



# MODEL SCHOOLS PAEDIATRIC HEALTH INITIATIVE: In-School Health Clinics Phase 1 Report

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Model Schools Paediatric Health Initiative: Phase 1 Evaluation  
Preliminary Report  
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## BACKGROUND

In 2010, the Toronto District School Board (TDSB) launched its Model School Paediatric Health Initiative (MSPHI)<sup>1</sup> as part of the TDSB's Model Schools for Inner Cities (MSIC) program. In 2011-12, the MSIC program served over 100 inner-city schools across the city where nearly half of the families earned less than \$30,000 per year, and most (85%) parents were born outside Canada. The aim of the MSPHI is to open in-school health clinics in priority neighbourhoods to serve children in the MSIC program. This integrated health initiative recognizes schools as an innovative access point for children facing healthcare barriers to receive needed services in the most direct and efficient way, including diagnosis, management, and follow up of multiple health and developmental concerns.

The initial concept of the MSPHI arose from concerning results documented in the Sprott Asset Management Gift of Sight and Sound Program report released in 2010, through the Toronto Foundation for Student Success (TFSS). In 2007, the Gift of Sight and Sound program assessed nearly 10,000 students for vision and hearing from TDSB schools in the MSIC program<sup>2</sup>. Seventy-five per cent (75%) of students with auditory referrals did not receive the services they required following the assessment.<sup>3</sup> The report reveals that nearly 30% of students referred for further vision or auditory services did not have coverage through the Ontario Health Insurance Plan (OHIP).



Qualitative data collected through interviews with clinic staff, school principals, and TFSS Program Management further revealed a range of health care accessibility barriers for families in inner-city communities. For instance, many of these families were faced with challenges such as:

- lack of valid health cards (e.g., OHIP)

<sup>1</sup> For more information go to <http://www.tdsb.on.ca/site/ViewItem.asp?siteid=263&menuid=38042&pageid=32086>

<sup>2</sup> Model Schools operate as lead schools within their clusters, or group of schools, from the same neighbourhoods. Model Schools become the “heart of the community” involving students, parents, and community members. Areas selected are those with the highest proportions of socio-economic challenges. For more information go to <http://www.tdsb.on.ca/site/ViewItem.asp?siteid=263&menuid=2370&pageid=1871>

<sup>3</sup> For more information go to <http://ckc.tcf.ca/org/toronto-foundation-student-success#vignette1>

- financial difficulties that made it hard for families to pay for extra transportation expenses for doctor’s appointments, or for parents to take time off work for appointments as many worked in hourly paid positions
- language barriers which reduced immigrant parents’ confidence and ability to navigate the health care system or other support systems
- lack of regular, primary health care practitioners

Interviews with stakeholders pointed out that the inability for parents in inner-city neighbourhoods to complete health care referrals stemmed from a combination of the above barriers.

In light of these concerns, the Model School Paediatric Health Initiative Working Group was formed. It proposed that health care services, including follow-up for routine hearing and vision assessment, should be provided directly in schools to meet students’ needs and eliminate several access barriers faced by families in priority communities (Wang, Bovaird, Ford-Jones, Bender, Parsonage, Yau, & Ferguson, 2011). In November 2010, the very first in-school health clinic was opened at Sprucecourt Public School (PS), a MSIC elementary school in the southern part of Toronto, in partnership with St. Michael’s Hospital. In April 2011, a second clinic, named the Paul Steinhauer Paediatric Clinic<sup>4</sup>, was set up at George Webster Elementary School (ES) in the east side of the city. Its community partnerships included Access Alliance Multicultural Health and Community Services<sup>5</sup> and Toronto East General Hospital. A third clinic was opened in November 2011 at Brookview Middle School in the northwest region, partnering with Black Creek Community Centre. Each of the three clinics produced success stories and received recognition from parents and the community<sup>6</sup>. Plans have been made to have a fourth in-school health clinic at a secondary school; additional clinics will also be organized as partners and sites are identified, and funding is secured.



All these in-school health clinics, that fell under the umbrella of the TDSB MSIC program, were operated under a three-way partnership – the TDSB, the Toronto Foundation for Student

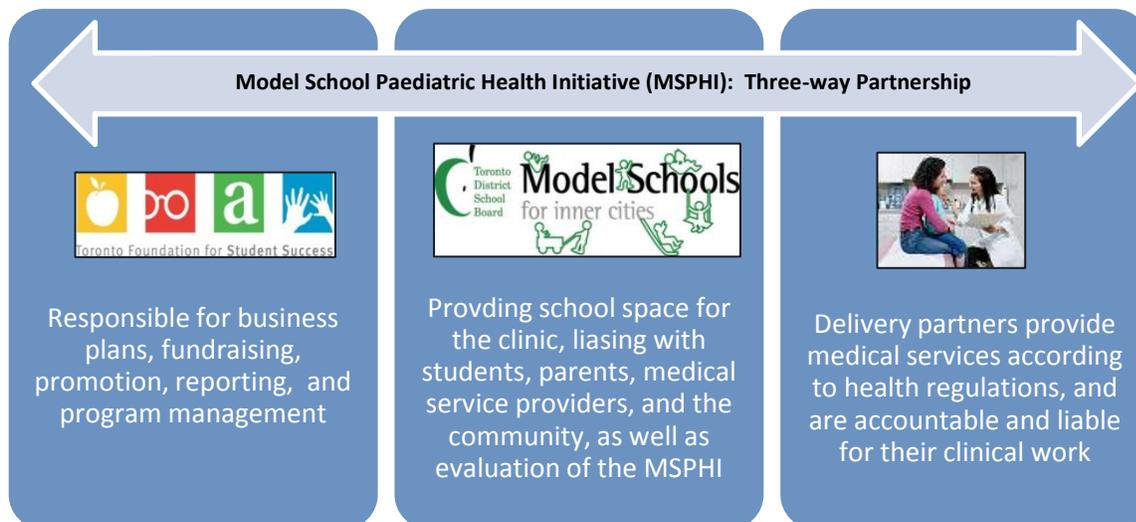
<sup>4</sup> The rest of this report shall refer to the Paul Steinhauer Paediatric Clinic as the George Webster ES clinic

<sup>5</sup> The rest of this report shall refer to Access Alliance Multicultural Health and Community Services as Access Alliance. For more information on Access Alliance go to <http://accessalliance.ca/about>

<sup>6</sup> For more information go to <http://www.thestar.com/news/article/1100248--a-bold-inner-city-project-brings-medical-care-to-kids-at-school#article>

Success (TFSS), and the medical service providers within each community (e.g., community health centres [CHC] and/or hospitals). The TFSS, the arm's length charitable foundation of the TDSB, leveraged funds for this new initiative while also securing commitments for the medical staffing and overseeing with the school board all the operational requirements (see Figure 1 for the key roles played by each partner).

**Figure 1: MSPHI Three-way Partnership - The TFSS, the TDSB, and Delivery Partners (community health centres, hospitals)**



During its pilot stage, the overall goals of the MSPHI were to:

- register 800 students at each clinic location and contact the families to compile an accurate and current patient database (including sibling information)
- to provide diagnosis and treatment of acute illness and injury, and collaborate and consult with other health partners including family doctors
- enable early detection and/or diagnosis of physical or mental health issues
- assist with management of previously diagnosed chronic illness
- offer preventative care and assessment
- discuss and provide mental health assessment
- offer health promotion and education
- offer referrals to medical and mental health subspecialties when required

## RESEARCH PLANS AND METHODOLOGIES

In Fall 2011, a multi-phase evaluation was planned to study the MSPHI. This report details the findings of Phase I research which was a retrospective assessment of the first pilot year of the initiative and an examination of its implementation process at the first two MSPHI clinics in Sprucecourt PS and George Webster ES. These first two in-school health clinics were examined as separate case studies with the use of both quantitative and qualitative data.



