TORONTO

STAFF REPORT
ACTION REQUIRED

2011 Update on Public Health Programs Funded by the Ministry of Children and Youth Services

Date:	May 24, 2011
To:	Board of Health
From:	Medical Officer of Health
Wards:	All
Reference Number:	

SUMMARY

Toronto Public Health (TPH) currently delivers four Ministry of Children and Youth Services (MCYS) funded programs: Healthy Babies Healthy Children (HBHC), Preschool Speech and Language (PSL), Infant Hearing (IHP) and the Blind-Low Vision (BLV) programs. Each of these programs is 100% provincially funded. Services within these programs are delivered in accordance with the Ontario Public Health Standards, related Protocols and/or Service Agreements with the Ministry.

Since 2006, Toronto Public Health has been identifying concerns to the Board of Health and the Ministry regarding funding levels for these programs. Current levels are insufficient to meet the needs of the children of Toronto and to comply with provincial standard protocols. Compounding this funding shortfall is the fact that, for the fourth consecutive year, funding levels have remained frozen, with no increase to address cost of living budget pressures. Further to this, the Ministry of Community and Youth Services recently advised Ontario public health units that a significant reduction in the universal postpartum component of the Healthy Babies Healthy Children program will go into effect on January 1, 2012. While Toronto Public Health will endeavor to maintain the highest level and quality of service possible, growing wait lists and impending service changes will have impacts on the health and well-being of the infants, children and families in Toronto.

RECOMMENDATIONS

The Medical Officer of Health recommends that:

1. The Board of Health forward this report to the Minister of Children and Youth Services, express concern regarding the proposed changes to the universal postpartum component of the Healthy Babies Healthy Children program and call for sufficient and sustainable provincial funding to ensure that Toronto Public Health can meet the needs of Toronto's families; and

2. The Board of Health forward this report to the Minister of Health Promotion and Sport and express concern regarding the impact of planned changes to the Healthy Babies Healthy Children program on other Reproductive Health and Child Health services; and

3. The Board of Health forward this report to the Minister of Children and Youth Services and call for sufficient and sustainable funding for the Toronto Preschool Speech and Language, Infant Hearing, and Blind-Low Vision Programs to achieve provincial service delivery targets; and

4. That this report be shared with the Association of Local Public Health Agencies (alPHa) and the Ontario Public Health Association (OPHA).

Financial Impact

All programs identified in this report are 100% funded by the Ministry of Children and Youth Services. There are no financial implications to the City directly resulting from this report.

DECISION HISTORY

A report entitled "Healthy Babies Healthy Children Program Funding" was received by the Board of Health in August 2006. It identified that provincial funding for the Healthy Babies Healthy Children program was insufficient to allow Toronto Public Health to deliver the program in accordance with Ministry requirements and service targets. Further updates on public health programs funded by the Ministry of Children and Youth Services were presented to the Board of Health in June 2009 and June 2010. Both of these reports identified continued budget pressures and resulting service impacts in the Healthy Babies Healthy Children, Preschool Speech and Language, Infant Hearing and Blind-Low Vision programs.

ISSUE BACKGROUND

As part of its Early Learning Initiative, the Ministry of Children and Youth Services (MCYS) funds Toronto Public Health to deliver four programs aimed at promoting the healthy growth and development of children between the ages of 0 and 6 years:

1. Healthy Babies Healthy Children (HBHC)
2. Preschool Speech and Language (PSL)
3. Infant Hearing (IHP)

4. Blind-Low Vision (BLV)

Toronto Public Health delivers the HBHC program in accordance with the Reproductive Health and Child Health requirements of the Ontario Public Health Standards. The companion HBHC Protocol identifies the minimum expectations of HBHC service delivery for prenatal women, postpartum mothers and high risk families with young children. According to the current HBHC Protocol, the screening component of the program should include universal prenatal, postpartum and early identification screening in partnership with other health care providers. The assessment component of the program should include a universal postpartum telephone brief assessment within 48 hours of hospital discharge and an in-depth assessment of high risk families. The final component of the HBHC program includes universal postpartum home visiting and blended high risk home visiting by Family Home Visitors and Public Health Nurses to provide education, counseling, service co-ordination and referral to community services.

