individuals to support students in their home environment, as the benefits of SHSS therapies transfer outside the classroom. However, a proportion of families do not believe they should play a role in supporting recommendations independently, as they perceive that this requires the expert guidance of specialized practitioners and cannot be transferred to those outside of these professional fields.

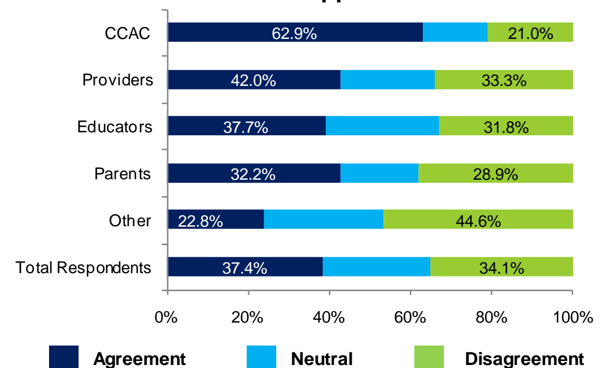
The complexity of children's health needs have evolved over time and their health supports in their respective learning environments have changed accordingly. This impacts the types of services that can be provided effectively by educators and families versus specialized health professionals. At times, a lack of clarity exists as to whether an activity falls under education responsibilities or the health service mandate. Compounding this lack of role clarity is the high turnover of education staff at some boards, and provider staff in some local areas, which has led to difficulty in coordinating care and knowledge of the client.

Managing Expectations

As there are varied mechanisms for communicating with parents, it is challenging to ensure consistent messages are conveyed. Similarly, due to the wide interpretations of the SHSS mandate, families do not fully understand the goals and objectives of SHSS, the corresponding services provided, the program's purpose in supporting their child's broader development, and the role of the program within the broader network of children's programs available in the community. Without consistent sharing of expectations for a child's development among case managers/care coordinators, providers, educators and families, it is challenging for parents to understand their child's capabilities in relation to their function or condition, and the support required to maintain and develop their functional abilities. This impacts the coordination of services for a child with other children's services, as parents often are required to be informed of their child's needs and inter-relationships between different services to enable effective coordination.

Inconsistent Transitions between Pre-school and SHSS

Variation exists across the province with regards to the process for referring children to SHSS from pre-school programs. For example, some CCACs require children to be formally discharged from pre-school programs to be eligible for SHSS, which can result in gaps of support services for children entering the school system. According to the survey results depicted on the right, less than half of respondents (37%) indicated that effective processes are in place to ensure students are properly transitioned from pre-school to receive SHSS. The majority of CCAC respondents (63%) indicated that these processes were effective, however, demonstrating a varied perspective across stakeholders. During local field consultations in the eight areas across the province, it was evident that variability exists across communities regarding the transitions for supporting students between pre-school programs and entry into schools.

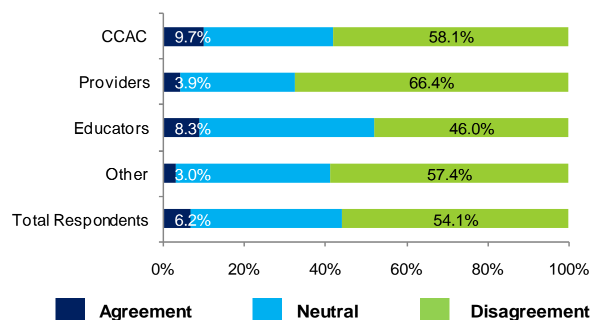


A proportion of children receiving early education support services encounter delays in accessing SHSS upon school enrolment. In areas where there are wait lists to receive SHSS, children transitioning between pre-school programs to SHSS may encounter gaps in services due to wait times. Further, as discussed in the previous findings, across the province there appears to be variation in age-appropriate eligibility for service. Gaps in service resulting from transition processes during this stage of development in a child's life can potentially result in regression of a child's functional ability. Transitions are further impacted where wait lists for pre-school services exist, resulting in reported cases where children 'age out' of the pre-school wait list, and are then transitioned on to the wait list for SHSS, resulting in a lengthy period without support services for the child.

In some areas transition mechanisms have been established to directly refer children to SHSS from pre-school. However, according to policy, all students are to be referred to SHSS by their attending school, which was the general practice followed in the local areas consulted. In the areas in which direct referrals occurred, stakeholders noted that the referral process was more efficient and decreased wait times to access service.

Variability around Inter-CCAC Transfers

The chart to the right demonstrates there is a perception that inter-CCAC processes are inconsistent across the province. The vast majority of survey respondents (94%) indicated that there is a lack of effective processes in place to ensure students receiving SHSS are properly transitioned upon moving to a new school. These findings correlate with the perceptions of stakeholder participants in the provincial and local area consultations.



For school boards that fall under the geographic areas of multiple CCACs, gaps in or cancellation of service may occur when a child transitions from one CCAC jurisdiction to another, even within the same Board. A child may be placed at the bottom of a wait list for service at the new CCAC, often further delaying access to needed therapy. Some educators felt that the transfer of cases from one school to another is a challenging process because of the variability in referral processes that exists among different CCACs and the associated administrative work involved. These transfers frequently result in incremental delays in service provision for the child.

Reduced Focus on High School Transitions

Stakeholders report that transfers between elementary school and high school can be confusing, especially when the high school is affiliated with a different CCAC, as eligibility criteria and referral processes can differ. At this developmental stage of a child's life, the majority of stakeholder groups across the province perceive that service levels drop. A proportion of stakeholders feel that, on average, adolescents and youths require less SHSS relative to the younger demographics. Regardless, it is perceived by parents and providers across the province that children who still require school support services in high school are underserved.

Limited Opportunities for Young Adults

While the majority of Boards, CTCs, other providers and programs conduct transition meetings proactively, a lack of clarity exists around the responsibilities of individuals involved in the planning process. There is often limited availability of community resources that provide appropriate programming for young adults once they leave the school system and are no longer eligible for SHSS. In addition, variability exists as to the stakeholder groups invited to participate in transition planning, which impacts the ability to understand feasible options for the students in their communities and other areas of the province. Therefore, despite the collective planning efforts in a given area, the finite availability of appropriate programs results in long wait lists to access these services, or the requirement for families to pursue private options.