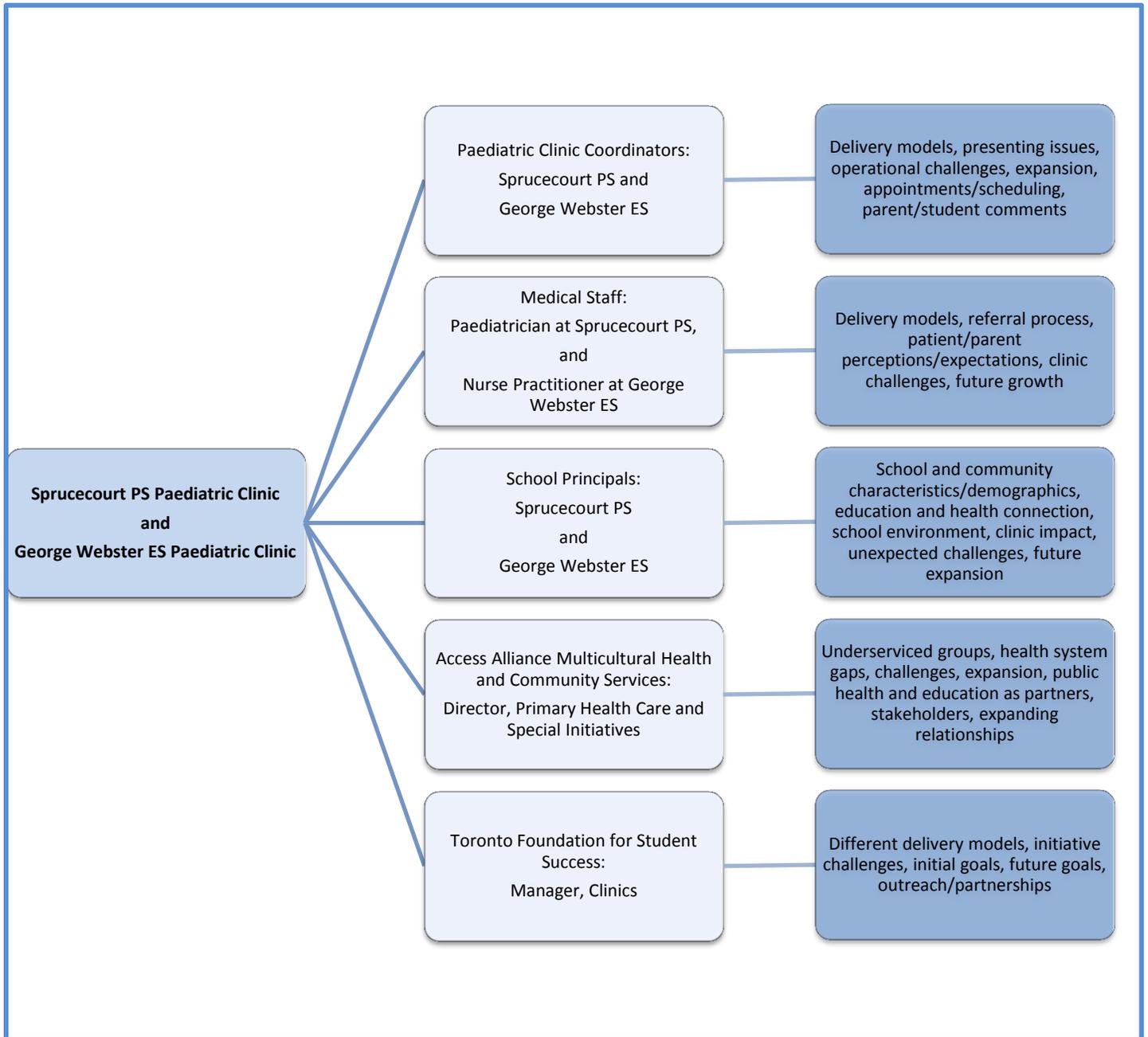
### Quantitative Data

The quantitative data employed in this Phase I report were collected by the site coordinators of the two clinics upon the student's clinic registration. The clinic data included the tracking of their services, registration growth data, and health issues presented at each clinic visit. A second source of quantitative data came from the TDSB's Research and Information Services department, which provided demographic information based on the TDSB's *2006 Student Census*, *2008 Parent Census*, and the Student Information System (SIS).

### Qualitative Data

A large part of the Phase I study was based on qualitative and anecdotal findings gleaned from site visits and interviews with various stakeholder groups and staff associated with the two clinics. The interview list was compiled in collaboration with research staff and TFSS Program Management (see Figure 2). The qualitative findings include the experiences of the front-line clinic workers, the commonalities and the differences between each clinic in terms of population served and the delivery model employed. In-depth interviews were conducted to align with the research plan objectives and were held at each participant's place of work with permission to be audio recorded. The interview data were summarized and were kept confidential by the TDSB research department.

Figure 2: Qualitative Methodology - Interviewees and Topics of Discussion





## **FINDINGS**

- **Literature Review Highlights**
- **Case Study 1: Sprucecourt Public School In-School Health Clinic**
- **Case Study 2: George Webster Elementary School In-School Health Clinic**



## FINDINGS

This report details the findings of the first two MSPHI clinics as separate case studies. It became apparent over the course of Phase I research that each of these two school communities had their own unique characteristics, and the clinics were diverse in their aspects of service and operation, as well as the needs of families they served. Since the two clinics essentially stemmed from different health care delivery models, it is important that the varying successes, observable impacts, challenges, and future goals of the clinics are highlighted separately.

In addition to the collection of primary data from the two MSPHI sites, ongoing literature reviews were conducted to examine existing in-school health clinic models in other regions and internationally. In the following, highlights of these literature reviews precede the two case studies which are presented in the remaining parts of the report.

### Literature Review Highlights

This section identifies existing in-school health clinics or school-based health care models known in the English-language literature for Canada, other commonwealth countries, and the United States (US). While different localities adopted different approaches or delivery models for their in-school health efforts, all shared the common goal of increasing access to comprehensive health care for marginalized student populations who faced barriers and challenges that prevented them from receiving proper health care, which in turn affected their educational outcome.

#### Canada

The concept of in-school health clinics is still very new and not widely practiced in Canada. Perhaps, there has been a strong assumption that this country offers a universal health care system, thereby assuring health accessibility for all citizens. However, research on vulnerable or marginalized populations, inner-city neighbourhoods, or new immigrant and refugee children and youth points to an accessibility gap between the health care services available and the accessibility of primary care by these underserved families and communities.

Based on a literature search, Nova Scotia had a system of school-based and school-linked services, which numbered 34 in 2002, with 80% of these located within schools (Collins, 2003; as referenced in Langille, 2006). These in-school health clinics were primarily accessed by students belonging to a vulnerable group or underserved youth population in specific communities.

In 2007 and 2008, the city of Saskatoon, Saskatchewan, opened its first two in-school health clinics at St. Mary's Community School and W.P. Bate Community School. Both in-school health clinics were supported by its Ministry of Health, local school board, and Tribal Council. The clinics served the neighbourhoods which were comprised of families with an average household annual income of less than \$30,000 and lacked access to many primary health and wellness services (Martin, 2011). The primary health care paediatric model used in Saskatoon was based on social paediatrics and a family-school-community approach which provided care to infants, and children and youth, while recognizing that the child existed within the context of the family, the community and society. Their paediatric services included management of chronic medical and mental health conditions, assessment and anticipatory guidance, and prevention and intervention services to help identify students-at-risk (Martin, 2011).

While anecdotal information points to the existence of similar initiatives in a few other Canadian regions, the lack of literature or publicly available documentation has deemed these other clinics unable to meet the search criteria for this review. In the case of Toronto, the TDSB launched its MSPHI with the opening of its first two in-school health clinics in 2010 and 2011, followed by a few other clinics in subsequent years. These MSPHI clinics are the subject of this multi-year research and are described at greater length in this current report.

## England

In 2011, Blair and Bell wrote an article outlining the history in England of in-school health services that were introduced by the government in 1906 throughout the school system, and continued to evolve, up to 2011. In the early 1900s, many teachers observed that a high number of children, that were also first time students, were unfit to take advantage of universal education due to poor health. According to Blair and Bell (2011), the introduction of these

health services by the government at the time followed a “seek and treat” approach (i.e., periodic examinations, and assessments for vision, hearing, learning difficulties, and physical abnormalities). Around the mid-1970s a paradigm shift in public health services began to emerge leading away from infectious disease and malnutrition treatments to more social and behavioural disorders. The demand in schools for guidance and counselling services continued to grow, through the 1980s, and the current “prevent and promote” model of care was developed (Blair and Bell, 2011). To support this model, there was also emphasis on a much wider team of professionals supporting health interventions for school-aged children with nursing seen as a core leadership role (Blair and Bell, 2011).

### **New Zealand**

In New Zealand, Denny, Balhorn, Lawrence, and Cosgriff (2003), compared where or from whom students accessed their primary health care, and how the quality of preventative health services differed between a school-based health clinic or other provider. The 343 surveyed students were from a single low-income school with the majority being non-White. It was found that although the population had a higher number of students with access to a Family Physician outside the clinic, the types of services provided were comparatively different when students used the school-based health clinic – for example, the assessment and counselling services were significantly higher when students used the in-school health clinic as opposed to other health care providers (Denny et al., 2003). Therefore, the authors concluded that the unmet health needs of this adolescent population, including assessment/counselling (e.g., for nutrition, physical activity, sexual health, and sexually transmitted infections) were more suitably met when students used the services of the government supported in-school health clinics (Denny et al., 2003).

### **United States**

Probably due to the lack of a universal health care system in the United States (US), the need for school-based health clinics (SBHCs) was apparent. Hence, SBHCs have a longer history and have been comparatively more prevalent in the US than in Canada. In the US, SBHCs were mainly funded through grants from philanthropists, foundations, as well as the state and federal governments. The first SBHC was established in 1970 in Dallas, Texas. By 1984, there

were 31 SBHCs operating in the US. In 1997, the number of SBHCs increased to 948 and were operating in 42 states. According to the National Assembly on School-Based Health Care (NASBHC)<sup>7</sup>, by the early 2000s, there were over 1,700 SBHCs across the country (NASCHC; as cited in Barron, 2008).

In the US, SBHCs provided comprehensive medical and mental health assessment and treatment for young people at their schools. Its SBHC model (1970 to mid-1990s) used Nurse Practitioners (NP) as clinic leaders and managers who were primarily responsible for health assessment, referral, and health education (Santelli, Morreale, Wigton, Grason, 1996). By the mid-1990s the delivery model expanded to also include primary care health services, reproductive health, mental health, and the creation of linkages with community-based organizations (Dryfoos, 1994). A survey of 24 SBHCs servicing all grade levels found that 77% employed an NP, 61% a Medical Doctor, 54% a Registered Nurse, and 27% a Psychiatrist (McKinney & Peak, 1994; as cited in Kaplan, Brindis, Naylor, Phibbs, Ahlstrand, Melinkovich, 1998).

### Concluding Remarks from the Literature

While ongoing literature reviews will be conducted in this multi-year study, it should be noted that there is a general dearth of research in this field, especially in terms of quantitative studies on the outcome of in-school health clinics for students. This is particularly true in Canada. Literature consistently states that Canadian studies are clearly required for an overall understanding of the state of in-school health clinic provision in this country. Particularly, there is a need for evidence-based research with primary information collection that would link health and educational data to assess impact on student health and education outcomes. These empirical findings are important for the government to recognize in-school health clinics as part of the primary care renewal package in Canada (Langille, 2006). Hence, the current MSPHI multi-year research plays a critical role in filling in this research gap.

Additionally, it is evident from the literature that successful in-school health clinics consistently document the importance of acquiring sustainable funding from more than one source. In fact,

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<sup>7</sup> For more information on NASBHC go to <http://www.nasbhc.org/site/c.ckLQKbOVLkK6E/b.7453519/k.BEF2/Home.htm>

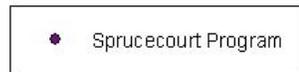
expanding and evolving clinics attribute their sustainability to funding provided from more than one government ministry – that is, a collaborative model between the Ministries of Education and Health recognizing the undeniable link between children and youth’s health and education outcome. The literature also cites the importance of in-school health clinics crossing political spectrums with embedded acceptance at all levels of governance - local, provincial/territorial, and federal (Langille, 2006).



