Children's Health Services – April 2024 – March 2025

To:	Chair and Members of the Board of Health
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Recommendations

It is recommended that the Board of Health receive this report for information.

Key Points

- The Children's Health Services (CHS) Program is fully funded by the Ministry of Children, Community and Social Services (MCCSS).
- Healthy Babies Healthy Children (HBHC), a blended home-visiting service, is a key component of the CHS program supporting eligible families from the prenatal period through to early childhood.
- Collaboration with community agencies is essential to enhance program delivery, increase awareness of public health services and improve navigation of community resources.
- The CHS program continues to evolve through innovative practices such as transitioning to a new documentation system to strengthen program planning and service delivery

Background

The *Healthy Babies Healthy Children* (HBHC) program, a comprehensive home-visiting initiative, is now part of the newly established *Children's Health Services* (CHS) team at Wellington-Dufferin-Guelph Public Health (WDGPH). This integration reflects a strategic shift toward a more flexible and responsive model of child and family health service delivery. By expanding beyond traditional home-visiting services, the program is better positioned to meet the evolving and diverse needs of families throughout the region. The primary goals of HBHC remain to promote optimal child health, foster healthy growth and development, and reduce health inequities among participating families.

HBHC is mandated by the Ontario Public Health Standards (OPHS) and is fully funded by the Ministry of Children, Community and Social Services (MCCSS).[1] The program focuses on the Healthy Growth and Development Program Standard in the OPHS. The home visiting team consists of Public Health Nurses (PHNs) and Family Visitors (FVs) who work with families from pregnancy through to the child's entry to school.[2] This voluntary service includes universal screening, targeted assessments and interventions for families.

Referrals

Referrals are primarily received from hospitals during the postpartum period. Additional referrals are accepted from the prenatal stage to early childhood via midwives, obstetricians, primary care providers, community partners and client self-referrals.

To improve the efficiency of the referral process and increase accessibility to the HBHC program, WDGPH implemented two key strategies aimed at supporting easier, more effective connections between referral sources and services for families.

First, an online referral form was launched on the WDGPH website, enabling healthcare providers, community partners, and clients to submit referrals directly.[3] This digital option improves convenience and helps reduce barriers to accessing services.

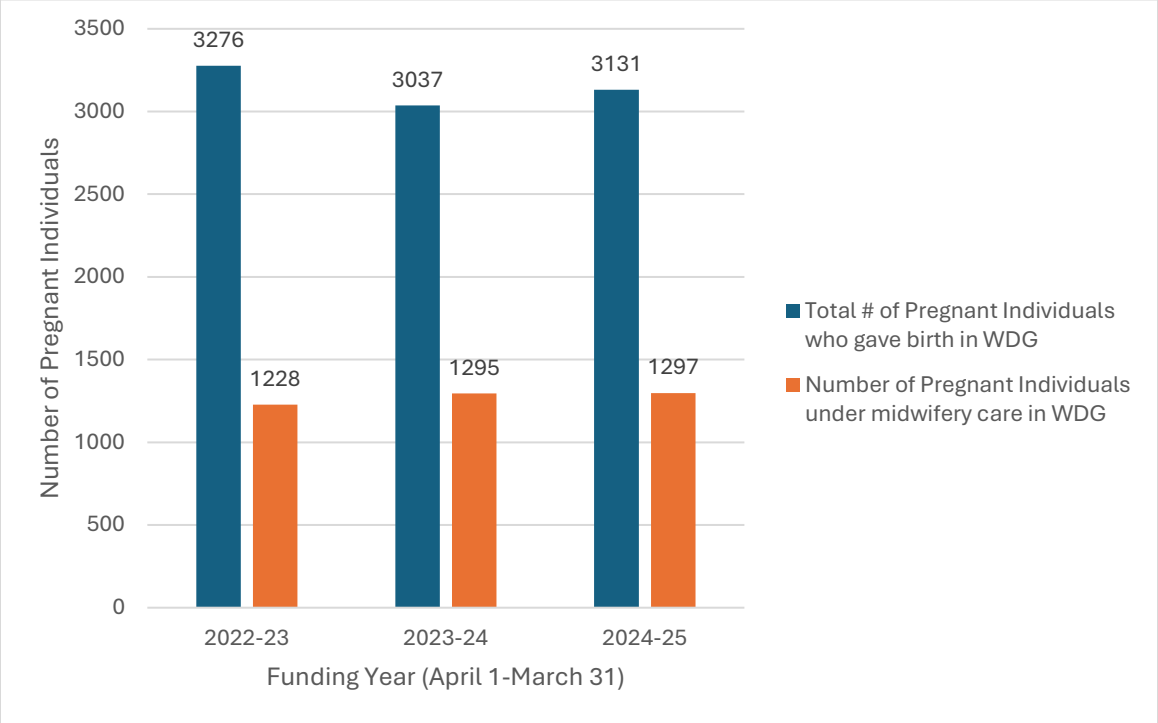
Second, a simplified, hospital-specific referral form was developed in collaboration with a local hospital (See Appendix A). Designed with direct input from hospital nursing staff, the form was tailored for ease of use to encourage adoption and increase the number of referrals from hospital settings.