7.1.3. Leading Practices from the Field and Research

The following leading practices from the field and from research present options to explore as additional considerations to enhance the coordination of the SHSS program:

Leading Practice from the Field:

- **Key Worker Model -** In the Children's Treatment Network (CTN) model, a dedicated Coordinator position refers student/families to appropriate services within the partnership network. Partner organizations include stakeholders that not only provide SHSS, but which also provide broader children services. This single point of contact helps families coordinate care across systems. Similar models have proven effective internationally in individualizing approaches based on family and child-centred needs, particularly in the United Kingdom.
- **Seamless Knowledge Transfer -** CTN utilizes the "Single Plan of Care", a comprehensive electronic record that is shared among the network of children's service organizations, which enables stakeholders to access accurate and timely information and allows practitioners to effectively plan for services to meet a child's holistic needs.
- **Knowledge Transfer Tools -** To promote the success of the consultative model and successful knowledge transfer, in several areas, providers take photographs or videotape SHSS sessions with students. This approach provides an accurate visual of therapies and a frame of reference to ensure the educator or parent can execute the recommendations of the service care plan effectively.
- **Building Skills and Capacity -** Stakeholders in the Sudbury area acknowledged that opportunities exist to assist educators and families in supporting a child's physical support needs while waiting for SHSS OT services. The providers at the Sudbury Regional Hospital's CTC developed booklets and resource kits entitled "OT Helpful Hints", to offer practical strategies and activities that a child and parent/educator can undertake to assist in improving the child's skills. In addition, educators apply these learnings to other students with similar challenges in the classroom, which builds the knowledge and capacity within schools to support children and facilitates OTs to work with children with higher complexity needs.

- **Population-Based Case Management -** Several CCACs have moved towards case management services based on population-based needs. Areas, such as Toronto Central and North West, have dedicated case managers/care coordinators to manage the needs of medically complex children and those requiring SHSS respectively. This enables the CCACs to optimize human resources in order to align with the support needs for the various populations, while also providing a focused, knowledgeable point of access for families and educators.
- **Coordination Across Sectors -** The Ottawa Children's Treatment Centre (OCTC) Liaison Teachers assist educators in incorporating SHSS therapies into their daily curriculum. As they possess an education background, the Liaison Teachers can offer practical strategies that are relevant to the teaching plan and can be integrated in classroom wide activities, to augment the traditional one-to-one approach with each student.
- **Transitions to Adult - I**n the North West area, SHSS eligibility extends to 23 years of age, rather than services ending at 21 years of age. Although visit allocations and intensity of SHSS are different for this population, therapists are able to support young adults in their new environments, address relevant equipment needs, and provide education to other support resources that will now interact with these SHSS participants. This enables improved continuity of care by engaging the SHSS therapists with the individual and any new providers through the transition into adult services.

Research-based Leading Practices:

- **Family Centred Approach** - Family-centered service recognizes that each family is unique, the family is the constant in the child's life, and that they are the experts on the child's abilities and needs. The family works together with service providers to make informed decisions about the services and supports the child and family receive. In family-centered service, the strengths and needs of all family members are considered (King et al., 2004). Family-centred care requires the follow provider behaviours:
    - Respectful, supportive, coordinated and comprehensive care
    - Enabling partnerships between parents and health professionals
    - Sharing of general and specific information about the child
- **Effective Coordination Model -** The Expert Panel on Paediatric Complex Care Coordination (Rosenbaum, 2008) developed the following elements critical for successful coordination:
    - Creation and funding for coordination role with sole mandate for care coordination, such as a Key Worker role. In addition, a most responsible physician should be identified for each child depending on special needs, circumstances and parental choice, with available support during regular office hours and extended access offered, if required.
    - Patient and family-centred
    - Care coordination service should be culturally sensitive
    - Approach to care should be consistent across regional and ministerial boundaries
    - This research identifies that a primary enabler for care coordination is an information system that includes patient data that can be used for decision-making and evaluation of services. Electronic Child Health Network (eCHN) is a suggested as a starting point by the researchers, as it is already in place in 83/150 hospitals, all CCACs, all CTCs and in some physicians offices in Ontario. However, the researchers note that eCHN would require an easier interface or increased training for clinicians, including inclusion of a one page summary in database or file to allow for concise and easily accessible information.
- **Integrated Children's Health Programs** - Researchers at the Royal Children's Hospital in Melbourne Australia advocate for integrated children's health programs that will create more comprehensive and cohesive services while increasing accessibility and responsiveness and

have identified best practices principles (Royal Children's Hospital Melbourne: Centre for Community Child Health, 2009):

- Shared understandings among service providers including integration policies, program philosophies, standardized processes for referrals and feedback
- Shared practices in which child outcomes based on evidence and outcomes with input from parents and staff
- Leaders that are well trained and able to work across many disciplines
- Staff induction process to support them in becoming effective and integrated team members
- Family and community involvement in planning and governance
- Accessibility regardless of geographic, cultural and linguistic barriers

- **Collaboration between OTs and Educators** - A number of research studies highlight the various strategies applied to enhance OT service delivery in the classroom:
  - When compared to direct OT therapy, collaborative consultation was perceived by teachers to be more impactful on student goals (Whalen, 2003)
  - OTs help 'reframe' more positive views of parents and teachers regarding child disabilities enabling more effective teaching and parenting strategies (Whalen, 2003)
  - Students receiving OT therapy in school and additional therapy provided by third party (teacher/parent) experienced a 17 month improvement in writing readiness demonstrating the importance of engaging parents/teachers in intervention (Whalen, 2003)
- **Primary Therapist Model** - This approach assigns an OT or PT as a primary therapist with consultations from the other discipline. This model has been proposed to improve availability, impact, and satisfaction with these services in educational settings, and may be more cost-effective than traditional models (Rainforth, 2002).
- **Key Factors for Successful Collaboration** - Two fundamental conditions exist for successful collaboration within SHSS (Villeneuve, 2009):
  1. Teachers need a clear understanding of provider roles so they know what to collaborate on
  2. Sufficient time is needed for collaboration
- **Early Transitions** - Transition services provided to children transitioning from pre-school to kindergarten that included additional therapy sessions, evening parenting education classes and joint visits with "old" and "new" therapists in schools resulted in higher functional outcomes, improved parent and client satisfaction (Stewart et al., 2004).
- **Information Sharing** – Research finds that a computerized self-directed software program, "All About Outcomes", is effectively designed to enable children's rehabilitation providers to make decisions about appropriate outcome measures. (Law et al., 1999).