## **CASE STUDY 1:**

### **Sprucecourt Public School In-School Health Clinic**

## Sprucecourt In-School Health Clinic and the Neighbouring Schools Served



Projection: NAD 1983 UTM Zone 17N  
Date: March 2012

Produced by: Research and Information Services  
Sources: TDSB; ESRI; DMTI

## Sprucecourt Public School: School Demographics

In 2010, Sprucecourt Junior Public School<sup>8</sup>, now referred to as Sprucecourt Public School (PS) had a student population of over 350. Based on the TDSB's 2011 Learning Opportunities Index<sup>9</sup> (LOI), Sprucecourt PS ranked at 8 out of a total 479 elementary schools within the school board. Essentially schools with a ranking closer to 1 experience a higher level of poverty-related challenges that affect student success. In fact, according to the TDSB's *2008 Parent Census*, while 50% of TDSB elementary school students were from families with a household income of less than \$49,999, as high as 92% of the students at Sprucecourt PS fell within this low income category.

**Table 1: Sprucecourt PS, School Characteristics**

School Characteristic	Sprucecourt PS Junior Public School (N=264)	TDSB (N=95717)
Parent born outside of Canada <sup>10</sup>	89%	66%
Students' primary home language (English and other, and other language only)	83%	56%
Two parent household	85%	81%
Mother's education level (university and college)	49%	67%
Father's education level (university and college)	58%	69%
Household income (below \$49,999)	92%	50%

Source: TDSB's 2008 Parent Census

As seen in Table 1, the TDSB's *2008 Parent Census* indicated that 89% of Sprucecourt PS parents were born outside of Canada – a percentage significantly higher than that of the overall TDSB population (66%). Correspondingly, Sprucecourt PS had a much higher proportion of students (83%) speaking a first language other than English at home than the TDSB as a whole (56%). Also, compared to the general TDSB population, Sprucecourt PS had a high percentage of students from two-parent families but a lower percentage of parents with a university education.

<sup>8</sup> For more information about Sprucecourt PS, access the school website at <http://www.tdsb.on.ca/schools/index.asp?schno=5278&Status=L>

<sup>9</sup> Learning Opportunities Index (LOI): Consists of two indices (one elementary, one secondary) providing a score and ranking for schools according to external challenges. The LOI is calculated from median income, proportion of low-income families, proportion of families receiving social assistance, education of adults, and proportion of single-parent families. For more information, access [http://www.tdsb.on.ca/wwwdocuments/about\\_us/external\\_research\\_application/docs/LOI2011.pdf](http://www.tdsb.on.ca/wwwdocuments/about_us/external_research_application/docs/LOI2011.pdf)

<sup>10</sup> The racial group with the largest representation at Sprucecourt PS (and compared with TDSB demographics) was South Asian: 65% at Sprucecourt PS, and 27% at TDSB.

## Sprucecourt In-School Health Clinic: Delivery Model

Sprucecourt PS adopted a *Primary Care Paediatric Delivery Model*, upon opening. At this early stage, the clinic model has been evolving with additional paediatric services based on the growing need for primary care within the community. As of March 2012, the clinic was staffed by:

1. a Paediatrician from St. Michael's Hospital – one half-day per week
2. a Specialist Developmental Paediatrician<sup>11</sup> – one half-day per month
3. two family doctors from St. Michael's Hospital – alternating one half-day per week
4. a Clinic Coordinator<sup>12</sup> (a multilingual International Medical Graduate [IMG]<sup>13</sup> funded through TFSS) - for 16 hours per week

## How did the Sprucecourt PS clinic work?

### *The role of Clinic Coordinator*

The Clinic Coordinator played a central role in bridging the school and medical partners that worked in partnership through the school clinic. The Clinic Coordinator fulfilled the following vital clinic responsibilities:

- Public relations through:
  - outreach activities hosted by the school to welcome the parents and community – for example, school council meetings, parent-teacher nights, or other school events, where questions and information regarding the clinic were provided to the parents in their first language<sup>14</sup>;
  - clinic outreach activities at school staff and principals' meetings;
  - promoting a positive image of the clinic to patients, families, and school staff. This would lead to increased word-of-mouth in the school and the community, thereby maximizing clinic usage by families; and
  - facilitating effective communication among school staff, school administration, clinic staff, and external partners.

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<sup>11</sup> Implemented March 2012, and will be covered thoroughly in Phase II.

<sup>12</sup> The Clinic Coordinator is paid through philanthropic funds, while other medical personnel are either salaried (CHCs) or they bill OHIP or Ministry of Health (Paediatrician).

<sup>13</sup> The Clinic Coordinator was a doctor in his country of origin and was completing his Canadian accreditation.

<sup>14</sup> The Clinic Coordinator was multilingual in four languages.

- Operations alignment to ensure:
  - Physician appointments and paediatric referrals at the school clinic were coordinated with the off-site schedules of medical staff;
  - appointments from the Physician or Paediatrician were recorded and accessible for collaboration between the two medical personnel; and
  - all scheduling and referrals, as well as management and updating of the patient databases was properly maintained.
  
- Family support to ensure:
  - translation and language support were made available for families that were in the process of applying for a Canadian health card or OHIP coverage;
  - students and parents had a positive experience in the clinic by providing a welcoming, culturally-sensitive atmosphere that was efficient and offered high quality care ;
  - translation support for families that needed help in understanding doctor’s instructions;
  - appointments were arranged to accommodate working parents; and
  - the clinic delivery model aligned to the needs of the patients, families, and the community.

### *Ongoing development and expansion of clinic services*

Aside from the vital role played by the Clinic Coordinator, as part of the evolving model, the clinic’s Paediatrician also attended the school’s Student Success Team (SST)<sup>[1]</sup> meetings, where as many as one-third of the SST referrals, mostly in relation to developmental concerns, were sent to the clinic for treatment. Indeed, in light of the growing number of SST referrals, efforts were made by the clinic’s Paediatrician to bring in a Developmental Paediatrician. In March 2012, a Specialist Developmental Paediatrician was recruited as an additional health support to the clinic – an addition which was highly valued by the school and the community.

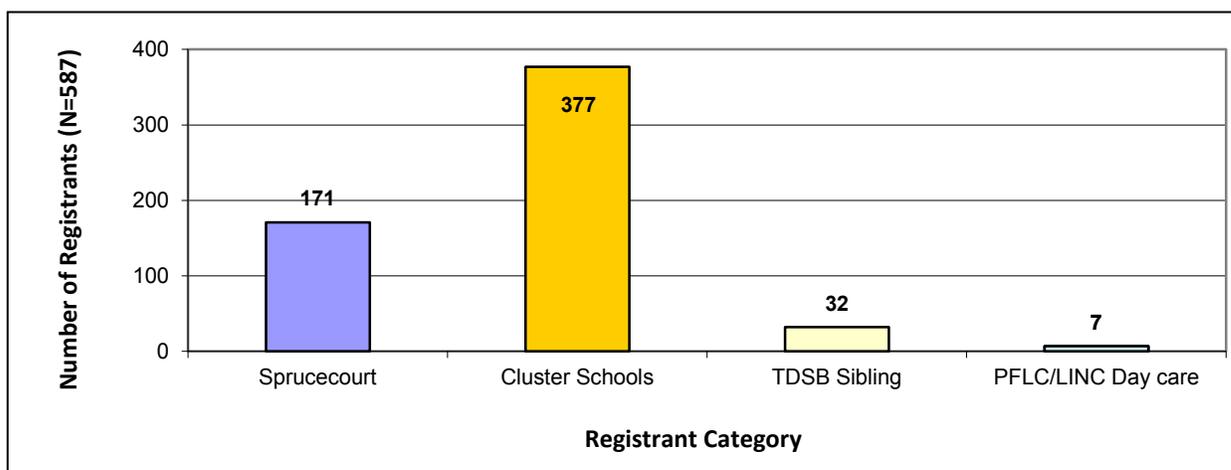
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<sup>[1]</sup> For more information on SSTs, go to [http://www.tdsb.on.ca/\\_site/ViewItem.asp?siteid=110&menuid=23355&pageid=20245](http://www.tdsb.on.ca/_site/ViewItem.asp?siteid=110&menuid=23355&pageid=20245)

## Number of Registrants

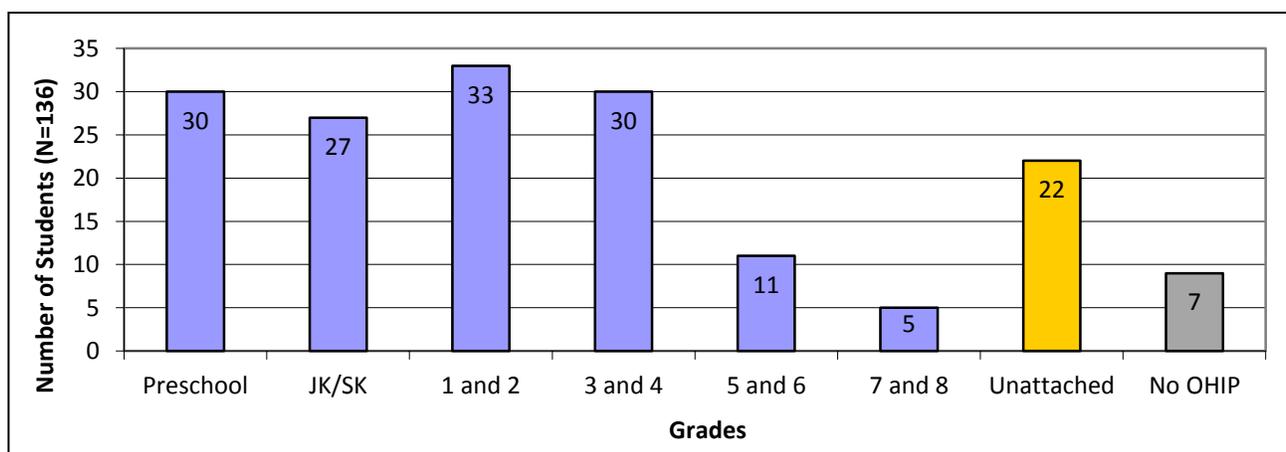
As of January 2012, there was a total registration of 587, 64% of whom were from neighbouring schools (see Figure3).