Program Delivery

According to the Better Outcomes Registry and Network (BORN) Information System, there were 3,185 live births in the region between April 1, 2024, and March 31, 2025 – a slight increase from 3,094 live births reported in the previous year.[4] This indicates a relatively stable regional birth rate. It should be noted that the reported number of pregnant individuals who gave birth is subject to change due to delayed reporting.

Midwifery care continues to be a significant provider of services to pregnant individuals in the Wellington-Dufferin-Guelph (WDG) region. In the past year, 41% of pregnant individuals in WDG received care from a midwife – a rate that has remained steady over recent years (see Figure 1).[4] In contrast, provincial data shows that less than 20% of pregnant individuals in Ontario accessed midwifery care over the past three years.

Figure 1: Rate of Pregnant Individuals Under Midwifery Care in WDGPH (Funding Year April 1-March 31)



Since the resumption of home visiting services in 2023, rates of screening, assessment, and visits have remained relatively stable when comparing the periods of April 1, 2024, to March 31, 2025, and April 1, 2023, to March 31, 2024. Table 1 presents updated figures reflecting home visiting data across the last three funding years.

Table 1: WDGPH HBHC Home Visiting Data (Funding Year April 1-March 31)

Funding Years	# of Families / # of Families Part of Home Visiting Program (HVP)	# of Visits / # of Visits Part of HVP	% of Visits Completed as Part of HVP
2024 - 2025	440/436	1951/1908	98%
2023 – 2024[1]	424/422	2093/2032	97%
2022 – 2023[1]	196/177	2309/2087	90%

To determine eligibility for the HBHC home visiting program, a PHN completes a Ministry-developed universal screening tool.[2] This validated tool identifies risk factors related to infant health, maternal health, family circumstances and parental concerns.

From April 1, 2024, to March 31, 2025, a total of 2,119 screens were completed - a slight increase compared to the previous funding year (N=2097). Table 2 outlines the number of screens completed at the prenatal, postpartum and early childhood (seven months to six years of age) over the past three years.

Table 2: HBHC Universal Screening Data (Funding Year April 1-March 31)

Funding Years	# of Prenatal Screens	# of Postpartum Screens	# of Early Childhood Screens
2024 - 2025	38	2009	72
2023 – 2024[1]	46	1987	64
2022 – 2023[1]	15	2131	61

Clients identified as potentially having risk factors from the initial screen are assessed using an In-Depth Assessment (IDA), identifying both strengths and areas for improvement for the family.[2]

Families deemed high risk are offered participation in the HBHC blended home visiting program.[2] Table 3 highlights the number of individuals who completed an IDA. Notably, there has been a slight decrease in the number of individuals identified as high risk in 2024-2025 compared to 2023-2024.[1]

Table 3: In-Depth Assessment Data (Funding Year April 1-March 31)

Funding Years	# of In-Depth Assessments	# of Individuals with High Risk In-Depth Assessment
2024 - 2025	376	143 (38%)
2023 – 2024[1]	369	158 (42%)
2022 – 2023[1]	56	52

Discussion

The program remains well-aligned with WDGPH's strategic priorities. Its emphasis on improving health outcomes, focusing on children's health, building strong partnerships, and driving innovation in programs and services reflects a commitment to building a sustainable public health system and healthier communities.

