Proposal by the Children's Health Coalition

CHEO | Children's Hospital London Health Sciences Centre | CMHO Children's Mental Health Ontario Santé mentale pour enfants Ontario | eko EMPOWERED KIDS ONTARIO | eao ENFANTS AVENIR ONTARIO | Holland Bloorview Kids Rehabilitation Hospital | Kids Health Alliance | McMaster Children's Hospital | SickKids

MAKE KIDS COUNT

A children's health action plan to ensure hospital capacity and provide timely access to care both in the immediate pandemic response and through recovery

September 2021

Before the pandemic children already waited too long for health care. Now the situation has deteriorated further and a generation of children are at risk of significant long-term health problems because critical early intervention windows are being missed.

Health system capacity for children is at risk. Investments are urgently needed to ensure the system is equipped to manage historical pressures, the current and projected increases in demand for hospital care arising from wave 4 and the upcoming viral season, the backlog of surgeries and procedures, and increasing hospitalizations and emergency department visits for mental health issues. The increased pressure is adding to a children's health care system where long wait times were already a significant challenge pre-pandemic in hospitals, community mental health, and children's rehabilitation.

EXECUTIVE SUMMARY

Every day matters in the life of a child.

Delayed care for critical children's health care services puts children at risk over the long term and has life-long consequences and costs to the health care system. An integrated approach across service settings and across physical, developmental and mental health is required to address both new and long-standing barriers to timely access to care. For example, the onset of the pandemic has exacerbated long standing capacity gaps, wait lists and delays in timely access to surgery, ambulatory care, inpatient rehabilitation, and diagnostic imaging. These delays can lead to ongoing health problems in adulthood. For the best possible outcomes, surgery in children very often needs to be timed to coordinate with developmental milestones or at least occur early enough in the child's life that it optimizes their future potential physical, psychological, and social development.

Furthermore, developmental and rehabilitation services provided in communities and schools are expected to face a surge of need from children after surgery and procedures due to backlogs. At the same time, they must ensure children who are already on growing wait lists for community-based rehabilitation services are not left behind. Investments are needed to address long wait times for community child and youth mental health treatment for those with more serious mental health issues to help prevent them from going to the hospital in crisis and to help preserve capacity in hospitals during wave 4 and beyond. Hospitals are critical for short-term stabilization of acute mental health issues, but treatment occurs over the long-term in community-based settings. As well, community-based treatment can prevent acute mental health issues and hospitalization.

As the province enters wave 4 of the pandemic and through recovery planning, the urgency of improving access to children's health care and addressing the historical pressures must be a top priority of the government.

1 Children refers to infants, children and youth ages 0 to 18. The report also uses "kids" and "children and youth" to refer to the same population.

The Make Kids Count Action Plan from the Children's Health Coalition represents an unprecedented coming together of Ontario's leading children's health care providers. This proposal represents a detailed analysis from the 115 cross-sectoral organizations that are represented within the Coalition. Other service providers also play a critical role in children's health care including primary care (e.g., family physicians and community pediatricians) and community and psychiatric hospitals. Each region has a unique configuration of service providers providing care to children. Working with Ontario Health Regional Leadership and community hospitals, members of the Children's Health Coalition will assess needs in Phase II of this work, with completion estimated by November 30, 2021.

The Children's Health Coalition's Make Kids Count Action Plan has identified a need for an investment of $83 million in 2021/2022, $234 million in 2022/2023 and $224 million in 2023/2024 to ensure timely access to health care as part of system recovery and to ensure hospital capacity through wave 4.

SOLUTION	2021/2022 Jan 1 – March 31	2022/2023	2023/2024	TOTAL
1. Provide timely access to care so children receive surgeries, diagnostic imaging, ambulatory services, diagnostic imaging and procedures, and post-operative rehabilitation supports within clinically appropriate times by addressing long wait times and backlogs and reducing wait lists.				
a. Address long wait times and the backlog in **surgeries, post-surgical inpatient rehabilitation, ambulatory services and procedures, and diagnostic imaging**, ensuring children receive care within target wait times	**$37 M**	**$100 M**	**$91 M**	**$228 M**
b. Reduce long-standing wait lists and expand **hospital and community-based rehabilitation and development** resources to ensure children have timely access to services within a window of opportunity to maximize each child's potential and recovery	**$9 M**	**$35 M**	**$35 M**	**$79 M**
2. Ensure hospital capacity in children's hospitals by right-sizing pediatric ICU capacity to meet current demands and address surges, and alleviate key hospital pressures from mental illness and eating disorders.				
a. Augment capacity for **pediatric intensive care** to right-size the system and manage upcoming pressures (Level 3 PICU, Level 2 PICU and critical care extender beds)	**$6 M**	**$19 M**	**$19 M**	**$44 M**
b. Add **acute mental health surge capacity** in hospitals and through hospital community partnerships for children and youth in crisis	**$7 M**	**$15 M**	**$13 M**	**$35 M**
c. Provide immediate support for specialized tertiary **child and youth eating disorders** programs*	**$8 M***	**$8 M**	**$8 M**	**$24 M**
d. Prevent children and youth with mental health issues from requiring hospital care and ensure step down care is promptly available by investing in **community-based child and youth mental health treatment** and innovative partnership models	**$16 M**	**$57 M**	**$58 M**	**$131 M**
TOTAL INVESTMENTS	**$83 M**	**$234 M**	**$224 M**	**$541 M**