Figure 3: Sprucecourt In-School Health Clinic Registrations, as of January 2012



The number of students or families that were patients of the Sprucecourt in-school health clinic is displayed by grade in Figure 4. The highest number of patients were in the lower grades (Grades JK-4). Figure 4 also shows the number of patients that were either unattached<sup>15</sup> (22) or had no OHIP coverage (7).

Figure 4: Sprucecourt In-School Health Clinic, Grade of Patients, 2010-11



<sup>15</sup> In this round of reporting, some double counting may have occurred between students that were recorded as unattached and also those without OHIP.

## Appointment Scheduling

According to the Clinic Coordinator, a high number of Sprucecourt PS parents were stay-at-home mothers. Therefore, the most convenient time for them to bring their child to the clinic was in the morning, when they were already coming to the school to drop off their child, and therefore would be able to minimize their child's time out of class. Hence, there was a high demand for morning appointments. The Clinic Coordinator emphasized that during these early stages of clinic operations, it was important to recognize a family or community's needs to ensure that appointments were made available during these popular times in order to meet the goals of convenience and accessibility for local families.

## Presenting Medical Issues for the Sprucecourt In-School Health Clinic

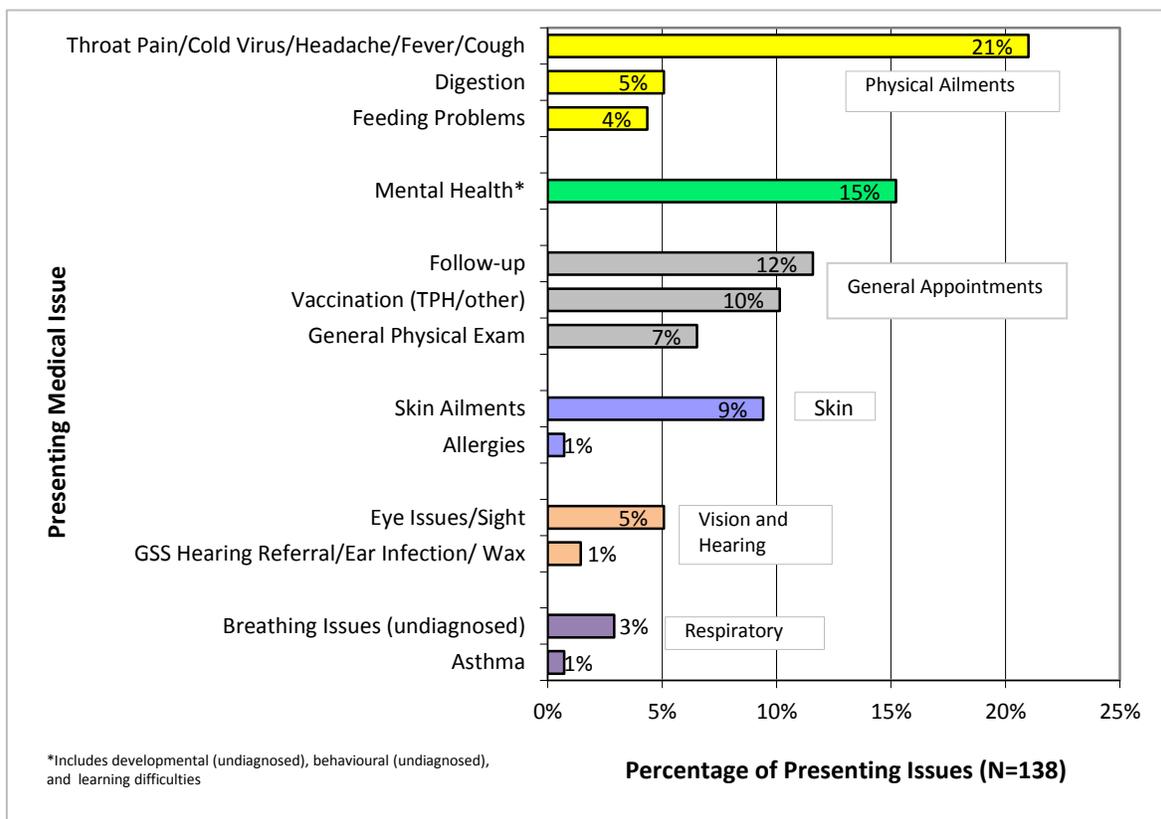
There were two types of appointments scheduled at this clinic.

1. Illnesses or health issues that were addressed, discussed, or treated during a visit with the clinic's Physician, and
2. Referred appointments with developmental, behavioral, or mental health issues that needed to be addressed or assessed by a Paediatrician.

## Physical Health Issues

Figure 5 illustrates the breakdown of 138 presenting medical issues at the Sprucecourt in-school health clinic for the 2010-11 reporting period. The highest number of visits was concerning general physical ailments including cold or viral symptoms; combining digestion and feeding issues, this represented 30% of the total medical issues presented. The second highest number of visits (28%), by grouping, included follow-up appointments, vaccinations, and general physical examinations (see Figure 5).

**Figure 5: Sprucecourt In-School Health Clinic, Presenting Issues as of January 2012**



### Mental Health Issues

Second to physical ailments or general appointments was the stand-alone category that included behavioral and developmental issues, and learning difficulties (see Figure 5). These combined, represented 15% of the total presenting medical issues at the Sprucecourt in-school health clinic. The Clinic Coordinator and Paediatrician agreed that mental health concerns were unexpectedly high. It was further pointed out by the Clinic Coordinator that although some children visited the clinic with a presenting physical ailment, like a stomachache, their symptoms could be related to mental health issues such as anxiety or depression, which the students themselves might not be fully aware of.

In fact, according to the School Principal, the connection between stress, mental health issues in children, and poverty were obvious in her students' classroom behaviours. The Principal spoke to how these anxiety and stress related issues had found their way into the classroom as behavioral problems. For instance, students' sleep deprivation was a concern. Due to some parents' work schedules, children were unsupervised in the evenings and left without a

consistent bedtime schedule. In addition, for many students, their sleep problems and stress levels could also be a result from the shared accommodation arrangements or small living spaces in the home.

## Observable Impacts from Sprucecourt In-School Health Clinic

Although it would be premature to determine the overall effectiveness of the clinic after merely one year of operation, some observable impacts could be gleaned from the interview comments of different stakeholders. While various stakeholder groups were interviewed with the use of different sets of questions, and each shared their observations from their own professional lens, common themes and similar impact statements emerged when the interview data were analyzed. The comments<sup>16</sup> collected from the different interviewees can fall under four impact categories:

1. Improving Student Health and Well-Being
2. Addressing Barriers for Marginalized Groups
3. Strengthening School, Parent, and Community Relationships
4. Increasing Opportunities for Student Success

### 1. Improving Student Health and Well-Being

The primary goal of the Sprucecourt in-school health clinic was to increase the accessibility to health care for marginalized populations including low-income families and newcomers to Canada. It is expected that the student's educational experience would be influenced by increasing their access to primary health care. The Paediatrician shared an impact she had observed while at the clinic:

*It is impressive that we can help children within such a large range of issues; for example, children that are undiagnosed with developmental issues, mental health issues, and childhood anxiety but also acute infections or chronic conditions; like asthma or diabetes.*

*A six year old boy who couldn't sleep and was suffering from recurring pain and lack of appetite received a medical check-up for the first time since he was born. He had these health problems for years but in his country of birth adequate health services were not available. The boy was diagnosed with cerebral palsy and his symptoms are now being managed and treated.*

<sup>16</sup> Selected impact statements from the various interviewees are presented in this section of the report. Additional, collaborating responses from various Sprucecourt PS interviewees for each Observable Impact Category can be found in Appendix 1.

The Paediatrician further explained the impacts from the in-school health clinic on student health and how their successes to date would lead to more positive outcomes for students as clinic services continued to expand:

*Our model leads to earlier detection and this makes treatment more effective. I've seen that the health needs of these students are beyond the acute care cases like viruses, colds, or emergencies. The clinic has grown and requires other professional services.*

## 2. Addressing Barriers for Marginalized Groups

The School Principal was knowledgeable about the various barriers that Sprucecourt PS families were facing. She discussed the positive impacts the in-school health clinic had already produced for families in the community:

*The families simply need it. The main point is that since transportation, along with taking time off work, are two main barriers that I see for these parents in finding health care - having the clinic here just makes sense. They already have many other barriers to face. The clinic here in our school really does help with not one, but many of these issues.*

The Paediatrician shared her further thoughts on how the clinic had helped overcome certain barriers in the Sprucecourt PS community:

*The model allows for more comfort and convenience for parents especially for complex cases that require other professional services and referrals. Our model does provide more accessibility to families that would've waited a long time to see a family doctor for acute care or primary care, but can now easily receive a referral to a Paediatrician; if that is also necessary.*

*The infant sister of a third grade student was brought to an in-school health clinic because it appeared as though she had lost her vision. Her family feared that their baby would be blind for life. A doctor on-site was able to confirm that the baby was suffering from paediatric cataracts. The in-school health clinic helped put the family in touch with the health care professionals they needed who were able to schedule the cataract surgery. She sees the world with clear and open eyes now.*

### 3. Strengthening School, Parent, and Community Relationships

The various stakeholders and staff at the clinic and school discussed how the clinic was helping to create a welcoming environment for families new to the community or unfamiliar with the Canadian health care system:

