Program/Service Information Report

Healthy Babies Healthy Children Program

2017 Annual

TO:	Board of Health
MEETING DATE:	April 4, 2018
REPORT NO:	**BH.01.APR0418.C07**
PREPARED BY:	Tricia Hardy, Manager, Family Health Programs
APPROVED BY:	Andrea Roberts, Director, Family Health
SUBMITTED BY:	Dr. Nicola J. Mercer, MD, MBA, MPH, FRCPC Medical Officer of Health and CEO

Key Points

- The Healthy Babies Healthy Children (HBHC) program in Wellington-Dufferin-Guelph Public Health (WDGPH) is delivered with high fidelity to the Ministry of Children and Youth Services (MCYS) HBHC Protocol (2018), within the limitations of the existing funding.
- HBHC program statistics are generated out of the MCYS database (HCD-ISCIS) and provide data for program planning, service delivery improvements and resource allocation. HBHC Monitoring Reports are submitted to MCYS on a quarterly and annual basis.
- ISCIS data is also reflected in the annual continuous quality improvement reporting as required by MCYS. Provincial benchmarks are presented annually with the opportunity for public health units to negotiate locally feasible targets.

Strategic Directions & Goals

Health Equity - We will provide programs and services that integrate equity principles to reduce or eliminate health differences between population groups.

- We will work to improve health services for priority populations.
- We will have an understanding of health equity and apply it in our work.
- We will enhance our understanding of the local needs and priorities of the communities we serve and develop programs and services in response to those needs.

Service Centred Approach - We are committed to providing excellent service to anyone interacting with public health.

- We will improve access to public health programs and services while enhancing the client experience.
- We will support a work culture of continuous learning.
- We will implement processes for continuous quality improvement.

Operational Plan Objectives

OPHS Program: Family Health

Goals:

- To enable individuals and families to achieve optimal preconception health, experience a healthy pregnancy, have the healthiest newborn(s) possible, and be prepared for parenthood.
- To enable all children to attain and sustain optimal health and developmental potential.
- To reduce the burden of preventable chronic diseases of public health importance.

Strategy:

- Screening and assessment (targeted screening for prenatal and early childhood; postpartum screening is population level screening).
- Postpartum follow-up for families screening “with risk”.
- Discontinue postpartum follow-up for “without risk” families and replace with resources (printed and a postpartum app).
- Postpartum home visiting for “with risk” families.
- Blended home visiting for families identified “with risk” that are requiring longer-term support, education, referrals and service coordination.
- Evidence based assessment and intervention regarding parent-child interaction and relationships.
- Service and system integration (systems level collaboration and planning of services for this population).
- Surveillance – HBHC data is utilized in aggregate format by individual public health units, MCYS, BORN[1], Public Health Ontario etc.
- Evaluation – public health units participate in provincial evaluations and program reviews.

Requirements:

Boards of health shall provide HBHC program services to women and their families in the prenatal period and to families with children up to six years old. The provision of the HBHC program is mandated and funded for all boards of health by the MCYS under the following:

- Heathy Growth & Development Standard, 2018
- Healthy Babies Healthy Children (HBHC) Protocol, 2018

Accountability Indicators:

- MCYS Annual Continuous Quality Improvement

[1] BORN (Better Outcomes Registration Network) – BORN is Ontario’s pregnancy, birth and childhood registry that that provides an information system for collecting, interpreting, and sharing data related to pregnancy, birth, and child outcomes provincially. More information about BORN is available at www.bornontario.ca.

Performance variance or discrepancy identified:

- There is little variance for local achievement in year to year trends. Efficiencies gained through ongoing refinement and local prioritization within program components have so far mostly offset service pressures such a steadily increasing birth rate and flat lined funding that gradually results in loss of staff and operating dollars.
- While there is consistent year-over-year performance within WDGPH, variances exist between most of the MCYS provincial benchmarks and local achievements. The inability to meet provincial targets is consistent across public health units delivering this program, including WDGPH. This is attributed to differing local client needs, unrealistic program targets, and local prioritization of HBHC resources. This service delivery prioritization is approved by MCYS. Public health units negotiate local targets annually and report on the resultant variances to MCYS.
- MCYS expectations for prenatal and early childhood screening are examples of unrealistic program targets. Postpartum screening is theoretically feasible at a population based screening level (approaching 100 %) as almost all women give birth in hospital or with a midwife. In contrast, while most women obtain prenatal care there is no ‘one stop point’ for prenatal screening; rather individual practitioners (obstetricians, family practitioners, midwives) are relied upon for screening. Many of the practitioners do not have the capacity to complete a HBHC screen on every patient and prefer to make needs based referrals to HBHC prenatally using a much condensed referral mechanism. Even 5% of early childhood HBHC population screening (900 children per year) is unattainable without a coordinated community approach or additional funding to host screening clinics. HBHC is limited to targeted screening only because it does not have population based screening infrastructure or capacity.
- The HBHC continuous quality improvement requirement changes annually. MCYS identifies provincial priorities with recommendations for all public health units to consider but each health unit selects two indicators to develop and implement improvement plans that will take the health unit incrementally closer to the benchmarks.

Highlights

Table 1 below provides the most significant indicators used for HBHC reporting purposes. Data is presented annually rather than in smaller increments due to the length of a HBHC client lifecycle and the data extraction logic in the reporting subsystem.

Table 1. HBHC Monitoring Indicators

Indicator	Targets or benchmarks	2014	2015	2016	2017
# births (as per BORN data)	n/a	2,381	2,995	3,169	3,135
# prenatal screens	10% of births screened	3.1%	3.7%	3.8%	3.9%
# postpartum screens	80-90% of births	91%	85%	79%	84%
# of early childhood screens	5% of early years cohort (WDG 0-6y cohort is ~18,000 children)	172 (0.9%)	122 (0.7%)	137 (0.8%)	103 (0.6%)
# of postpartum contacts	80% of births	1,370 (58%)	1,389 (46%)	1,463 (46%)	1,545 (49 %)
# of postpartum home visits (only eligible if with risk)	~ 50% of total postpartum screens	446 (37%)	494 (33%)	417 (26%)	397 (25%)
# of prenatal/postpartum/early childhood in-depth assessments	70% of with risk screens receive an in-depth assessment	620 (44%)	542 (42%)	550 (42%)	527 (39%)
# of active long-term or blended home visiting families	Former benchmark – any family referred to long-term home visiting *New benchmark – # active families with 4 or more visits (blended home visiting)*	557	190	207	230
# of visits by PHN (blended home visiting)	No target for # of home visits; targets provided for home visit frequency and interval	1,912	2,170	2,199	2,187
# of visits by family visitor (blended home visiting)		1,458	1,325	1,467	1,279
# of joint home visits (blended home visiting)		520	543	463	539
total # of visits (blended home visiting)		3,370	3,495	3,666	3,466
# referrals to other services	All families have a service coordinator	1,177	938	984	1,106

Beyond the recurring monitoring report indicators (sample as above), MCYS sets additional targets for continuous quality improvement requirements. These values are based on provincial performance and/or best practices. Table 2 provides highlights of WDGPH continuous quality improvement achievements and explanation of variances for 2017.

Table 2. WDGPH HBHC Continuous Quality Improvement Reporting Highlights

Activity	Target	2016	2017	Comments
Prenatal screening	10% of provincial births are screened (Local target 7%)	3.8%	3.9%	Rate/quality identified for improvement-2018 continuous quality improvement plan
Home visit quality	Ave. length of blended home visiting (min. 6-12 months)	6.12 months	6.87 months	Although meeting targets; identified in 2017 and 2018 for enhancement – ongoing continuous quality improvement work plan
	Ave. frequency of blended home visiting (time between home visits no longer than 14 days)	10.98 days	10.51 days	

The 2018 continuous quality improvement goals and plans focus on:

- Continued implementation of prenatal screening promotion (i.e. referrals for with risk families to HBHC) with healthcare professionals.
- Increasing the frequency of use of the NCAST© Parent-Child Interaction scales by certified public health nurses within the HBHC program.

Related Reports

For additional information regarding the HBHC program, refer to:

Healthy Babies Healthy Children Program Update – BH.01.MAY0317.R11