* Proposal submitted July 2021, emergency in year funding ask is for 2021/22

A provincial, system wide action plan is necessary given that children's health care is delivered locally, regionally and provincially, as well as across multiple settings (e.g., hospital, community, home, school) and requires specialized health human resources. Changes and pressures in one part of the system have profound impacts throughout the system. Pressures on hospitals are a symptom of long-term under resourcing in all aspects of children's health care including timely access to community-based care that can both prevent children from needing to go to the hospital as well as provide necessary treatment and services after hospital care. For example, a lack of timely access to community child and youth mental health care for a child with mental illness leads to increased pressures on hospitals as families in crisis turn to emergency departments. Long wait times for rehabilitation and development services mean that children who need high priority post-operative rehabilitation and clinical services are prioritized, and those who were considered priority on wait lists continue to wait. In some cases, children who were waiting for community-based rehabilitation care now instead require surgery because of delays in care.

As a result of the inter-connected nature of children's health care, the Children's Health Coalition is working closely with Ontario Health through the Children's COVID-19 Response and Recovery Table (under development) to ensure a **provincial, system-wide view on solutions, investments and planning**. In an environment with constrained health human resources, system wide planning is essential as investments in one part of the children's system may have consequences in another part of the system and further exacerbate wait times, service provision and availability of health human resources. This collaborative work with Ontario Health will help support implementation and accountability on outcomes and metrics, as well as an integrated and enhanced response with the existing regional and provincial structures.

IMPACT OF THE PANDEMIC ON CHILDREN'S HEALTH AND ACCESS TO CARE

The pandemic has had a profound impact on the health and well-being of Ontario's 2.3 million children and youth. Closures of schools and other in-person supports, services and activities for children and youth have impacted the development, well-being and mental health of an entire generation. Moreover, we know that the impacts have been inequitable – those children with disabilities or mental health issues, and those from low-income families, Black, Indigenous and racialized communities have been disproportionately negatively impacted.

The cumulative impact of historical capacity challenges in children's health care, combined with the impact of the pandemic on children and families directly and on the health human resource workforce (which is very specialized in the delivery of pediatric care), have led to greater pressures on our children's health care system and increased barriers to accessing care. Some examples of the increased pressures in children's health care through the pandemic include:

- **Over 4,200 surgeries at children's hospitals were cancelled between March 1, 2020 and May 31, 2021**
- **Over 209,000 non-surgical appointments/procedures at children's hospitals were cancelled** between March 1, 2020 and May 31, 2021. While many appointments (>100,000 from March 1, 2020 to May 31, 2021) have been successfully conducted virtually, pediatric virtual care has unique challenges not faced by adult care and a much larger proportion of patients require in-person visits.
- **More than 5,000 children and youth missed the opportunity for school-based rehabilitation services** because of the pandemic – a reduction of seven per cent in less than one school year.

- **Eating disorder emergency department visits at children's hospitals increased by 1.5 to 2.6 times** with hospitalizations increasing 1.5 to 1.9 times. Eating disorders account for a large proportion of the increase in mental health hospitalization visits and have the longest length of stay of any mental illness (Sick Kids, 2021; ICES, 2021)
- **Wait lists and demand continue to rise for specialized community-based mental health treatment** for children and youth with serious mental illness.
  - Kinark Child and Family Services, the largest community-based provider in Ontario, has reported a 15 per cent increase in wait lists. In some areas of the province, some children are waiting more than three years.
  - In the Parry Sound area, there was a 184 per cent increase in requests for service.
  - In Ottawa, there has been a 30 per cent increase in demand for counselling and therapy.

As a result of these pressures in children's health care, wait lists and wait times have grown:

- **Over 28,000 children/youth are waiting for diagnostic imaging across the province's children's hospitals.**
- **Over 31,000 children/youth are on wait lists for ambulatory services across the children's hospitals.**
- **Over 8,300 children and youth are waiting for surgery at children's hospitals** in Ontario. Over 50 per cent of these patients have already been waiting for longer than the recommended clinical wait times.
- **9,500 children are waiting for ambulatory clinic visits** in their communities, e.g., consultations with developmental pediatricians, seating, orthotics, feeding, cleft palate and other ambulatory services.
- **More than 28,000 children are waiting for mental health treatment** across the province. Average wait times for community-based mental health treatment are at least 3 times recommended clinical wait times.

PRE-PANDEMIC BARRIERS TO CARE FOR CHILDREN, YOUTH AND FAMILIES

These added pressures from the pandemic come on top of a system that was already under resourced. Before COVID-19, Ontario families faced long wait times and barriers to accessing children's health care. Before the pandemic:

- **30,000 children and youth were waiting for community-based rehabilitation services before the pandemic.** That number is growing and those already on the wait list will wait longer. Many will require acute care followed by longer community-based rehabilitation as a result. This is a trend that will only continue upward if not addressed.
- Over a 10-year period, **there has been a 71 per cent increase in the rate of children and youth hospitalized for mental disorders in Ontario** (CIHI, 2019), while hospitalizations for other childhood conditions have fallen by 26 per cent. This is an indication that children and youth are not getting adequate care in the community so they end up in crisis in the hospital.
- **Over 28,000 children and youth were waiting for community mental health care**, with some waiting as long as 2.5 years for specialized services. The average for intensive treatment services was 92 days and 67 days for counselling and therapy; well beyond the clinically appropriate wait times (CMHO, 2020).