*Parents often say how privileged and grateful they are to be able to see a doctor so quickly. They often cannot believe how easy it was. It is a different reaction in this community when they speak about feeling privileged, then if the clinic was in a different community that already had these services available.*

The School Principal also explained how the clinic operating within the school was having a positive effect in strengthening parent-school relationships:

*The clinic is successful because it is attached to this school where parents, especially those new to Canada, already trust the teachers and school staff. In fact, I see that a referral to the clinic from a teacher is a trusted referral. Parents comment that this clinic makes their school special and that it is a privilege to see a doctor with such convenience. Also of importance, is that primary health care with this high level of accessibility is a novel idea to many of the parents. It isn't considered a right, but a privilege by this community.*

### 4. Increasing Opportunities for Student Success

The Clinic Coordinator had noted other potential impacts on student learning as awareness of the clinic amongst the community continued to grow:

*Many parents now know that we are here and because they are pleased with the clinic services they are telling other parents. As we grow, we also see the needs of families continuing to grow. We see how these needs are related to the children and what they need to be successful in the classroom for learning.*

According to the Clinic Coordinator, classroom teachers could also detect positive and potential impacts of the clinic on their students:

*Teachers do come in and speak with us. This is the very impressive part of this clinic. All the people that need to be involved with the health of a child can easily work hand in hand. The relationship in this clinic has been the most impressive thing. This kind of service with both professions connected is what can work best to help a student be successful.*

## **Next Steps for the Sprucecourt In-School Health Clinic**

### **Need to outreach**

The clinic's Paediatrician was confident in the clinic's success to date but did express that a challenge of the clinic was reaching out to more children from the neighbourhood schools around Sprucecourt PS. While recognizing that the clinic was still in the early stages of development and that increased exposure would take time, she suggested that promoting the new clinic specifically to the Principals of the neighbouring schools – for example, through schools' Student Success Team (SST) meetings - would be important for continued growth. The Clinic Coordinator echoed the importance of outreach, "Before parents can see this clinic as a "tool"... [for student success in the classroom], they first need to know that it is here in their school." He provided examples of various outreach activities and school events where information was shared with teachers, school staff, and parents about the clinic's culturally sensitive care, multilingual environment, and various services.

### **Need to connect with teachers**

The Clinic Coordinator highlighted the importance of connecting the clinic to classroom teachers. He explained that to this community specifically (i.e., with the high number of newcomers to Canada) teachers would be an excellent resource for clinic referrals. While parents could be distrustful of the Canadian health system, they were more familiar with, and trusting, of the child's school, and would be more likely to perceive a teacher referral as a trusted referral. With the support of and referral by teachers, he believed the clinic could continue to establish the credibility and image they wished to build for the community.

### **Need to connect with additional professional supports including those within the TDSB**

In light of the various needs that were consistently presented at the clinic, both the School Principal and the clinic's Paediatrician agreed that extended health services were required – for example, the inclusion of a Specialist Developmental Paediatrician. In addition, based on her professional observations while practicing at the clinic, the Paediatrician saw the need to connect with the TDSB's professional support staff such as Child Psychiatrists and Social Workers as well as to schedule dedicated services by a Neurodevelopmental Nurse to support the clinic.



## **CASE STUDY 2:**

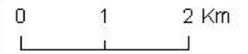
### **George Webster Elementary School In-School Health Clinic**

## George Webster In-School Health Clinic and the Neighbouring Schools Served



\* The Paul Steinhauer Paediatric Clinic

● George Webster Program



Projection: NAD 1983 UTM Zone 17N  
Date: March 2012

Produced by: Research and Information Services  
Sources: TDSB; ESRI; DMTI

## George Webster Elementary School: School Demographics

In 2010-11, George Webster Elementary School (ES)<sup>17</sup> had a student population of nearly 420. Based on the TDSB's 2011 Learning Opportunities Index<sup>18</sup> (LOI), George Webster ES ranked 79 out of 479 elementary schools within the school board. Essentially schools with a ranking closer to 1 on the LOI experience a higher level of poverty-related challenges that affect student success. According to the TDSB's 2008 *Parent Census*, while 50% of TDSB elementary school students were from families with a household income of less than \$49,999, nearly three quarters (73%) of the students at George Webster ES fell within this low-income category.

**Table 2: George Webster ES, School Characteristics**

Source: TDSB's 2008 Parent Census

School Characteristic	George Webster Elementary School (N=254)	TDSB (N=95717)
Parent born outside of Canada	65%	66%
Students' primary home language (English and other, and other language only)	68%	56%
Two parent household	69%	81%
Mother's education level (university and college)	57%	67%
Father's education level (university and college)	61%	69%
Household income (below \$49,999)	73%	50%

Table 2 further shows that about two thirds (65%) of George Webster ES parents were born outside of Canada - similar to the overall TDSB results. Correspondingly, George Webster ES had over two thirds (68%) of its population of students speaking a first language other than English at home – a proportion higher than the TDSB as a whole (56%). Also, compared to the general TDSB population, George Webster ES had a lower percentage of students from two-parent households (69%) and a lower percentage of parents with a university education.

<sup>17</sup> For more information about George Webster ES Elementary School, access the school website at <http://www.tdsb.on.ca/schools/index.asp?schno=1130&Status=L>

<sup>18</sup> Learning Opportunities Index (LOI): Consists of two indices (one elementary, one secondary) providing a score and ranking for schools according to external challenges. The LOI is calculated from median income, proportion of low-income families, proportion of families receiving social assistance, education of adults, and proportion of single-parent families.

## George Webster In-School Health Clinic: Delivery Model

George Webster ES adopted a *Nurse Practitioner-Led Clinic (NPLC)*<sup>19</sup> delivery model. The clinic was supported by:

- a Nurse Practitioner (NP) employed by Access Alliance Multicultural Health and Community Services – for two half-day clinics per week
- a Paediatrician from Toronto East General Hospital - one half day per week
- an off-site consulting Physician from Access Alliance – on as-needed basis
- a Clinic Coordinator<sup>20</sup> (a multilingual International Medical Graduate [IMG]<sup>21</sup> funded through TFSS) – for 16 hours a week.

### How did the NP model work at George Webster ES?

The NP model adopted by George Webster ES was a relatively new comprehensive primary health care model in Ontario and Canada. The model was designed to improve access to care for individuals and families without a primary health-care provider. At the George Webster in-school health clinic, the two key medical personnel were a Nurse Practitioner (NP) and a consulting community Physician, both employed through Access Alliance.

### The role of the NP and other medical service providers

Nurse Practitioners (NPs) are registered nurses with an expanded legislated scope of practice that deliver nursing care at an advanced level to specific patient populations in a variety of health care settings. According to the Director of Primary Health Care and Special Initiatives at Access Alliance in Toronto, NPs are a knowledgeable, professional group with a scope of practice that is almost as wide as a Family Physician. The NP's role includes physician services typical of other primary care delivery models, which are:



George Webster ES Principal, Nancy Steinhauer (left), and Nurse Practitioner

<sup>19</sup> Nurse Practitioners (NPs) have acquired additional education, experience, and registration in the *extended class* with the College of Nurses of Ontario. The *Expanded Nursing Services for Patients Act* was proclaimed in 1998 (following 25 years of lobbying) and this marked the beginning of enabling nurses to be registered with the College of Nurses under this new “Extended Class”. The Nurse Practitioners’ Association of Ontario (NPAO) has described the role of an Ontario NP as one that has developed over time. For more information on Nurse Practitioners, go to <http://npao.org/about/>

<sup>20</sup> The Clinic Coordinator is paid through philanthropic funds, while other medical personnel are either salaried (CHCs, Access Alliance Multicultural Health and Community Services) or they bill OHIP or Ministry of Health (Paediatrician).

<sup>21</sup> The Clinic Coordinator was a doctor in her country of origin, and was working towards her Canadian accreditation.

- immunizations
- annual physicals
- episodic illness care
- injury and illness prevention
- health promotion (i.e., nutrition, hygiene)
- detection and management for chronic disease conditions such as diabetes, asthma, and mental health

At the George Webster NPLC, if the types of care required were beyond the NPs scope of practice and expertise, the NP would then consult with the Access Alliance community Physician and if necessary, refer to the Physician or clinic's Paediatrician. The key to this model was a professional acknowledgement between the NP, Paediatrician, and consulting Physician regarding each other's scope of practice and their commitment to a strong team approach. According to the Access Alliance Director of Primary Care and Special Initiatives, this collaborative working relationship was essential to the success of the NP model.

Aside from treating common ailments, the NP at the in-school health clinic also provided preventative care by offering a range of health services that helped individuals and families maintain or improve their overall health. Health promotion, illness prevention, as well as helping clients navigate through the health care system were an important and integral part of the NPLC model. The NP explained that the model supported a preventative lens including health promotion with all families - for example, calcium intake, eating vegetables and fruits, and other topics specifically for boosting immune systems. She believed that dietician services would help families in this community for preventing illnesses. The TFSS Manager (Clinics) also spoke to this issue of preventative health and the NP model when he explained:

*I believe that although the (clinic) pamphlets and literature are important, we need to go beyond this and have more communication with these children and families on different topics at different ages dealing with prevention issues. Starting with personal hygiene at younger ages and also continuing to make healthy choices as they get older.*

### *The role of Clinic Coordinator*

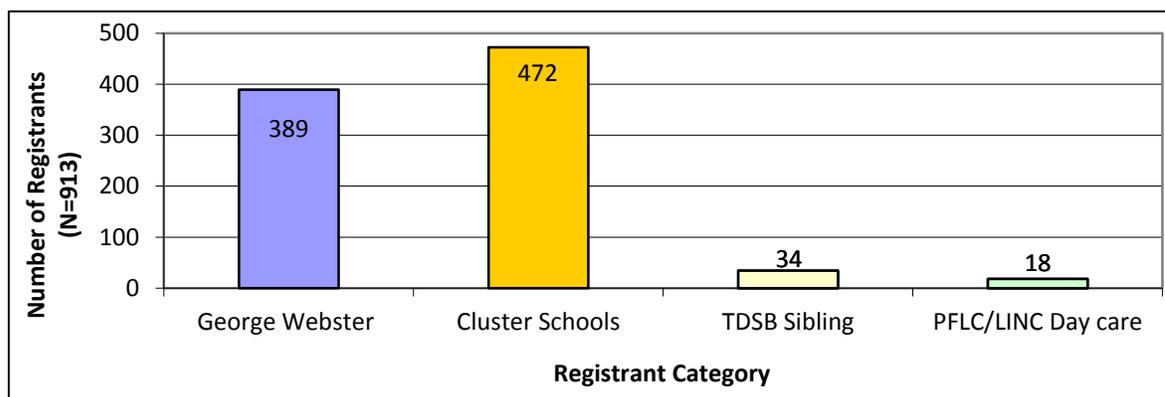
The Clinic Coordinator played a central role in coordinating the various external stakeholders, clinic staff, and educational professionals associated with the clinic. Essentially, she was a critical link between the school and the health service providers that operated through the clinic. For instance, the Clinic Coordinator was instrumental in the following areas of clinic operations.