While the PSL, IHP, and BLV programs are not part of the Ontario Public Health Standards, Toronto Public Health is the lead agency for Toronto. Because the goals, objectives and clients of these programs align so well with Toronto Public Health's Child Health programming, TPH is particularly well suited to be the lead agency for them. These programs are delivered in accordance with a Service Agreement with MCYS, which establishes the funding level and specific service requirements and targets for each program.

The PSL program includes early identification and screening, direct speech and language therapy for children and training and education for parents and care providers. The IHP program began in 2003 and includes universal newborn screening, regular monitoring of at risk children, audiology assessment and support for families who have a child with an identified hearing loss. BLV is the newest of the programs, beginning in 2007. It includes support and service co-ordination for families who have a child that has been diagnosed as blind or with low vision. All three of these programs are delivered across Toronto through a combination of direct TPH service delivery and purchase of service contracts with community agencies that have specific expertise.

Since the programs began in 1998, funding levels for the HBHC and PSL programs have never been sufficient to achieve compliance with Ministry established service delivery targets. Despite an already insufficient level of funding, the HBHC budget has not been increased since 2007. PSL funding is still at the 2007/08 level. Funding for IHP was increased by $39,600 in 2008/09 and has remained at that level since then. BLV funding has not increased since the program began in 2007/08. At the same time, salary, benefits and non-salary cost of living expenses have increased by approximately 3% each year for the past four years. The cumulative impact of flat-lining has therefore been an approximate de facto reduction of funding of almost 13% over a four year period.

COMMENTS

The Ministry of Children and Youth Services has confirmed that the 2011 funding level for the HBHC and the 2011/12 funding levels for the PSL, IHP and BLV programs have been frozen at 2010 and 2010/11 levels respectively. While TPH appreciates the fact that in the current economic environment there have been no funding reductions, these funding levels fail to address the ongoing financial and service pressures faced by these programs.

TPH has made every effort to address these funding pressures without reducing service delivery levels for children and families. This has included realigning and leveraging administrative resources, minimizing non-salary operating expenses (which represent less than 9% of the total budgets) and flat-lining purchase of service contracts. However, even these strategies have an impact on families. For example, HBHC funding includes the distribution of food certificates to low income families to support healthy child growth and development. This year it became necessary to restrict the availability of this support to emergency situations only.

Unfortunately, non-salary reductions have been insufficient to fully address the funding shortfalls and there has, therefore, been a gradual reduction in the staffing levels of the programs. Not surprisingly, this gradual reduction in staff has had an impact on service delivery. For all four programs, decisions about service impacts have been made based on client need, potential risk and evidence of best practice.

Healthy Babies Healthy Children

When making service reduction decisions for the HBHC program TPH has given priority to blended home visiting for high risk families that have children between the ages of 0 and 6 years. Consequently, the number of Public Health Nurse and Family Home Visitor home visits has risen slightly over the past several years and now remains relatively constant at approximately 37,000 home visits per year. Over the past four years, service impacts in the HBHC program have included:

- Focusing screening on postpartum and at risk families. As a result, TPH is not conducting universal prenatal screening. Only 3.4% of prenatal women are screened.
- Discontinuing weekend postpartum services. This has significantly reduced TPH's ability to meet the Ministry's requirement for all postpartum mothers to receive telephone contact within 48 hours of hospital discharge. TPH currently contacts approximately 74% of postpartum mothers within 48 hours.
- Limiting the offer of a postpartum home visit to only those mothers assessed as at risk during the postpartum telephone call. This means that TPH is not meeting the Ministry's requirement to offer a home visit to 75% of postpartum mothers. TPH is currently visiting only 7% of all postpartum mothers.
- Revising the referral criteria to the HBHC high risk blended home visiting program for prenatal women and families with young children, and increasing the level of risk required to enter the program. In 2008, there were 2,025 families referred into the program. By 2010, this number had dropped to 1,540 families.

- Establishing a wait list for the blended high risk home visiting program. This generates concern that at risk families will be lost and/or decline service when their name finally comes to the top of the list.
- Eliminating active promotion of the program and outreach to at-risk populations resulting in reduced public awareness about the program.