MAKE KIDS COUNT: AN INTEGRATED CHILDREN'S HEALTH ACTION PLAN

As the province moves through wave 4 of the pandemic and simultaneously lays the foundation for health system recovery, timely access to care for children must be a top priority. The enclosed action plan from the Children's Health Coalition is focused on the following objectives:

1. Provide timely access to care so children receive surgeries, ambulatory services and procedures, diagnostic imaging, and post-operative rehabilitation supports within clinically appropriate times by addressing backlogs and reducing long-standing wait lists.

a. Address long wait times and the backlog in **surgeries, post-surgical inpatient rehabilitation, ambulatory services and procedures, and diagnostic imaging**, ensuring children receive care within target wait times

b. Reduce long-standing wait lists and expand **hospital and community-based rehabilitation and development** resources to ensure children have access to services within a window of opportunity to maximize each child's potential and recovery

2. Ensure hospital capacity in children's hospitals by right-sizing pediatric ICU capacity to meet current demands and surges, and by alleviating key hospital pressures from mental illness and eating disorders:

a. Augment capacity for **pediatric intensive care** to right-size the system and manage upcoming pressures (Level 3 PICU, Level 2 PICU and critical care extender beds)

b. Add **acute mental health surge capacity** in hospitals and through hospital community partnerships for children and youth in crisis

c. Provide immediate support for specialized tertiary **child and youth eating disorders programs**

d. Prevent children and youth with mental health issues from requiring hospital care and ensuring step down care is promptly available by investing in **community-based child and youth mental health** treatment and innovative partnership models

Improving timely access to care and preserving hospital capacity through wave 4 and the pandemic recovery is critical and is the focus of this proposal. While not covered in this proposal, prevention and health promotion, school safety and keeping schools open for in-person learning for the entire school year, "catch-up" immunizations, vaccination for everyone who works with children, and investments in the social determinants of health and regular primary care visits are also needed now and throughout the recovery period.

OPPORTUNITY FOR A PROVINCIAL, SYSTEM WIDE APPROACH TO IMPROVING ACCESS TO CARE FOR CHILDREN AND YOUTH

Given the interconnected nature of children's health and health care services, a provincial, system wide approach is needed. Children's health care operates locally, regionally and spans the province. Pressures in one part of the children's system have ripple effects across the system. For example, long wait times for community-based mental health and development and rehabilitation services lead to added pressures on the acute care system. And without additional community-based capacity, children's hospitals face challenges with stepping patients down from inpatient services. Moreover, constrained health human resources, amplified in pediatric care where the skills are highly specialized, mean that without a system wide view on planning, investments in one part of the system may inadvertently pull away health human resources from another.

The interconnected nature of children's health care also creates opportunities for collaborative models of care and innovative partnerships that not only are a better use of resources, but also provide more accessible care for families. Managing a capacity challenge and planning for recovery entails optimizing the use of the entire system's assets and strategically expanding capacity where possible to take pressures off of hospitals. Some leading examples of collaboration that can be leveraged include:

- Holland Bloorview Kids Rehabilitation Hospital's (HBKR) provincial intensive rehabilitative, post-surgical and post-trauma care takes referrals from the entire province.
- Children from across the province return to their communities after surgery and medical procedures at Ontario's specialty children's hospitals; many require community-based rehabilitation services from Children's Treatment Centres when they return home as part of their post-procedure care.
- Cardiac surgery is performed at SickKids and CHEO, with further cardiac care available at four sites in Ontario.
- Pediatric cancer care is coordinated provincially through the Pediatric Oncology Group of Ontario (outside of the Cancer Care Ontario arm of Ontario Health).
- Community-based mental health secure treatment beds operate at three sites provincially, in Ottawa and Toronto, and are a crucial resource for acute care inpatient units and community-based providers, serving youth with the most serious and high-risk psychiatric illnesses.
- Live-in treatment community-based mental health beds and other intensive treatment services can span multiple Ontario Health regions and serve in partnership with pediatric and community hospitals to serve children and youth with serious mental health issues.
- Children's Treatment Centre services for medically-fragile and medically-complex children can span multiple Ontario Health regions and serve as a resource to Ontario's specialty children's hospitals.

In this stage of the pandemic, the situation has intensified. Children's hospitals are at capacity and modelling predicts they may be over-capacity in the fall. This is in stark contrast to previous stages of the pandemic when children's hospitals cared for adult COVID patients when other hospitals were over-capacity. In addition, while adult patients could be and were moved across the province to manage capacity challenges, it will be important to ensure that children are kept as close to home as possible.

Ensuring timely access to care and a system-wide approach on children's health care capacity is essential to the province's success in wave 4 and in pandemic recovery.

IMPLEMENTATION DETAILS AND TRACKING OUR PROGRESS

The Children's Health Coalition has prepared detailed implementation reports for our recommendations. Enclosed are reports that include implementation details and costing. The detailed implementation reports also include draft metrics to track progress; these metrics are intended to be a starting point for discussion with Ontario Health and the Children's COVID-19 Response and Recovery Table.