- Public relations through:
  - clinic outreach activities such as school information nights, school community barbeques, and parent-teacher interview evenings – where the Clinic Coordinator provided literature to parents about the clinic, and discussed the clinic with parents in their first language (as she was multilingual in six different languages); and
  - effective communication with the School Principal, clinic staff, and other partners.
- Operations alignment to ensure:
  - all patient information was collected and recorded from the initial visit or follow-up appointment and accessible to clinic medical staff;
  - all scheduling and referrals, and updating and management of the patient database were maintained;
  - frequent communication amongst team members regarding patients, referrals, and follow-up care; and
  - alignment of NP appointments and paediatric referrals at the school clinic with the off-site schedules of medical staff.
- Family support to ensure:
  - the clinic offered an environment of culturally-sensitive care;
  - families received translation or assistance when filling out application forms for health cards;
  - parents received translation assistance to understand the NP's or Paediatrician's instructions following their child's appointment; and
  - that the unique needs of patients, their families, and the community were supported by the clinic.

## Number of Registrants

As of January 2012, the George Webster in-school health clinic had a total registration<sup>22</sup> of 913, and 52% of whom were from neighbouring schools (see Figure 6).

Figure 6: George Webster In-School Health Clinic Registrations, as of January 2012



## Appointment Scheduling

According to the Clinic Coordinator, a high number of George Webster ES parents (mothers) worked outside the home. Therefore, afternoon time slots were in higher demand as this coordinated better with their work schedules.

## Presenting Medical Issues for the George Webster In-School Health Clinic

There were two types of appointments addressed by the clinic.

1. Illnesses or health issues that were assessed, discussed, or treated during a visit with the NP, and
2. Referral appointments with developmental or behavioral components, mental health issues, or specialist referrals that needed to be addressed or assessed by the Paediatrician.

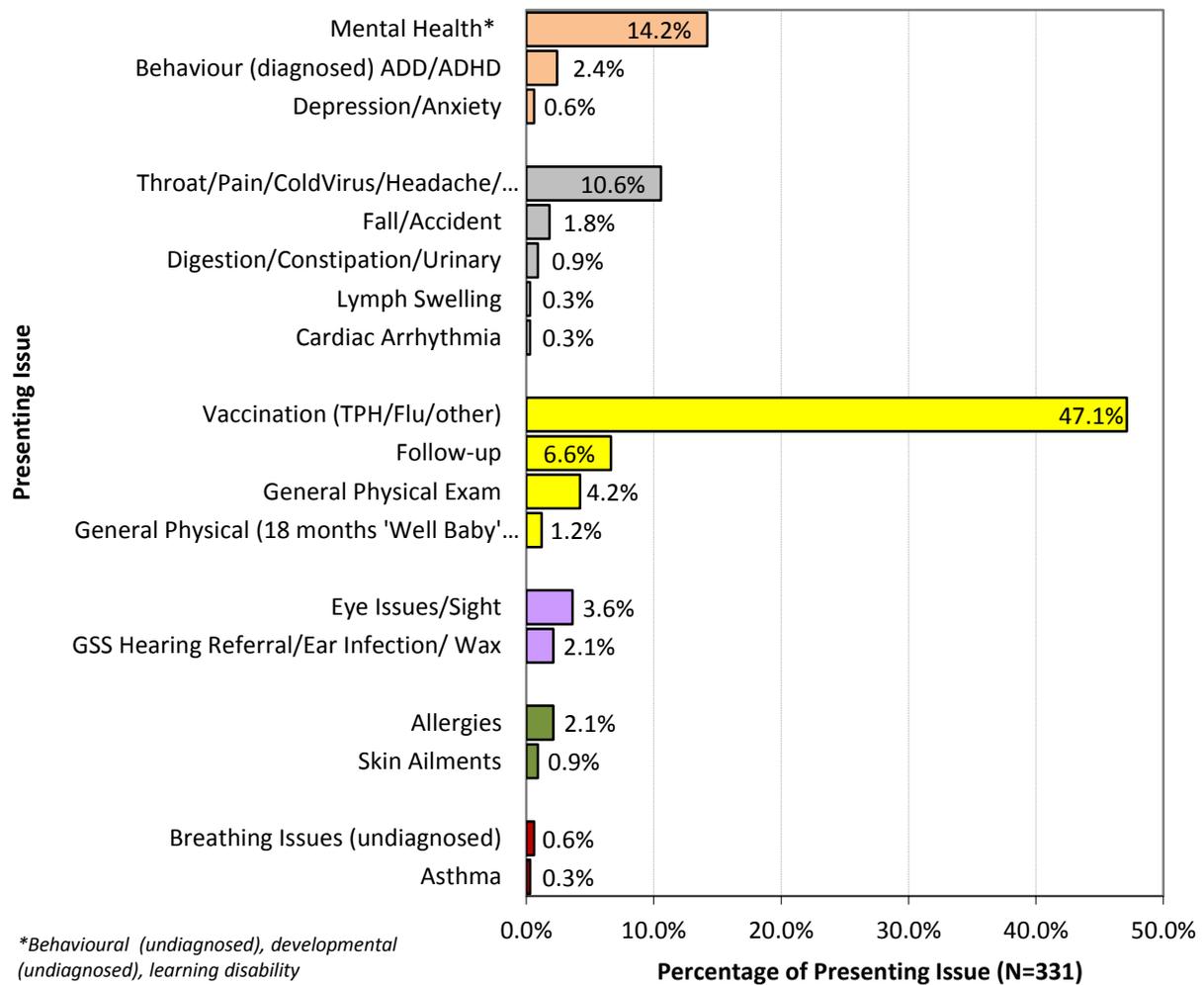
Figure 7 displays the presenting issues at the George Webster clinic based on the cumulative total of patient visits up to January 2012.

<sup>22</sup> George Webster ES has had a shorter amount of data collection time (compared to the clinic at Sprucecourt PS) and therefore the participant by grade breakdown will be available in the next reporting period.

## Physical Health Issues

Physical ailments such as colds and viral infections represented 14% of the presenting issues. The highest percentages of visits were for vaccinations<sup>23</sup>, follow-up, and general physical examinations (totaling 59%) - which were of more preventative type of treatment.

**Figure 7: George Webster In-School Health Clinic, Presenting Issues as of January 2012**



<sup>23</sup> One clinic day was specifically set aside for flu shots.

### *Mental Health Issues*

In George Webster ES, the second largest type of presenting issue concerned undiagnosed behavioral and developmental issues, and learning difficulties (17%). This category also included depression/anxiety and diagnosed behavioral issues (i.e. ADD/ADHD).

The NP and Clinic Coordinator both explained that the Canadian newcomer parents faced multiple barriers related to income, housing, employment, and other settlement issues. While these parents might anticipate the upcoming stages of settlement and understand the successive and expected challenges at each stage, it was harder for the children to foresee future changes, therefore leading to their increased level of stress, anxiety, and fear. Their fear, loneliness, and frustration could be detected in the classroom as behavioural difficulties. According to the Clinic Coordinator, the clinic had helped alleviate these students' associated stress and emotions related to their settlement situation, which would otherwise have affected their schooling experience.

## Observable Impacts from George Webster In-School Health Clinic

While it would be too soon to determine the effectiveness of the George Webster in-school health clinic after less than one year of operation, interviews with different stakeholder groups did reveal a number of observable impacts the clinic had already exhibited for students and the school community. Although different interviewees' experiences with the clinic varied depending on their profession or role associated with the clinic, they shared common observations and comments<sup>24</sup> about the positive and potential impact of the clinic, which can be categorized into the following four themes.

1. Improving Student Health and Well-Being
2. Addressing Barriers for Marginalized Groups
3. Strengthening School, Parent, and Community Relationships
4. Increasing Opportunities for Student Success

### 1. Improving Student Health and Well-Being

The primary goal of the NPLC at George Webster ES was to provide its students direct access to primary health care, thereby improving their health and well-being for schooling. As observed by the School Principal:

*Especially for students with complex issues, many are becoming clients of the clinic because the communication for all involved with that child's health is much easier. Our clinic is that connection between the child's school experiences and their health issues.*

The TFSS Manager (Clinics) also shared his observations about the impact of the clinic on student health and well-being:

*I strongly believe in prevention and this is taking place in the clinic because the (Nurse Practitioner) service is personalized and comprehensive. Adding outreach to pull in other professional services will also create personalized care. That is what the clinic is offering- and also what we will continue to strive for.*

*We had a child who was suspected to have behavioural issues and was suspended from school. The parents were new immigrants, struggling with settling-in and they were very anxious about their child. Now, the parents are very thankful that our clinic helped to identify some of the reasons for the behavioural issues: stress from a language barrier, environment and lifestyle change. The school took actions as advised by the clinic and the child is now enjoying school and new friends. The whole process took a very short time, and it was only possible because we are an in-school clinic.*

<sup>24</sup> Selected impact statements from the various interviewees are presented in this section of the report. Additional collaborating responses from various George Webster ES interviewees for each Observable Impact Category can be found in Appendix 2.