These impacts will continue into 2011. The non-salary operating budget has been further reduced and represents only 6% of the total budget. This has been achieved by further reducing the food supplement and interpretation budgets and reducing printing costs for program promotional material and parenting education resources. From a service delivery perspective, TPH will further reduce the number of postpartum mothers who receive a telephone call within 48 hours of hospital discharge. Using the screening criteria provided by the hospital at discharge, only at risk mothers will receive a phone call. Those mothers assessed as not at risk will be sent a letter and community resource information through the mail. In addition, the wait list for high risk home visiting will increase by approximately 1 month to 3 to 4 months.

These service reductions significantly limit TPH's compliance with the HBHC Protocols of the Ontario Public Health Standards and the program's ability to achieve program goals and objectives.

Proposed Provincial Changes to HBHC

Ontario Public Health Units were notified earlier this year that MCYS is in the process of planning a number of revisions to the HBHC program and the related protocol. These changes are planned to go into effect on January 1, 2012 and, while they will strengthen the high risk blended home visit component of the program, they will significantly reduce the universal postpartum component of the program. More specifically, the changes include:

- A new, more detailed and evidenced-based HBHC screening tool that will replace the currently used Larson prenatal and Parkyn postpartum screening tools. This new tool, which has yet to be validated, is intended to provide greater focus on risk identification and will enable HBHC Public Health Nurses to identify and support vulnerable families more quickly;
- A streamlined screening process that will eliminate the need for the current multiple screens in order to enter the high risk component of the program;
- Discontinuation of the postpartum phone call and home visit;
- An information package for new parents that will be provided before mother and baby leave the hospital, to include child development information, a description of programs available to support children and families, and important contact numbers for further assistance;
- Strengthened home visiting through training and the introduction of province-wide best practice guidelines; and
- The option for public health units to include a social worker on the HBHC home visiting team (although no new funding for this).

Health Units have been advised that these changes are part of the government's overall commitment to improve services for children and their families through its Best Start initiative. Funding levels will remain consistent despite these changes, allowing the funding and resources previously allocated to the universal postpartum component of the program to be realigned to the high risk component of the program. Along with provincial support for training and best practice guidelines, these changes are a very positive step towards strengthening the high risk component of the HBHC program. In the case of TPH, this will mean increased home visit intensity, the capacity to have high risk women enter the program earlier (i.e. prenatally), an increased number of high risk families receiving service and the reduction/elimination of the waiting list.

Unfortunately, these service enhancements will come at the expense of services to other postpartum women. The universal nature of the postpartum program is a critical component of the full HBHC program for a number of reasons:

- It ensures that no one falls through the cracks. In the absence of information about and validation of the new screening tool, there is no way to be sure that the tool will accurately screen for risk. Furthermore, Toronto works with 12 different birthing hospitals to support the completion of the current screening tool. Experience to date has demonstrated that for a variety of reasons there is a great deal of variability in hospital staff completion rates and accuracy of the Parkyn tool. There is no reason to believe that this would not be the same for the new tool.
- It allows women to enter the high risk home visiting component of the program without the stigma of being labeled as "high risk" at hospital discharge. There is a risk that women who could benefit from the program may decline consent for referral to the program because of this.
- It identifies maternal and infant health risks that may not be apparent in hospital. Of particular concern are breastfeeding problems and postpartum depression. Neither of these is likely to be present at time of hospital discharge when the new screening tool will be completed. For example, the *2010 Breastfeeding in Toronto Report* showed that exclusive breastfeeding rates dropped to 54% at two weeks postpartum. A universal postpartum telephone call would facilitate the identification of women experiencing breastfeeding problems.
- It facilitates referral to other TPH and community resources. While the proposed information package is meant to provide information about the availability of such resources, there are concerns about the effectiveness of this type of strategy in Toronto. Past experience has demonstrated significant cost and logistic challenges in distributing information packages to hospitals and, then in turn, to postpartum women. More importantly, there has been no commitment to-date from MCYS that these information packages will be available in the broad range of languages that will be necessary to meet the needs of Toronto women.