1. **Provide timely access to care so children receive surgeries, ambulatory services and procedures, diagnostic imaging and post-operative rehabilitation supports within clinically appropriate times** by addressing backlog and reducing long-standing wait lists.

   a. Address long wait times and the backlog in **surgeries, post-surgical inpatient rehabilitation, ambulatory services and procedures, and diagnostic imaging**, ensuring children receive care within target wait times

      Draft metrics:

      - ❏ Number of patients on wait lists
      - ❏ Average wait times
      - ❏ Average volumes

   b. Expand **hospital and community-based rehabilitation and development** resources to ensure children have access to services within a window of opportunity to maximize each child's potential and post-surgery recovery

      Draft metrics:

      - ❏ Number of kids on wait lists
      - ❏ Total number of days waiting

2. **Ensure hospital capacity in children's hospitals by right-sizing pediatric ICU capacity to meet current demands and address surges, and alleviate key hospital pressures from mental illness and eating disorders:**

   a. Augment capacity for **pediatric intensive care** to right-size the system and manage upcoming pressures (Level 3 PICU, Level 2 PICU and critical care extender beds)

      Draft metrics:

      - ❏ Occupancy rate
      - ❏ Average length of stay

   b. Add **acute mental health surge capacity** in hospital and through hospital-community partnerships for children and youth in crisis

      Draft metrics:

      - ❏ Number of emergency department visits
      - ❏ Length of stay mental health beds
      - ❏ Readmissions within 30 days
      - ❏ One year rate of repeat hospitalizations
      - ❏ Patients hospitalized for more than 30 days in a year

c. Provide immediate support for specialized tertiary **child and youth eating disorders** programs

Draft metrics:

- ❏ Occupancy rate
- ❏ Average wait times
- ❏ Average length of stay

d. Prevent children and youth with mental health issues from requiring hospital care and ensuring step down care is promptly available by investing in **community-based child and youth mental health** treatment and innovative partnership models

Draft metrics:

- ❏ Average wait time by core service
- ❏ Number of kids waiting by core service

ABOUT THE CHILDREN'S HEALTH COALITION

The Children's Health Coalition represents an unprecedented collaboration of Ontario's leading children's health care providers and representative associations, including:

- **CHEO**
- **Children's Mental Health Ontario**
- **Empowered Kids Ontario-Enfants Avenir Ontario**
- **Holland Bloorview Kids Rehabilitation Hospital**
- **Kids Health Alliance**
- **Children's Hospital, London Health Sciences Centre**
- **McMaster Children's Hospital**
- **SickKids**

Proposal prepared by: CHEO, Children's Mental Health Ontario, Empowered Kids Ontario, Holland Bloorview Kids Rehabilitation Hospital, Kids Health Alliance, Children's Hospital – London Health Sciences Centre, McMaster Children's Hospital and SickKids.

MAKE
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COUNT

Implementation Details

Address long wait times and the backlog in **surgeries, post-surgical inpatient rehabilitation, ambulatory services and procedures, and diagnostic imaging**, ensuring children receive care within target wait times

Part of an action plan from the Children's Health Coalition to ensure hospital capacity and provide timely access to care both in the immediate pandemic response and through recovery

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Overview

The onset of the COVID-19 Pandemic has exacerbated long-standing capacity and waitlist challenges for Ontario's children's hospitals. With child, youth, and family needs already outstripping current capacity, additional funding support is urgently needed to stem the growth in waitlists and delays in timely access to surgery, ambulatory care, inpatient rehabilitation, and diagnostic imaging.

Unacceptably long wait times for pediatric care has serious consequences to the health and long-term well-being of the child, often leading to ongoing health problems in adulthood. For the best possible outcomes, surgery in children very often needs to be timed to coordinate with developmental milestones or at least occur early enough in the child's life that it optimizes their future potential physical, psychological, and social development. Families and children are frustrated by the inability to access timely care and burdened by long waiting periods, uncertain about when they'll get the care required for their child. As the pandemic continues to exert pressure on the health care system for the foreseeable future, boosting capacity across the continuum of care and addressing backlogs in care must be a top priority. We must do better for our children.

The Children's Health Coalition has identified the need for $228 million in funding for pediatric hospitals in order to build additional capacity, recruit highly specialized staff, improve access, eliminate the COVID-related backlog, and reduce the chronic long-standing waitlists in the next two years.

	Overall Funding Request for Pediatric Hospitals			
	Funding for Fiscal Year 2021/2022	**Funding for Fiscal Year 2022/2023**	**Funding for Fiscal Year 2023/2024**	**Total**
SickKids / CHEO	$10,938,407	$40,803,628	$40,823,628	**$92,565,663**
	$8,390,851	$22,623,640	$23,511,852	**$54,526,343**
Children's Hospital London Health Sciences Centre	$4,819,160	$11,818,672	$3,045,671	**$19,683,503**
McMaster Children's Hospital	$11,974,643	$20,121,458	$19,047,379	**$51,143,480**
Holland Bloorview Kids Rehabilitation Hospital	$1,138,452	$4,373,807	$4,373,807	**$9,886,066**
Total	**$37,261,512**	**$99,741,206**	**$90,802,337**	**$227,805,055**

In addition, Community Hospitals play an integral role in the delivery of pediatric care close to home. Working with Ontario Health Regional Leadership and those providers, members of the Children's Health Coalition will assess needs in Phase II of this work, with completion estimated by November 30, 2021.

This additional funding for children's hospitals and community hospitals will ensure that we are able to address backlogs and children will receive surgeries and procedures within clinically appropriate times.

In alignment with the work at the Provincial Recovery Table, the proposed Children's COVID-19 Recovery and Response Table will work to develop a set of metrics to monitor and report to the Ministry of Health. Potential metrics include:

- Number of patients on waitlists
- Average wait times
- Average volumes

Key Pediatric Challenges

Historical under-resourcing compounded by the COVID-19 pandemic has resulted in unprecedented demand for services and increasing waitlists. While the entire health care system is under strain, there are several unique challenges confronting the pediatric population.