Having treated students with various medical issues in the clinic, the NP shared her following observations:

*Any sort of ailment can keep a child from learning in the classroom; for example, children are sitting in class with tooth decay and it's painful. They cannot concentrate. Vision problems can cause headaches and they will have trouble reading or paying attention. Children that have sleep issues, because they are itchy from bed bugs will also be affected in class. As more issues come to us at the clinic, and we add more professionals to our team, we will all be working together to support the health of the whole child.*

## 2. Addressing Barriers for Marginalized Groups

The Access Alliance Director of Primary Care and Specialty Programs explained a difficult choice that many parents would make regarding their child's health when they were from lower income neighbourhoods and/or their child lacked health coverage:

*Whether the children have OHIP or not, they can come to this clinic and can receive quality health care. If they have been able to find a health clinic outside the school, those without OHIP, will be required to pay the \$75 fee-for-service doctor at that other clinic; this is a detriment and a barrier. The parents may be making a choice between: 'Do I go to this doctor and pay the \$75; or do I buy food for my family?' And that's a horrible choice that someone shouldn't have to make.*

The effects of low income on this community were indeed discussed repeatedly by different stakeholder groups. The School Principal explained how this barrier could be alleviated with the MSPHI:

*Many of our students live in poverty and it is important to recognize that education IS the way out for these students. They need to be in school, and we need to minimize their time away from class, for whatever reason that may be, and we need to do everything possible for our students so they are free to access every educational pathway available. The clinic can help in many different ways to keep these children in class and at school.*

### 3. Strengthening School, Parent, and Community Relationships

The goal of the George Webster in-school health clinic, as discussed by clinic staff, school staff, and a community agency manager, was to create an image of the clinic as an additional support system for the child and their family. They were all committed to having the parents feel welcome in the clinic, thereby increasing parent engagement in the school and community. For instance, as commented by the Clinic Coordinator:

*I attend school BBQs, parties, and parent-teacher meeting nights. When the parents meet me, and I am able to answer their questions about health in their own language, it helps them to feel relaxed and welcomed. They want to come to the clinic and are excited that it is so easy to get help for their child. It helps them to understand what we do here and also this builds a stronger relationship between the parents and the school.*

Additionally, many immigrant families within the George Webster ES community were unfamiliar with the health care system and felt unsure about finding care for their children. As observed by the Clinic Coordinator:

*For the parents using this clinic it is about trust. They have their own perspective on our clinic depending on what they hear about us from other parents in the community. This is why outreach for the clinic is very important. Parents want to come here with their children because they have heard positive things. They also feel more welcome in this school because of the clinic.*

### 4. Increasing Opportunities for Student Success

Speaking to the impacts of the clinic at the school level, the Principal discussed absenteeism and student success:

*We had a list of 25 students that would've been suspended because they were missing vaccinations in their medical history. With the clinic here we were able to immunize them right at the clinic and save these students from missing many days of school. Having the students in class is most important for their success.*

The School Principal also discussed the importance of early intervention and the effect this could have on students' school experience:

*The earlier we can offer support the more effective the intervention will be. Making all children able to access all the opportunities available to them in education by staying healthy from an early age and onwards is key.*

*A Grade 5 boy began disrupting classes, berating other students and engaging in fights. A school Vice-Principal referred the boy and his family to an in-school clinic doctor. He was then referred to mental health therapy where it was discovered that language-learning barriers were causing him stress that resulted in his misbehaviour. With the help of mental health professionals, his teachers, and his family, this young boy is now learning how to communicate and beginning to do much better in school.*

## Next Steps for the George Webster In-School Health Clinic

### Need to familiarize the community with the NP model

While stakeholders agreed with the strengths of the NP model and its appropriate fit for the George Webster ES community, they still saw the need to educate the community about the healthcare capabilities of NPs, and the range of services they could provide. It is important to attain the understanding and confidence of the community in this relatively new primary care delivery model. For instance, the NP cited an experience where a parent who visited the clinic for the first time mistakenly presumed their child would see a Paediatrician on that initial visit. These misunderstandings were even more common among referred students of families that did not attend George Webster ES. In fact, it should be noted that the unfamiliarity with the NP model occurred across all cultures, regardless of the length of time living in Canada or whether they were born in Canada. Parents generally accepted the traditional roles of health care where doctors played the primary role and nurses fulfilled a supportive role as assistants, whereas the NP model allowed nurses to make decisions which they were trained for and qualified to do. Essentially, in this model NPs worked to their full scope of practice.

In addition to the traditional views attached to professional titles, the issue of gender-roles was also discussed. Traditionally, nursing was viewed as a female profession, while Physicians were expected to typically be older and male. The NP model challenged both of these stereotypes simultaneously by having NPs who were generally female and younger performing duties that traditionally were associated with visiting a doctor. Consequently, all stakeholders emphasized the importance of community outreach to promote and familiarize the community with the relatively new NP model and to address the traditional health care perceptions (e.g., age and gender) that tended to reside within the public as well as the medical communities.

Access Alliance Multicultural Health and Community Services, associated with the George Webster in-school health clinic, addressed these biases by using non-gender based language and by assuring that professional titles were not tied to traditional terminologies. It was suggested that community outreach, along with literature or posters displayed at the NPLC, would help generate a better understanding of the advanced level of training, qualifications,

and expertise that NPs had. Furthermore, community education could help promote the NP model as a more cost-efficient alternative, as well as a long-term cost-effective approach with its comprehensive nursing perspective on preventative health care, such as, disease prevention and health promotion.

### **Need to connect with the TDSB's professional services and family doctors in the community**

All interview participants shared their vision of growth for the clinic, and expressed the importance of interdisciplinary care. Requests were made to include other health related professionals in areas such as social work, developmental paediatrics, nutrition, occupational therapy, and speech therapy. Many of these professional supports were indeed available within the TDSB. Therefore, a stronger link should be forged between the medical service providers associated with the in-school clinic on one hand, and the TDSB professional support staff teams on the other. There was also an expressed need to connect with family doctors in the community. As explained by the School Principal:

*There is a reciprocal benefit to keeping all the services together in a clinic contained within a school. There are long waiting lists for specialist services. It's hard for these parents to even get access to a family doctor, but there are many children that also need access to a Developmental Paediatrician, Occupational Therapist, Speech-Language Therapist....Having all the services available at one place opens communication between all professionals and eliminates the waiting. It is very difficult to connect externally and can take weeks for myself, involved with the child's education, to connect with an external service agency that is involved with the child's physical or mental health. The clinic can provide this care in one place with other community partners or professionals involved.*

### **Need for extended hours of service and back-up staff**

The Clinic Coordinator reported that there were demands for appointments beyond the clinic's operating hours. The concern was that having to cancel appointments or having parents find the clinic closed would counter the increased accessibility image they had worked hard to build in the community. As she put it, "What does a parent think when their experience is not positive because we needed to cancel? What message are we sending out when we have to turn children away?" (Clinic Coordinator, personal communication, December 19, 2011). Hence, suggestions were made to extend the clinic hours, especially during the popular

appointment time slots (i.e., the afternoon) and to have a back-up NP when necessary. This ran parallel to a need for increased staff and in turn increased funding.

### **Need for long-term funding, partnership growth, and support for sustainability**

The operation of the George Webster in-school health clinic was based thus far on community funds raised in honour of Dr. Paul Steinhauer, a renowned Child Psychiatrist, on the 10<sup>th</sup> anniversary of his death. This community-based fundraising effort continued to be the source which operated the clinic. All interviewed participants expressed the dire need for adequate and long-term funding from the government – especially the Ministry of Education, the Ministry of Health, and the Ministry of Citizenship and Immigration. The need for a long-term financial commitment and strong partnership was echoed by the Clinic Coordinator in order to reach further out into the community and to meet the clinic’s need for extended services. As commented by the Clinic Coordinator, “A partnership is required in advance of reaching goals; not just as each goal is met” (personal communication, December 19, 2011).

## NEXT STEPS IN THE RESEARCH

This Phase I Report examines the TDSBs MSPHI efforts by examining the first two in-school health clinics as separate case studies. In each case, the unique needs and characteristics of the community it served, the delivery model, the implementation process, perceivable benefits, and potential challenges were explored. These findings will help guide further research in the Phase II evaluation of these first two clinics, especially in terms of its effectiveness and impact on students. The Phase II study will include data collection from the users (both students and parents) as well as linking the clinics' cumulative database with other available empirical data sources (e.g., MSIC research data, attendance data, and school report card information) maintained by the Board's research department. The current Phase I findings would also aid in the investigation of the third new clinic in a middle school, and a few others that would soon be opened. Finally, as noted earlier, this multi-year MSPHI study based on both qualitative and quantitative methodologies will contribute to the dearth of Canadian research in this area, and will help assess over time how such school-based integrated service efforts would have affected the health and educational outcomes of students in high-needs communities.

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Observable Impacts from Sprucecourt  
In-School Health Clinic

1. Improves Student Health  
and Well-being

*Paediatrician*  
It is impressive that we can help children within such a range of issues; for example, children that are undiagnosed with developmental issues, mental health issues, childhood anxiety but also acute infections or chronic conditions; like asthma or diabetes.

*Paediatrician*  
Our model leads to earlier detection and this makes treatment more effective.

*Paediatrician*  
The health needs of these students are beyond acute care, for example just viruses, colds, or emergencies. The clinic has grown and requires other professional services.

2. Addresses Barriers  
for Marginalized Groups

*Paediatrician*  
Our model does provide more accessibility to families that would've waited a long time to see a family doctor and now they can also easily receive a referral to a Paediatrician- if it is necessary.