As the program has reached a point of stabilization post-pandemic, the next step is to increase service uptake in the prenatal stage, enhance internal and external collaboration, and ensure that all families expecting a child or raising young children are aware of this publicly funded service.

Prenatal Referrals

As the program continues to strengthen partnerships with community agencies and re-establish connections with healthcare providers like midwives and primary care providers, a key priority is to enhance early access to services by increasing prenatal screening rates.

By reaching individuals earlier in the prenatal period, the program aims to provide early health guidance and facilitate timely access to intervention services - laying the foundation for improved health outcomes during the postpartum and early childhood stages. This approach aligns with the *Public Health Agency of Canada's Family-Centred Maternity and Newborn Care Guidelines*, which emphasize that early and regular prenatal care contributes to improved maternal and infant health through comprehensive health promotion and supportive services.[5]

WDGPH's Community Health Division

WDGPH already offers a range of programs and services that engage this target population. The CHS team is actively working to increase internal referrals from programs such as Clinical Services and Dental. In turn, the CHS team promotes other WDGPH programs and services with families to increase awareness and ease of access for families.

The CHS team also collaborates closely with the Client and Community Support (CCS) team to streamline referrals between programs and support information sharing. This ensures that pregnant individuals and parents who contact WDGPH for assistance receive timely and accurate information about available resources and can be referred to the HBHC service if appropriate. Establishing an early connection between families and Public Health is important - even if a family is not eligible for HBHC, they can still access parenting support and child health guidance by speaking with a PHN through the health line.

Building Strong Partnerships

Canadian Mental Health Association (CMHA) Waterloo Wellington's Transition to School

The CHS team has recently joined the *Transition to School* (TTS) service offered by the Canadian Mental Health Association Waterloo Wellington (CMHA WW). This service supports families with children entering kindergarten by facilitating the sharing of relevant information with schools prior to the start of the school year.

PHNs participating in this service contribute to sharing key information about children and families entering the school system. This collaboration represents a valuable opportunity for the CHS team to work closely with CMHA WW to enhance the transition to school experience for families participating in the HBHC program.

Early Years Community Planning Tables

As part of its commitment to supporting Healthy Growth and Development in the region, WDGPH participates in planning tables across Wellington and Dufferin counties. These forums provide opportunities to share information, offer recommendations, and foster collaboration among key community partners.

Participation at these tables also offers a platform to promote WDGPH services to partners who work directly with families. As program planning continues, the goal remains to allocate resources effectively to meet both community needs and the requirements set by the MCCSS.

Prenatal Partnership with Dufferin EarlyON Child & Family Centres

To support capacity building among community partners and enhance prenatal education, the CHS team is collaborating with Dufferin EarlyON to develop a prenatal education package for EarlyON staff who collaborate closely with pregnant individuals. This initiative ensures that families can access valuable information while already engaging with services they trust.

EarlyON staff, who have built strong relationships with families, are well-positioned to bridge the gap for families who may benefit from information and support, but do not require the HBHC program.

The prenatal education package will align with key components of WDGPH's online prenatal education program, equipping EarlyON staff to better support families during pregnancy into the postpartum period. This pilot project with Dufferin EarlyON will be evaluated with the goal of expanding access to Guelph and Wellington EarlyON centres, ensuring equitable access to prenatal education across the region.

Innovation of Programs and Services – Transition to Collaborative Health Record

In accordance with Ministry requirements, CHS staff are required to complete documentation within the provincial Healthy Child Development – Integrated Services for Children Information System (HCD-ISCIS).[2] This provincial database stores information related to screening tools, IDAs, family communication and home visiting activities. However, extracting data from HCD-ISCIS is limited and presents challenges for identifying trends and assessing family needs, which in turn impacts effective program planning and evaluation.