Early intervention is critical in pediatrics: Children and youth have different and unique developmental physiology which often translates into diagnoses, treatment, procedures, and rehabilitation that is intrinsically linked to time-sensitive interventions to achieve the best possible health outcome. Receiving the appropriate care, at the right time has a critical impact on the growth and development of the child. It is also less costly for the health care system and society as a whole as better pediatric outcomes lead to fewer needs and interventions for most adults.

Unsustainable waitlists compromising care: With hospitals operating at capacity, infection control measures have reduced the number of patients who can be seen at any one time, wait times for services have increased, and patients are desperate for care as they languish on our ever-expanding waitlists. In fact, >50% of patients on surgical waitlists across our children's hospitals have been waiting for longer than the recommended clinical wait times. As we are only able to care for the sickest patients, many on our waitlists may never get care and may end up transitioning into the adult system with slowly deteriorating life-long conditions which could have been averted or reduced in severity with early intervention.

In addition, we expect our already long waitlists to substantially grow over the coming months. As public health restrictions are relaxed, we expect to see undiagnosed children and families who stayed away from the health care system and/or weren't diagnosed during previous waves of the pandemic to begin to seek care again, oftentimes with increased acuity due to the delay.

Lack of capacity compounded by more severe seasonal surges: Pre-pandemic, hospital bed occupancy levels were regularly at or over capacity, and the pandemic has only worsened an existing crisis. Without further financial support, the province's pediatric hospitals do not have the ability to meet the needs of children, youth and families or substantially increase services to address the backlog in care.

In addition, it is expected that with the relaxing of public health measures (which have limited exposure of children to typical childhood viruses), resumption of regular activities, and the return of in-person school in September, we may experience an earlier and extended RSV/Influenza season. In fact, multiple pediatric Emergency Departments as of mid-July were already reporting an increase in volumes (typically experienced from November to March). Reduced immunity to Influenza due to the

skipped 2020 season added to the fact that children under 12 will remain unvaccinated for COVID-19 amidst a rising Wave 4 of the pandemic mean that we may be facing unprecedented volumes in the coming months.

There is no 'flex' left in the system and without added supports to substantially increase capacity, any upcoming surge equals more backlog, longer wait lists and wait times, and more children and families in crisis. The longer we take to address our capacity issues, the harder and more costly it will be to recover.

Challenges with burnout and recruiting: Across the health care system, frontline staff are reeling from staff burnout and the prolonged stress of dealing with the pandemic. Many are refusing overtime or extra shifts and some are leaving hospitals altogether in favour of other alternatives (e.g., schools, public health) or retirement and staffing shortages only compound the pressure on remaining staff. Existing resources have been stretched to unsustainable levels and are increasingly compromising care.

Filling staff vacancies has been challenging with a shrinking number of available candidates, this is especially severe in pediatrics where the specialized skills required further limit the list of potential candidates. In addition, in the current competitive environment, it is extremely difficult to hire staff on a non-permanent basis and without sustained base funding increases, we will continue to face challenges in recruiting.

Increasing Surgical Capacity to Meet Demand and Address Backlog Services

Elective surgery in children is not optional surgery. Children's procedures are frequently highly time sensitive and delays to surgery are the source of major morbidity because:

- The timing of surgery has a critical impact on the growth and development of the child;
- Treatable conditions deteriorate dramatically over time because of the effects of growth; and
- Excessive surgical wait times result in the need to perform more complex surgeries than were originally planned, leading to an increase in avoidable complications.

During the first wave of the pandemic, children's hospitals were directed to reduce elective surgeries and other non-emergency clinical activities to preserve capacity. Despite a resumption in non-emergency clinical activities last summer, most hospitals continued to face constraints in capacity and health human resources, impacting surgical volumes. In the meantime, waitlists continue to grow.

- Over 4200 surgeries at children's hospitals were cancelled between March 1, 2020 and May 31, 2021.
- Over 8300 children/youth are waiting for surgery at children's hospitals in Ontario. Many have been waiting for years.
- Over 50% of patients on surgical waitlists across our children's hospitals have been waiting for longer than the recommended wait times with potentially detrimental consequences to their health.
- Modelling from SickKids predicts that that even at fully funded capacity (100% activity) the waitlist will continue to grow precipitously at 3% per month.

Due to the rapid growth of the child, many conditions may dramatically deteriorate while waiting for scheduled surgery, conditions that are treatable with a relatively straightforward surgery can require a major change of surgical plan if excessive wait times exist such that the original surgery is no longer feasible. Not only does this increase the risk to the patient, it is much more costly to the health care system.

Delays leading to changes in surgical plan with added risks and costs

There are many infants whose skull sutures prematurely fuse, preventing normal skull growth, resulting in an obviously misshapen head, and putting them at risk for raised intracranial pressure and vision loss. A minimally invasive procedure performed through small incisions, termed 'endoscopic strip craniectomy' is done at 4 months of age, takes 3 hours of operating room time, a 1-night stay and 40% transfusion rate. The surgical costs are minimal.

When the window of opportunity is missed for this surgery, the surgical procedure called a 'cranial vault reshaping' needs to be delayed to 9-12 months of age. This procedure takes double the time - 6 hours in the operating room under anesthetic, a 3 night's stay with one in the ICU, and 80% transfusion rate with surgical costs for plates and screws of around $7000.