- Vulnerability for poor developmental outcomes may not be limited to those families that are screened through the new screening tool. Charles Pascal, in *With Our Best Future in Mind: Implementing Early Learning in Ontario*, states that "the majority of vulnerable children – more than 60 percent – live in moderate, middle-class and affluent families. A universal approach to program provision, in which dedicated poverty reduction initiatives are embedded, has been found to magnify the social, economic and academic benefits" (pg 11).

Over the past several, the Toronto Board of Health has expressed its concerns about HBHC funding levels and the resulting impact on service levels. As resources were gradually eroded, TPH reluctantly reduced the postpartum component of its program. TPH has always been concerned about the necessity of making such changes and their impact on families as described above. These concerns are now more profound than ever given the direction that the province has currently decided to go in.

Preschool Speech and Language, Infant Hearing and Blind-Low Vision

Since the 2007/08 fiscal year, there has been a cumulative reduction of 10 FTEs in the PSL program. Efforts have been made to reduce the impact of this reduction on the number of children served through revisions to the service delivery model. By offering more group programs and reducing the intensity of service to each child, the total number of children served by the program has remained relatively stable at approximately 7,000 per year. It remains necessary to determine if this revised service delivery model can achieve the same outcomes for the children. It has also been necessary to increase the length of the wait list which will grow from 18 weeks in 2007/08 to 27 weeks in 2011/12. This means that children aged four years and older who are referred to the program are likely to age out of the program (at school entry) while they are on the waitlist and never receive service.

The priority for IHP continues to be screening all newborns for potential hearing problems prior to hospital discharge. In order to achieve this, it has been necessary to reduce the availability of weekday clinic hours and this year, it will be necessary to discontinue the Sunday clinic. This means parents are waiting up to 2 months for a repeat newborn screening assessment. In addition, it is no longer possible to conduct the provincially-required 18 month telephone surveillance call. An additional pressure on the IHP budget is a chronic shortage in funding for screening supplies (that has been addressed over the past several years by end of year one time grants) and aging equipment that is in need of replacement. These costs have quadrupled, from $15,000 per year to $60,000 per year, over the past three years. TPH will continue to seek one time provinicial funds to address these pressures.

Despite no increase in the BLV program since it began in September 2007, the program currently has 35% more families than the program was originally funded to serve. This has been achieved through a number of innovative approaches to service delivery that include more group and telephone contact with families instead of individual home

visiting. Given that the program is now beyond its capacity, in 2011/12 it will be necessary to establish a wait list for new referrals to the program.

TPH will continue to work closely with the Ministry of Children and Youth Services to address program and funding concerns. MCYS has indicated a willingness to work with the field on establishing the details of these changes and TPH will participate fully in every opportunity to provide input into the revised Protocols, screening tool, information package, training materials, and guidelines. TPH will also continue to work closely with MCYS to clearly articulate the impact of funding levels on service delivery in the PSL, IHP, and BLV programs and to advocate for additional, sustainable funding. Other opportunities for funding (e.g. one time grants) have and will continue to be explored.

In addition, TPH continues to seek solutions to maximize the efficiency of all of our MCYS funded programs. In 2010, a review of the organizational structure of the Healthy Families Directorate was completed and implemented. This resulted in the establishment of a separate HBHC service unit which has increased our ability to more effectively manage both fiscal and human resources. Also in 2010, a review of the PSL program was completed. A feasibility assessment of the recommendations and implementation planning is currently underway.

Finally, TPH is actively engaged in consultations regarding the development of a provincial framework for the Best Start Child and Family Centres that were proposed by Dr. Charles Pascal in the *"With Our Best Future In Mind: Implementing Early Learning in Ontario"* report. The report clearly identifies the HBHC, PSL, IHP and BLV programs as integral components of these Centres. While the province has signaled that these Centers will be established through a "re-engineering" of the current system with no new funding, TPH will actively explore opportunities for funding and service efficiencies through the establishment of these Centres.

TPH remains committed to delivering the highest quality of service possible with available resources and to identifying and implementing customer service improvements wherever possible. However, the ongoing erosion of staffing levels puts the achievement of expected outcomes such as early identification, positive parenting and healthy growth and development of young children at risk.

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