To enhance data monitoring, reduce the time spent on documentation using tailored forms and centralize all assessments, referrals and records, the CHS team is transitioning to the TELUS Collaborative Health Record (CHR) system. TELUS CHR is already in use within the agency for other documentation purposes, ensuring greater integration across services.

Focusing on Children's Health and Improving Health Outcomes

The goal of the CHS program is to promote positive lifelong outcomes through early intervention and support in a child's life. Early experiences are critical in shaping adulthood. Mitigating the impact of Adverse Childhood Experiences (ACEs), which are potentially traumatic events occurring before age 18, can significantly reduce the risk of negative health outcomes later in life.[5] Stable, nurturing relationships with parents and caregivers are key protective factors that help children develop strong coping skills and reduce the risk of ACEs.[6]

The CHS team focuses on improving parenting capacity by supporting the development of healthy, secure attachments and stable relationships. Using a strengths-based approach, the team works collaboratively with families to develop skills and achieve mutually-agreed-upon goals within family service plans. All CHS staff have completed training on ACEs and understand the importance of early intervention.

Health Equity Implications

The program continues to support vulnerable families, including a growing number of families who are Newcomers to Canada within the WDG region. In collaboration with local community agencies, ongoing efforts are focused on addressing the diverse and evolving needs of this population.

A key component of this work is effective information sharing among community partners who also support these families, helping to ensure they are connected to the most appropriate services and reducing duplication of efforts.

The HBHC screening process includes targeted measures to identify newcomer families and those without Ontario Health Insurance Plan (OHIP) coverage. The CHS program remains accessible to all families, including those without OHIP, as services are publicly funded and intended to support all children living in the community—regardless of immigration or insurance status.

To reduce barriers to access, referrals, including self-referrals, are accepted by phone, fax or email. The CHS program remains committed to health equity by ensuring that all families in the community have the opportunity to thrive.

Conclusion

The CHS program remains committed to continuously monitoring community needs and emerging trends related to pregnancy, postpartum, and early childhood. This ongoing assessment informs and strengthens the innovative approaches to promoting positive outcomes for families from the prenatal period to early childhood.

A continued focus will be placed on increasing prenatal referrals, recognizing the critical importance of early intervention and support. This will be achieved through enhanced collaboration with community partners and the adoption of targeted strategies to reach pregnant individuals.

Collaboration with community agencies remains essential to improving program delivery, increasing awareness of public health services, and supporting effective navigation of community resources. As the program continues to evolve, innovative practices - such as the transition to a new documentation system - are being implemented to strengthen program planning and service delivery.

Through these collective efforts, the CHS program remains dedicated to fostering healthy beginnings for all families across the Wellington-Dufferin-Guelph region.

Ontario Public Health Standards

Foundational Standards

- ☐ Population Health Assessment
- ☒ Health Equity
- ☒ Effective Public Health Practice
- ☐ Emergency Management

Program Standards

- ☐ Chronic Disease Prevention and Well-Being
- ☐ Food Safety
- ☐ Healthy Environments
- ☒ Healthy Growth and Development
- ☐ Immunization
- ☐ Infectious and Communicable Diseases Prevention and Control
- ☐ Safe Water
- ☐ School Health
- ☐ Substance Use and Injury Prevention

2024-2028 WDGPH Strategic Goals

More details about these strategic goals can be found in WDGPH's 2024-2028 Strategic Plan.