The pandemic has resulted in cases being done in even older kids – now 16 to 18 months of age. Not only is it a more challenging procedure (bone is thicker, operating time is longer, patients are older and more aware), the cost of hardware is increased as more plates and screws are needed ($10,000 to $12,000), the length of stay is longer around 4 to 5 nights, and the transfusion rates are similar at 80% to 90%.

In the worst scenarios, delays in care turn treatable conditions into life-long disability and may even be fatal. For example:

- Glaucoma is a blinding disorder in children and is associated with 100% rate of vision loss and pain if untreated in infancy. Patients require routine surveillance in the operating room. Delays in care can result in irreversible loss of optic nerve function leading to loss of vision and visual field deficits.
- Retinoblastoma is the primary malignancy of retina and is universally fatal if not treated. It requires multiple exams under anesthesia to monitor existing and new tumour growth. An increase in the intervals between surveillance exams is associated with poor local control of tumour and permanent loss of vision, putting children at risk for tumour metastasis and death.
- Tracheotomy dependent children have incalculable morbidity waiting for airway reconstruction and decannulation.
- Hearing-impaired children accrue irreversible decrements in speech and language development and non-recoverable decrements in IQ if not habilitated aggressively and without delay.

Delay in Care Leading to More Costly Care

Brothers Kaleb and Liam Cavalier had vastly different experiences with the same operation due to surgical delays caused by COVID-19 restrictions.

The Branchton, Ontario boys, both patients at Hamilton Health Sciences' McMaster Children's Hospital (MCH), were born with Duchenne Muscular Dystrophy, a genetic disorder causing

progressive muscle degeneration and weakness. As a result, both needed scoliosis spinal surgery. Liam, 12, had a positive experience with his surgery, which took place recently and was not delayed thanks to hospital ramp-up and increased resources. "He's now recovering and doing fantastic," says his dad Josh Cavalier.

Unfortunately, Kaleb's experience with the same surgery was much different. Kaleb's operation, which took place last year, was delayed from May to October due to the province's cancellation of `elective' surgeries. The 15-year-old boy suffered from increasing discomfort during the wait as the curvature in his spine worsened. ***While younger brother Liam's surgery took 10 hours, Kaleb's lasted 14 hours due to his worsening condition. Kaleb also had a longer stay in the pediatric intensive care unit post-surgery due to pain management issues.*** *This meant a longer separation from his family and more missed work for Josh.*

"Their healthcare journeys were like night and day due to the delays Kaleb experienced," says Josh. "My family experienced first-hand what happens when children's surgeries are delayed, and we share McMaster Children's Hospital's commitment to delivering timely, high-quality care to all of their young patients."

– Josh, father of Kaleb and Liam

An increase in surgical capacity over and above typical volumes is needed to address the backlog of cases and ensure that the children on our waitlists do not deteriorate and end up with increased surgical complexity with inferior outcomes. Hospitals require an immediate investment to increase capacity by adding weekend and evening surgeries, clinics, and appointments to meet the need.

	Funding Request to Support Surgical Capacity			
	Funding for Fiscal Year 2021/2022	**Funding for Fiscal Year 2022/2023**	**Funding for Fiscal Year 2023/2024**	**Total**
SickKids	$5,826,284	$23,305,136	$23,325,136	**$52,456,556**
CHEO	$2,385,337	$3,972,431	$4,171,053	**$10,528,822**
Children's Hospital London Health Sciences Centre	$1,161,667	$301,600	-	**$1,463,267**
McMaster Children's Hospital Hamilton Health Sciences	$2,824,372	$9,247,789	$8,160,145	**$20,232,306**
Total	**$12,197,660**	**$36,826,956**	**$35,656,334**	**$84,680,950**

Augmenting Inpatient Rehabilitation Services to Support Post-Surgical Rehabilitation

The children's health care system is inter-connected and capacity needs to be increased across the continuum of care. In addition to increasing funding for surgical services, corresponding increases are needed downstream, including inpatient rehabilitation. If a surgery occurs without ensuring there is capacity for proper post-surgical care and rehabilitation, the child may not recover from their physical illness or reach developmental milestones.

As the government invests in increasing surgical capacity, a corresponding investment of **$4 million** for additional resources and beds for inpatient rehabilitation is needed to support post-operative rehabilitation.

	Funding Request to Support Inpatient Rehabilitation Capacity			
	Funding for Fiscal Year 2021/2022	**Funding for Fiscal Year 2022/2023**	**Funding for Fiscal Year 2023/2024**	**Total**
Holland Bloorview Kids Rehabilitation Hospital	$277,500	$930,000	$930,000	**$2,137,500**
CHEO	$459,433	$753,619	$791,300	**$2,004,351**
Total	**$736,933**	**$1,683,619**	**$1,721,300**	**$4,141,851**

Addressing the Backlog in Ambulatory Services

Across the board, wait times for ambulatory services have increased and patients and families are desperate for care. While virtual care has helped ensure many patients continue to receive care during the pandemic, barriers exist which make it a less suitable option in pediatrics on an ongoing basis. Younger children may not have the capacity to describe their symptoms, be able to undergo a virtual examination (e.g., hold still in front of the camera), or receive therapies virtually. While virtual care will continue to be pursued, pediatrics still faces unique pressures in ambulatory care and needs a significant increase in their ambulatory capacity to address the backlog.