7.2. Recommendations

Effective coordination is needed for SHSS to link children and their families with the services they require, integrating services and resources, avoiding service duplication and unnecessary costs, and ensuring smooth transitions from one service to another. For effective coordination to occur, structures, tools and processes to facilitate communication and collaboration are required across multiple stakeholder groups – children and families, case managers/care coordinators, educators, SHSS service providers, CTCs and broader service providers, at various points in a child's development.

Based on the findings from the review, the following recommendations are identified related to the coordination of the SHSS program:

Recommendation 7: Develop and implement common guidelines to achieve a "shared care and service plan" for each child that engages appropriate stakeholder groups

Proposed Outcomes:

Guidelines for a "shared care and service plan" will stem from the program mandate and principles, and will:

- Facilitate shared planning across stakeholder groups for children and their families
- Reduce service and knowledge fragmentation
- Enable CCAC, providers, educators and families to maintain and monitor up-to-date information on a child's progress within the SHSS program

Recommendation Description:

The guidelines developed and implemented for a "shared care and service plan" can be achieved through the following:

7.1. Establish a shared care and service plan to enable stakeholders to participate in SHSS program planning for the individual child

- Develop mechanisms to enable establishment of SHSS goals, as part of broader holistic goals for child and family, across sectors
- Connect with existing family and child support requirements to inform local cross-sector planning for appropriate SHSS
- Assess current communication processes and determine mechanisms to enhance and coordinate communication (e.g. case conferences, involvement in IPRC/IEP processes)
- Develop family-focused and user-friendly reporting protocols that support a consistent and informed approach to the services provided (e.g. communication books, email protocols)

7.2. Explore options to implement a shared record through existing technology platforms to share outcome information and manage client records

- Assess functionality of an enhanced shared record to link stakeholder assessments, evaluations, interventions, and communication plans, such as the Children's Treatment Network Single Plan of Care tool, eCHN, or other provincial platforms
- As information systems are reviewed, consider options to link information with web-based portals that can provide on-going communication across stakeholder groups
- Build a business case to validate appropriate cost-benefit and supporting system implementation plan, if deemed feasible

Recommendation 8: Assess effectiveness of case management services across all student population types to determine appropriate case management models to deploy

Proposed Outcomes:

By enhancing the case management model to meet the needs of SHSS students, the model can:

- Reduce administrative efforts and minimize potential service duplication
- Limit potential communication delays, and reduce related wait times for service
- Optimize SHSS roles to enable stakeholders to increase time spent on direct client service delivery

Recommendation Description:

Assessing the effectiveness of case management for SHSS entails conducting the following actions:

8.1. Re-examine the appropriateness of case management across various student populations, and determine the most appropriate balance across CCAC case managers/care coordinators and providers. Considerations for this balance are noted in the table below.

Case Management Models	Current State and Considerations
Children Requiring Single Services	• A proportion of children may require finite health support from one health discipline, which suggests that this population may require limited case management services
Children Requiring Multiple Services	• Depending on the number of professionals involved in a child's life, case management services may be more complex, and require regular case reviews and seamless coordination of services
Care Coordination and Case Management Services	• While the CCAC care coordinators and case managers/care coordinators are currently charged with providing care coordination and case management services, the Ministries should explore the most appropriate role to assume responsibilities for these services by population need, and the impact to resources and costs of shifting accountability, • If role changes are deemed appropriate, this can be done in alignment with the Integrated Client Care Project underway, which aims to move toward a value based model of care organized around clinical conditions that will improve health outcomes for clients.
Navigation	• Determine the feasibility and effectiveness of providing navigation services within the case manager/care coordinator role, or through linking navigation to other supports provided to famililes and educators.

Recommendation 9: Develop common protocols for SHSS transition processes across a child's life stages and across organizations

Proposed Outcomes:

Transitions between key life stages have been identified as critical areas upon which to focus as children develop. The proposed outcomes that will occur as a result of these recommendations include:

- Enable seamless coordination and knowledge sharing to facilitate smooth transitions for children between key life stages and across jurisdictions, which may increase their likelihood for successful development
- Enhance appropriate community programs, vocations, or residences for youths upon graduation from SHSS, which can allow SHSS students to maintain functional abilities in their next life stage

Recommendation Description:

Transition processes into, throughout and out of the SHSS program can be improved and made more seamless through the execution of the following activities:

9.1. Examine transition agreements and processes to SHSS from pre-school programs across CTCs, service providers, CCACs and school boards

- Areas of focus should include eligibility criteria, waitlist management, information sharing and report transfers
- Develop communication protocols to set expectations when children and families transition from early education programs into SHSS service model
- Consider enabling direct referrals from pre-school to SHSS across the province
- Coordinate waitlists across pre-school and SHSS at the local level

9.2. Enhance planning and transition from SHSS to adulthood with broader community services

- Examine and address broader system service gaps to facilitate transitions into adulthood
- Similar to North West area, consider extending relevant SHSS beyond 21-years of age to promote continuity of care and support smooth transitions to individuals involved at the client's next life stage
- Collaborate with MCSS, other Ministries and related sectors to enhance the availability of appropriate programs and services once a client has transitioned into adulthood

9.3. Standardize processes when students transfer between schools to minimize SHSS disruption and delays

- Optimize inter-CCAC transfer processes to maintain child and family-centred care, coordinate waitlists and placement, and improve CCAC-to-CCAC knowledge transfer
- Improve school-to-school communication to streamline SHSS referral transfer processes, documentation and educator knowledge transfer
- Improve provider-to-provider communication, information sharing and coordination to reduce duplicate documentation and assessments
- Improve linkage and navigation for children and families to SHSS and broader children's services when shifting communities

Recommendation 10: Establish navigation support to assist families in better understanding and navigating the services available for children requiring SHSS

Proposed Outcomes:

The need for specific navigation mechanisms and roles to assist families emerged in a wide proportion of consultations and survey responses across the province. This recommendation is intended to:

- Empower families to understand the breadth of health support services available and make informed decisions about their child's care
- Disseminate relevant information to assist case managers/care coordinators, educators and providers to focus on direct client support

Recommendation Description:

Further analysis will be required across sectors to determine the most appropriate navigation supports and model to best support families in navigating SHSS and broader children's services.

