Chair's Report

February 2011

Special Education

School Health Support Services (SHSS)

School Health Support services and the corresponding memo PPM81 were designed in 1984 to allow students with medical problems to attend school like other children and is an important part of their access to education as promised in BILL 82. However, since its inception little change has been made to the service, while other parallel services for schools, such as mental health services, have been slowly developing. The all- day kindergarten program has also raised issues, as those special-needs children now at school, would in the child -care system have received more extensive medical support. In 2009 the Hamilton-Wentworth District School Board sent two resolutions regarding School Health Support Services to the annual meeting of Ontario Public School Board Association asking that OPSBA be involved in any review of these services and the second noting the need for changes as it was critical of the adequacy, timeliness, and range of standards of care provided by SHSS.

In 2010 the Province announced that a review of School Health Support Services would be undertaken by Deloitte and Touche. OPSBA submitted a brief, and HWDSB was one of the few boards that were directly consulted by the review team, and it helped other stakeholders to submit their concerns.

The report from Deloitte and Touch has been finally made public. It shows that the concerns that HWDSB and other boards raised were legitimate. It found large waiting lists, that differed by region. HWDSB happens to be in a LHINN where the waiting times for Speech and Language services are far higher than the rest of the province. No wonder we hear of two- year waiting lists for service. Waiting times for service for private schools are much shorter than for public schools. Standards of provision vary across the province.

Many of OPSBA's recommendations, that were developed with HWDSB input, have had some recognition in the report. They included that the model of services :

- be child-oriented rather than an "adult" model,
- incorporate social, emotional and behavioural needs as well as strictly physical health needs,
- have dedicated funding for children so that needs are not in competition with community health priorities,
- take a Multi-year approach to funding to promote continuity and long-term planning,
- Include a fuller range of health professionals to work with families and facilitate earlier identification of complex health and developmental conditions,
- Protect children and family from fragmentation of services – have a harmonized approach to policies, regulations and services across systems and communities. Specific concern with fragmentation in Speech and Language Services
- Ensure that services available to pre-school children are maintained as they move to school-age.
- Address length of wait times – this is more critical for developing children than for adults
- Coordinate sharing of information to eliminate duplication and burdens on families.
- Ensure cross-ministerial coordination to provide seamless service for children and families
- Provide families with a care co-ordinator to help them navigate the system.
- Build improvements that are guided by recognized research and leading practices.

WE must continue to monitor the implementation of this report to ensure that all outr children can do well in school

Key Points in OPSBA Submission to Review	Relevant Recommendations in SHSS Report
Ensure that the model of services is child-oriented rather than an “adult” model.	Assess effectiveness of case management services across all student population types to determine appropriate case management models – determine best balance across CCAC case managers and providers to look at most appropriate role to assume care and coordination and enhance navigation services for families.
Incorporate social, emotional and behavioural needs as well as strictly physical health needs.	Develop and implement common guidelines to achieve a “shared care and service plan” for each child – mechanisms for holistic goals; family-focussed reporting protocols; explore implementation of shared records through technology to link assessments, evaluations and interventions.
Dedicated funding for children so that needs are not in competition with community health priorities.	Assess SHSS program outcomes in achieving the mandate – develop province-wide indicators and measurement processes; include impact on academic performance, evaluation of child’s social and emotional progress; child and family experience and burden of care in supporting health needs in the educational environment; role of education in reporting academic goals in SSHS context; linkage with other health outcomes; mechanisms to share/compare results across the province.
Multi-year approach to funding to promote continuity and long-term planning	Develop formal forums and processes for proactive service planning – promote collaboration around impacts of evolving population service demands, changes in education practices such as integrated classrooms; determine SSHS alignment with children’s broader needs.
Include a fuller range of health professionals to work with families and facilitate earlier identification of complex health and developmental conditions.	Implement effective skill mix, e.g. combination of professional and paraprofessional support.
Protect children and family from fragmentation of services – have a harmonized approach to policies, regulations and services across systems and communities.	Increase awareness of SHSS provincially and locally – enhanced communications including peer-peer mentoring for families, examine what families need to better navigate the system; Assess locally the feasibility of a single point of access for all children’s services including SHSS.
Specific concern with fragmentation in Speech and Language Services	Coordinated approach to provision of Speech and Language services
Ensure that services available to pre-school children are maintained as they move to school-age.	Develop common protocols for SHSS transitions across a child’s life stages and across organizations – examine transition agreement re pre-school to school in terms of

	eligibility criteria, wait list, information-sharing; enable direct referrals and coordinate wait lists; address service gaps to facilitate transitions to adulthood; standardize processes for inter-school and inter-community transfers.
Address length of wait times – this is more critical for developing children than for adults.	Establish alternative models of service delivery to improve access/wait times – improve information sharing and ongoing evaluation; examine leading practices such as screening clinics, summer programs to prevent regression, home sessions to enhance family engagement; integrate SSHS visits in classrooms; make better use of technology;
Coordinate sharing of information to eliminate duplication and burdens on families.	Assess, develop, and implement mechanisms to enhance knowledge transfer among stakeholders – encourage educators and families to participate in consultative model and support with appropriate tools; distribute practical strategies to be used while students are waiting for service.
Ensure cross-ministerial coordination to provide seamless service for children and families	Clarify scope of services under the SHSS program mandate – establish working group to examine and consider coordination/integration with other health and children's services – look at supporting developmental milestones, holistic goals, children's services including mental health, a coordinated approach to speech and language services, review of legislation, policies including PPm#81. Enhance cross-sector collaboration – enable collaboration across stakeholder groups through standardized structures/guidelines; shared principles around performance and accountability, flexibility and focus on child outcomes.
Provide families with a care co-ordinator to help them navigate the system.	Establish navigation support to assist families - examine feasibility of implementing accessible navigation or advocacy roles to support families.
Address inequities in service for communities in rural and Northern regions.	Develop access guidelines and tools for service delivery – standards that enable local flexibility; consider underserved populations (including individuals living in rural, remote and northern communities), clarify expectations to limit variances in referral practices; address variability among CCACs; examine cross-sector policies to enable better coordination of resources; consistent eligibility/discharge criteria, standardized forms/processes, common assessment tools, improved cross-sector collaboration to better manage wait lists.
Build improvements that are guided by recognized research and leading practices.	Establish provincial mechanism to review SHSS models and clinical leading practices –

	integrate results in SSHS program – commission research, leverage existing leading practice research, share findings and practices; work through existing local working groups to tailor and implement practices. Establish tools to determine weighting or required intensity of services for SHSS – identify tools to monitor complexity of cases (cognitive, functional, social, environmental; develop tools to support care planning and quality improvement; determine workload requirements for effective service case management. Establish initial and ongoing SHSS professional development requirements for stakeholders – for CCAC case managers, educators and providers; coordinate curriculum development and delivery across sectors (health, education, CYC) to leverage existing knowledge, resources. leading practices.

FINAL REPORT OF SCHOOL HEALTH SUPPORT SERVICES REVIEW
Summary Recommendations

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

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

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

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