Children and youth are waiting far too long for diagnosis and care, with many presenting with increasingly complex health concerns due to the delay.

- Over 209,000 non-surgical appointments/procedures at children's hospitals were cancelled between March 1, 2020 and May 31, 2021. While many appointments (>100,000 from March 1, 2020 to May 31, 2021) have been successfully conducted virtually, pediatric virtual care has unique challenges not faced by adult care and a much larger proportion of patients require in-person visits.
- Over 31,000 children/youth are on waiting lists for ambulatory services across the children's hospitals.

- 55% of children/youth waiting for ambulatory services at CHEO and Holland Bloorview have been waiting longer than the recommended clinical wait times.

Ivona lives with her husband Iwan and son, Noah (5). A Holland Bloorview client, Noah lives with a spinal cord injury as a result of being diagnosed with cancer when he was less than three months old. Noah uses a wheelchair and other mobility supports (e.g., stander) and he is considered high-risk when it comes to transmission of COVID-19.

During the pandemic, Ivona and her husband found it very challenging to balance Noah's safety with his need for physical and emotional support. ***He hasn't been able to get his leg braces adjusted or receive Botox injections to help regulate his bathroom visits as these were services all deemed "non-essential," yet have the ability to impact his health long term.*** *Everything felt like a battle. Ivona says, "if I told you casting a broken leg was considered non-essential during COVID, there would be an uproar. So why was it so easy to take away a child's right to move and call it a non-essential service?"*

We had to wait for ambulatory EEG in neurology. In the meantime, additional ED visits and stays occurred. The only way to get the 24-hour EEG was to be an inpatient during a pandemic and occupying a room for something that could have been done as an outpatient, except there are not enough machines to accommodate the need.

As experienced medical families we know we go to the ED to expedite testing we are awaiting. But this risks children picking up other infections, waiting for hours and from a behaviour perspective, becoming averse to attending CHEO at all. When we move on for surgery, the wait delays recovery and improvement of quality of life. Sit and wait is our motto. In the meantime, we use more medications or 'band aids' until the surgery occurs and other complications occur while we wait.

- Staff and parent of patient at CHEO

An increase in funding is urgently needed to reduce the enormous backlog in ambulatory care that pre-dated the COVID-19 pandemic but has now escalated to critical levels. This funding will help hire additional staff to extend clinic hours, purchase and implement technology to optimize scheduling and make the best use of existing resources, and purchase supplies needed to support care. This added capacity will bolster out ability to address the backlog and ensure our children care within clinically appropriate wait times.

	Funding Request to Support Ambulatory Capacity			
	Funding for Fiscal Year 2021/2022	Funding for Fiscal Year 2022/2023	Funding for Fiscal Year 2023/2024	Total
SickKids	$3,784,409	$14,187,637	$14,187,637	**$32,159,684**
CHEO	$3,813,616	$14,569,415	$15,054,915	**$33,437,947**
Children's Hospital London Health Sciences Centre	$913,441	$2,815,317	$2,864,680	**$6,593,438**
McMaster Children's Hospital	$2,287,959	$9,229,873	$9,409,471	**$20,927,303**
Holland Bloorview Kids Rehabilitation Hospital	$860,952	$3,443,807	$3,443,807	**$7,748,566**
Total	**$11,660,377**	**$44,246,050**	**$44,960,511**	**$100,866,938**

Addressing Unsustainable Wait Times in Diagnostic Imaging Services

Before COVID-19, Ontario was already experiencing challenges in meeting the demand for medical imaging due to the lack of imaging equipment, health human resources and infrastructure to support these services. Demand for diagnostic imaging services has always exceeded capacity. The imaging services provided at our children's hospitals are a unique and critical resource for the province. Many pediatric imaging services are not available at adult community hospitals.

Long waits for diagnostic imaging have a compounding effect on care, with delayed diagnosis potentially leading to more acute presentations, more complex treatments, and inferior outcomes. The waits for diagnostic imaging, already at record levels, was further exacerbated by the onset of the pandemic, with particularly long wait times for imaging where patients require general anesthesia (i.e., CT, MRI, IGT).

- Over 28,000 children are waiting for diagnostic imaging across the province's children's hospitals
- According to the latest data from Ontario's Wait Time Information System (WTIS), only 42% of pediatric patients in the province received their MRI scan within target wait times.
- 96% of patients waiting for magnetic resonance imaging (MRI) at the Children's Hospital, London Health Sciences Centre have been waiting for longer than the recommended clinical wait times.
- 94% of patients waiting for nuclear medicine imaging at SickKids have been waiting for longer than the recommended clinical wait times.
- 86% of patients waiting for image guided therapy (IGT) at SickKids have been waiting for longer than the recommended clinical wait times.
- 80% of patients waiting for MRI at the McMaster Children's Hospital have been waiting for longer than the recommended clinical wait times.
- 71% of patients of patients waiting for computerized tomography (CT) scans at the Children's Hospital, London Health Sciences Centre have been waiting for longer than the recommended clinical wait times.

- 75% of patients waiting for nuclear medicine imaging at the Children's Hospital, London Health Sciences Centre have been waiting for longer than the recommended clinical wait times.
- 75% of patients waiting for IGT at CHEO have been waiting for longer than the recommended clinical wait times.

Over the past 5 years SickKids has experienced 5 Serious Safety Events (SSE) resulting in harm to a patient directly related to delays in access to IGT for feeding tube management and central venous line removals in particular. While the hospital has examined systemic issues related to access and have made significant improvements, demand for these services consistently surpasses its ability to provide timely access to services.