10.1. Explore the feasibility of establishing an accessible navigation or advocacy roles to support families throughout the SHSS coordination process

- As outlined in Recommendation 6, establish communication channels and forums for families to understand the SHSS model and effectively navigate through the required processes to receiving services
- Link role to case management decisions determined through Recommendation 8

Recommendation 11: Assess, develop and implement mechanisms required to enhance knowledge transfer among stakeholders in service delivery

Proposed Outcomes:

Through effective knowledge transfer, the SHSS program can achieve the following proposed outcomes:

- Build capacity within the system to not only support the needs of children, but also apply relevant strategies to other students with similar challenges
- Reduce the reliance on specialized clinicians and therapists to deliver certain types of support services, and enable them to address students with more complex support needs

Recommendation Description:

The program should incorporate consistent mechanisms to enhance knowledge transfer for effective service delivery, for example, utilizing videotaping and tools, optimizing resource people/roles, and incorporating toolkits to facilitate knowledge transfer.

11.1. Encourage educators and families to participate in consultative model, improve self-managed care by families and children and support families with appropriate tools to guide supportive care

11.2. Distribute practical strategies for educators and families to employ while students are waiting for services

11.3. Support and disseminate leading practice research that investigates appropriate application of and support for consultative therapy models, as noted further in Recommendation 13

8. Quality

Continuous quality improvement in a program involves assessing the degree to which goals and objectives have been achieved, as well as determining potential strategies to further enhance program performance. The review of program performance may include indicators such as child health outcomes, utilization metrics or stakeholder satisfaction and feedback. Ongoing monitoring of the SHSS program can inform planning processes, as organizations build their understanding of appropriate resourcing and capacity required for program delivery, to assist in designing an optimal service model that maintains quality support for the child.

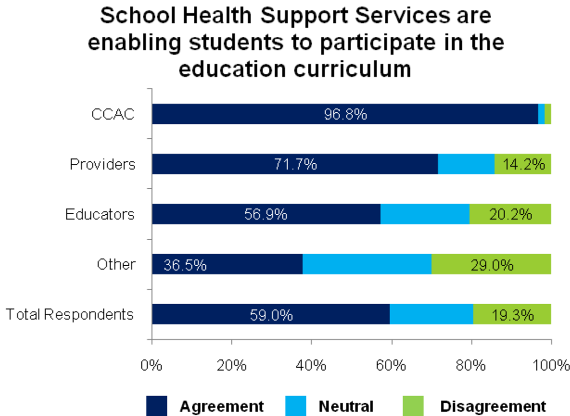
The integration of leading practices is critical to building quality within the SHSS program. Mechanisms for seeking, sharing, understanding and implementing leading practices need to be in place so that they can be incorporated into the program for ongoing improvement. The incorporation of leading practices may impact roles and responsibilities for individuals involved within the program, which requires flexibility to accommodate change across different stakeholder organizations and sectors. Effective professional development is also required for stakeholders to understand and buy-in as leading practices evolve for the SHSS program.

8.1. Current State Findings

8.1.1. Strengths

Achieves SHSS Foundational Goal

Overall, there is general agreement that the SHSS program achieves its overall intent in assisting children to participate in the school curriculum. As evidenced in the graph on the right, survey participants agreed that the health support services allowed students to participate in the education curriculum, which achieves the goals of the stated program mandate. However, as described earlier, varied interpretations of the SHSS mandate exist, particularly among parents, regarding the extent of health support services required to meet their perceived needs of their children.



Clear Goals for Each Child

Across the local areas consulted, stakeholders report that the goals and activities of a child's given plan are clearly documented in the individual service plan. In several areas, case managers/care coordinators, service providers, educators, and parents are aware of the goals and interventions related to the child's functional needs or health issues, and the progress the child has made to achieve these goals.

Family-Centred Philosophy

CCACs, educators and providers acknowledge parents as key partners in successfully supporting children to enhance their functional abilities, thus a family-centred approach is critical to maintain when structuring relevant services. A proportion of areas have developed programs to promote family involvement within their child's rehabilitation or chronic disease management journey. While stakeholder groups recognize the need to enhance the family-centred approach in the delivery of SHSS, there is general consensus that the adoption of this perspective is critical to building the right support system around the child.

In general, families and children who have been involved with health system partners at an early age, as a result of their complex care needs, are aware of the communication modes available to seek accurate information and provide timely feedback. Consequently, the team of individuals involved in the family's life has the ability to better plan for the unique needs of the child.

Continuity of Care

Stakeholders across the provincial and local area consultations, and the external scan literature review, emphasize the importance of continuity of care in delivering services. Although the program is intended to deliver support services during the school year, a number of CCACs, providers and educators recognize the benefits of continuing support to children during the summer months to minimize regression, promote concrete skills development, and increase their likelihood of success in the classroom. A number of areas incorporate summer speech or writing camps to enable children to continue working on their functional goals in an environment with like-minded peers.

Evidence-based Practice

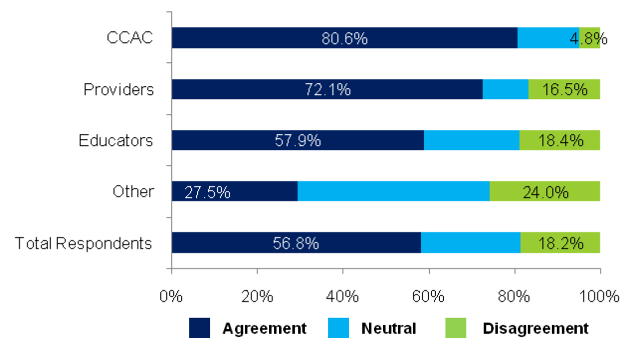
Generally, service providers and the CCACs utilize various mechanisms or avenues to maintain their knowledge base regarding emerging leading practices within children's health services and emerging trends. Examples of these avenues include attending relevant conferences, independent learning via virtual curriculums, and sponsoring key industry leaders to deliver presentations to practitioners. In a variety of areas, the CTCs provide valuable knowledge about current trends and practices in children's services to educators, other service providers and case managers/care coordinators.

Evolving Support Services to Meet Student Needs

A higher portion of students integrated in classrooms today cope with complex medical conditions and require higher physical supports compared to students attending class when the SHSS program started approximately 25 years ago. As a result, the types of health support services delivered in schools have changed significantly and the roles providing these services have also shifted to meet demand where possible. Nurses, therapists and educators are often part of a cross-disciplinary team that actively provide and support SHSS for these students with higher acuity needs.