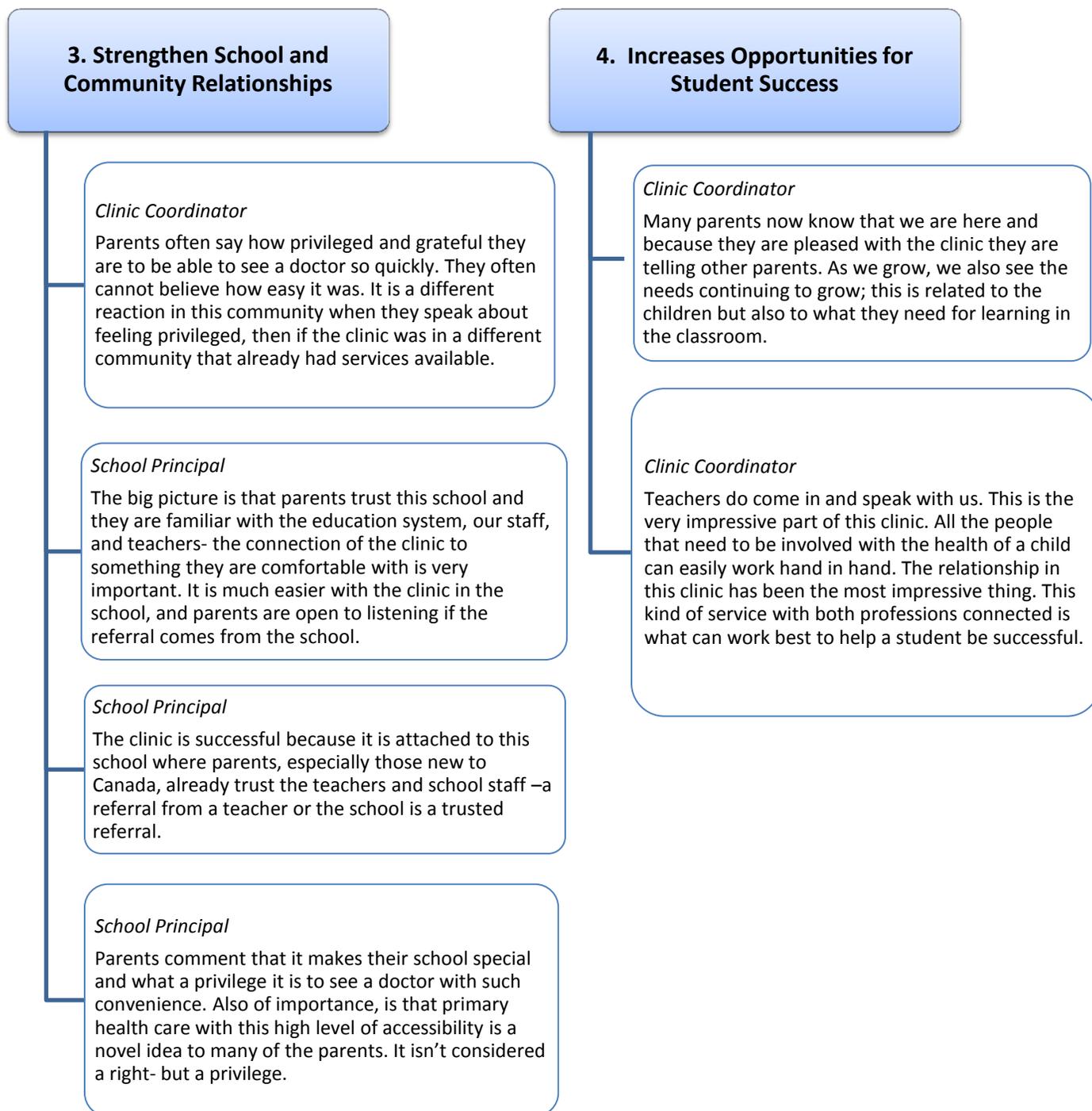
*Paediatrician*  
The model allows more comfort and convenience for parents especially for complex cases that require other professional services and referrals.

*School Principal*  
The families simply need it. The main point is that since transportation, along with taking time off work, are two main barriers that I see for these parents, having the clinic here just makes sense. They already have so many barriers to face. The clinic here in our school really does help with not one, but many of these issues.

*School Principal*  
The clinic in the school just makes sense! We are able to help parents lower their stress. They can also learn how to obtain a health card. Making health care easy and accessible, especially for parents that are unfamiliar with the Canadian health system, is what we are offering our parents. These children now have care when they likely wouldn't have been receiving it otherwise.

*School Principal*  
This clinic's model also cuts down on the back and forth between parents and other appointments if a child needs to see a Paediatrician or needs a referral to another service. There is faster communication between all those involved helping a child.

## Observable Impacts from Sprucecourt In-School Health Clinic



## Observable Impacts from George Webster In-School Health Clinic

### 1. Improves Student Health and Well-being

#### *TFSS Programs Manager*

I strongly believe in prevention and this is taking place in the clinic because the (Nurse Practitioner) service is personalized and comprehensive. Adding outreach to pull in other professional services such as mental health, dietary, and developmental will also create personalized care. That is what the clinic is offering- and also what we will continue to strive for.

#### *Access Alliance Programs Manager*

This initiative is going beyond a diametrically opposed way of thinking of services; away from the either/or and focusing on 'if you have a clinic in your school and you also have a Physician or practitioner in the community- how do we ensure that communication is being sent amongst those that work with the same patient? We are in a transition period, but when we look 10 years down the road those issues should be easy to solve. It can be addressed with electronic based care. It's the shared care model of medicine that we're talking about here.

#### *Access Alliance Programs Manager*

Our citywide mandate, and board of Directors wanted to make points of access out in the community and increase health care accessibility for many people. We look at putting services where it makes sense; and when TDSB was looking around for partners, it just made perfect sense for us to be in the school. The answer just seemed so obvious that 'yes it would be an amazing idea and that, yes, we would want to do it.'

#### *Access Alliance Programs Manager*

To turn a person away- if they are ill and contagious and need care is ridiculous. To put up a barrier and say they must pay to see a doctor, but won't even be able to afford the drugs they need to get well is also irresponsible- from a public safety perspective; especially if we're facing a contagion. More and more people could get sick and then the costs will become huge. You need to address the care of that person because they are here- regardless of their status. From not only a public health perspective but also a public safety perspective you have to care for people that are ill.

### 2. Addresses Barriers for Marginalized Groups

#### *School Principal*

I see that the clinic makes accessing the health care system a lot less intimidating. The parents are feeling scared and already have so many barriers to face and try to overcome: poverty, language, new health system, housing, and transportation. With the many steps in place for settlement, and all the paperwork, they can also feel mistrustful of this new system. There is a lot of paperwork they may not understand it because of the language barrier.

#### *TFSS Programs Manager*

There is lack of information about available services for the parents but this clinic can help them see that there are things in place to help. The parents then begin to see the school as a whole support team for their adjustment and settlement into Canada; this settlement integrates their learning and health.

#### *TFSS Programs Manager*

Parents are very busy making a living and they don't have the time and sometimes they aren't sure what is available because of their background. This program helps parents to identify what is wrong with their child and the parents see that our medical system is here to help. This view about better access and care will be passed to their children - the next generation. Using this clinic program and the Canadian medical system for these children *now* will mean that when they grow up they will know how that system can help them; that means both education and medical. This is very important for the new families that come to Canada. It raises awareness and it will be an advantage so that future generations of children will not have the same experiences and barriers later that they can overcome now.

## Observable Impacts from George Webster In-School Health Clinic

### 3. Strengthen School, Parent, and Community Relationships

*School Principal*  
We have a student that had many days absent last year because of complex issues. After connecting with the clinic this child is now in school much more. It has had a positive impact on that student and especially helped to alleviate the mother's stress.

*Clinic Coordinator*  
I attend school BBQs, parties, and parent-teacher meeting nights. When the parents meet me, and their questions about health care can be answered in their own language it helps them very much. It also builds a relationship between the parent and the school - through this clinic.

*Clinic Coordinator*  
For parents using the clinic it's about trust. They will have their own perspective depending on what they see and hear about us at the clinic. This is why outreach for the clinic has been very important. Parents want to come here with their children and they also feel more welcome in the school.

*School Principal*  
Especially for children with complex issues, many are becoming clients of the clinic because the communication for all involved with the child is much easier. The clinic is that connection between the child's school experience and their health issues. There's a reciprocal benefit to keeping all services together at a clinic in the school. It eliminates communication and travel problems, or wait-times. The clinic can bridge a child's education to their health; which is something that just wouldn't be possible in this community without the clinic

*School Principal*  
We had been promoting public health to our students already and we had good relationships in place before the clinic came. There was also a lot of support and energy from the community to bring the clinic to George Webster ES and parents are proud that the clinic is here and proud of their school.

### 4. Increases Opportunities for Student Success

*School Principal*  
We had a list of 25 students that would've been suspended because they were missing vaccinations in their medical history. With the clinic here we were able to immunize them right at the clinic and save these students from missing many days of school.

*School Principal*  
The big picture is that parents trust this school and they are familiar with the education system, our staff, and teachers- the connection of the clinic to something they are comfortable with is very important.

*School Principal*  
The earlier we can offer support the more effective the intervention will be. Making all children able to access all the opportunities available to them in education by staying healthy at all ages is key.

*School Principal*  
Many of our students live in poverty and it is important to recognize that education IS the way out for these students. They need to be in school, and if we can minimize their time away from class, then we need to do everything possible so they are free to access every educational opportunity.

*Nurse Practitioner*  
Any sort of ailment can keep a child from learning in the classroom. For example, children are sitting in class with tooth decay and it's painful- they cannot concentrate. Vision problems can cause headaches and they will have trouble reading or paying attention. Children that have sleep issues, because they are itchy from bed bugs will also be affected in class. As more issues come to us at the clinic, and we add more professionals to our team, we will all be working together to support the health of the whole child.