- ☒ Improve health outcomes
- ☒ Focus on children's health
- ☒ Build strong partnerships
- ☒ Innovate our programs and services
- ☒ Lead the way toward a sustainable Public Health system

References

1. Wellington-Dufferin-Guelph Public Health. Consent Agenda to the Board of Health. BH.01.DEC0424.C17 Healthy Babies Healthy Children Program. [Internet]. 2024 December 4. [cited 2025 Apr 27]. Available from: https://wdgpublichealth.ca/sites/default/files/bh.01.dec0424.c17_-_hbhc.pdf

2. Ontario. Ministry of Children and Youth Services. Healthy Babies Healthy Children Program Protocol, 2018. [Internet]. 2018 [cited 2025 Apr 27]. Available from: https://files.ontario.ca/moh-healthy-babies-children-protocol-en-2018.pdf

3. Wellington-Dufferin-Guelph Public Health. Healthy Babies Healthy Children (HBHC) Program. [Internet]. 2024 [cited 2025 May 8]. Available from: https://wdgpublichealth.ca/your-kids/healthy-babies-healthy-children-hbhc-program

4. BORN Ontario. BORN Information System [Internet]. Ottawa, ON.: BORN Information System, 2023 [cited 2025 May 16]. Available from: Access the BORN Information System - BORN Ontario5. Public Health Agency of Canada. Family-Centred Maternity and Newborn Care: Chapter 3 – Prenatal Care. [Internet] 2020 January 27. [cited 2025 May 4]. Available from: https://www.canada.ca/en/public-health/services/publications/healthy-living/maternity-newborn-care-guidelines-chapter-3.html

6. Community Resilience Coalition Guelph & Wellington. What are ACEs?. [Internet]. 2022. [cited 2025 Apr 28]. Available from: https://communityresilience.ca/what-are-aces/

Appendix A

Fax 1-844-202-7747 or email hbhcprogram@wdgpublichealth.ca

*If transmission problems occur, call 1-800-265-7293 x7006

HBHC Referral Form for Hospitals

FAMILY INFORMATION (REQUIRED): No minimum gestation for prenatal referrals.

Referral Stage: ☐ Prenatal ☐ Postpartum ☐ Stillbirth ☐ Early Childhood (> 6 weeks & 6 days of age)	
ADDRESSOGRAPH:	☐ Due Date (*prenatal*) (yy/mm/dd): _____/_____/_____ ☐ Date Of Birth (*child*) (yy/mm/dd): _____/_____/_____
	Interpreter required: ☐ Yes ☐ No Language:
	Phone #: (Required for call or text)

REFERRAL SOURCE (REQUIRED):

Name:	☐MD ☐RM ☐NP ☐RN/RPN ☐SW Other:
Phone number: Fax number: Organization:	Referral date (yyyy/mm/dd):

A. Contact from a Public Health Nurse (see details on next page)

A received referral confirms the client's consent for follow-up calls or texts with the contact information provided.

Indicate applicable information to support the PHN calling	
☐ No concerns	☐ No primary care provider for mom &/or baby
☐ Pregnancy complications for mom &/or baby	☐ Health challenges/concerns with infant
☐ Birth complications for mom &/or baby	☐ Breastfeeding/infant feeding/nutrition concerns
☐ Inadequate prenatal care	☐ Newcomer to Canada
☐ Premature [Please indicate # of weeks _____]	☐ Lack of social supports
☐ Multiple birth (please send 1 form per child)	☐ Mental health history which could impact care
☐ Baby has or will spend time in a special care nursery or NICU [Please indicate hospital: _____]	☐ Concerns/stressed about infant care

Comments: Please add any further relevant concerns or information.

B. Online Prenatal & New Parent Program: (see program description on next page)

FREE online prenatal and new parent program:

☐ **Client consents to being registered for the online program.**

***A program access code will be granted to the e-mail provided below

Client email address (req'd for program sign-up):

The information on this form is collected under the authority of the *Health Protection and Promotion Act* in accordance with the *Municipal Freedom of Information and Protection of Privacy Act* and the *Personal Health Information Protection Act*. This information will be used for the delivery of public health programs and services; the administration of the agency; and the maintenance of healthcare databases, registries and related research, in compliance with legal and regulatory requirements. Any questions about the collection of this information should be addressed to the Chief Privacy Officer at 1-800-265-7293 ext. 4340.

Updated 2025.04.14
HBHC Referral Fax Form: CA.30.03.209