8.1.2. Challenges

Variation in Goal Setting



As evidenced by the survey responses detailed on the right, stakeholders are in agreement that the goals outlined for students are appropriate in supporting their progress to participate in the classroom environment. Overall 57% of respondents indicated agreement that goal and outcomes established for a student's SHSS plan are reasonable and appropriate to the student's needs. However, it is evident that variation exists among the local areas in setting an individual's goals. Consultations revealed that the type of goals established ranged from comprehensive functional goals related specifically to the child, to goals directed at the individuals supporting the student in the classroom. As a result, it is difficult to assess the effectiveness of services among the different areas of the province based on service plan outcomes. Further, the variation in interpretation of the SHSS mandate and objectives impacts the setting of goals for a given student. The goals and evaluation outcomes currently used in an individual's service plan may not accurately align with a child's functional needs or health issues, as they are generally focused on targeted goals for improvement rather than on the child and family's broader holistic needs.

As described in the Mandate and Accountability section of this report, a philosophical divide exists among stakeholders with regards to the scope of the program mandate. A proportion of individuals perceive that SHSS should focus on supporting the current needs of children, while others feel the program should address the long-term needs of their functional status and develop their service plan accordingly. Consequently, these diverging philosophies result in contrasting perspectives as to the range of goals required to support a child's health-related needs in the classroom. In the majority of areas, a disconnect exists among stakeholder groups regarding a student's expected functional outcomes achieved through SHSS.

Limited Formal Performance Management Processes

Currently, consistent quality outcome indicators for the SHSS program across the province do not exist; this impacts the ability to regularly monitor services and inform the Ministries of overall program performance. While service providers and CCACs track a child's achievement of SHSS goals as set out in the service plan, there are limited indicators monitored to provide insights on the effectiveness of service delivery:

- For example, the current SHSS mandate indicates students will receive effective services appropriate to their needs to attend school, participate in school routines, and receive school instruction, including satisfactory instruction at home.
- However, the program does not track the impact of SHSS on a child's academic-related achievements.

Without holistic performance measurement metrics, it can be difficult to understand how the service model must change to meet the needs of the community.

The number of SHSS professionals involved in a child's service plan, and their corresponding visit volumes, assist stakeholder groups to understand a portion of the service levels required to address the health support needs in their respective communities. However, the intensity of support services required for a given child cannot be determined in a consistent manner relative to other children, as the SHSS program does not incorporate assessment tools to monitor this dimension of service delivery and allocation. Without this type of information, it is challenging to understand the collective levels of service appropriate to meet SHSS demand or to project future service needs for local area populations.

Inconsistent Awareness of Feedback Mechanisms for Students, Families, and Educators

Although the CCAC provides families with information on communication options and feedback mechanisms upon admission to the program, it is perceived that this information is not consistently retained by parents. Interviews and focus groups with parents revealed inconsistency among families regarding their awareness of an appeal process to review cases. It was reported that a proportion of parents are hesitant to raise concerns around the management of their child's case or the performance of a given individual involved, as they feel that there may be repercussions to their actions and the health support services currently provided would be impacted. Generally, families perceive that the current cross-disciplinary team delivering the SHSS program – case managers/care coordinators, educators and service providers – cannot act in an advocate role to truly meet the support needs of the family.

Limited Formal Research and Information Sharing

A number of areas have embarked on various SHSS pilot projects and initiatives to trial innovative processes that enhance service delivery for the child and family. While stakeholders reported these are effective approaches to determine the applicability of alternative practices in their respective areas, there appears to be a lack of a formal, integrated mechanism to conduct and disseminate findings from pilot initiatives and research trials. As a result, it is challenging to promote awareness among colleagues of the research underway to address common issues in delivering SHSS, or share experiences and lessons learned with colleagues across the province.

Variation of Direct Intervention and Consultative Service Delivery Models

The majority of areas use a mix of direct intervention and consultative therapy approaches to deliver SHSS. While it is appropriate to provide a blend of both models to serve the unique needs of the child, there appears to be a lack of clarity regarding the definition of these approaches, the range of services offered under each, and the benefits of each model in improving a child's health outcomes. As described under the Mandate and Accountability section of this report, survey results indicate that the majority of respondents (70%) feel that SHSS does not employ an appropriate combination of consultative and direct therapies.

Compounding this challenge, an examination of existing research and consultations with academic experts at CanChild indicates that due to the limitations in the available research:

- Definitive conclusions cannot yet be drawn regarding the respective effectiveness of the direct therapy and consultative models of service delivery in relation to different child support needs
- It is not yet possible to determine the extent of positive outcomes for each approach with regards to increased participation in school-based activities.

As noted above, further investment in research is needed to enhance the understanding of the benefits and outcomes that can be achieved through the direct therapy and consultative models, so that an appropriate balance can be delivered in the SHSS program.

Lack of Effective Knowledge Transfer

Some providers revealed challenges in sharing their knowledge to educators and parents to enable a consultative model of service delivery, as educators and parents may not possess required specialized training relevant to a child's health needs. Educators and parents report variable understanding of SHSS recommendations, and, at times, feel reluctant, ill-equipped and that services are outside their own skills, to carry out the activities instructed by the therapists. Consultations revealed educational assistants perceive there is inadequate training to perform SHSS-related activities, and that turnover of school staff leads to lack of knowledge regarding appropriate care for a given child. As there are a finite number of SHSS visits allocated to children, it is perceived to be difficult for providers to transfer sufficient knowledge to educators and parents:

- Providers reported that it is challenging to set up time with teachers, educational assistants and parents to realize a truly consultative model.
- Since the program is intended to be provided in the schools, therapists have limited opportunity to work with the parents in a collaborative model outside of the school environment.
- Further, there is limited follow-up to ensure activities are being executed by teachers and parents.

Challenges in knowledge transfer and education for educators are also noted with regards to SHSS referrals. Stakeholders report variability among educators regarding their ability to appropriately assess a child's need for service. Educators across the province receive a varied level of education and training on how to conduct these assessments, and stakeholders report variability in the knowledge and capacity of educators to consistently identify clients for appropriate health support services.

Barriers to Adopting Technology

Technology advances, such as assistive communication devices, have enabled children to participate in the classroom in a more fulsome manner. However, it is perceived that there is inconsistency among educators as to their abilities in utilizing these supports effectively. A proportion of educators receive insufficient training to understand and apply these tools or programs appropriately. As a result, communication devices are not consistently used in the classroom when they would be beneficial, and the child may not benefit from potential learning opportunities that could result in better participation in the education curriculum.

8.1.3. Leading Practices from the Field and Research

The following leading practices from the field and from research present options to explore as additional considerations to enhance the quality of the SHSS program:

Leading Practice from the Field:

- **Current Research** – CanChild Centre for Childhood Disability Research is widely acknowledged as an expert resource for child and youth disabilities and regularly collaborates with cross-sector stakeholders to share valuable information. The studies conducted by CanChild dovetail with the services delivered in the SHSS program and provide evidence to support practices. Currently, the *Partnering for Change* initiative is underway, which is being led by CanChild in partnership with the Central West CCAC, Halton District School Board and providers. This initiative is investigating an innovative model to enhance health support services for children with Developmental Coordination Disorder (DCD), an emerging issue for today's school-aged population
- **Family-centred Services –** The Hamilton area CCAC and therapists offer evening clinics for students and families to attend after work hours. This strategy promotes family participation and fosters utilization of therapies in the home environment.

Research-based Leading Practices:

- **Standardized Outcome Measurements** – A number of valid assessment and measurement tools currently exist that are applicable to the delivery of SHSS services:
  - Measures of Processes of Care (MPOC-56 and MPOC-20) assess parents' perceptions of the care their children receive and extent to which services are family centered. These tools evaluate services in terms of the following factors: enabling partnerships; providing general information; providing specific information about child; coordinated and comprehensive care for child and family and respectful and supportive care (King et al., 1995; King et al., 2004). In addition, MPOC-SP has been developed for service providers to assess their perceptions of their behaviours for providing family centred therapy (Woodside, 1998).
  - Participation and Activity Limitation Survey (PALS) is a survey measuring complexity of child disabilities by focusing on how disability impacts participation in activities of daily living (Law and Jaffer, 2007)
  - Gross Motor Function Classification System (GMFCS) is a 5 level classification system describing gross motor functions of children with cerebral palsy while emphasizing performance in home, school and community. An expanded and revised version includes 12-18 year olds, and reflects impacts of ICF's personal and environmental factors on mobility (Palisano et al., 2008).
  - The Perceived Efficacy and Goal Setting System (PEGS) is an instrument and a process that enables children with disabilities to reflect on their ability to perform everyday occupations and to identify goals for OT intervention. Children were able to use the perceived efficacy information to identify and prioritize goals for intervention. OTs can use the PEGS to facilitate client-centered practice to help the child set goals for therapy and incorporate perspectives of parents and teachers (Missiuna et al., 2006).
- **Consultative and Direct Approach Continuum** – A variety of perspectives exist regarding the appropriateness of service delivery in meeting the SHSS OT support needs for children:
  - A consultative OT delivery model in SHSS in London-Middlesex that involves parents/teachers in the assessment and identification of target areas, and provides consultation/education on the implementation of strategies in classrooms and homes, resulted in significant improvements in children's written communication and fine motor skills. Prior to consultation only 26% of teachers used additional child individualized strategies compared to 70% using them following OT consultation services (Bayona et al., 2006).

- Students receiving OT therapy based on The Occupational Therapy School-Based Consultation Model that focuses on the education of teachers and/or parents, the provision of recommendations and introduction of resources resulted in significant improvements on the performance and satisfaction scales of the Canadian Occupational Performance Measure (COPM). Increased teacher awareness and subsequent implementation of OT strategies by teachers are positively related to increased COPM scores (Reid et al., 2006).

- **Knowledge Transfer** – Knowledge Translation methods (e.g. DVDs, interactive websites, screening activities) delivered by an OT to educate family physicians to identify children with DCD improved physicians' ability to identify patients with DCD from 0.5% to 90% accuracy in identifying children with motor problems (Missiuna, 2009). The Knowledge Translation Model in Partnering for Change in which OTs act as 'coaches' embedded in the classroom to help facilitate the participation of children with DCD has proved successful in pilot projects in reaching more children and enhancing teacher capacity to meet students needs. Teachers attending educational workshops about attention disorders demonstrated a change in knowledge but little change in their perception of ability to manage children with disabilities. Instead of educational workshops alone, it would be more beneficial for OTs to work in classrooms with teachers to collaboratively develop strategies of care (Missiuna et al., 2005).

8.2. Recommendations

An enhanced focus on quality is needed through several dimensions of the SHSS program to support improved access, equity, coordination and program management. Based on the findings from the review, the following recommendations are identified related to the quality of the SHSS program:

Recommendation 12: Assess SHSS program outcomes in achieving its mandate, with defined indicators and measurement processes

Proposed Outcomes:

Through the assessment of SHSS program alignment with the overall mandate, and improved use of outcomes for ongoing program monitoring, the following objectives can be achieved:

- Evaluate the effectiveness of the SHSS program and models in achieving its mandate and objectives
- Enhance the accountability of the program with indicators that assess whether the program mandate, objectives, roles and responsibilities are being achieved
- Determine changes required to the program to enhance its effectiveness
- Promote child and family-centred approaches by examining client outcomes and directly linking them to quality improvement plans
- Determine appropriate SHSS program outcomes and indicators that are meaningful to each of the ministries/sectors and system goals
- Set accountability structures to measure, monitor and act on results of the program outcomes
- Establish province-wide guidelines for outcome measurement tools and data reporting

Recommendation Description:

In order to assess program outcomes, ongoing evaluation of the SHSS program at a provincial level must be conducted, which should include the following:

12.1. Develop and implement province-wide indicators and define measurement process to effectively assess program performance against its mandate.

Based on the refined program mandate and scope that emerge with Recommendation 1, the Ministries need to determine the broad determinants and indicators that accurately portray the effectiveness of the program, including the roles for stakeholders to measure and report on these trends. The following table outlines key areas for the Ministries to consider in shaping the evaluation dimensions for the future.

Dimensions	Considerations
Breadth of SHSS Indicators	The Ministries should determine the comprehensive indicators that offer insights regarding the program's impact toward achieving its mandate. In addition to indicators that are currently tracked, potential considerations include: • Impact to ADLs relevant for the classroom environment, e.g. use of Participation and Activity Limitation Survey (PALS) tool • Impact of SHSS interventions on a child's academic performance • Evaluation of a child's social and emotional progress, if relevant • Child/family experience and burden of care in supporting a child's health support needs in an education environment, e.g. MPOC tool currently used by CTCs to assess effectiveness of coordination and communication and engagement indicators
Reporting Roles	• Establish the role of Education in reporting academic goals within the context of SHSS • Determine linkages with other health outcome information
Performance Management	• Determine mechanisms to incorporate ongoing feedback regarding the effectiveness of the program

12.2. Develop mechanisms to assess client outcomes at the local level that are consistent across the province.

- Set guidelines to develop an individual child's goals and assess outcomes that align with the program mandate (e.g. outcome measures that assess the ability of SHSS in enabling students to participate in all aspects of the education curriculum), linked to broader holistic child and family goals across sectors
- Examine incorporation of existing evidence-based outcomes assessment tools into practice (e.g. MPOC, GMFCS)

12.3. Determine how existing information systems can be used to measure, monitor and assess program outcomes

- For example, consider the enhanced utilization of the CHRIS database or other systems

12.4. Develop mechanisms to share and compare results across the province to enhance continuous program improvement

Recommendation 13: Establish a provincial mechanism that objectively reviews SHSS models and clinical leading practices on an ongoing basis, and integrates results into the program

Proposed Outcomes:

The proposed outcomes of establishing a provincial mechanism to direct leading practice research and implementation include the following:

- Promote child and family-centred goals and outcomes by incorporating practices that lead to improved client outcomes
- Address needs of providers and educators in supporting goal achievement
- Build a base of evidence and leading practices research to support SHSS
- Enhance integration of leading practices into service delivery

Recommendation Description:

For a provincial mechanism to be effective in reviewing SHSS models and leading practices, the following should be carried out:

13.1. Commission and communicate research to build an evidence base of leading practices, and establish service models for key areas of interest in the SHSS program; for example:

- Consultative versus direct approach
- Discipline-specific services
- Function-specific needs
- Children with single service support needs
- Children with multi-service or long-term support needs

13.2. Determine the appropriateness of developing holistic goals, balanced with functional needs for students.

- For example, leverage existing evidence-based models such as the WHO International Classification of Functioning (ICF) model

13.3. Leverage existing provincial mechanisms that conduct leading practice research to support similar work for the SHSS program

- For example, build upon the roles of the Provincial Council for Maternal, Newborn, Child and Youth Health Care, the Ontario Health Quality Council, CanChild or others

13.4. Establish mechanisms to share and compare program data, research findings, leading practices, and pilot study results from across the province

13.5. Establish and work through existing local working groups to tailor and implement leading practices

Recommendation 14: Establish tools to determine weighting or required intensity of services for SHSS

Proposed Outcomes:

By measuring the complexity of clients for the SHSS program, the following objectives can be fulfilled:

- Assist in projecting future client population service demand and resource requirements
- Facilitate proactive program planning for SHSS by developing strategies to allocate and optimize available resources to meet current and future service demands

Recommendation Description:

This recommendation can be achieved through the following activities:

14.1. Identify information requirements and tools to monitor the complexity of SHSS cases

- Examples of these requirements include information related to a child's cognitive, functional, social and environmental needs

14.2. Develop or obtain tools to support care planning, quality improvement, and outcome measurement

- Examples of similar tools include the Resident Assessment Instrument (RAI), which is a series of assessment instruments that assesses a client's current medical, functional, social, and environmental issues

14.3. Once tools are implemented, determine workload requirements for effective service delivery and case management on an on-going basis

Recommendation 15: Establish initial and ongoing SHSS professional development requirements for stakeholders

Proposed Outcomes:

Dedicated professional development opportunities aligned to the needs of the various SHSS stakeholders can result in the following outcomes:

- Facilitate knowledge exchange and capacity building among stakeholders, across sectors
- Update stakeholders on leading practices to be deployed in service delivery and help to build an understanding of the impact on their own practices

Recommendation Description:

The development of education programs specific to SHSS entails meeting the tailored needs of case managers/care coordinators, service providers, and educators. Across stakeholders, while professional development requirements will differ, common education around leading practices, system trends, roles and responsibilities of stakeholders, is critical information to share on an on-going basis. Specifically, the recommendation can be achieved through the following activities:

15.1. Develop and implement professional development requirements for CCAC case managers/care coordinators to support their role in SHSS

15.2. Develop and implement professional development requirements of educators to effectively deliver children's SHSS

15.3. Develop and implement professional development requirements of providers to effectively deliver children's SHSS

15.4. Coordinate education curriculum development and delivery across sectors (health, education and children and youth services) to leverage existing knowledge, resources and leading practices

9. Moving Forward

This School Health Support Services Review aims to build on the successes of the program since its inception over 25 years ago, address some of its challenges, and support the province in a critical first step toward improving the program. The findings and recommendations of this Review outline steps toward change to improve the program, align services across sectors and with other programs, and enable SHSS to better serve children and families.

Given the many stakeholders involved in the SHSS program across Ontario, the recommendations coming from this Review will require a collaborative commitment and effort across all relevant sectors, involving stakeholders at both the provincial and local levels. Leadership and commitment are needed from both levels for the different recommendations, to ensure that strategies implemented are effective and sustainable.

The following table summarizes the recommendations from this review with their associated intended outcomes. Additional sub-recommendations are identified in Sections 5 – 8 of this report, which support each of the recommendations and outcomes summarized below. Through continued commitment and involvement at the provincial and local levels, the recommendations from this review can enhance SHSS throughout the province.

Recommendations	Proposed Outcomes
Mandate and Accountability	
Recommendation 1: **Clarify the scope of services delivered under the mandate of the SHSS program**	• Establishment of a common understanding of SHSS program purpose and objectives across stakeholders for more consistency in service delivery across the province • Clarification of roles, responsibilities and accountabilities across stakeholders to deliver SHSS • Optimal use of speech and language resources that are coordinated to meet the needs of children requiring them • Examination of legislation that will identify appropriate policies required to support the program mandate and scope of services delivered
Recommendation 2: **Under the SHSS mandate, enhance cross-sector collaboration to deliver SHSS that optimizes expertise and resources**	• Assist in establishing a common understanding of the SHSS program • Facilitate working relationships, service delivery, planning and coordination among local area stakeholders • Define program accountability, roles and responsibilities and performance expectations that relate to child and family focused outcomes • Promote innovative service delivery models that optimize the use of available resources

Recommendations	Proposed Outcomes
Access and Equity	
Recommendation 3: **Develop access guidelines and tools to guide service delivery**	• Enable equity of SHSS program access across the province • Enhance collaboration across sectors and SHSS stakeholders to meet the needs of the population • Create mechanisms to share information across stakeholder groups to help inform program planning • Determine how to addresses challenges of program planning among competing initiatives by aligning population needs and sector changes with resource capacity
Recommendation 4: **Develop formal forums and processes for proactive service planning**	• Enhance collaboration across sectors and SHSS stakeholders to meet the needs of the population • Create mechanisms to share information across stakeholder groups to help inform program planning • Determine how to addresses challenges of program planning among competing initiatives by aligning population needs and sector changes with resource capacity
Recommendation 5: **Establish alternative models of service delivery across the province to improve access and wait times**	• Enhancing optimization of finite resources with the introduction of alternate health professionals, which aligns with leading practice • Increasing access to specialized expertise to better support children's needs in a timely manner
Recommendation 6: **Increase awareness of the SHSS program provincially and locally**	• Increase ability for families, educators, and other stakeholders to identify and refer children to appropriate supports • Offer relevant information to families in ways that resonate with them and enhance their understanding of the network of services available • Reduce confusion for families in navigating the system through a single point of access

Recommendations	Proposed Outcomes
Coordination	
Recommendation 7: **Develop and implement common guidelines to achieve a "shared care and service plan" for each child that engages appropriate stakeholder groups**	• Facilitate shared planning across stakeholder groups for relevant clients • Reduce service fragmentation • Enable CCAC, providers, educators and families with up-to-date information on a child's progress within the SHSS program
Recommendation 8: **Assess effectiveness of case management services across all student population types to determine appropriate case management models to deploy**	• Reduce administrative efforts and minimize potential service duplication • Limit potential communication delays, and thereby, reduce wait times for service • Optimize SHSS roles to enable stakeholders to increase time spent on direct client service delivery
Recommendation 9: **Develop common protocols for SHSS transition processes across a child's life stages and across organizations**	• Enable seamless coordination and knowledge sharing to facilitate smooth transitions for children between key life stages and across jurisdictions, which may increase their likelihood for successful development • Enhance appropriate community programs, vocations, or residences for youths upon graduation from SHSS, which can allow SHSS students to maintain functional abilities in their next life stage
Recommendation 10: **Establish navigation support to assist families in better understanding and navigating the services available for children requiring SHSS**	• Empower families to understand the breadth of health support services available and make informed decisions about their child's care • Disseminate relevant information to assist case managers/care coordinators, educators and providers to focus on direct client support
Recommendation 11: **Assess, develop and implement mechanisms required to enhance knowledge transfer among stakeholders in service delivery**	• Build capacity within the system to not only support the needs of children, but also apply relevant strategies to other students with similar challenges • Reduce the reliance on specialized clinicians and therapists to deliver certain types of support services, and enable them to address students with more complex support needs

Recommendations	Proposed Outcomes
Quality	
Recommendation 12: Assess SHSS program outcomes in achieving its mandate, with defined indicators and measurement processes	• Evaluate the effectiveness of SHSS program and models in achieving its mandate and objectives • Support accountability of the program with indicators that assess whether the program mandate, objectives, roles and responsibilities are being met • Determine changes required to the program to enhance its effectiveness • Promote child and family-centred approaches by examining client outcomes and directly linking them to quality improvement plans • Determine appropriate SHSS program outcomes and indicators that are meaningful to each of the ministries/sectors and system goals • Set accountability structures to measure, monitor and act on results of the program outcomes • Establish province-wide standards for outcome measurement tools and data reporting
Recommendation 13: Establish a provincial mechanism that objectively reviews SHSS models and clinical leading practices on an ongoing basis, and integrates results into the program	• Promote child and family-centred goals and outcomes by incorporating practices that lead to improved client outcomes • Address needs of providers and educators in supporting goal achievement • Build a base of evidence and leading practices research to support SHSS • Enhance application of leading practices into service delivery
Recommendation 14: Establish tools to determine weighting or required intensity of services for SHSS	• Assist in projecting future client population service demand and resource requirements • Facilitate proactive program planning for SHSS by developing strategies to allocate and optimize available resources to meet current and future service demands
Recommendation 15: Establish initial and ongoing SHSS professional development requirements for stakeholders	• Facilitate knowledge exchange and capacity building across sectors • Update stakeholders on leading practices to be deployed in service delivery and help to build an understanding of the impact to their own practices.

Appendices

The following appendices support the findings and recommendations presented in this report for the School Health Support Services Review:

- Appendix A – External Scan Bibliography
- Appendix B – List of CCAC/LHIN Communities

Appendix A – External Scan Bibliography

The following published research, presentations and other sources of information were considered during the External Scan supporting the SHSS Review.

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Appendix B – List of CCAC/LHIN Communities

The table below outlines the communities used to describe each CCAC / LHIN in the SHSS Review survey. All communities included within each CCAC / LHIN are not listed; rather, a selection of communities is identified to provide an overview of the geography of each CCAC / LHIN.

CCAC/ LHIN Area	Communities
Central	Newmarket, North York, Richmond Hill, Vaughan
Central East	Campbellford, Haliburton, Lindsay, Oshawa, Peterborough, Port Hope, Scarborough, Whitby
Central West	Brampton, Orangeville
Champlain	Ottawa, Alexandria, Carleton Place, Casselman, Cornwall, Hawkesbury, Hazeldean, Orleans, Pembroke, Winchester
Erie St. Clair	Chatham-Kent, Sarnia-Lambton, Windsor-Essex
Hamilton Niagara Haldimand Brant	Hamilton, Niagara, Haldimand-Norfolk, Brant, Burlington
Mississauga Halton	Oakville, Mississauga, Milton, Georgetown
North East	Kirkland Lake, North Bay, Parry Sound, Sault Ste. Marie, Sudbury, Timmins
North West	Thunder Bay, Dryden, Fort Frances, Kenora, Red Lake/Ear Falls, Rainy River, Atikokan, Marathon, Geraldton
North Simcoe	Barrie, Midland, Collingwood, Muskoka, Orillia
South East	Bancroft, Belleville, Brockville, Kingston, Northbrook, Selby, Smith Falls
South West	London, Owen Sound, St. Thomas, Seaforth, Stratford, Strathroy, Walkerton, Woodstock
Toronto Central	Toronto
Waterloo Wellington	Kitchener, Cambridge, Guelph

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