Imaging services are often a central aspect of the patient journey and delays in testing can impact diagnosis, treatment, length of stay, patient satisfaction, and outcome. In order to build and sustain the capacity needed to address the backlog of cases, significant investment in human and capital resources is required to ensure children receive imaging services within clinically appropriate times.

	Funding Request to Support Diagnostic Imaging Capacity			
	Funding for Fiscal Year 2021/2022	**Funding for Fiscal Year 2022/2023**	**Funding for Fiscal Year 2023/2024**	**Total**
SickKids	$1,327,714	$3,310,855	$3,310,855	**$7,949,424**
CHEO	$1,732,464	$3,328,175	$3,494,584	**$8,555,223**
Children's Hospital London Health Sciences Centre	$2,744,052	$8,701,755	$180,991	**$11,626,798**
McMaster Children's Hospital	$6,862,312	$1,643,796	$1,477,763	**$9,983,871**
Total	**$12,666,542**	**$16,984,581**	**$8,464,192**	**$38,115,315**

Appendix A: Funding Required by Service

Funding Needed for Surgical Services					
	SickKids	**CHEO**	**Children's Hospital, LHSC**	**MCH**	**Total**
HHR					
2021/22	$4,777,617	$835,817	$112,483	$1,533,004	**$7,258,921**
2022/23	$19,110,468	$3,510,431	$301,600	$8,663,092	**$31,585,591**
2023/24	$19,110,468	$3,685,953	-	$7,721,622	**$30,518,043**
Capital Improvements and Equipment					
2021/22	-	$1,413,000	$410,000	$1,155,677	**$2,978,677**
2022/23	-	-	-	-	**-**
2023/24	-	-	-	-	**-**
Supplies					
2021/22	$332,405	$136,520	$621,184	$92,131	**$1,182,240**
2022/23	$1,329,620	$462,000	-	$422,217	**$2,213,837**
2023/24	$1,349,620	$485,100	-	$316,663	**$2,151,383**
Other					
2021/22	$716,262	-	$18,000	$43,560	**$777,822**
2022/23	$2,865,048	-	-	$162,480	**$3,027,528**
2023/24	$2,865,048	-	-	$121,860	**$2,986,908**
Total					
Total 2021/22	$5,826,284	$2,385,337	$1,161,667	$2,824,372	**$12,197,660**
Total 2022/23	$23,305,136	$3,972,431	$301,600	$9,247,789	**$36,826,956**
Total 2023/24	$23,325,136	$4,171,053	-	$8,160,145	**$35,656,334**
Total All Years	**$52,456,556**	**$10,528,822**	**$1,463,267**	**$20,232,306**	**$84,680,950**

Funding Needed for Inpatient Rehabilitation Services			
	CHEO	**HB**	**Total**
HHR			
2021/22	$179,433	$178,750	**$358,183**
2022/23	$753,619	$715,000	**$1,468,619**
2023/24	$791,300	$715,000	**$1,506,300**
Capital Improvements and Equipment			
2021/22	$280,000	$45,000	**$325,000**
2022/23	-	-	**-**
2023/24	-	-	**-**
Supplies and Other expenses			
2021/22	-	$53,750	**$53,750**
2022/23	-	$215,000	**$215,000**
2023/24	-	$215,000	**$215,000**
Total			
Total 2021/22	$459,433	$277,500	**$736,933**
Total 2022/23	$753,619	$930,000	**$1,683,619**
Total 2023/24	$791,300	$930,000	**$1,721,300**
Total All Years	**$2,004,351**	**$2,137,500**	**$4,141,851**

Funding Needed for Ambulatory Services						
	SickKids	**CHEO**	**Children's Hospital, LHSC**	**MCH**	**HB**	**Total**
HHR						
2021/22	$3,534,409	$3,469,347	$687,436	$2,112,461	$717,460	**$10,521,114**
2022/23	$14,137,637	$13,835,610	$2,797,865	$8,613,841	$2,869,839	**$42,254,793**
2023/24	$14,137,637	$14,285,870	$2,846,827	$8,781,118	$2,869,839	**$42,921,291**
Capital Improvements and Equipment						
2021/22	-	$160,000	$216,005	-	-	**$376,005**
2022/23	-	-	-	-	-	**-**
2023/24	-	-	-	-	-	**-**
Supplies						
2021/22	$250,000	$184,269	-	$175,498	$143,492	**$753,259**
2022/23	$50,000	$733,805	$17,452	$616,032	$573,968	**$1,991,257**
2023/24	$50,000	$769,046	$17,853	$628,353	$573,968	**$2,039,220**
Other						
2021/22	-	-	$10,000	-	-	**$10,000**
2022/23	-	-	-	-	-	**-**
2023/24	-	-	-	-	-	**-**
Total						
Total 2021/22	$3,784,409	$3,813,616	$913,441	$2,287,959	$860,952	**$11,660,377**
Total 2022/23	$14,187,637	$14,569,415	$2,815,317	$9,229,873	$3,443,807	**$44,246,050**
Total 2023/24	$14,187,637	$15,054,915	$2,864,680	$9,409,471	$3,443,807	**$44,960,511**
Total All Years	**$32,159,684**	**$33,437,947**	**$6,593,438**	**$20,927,303**	**$7,748,566**	**$100,866,938**

Funding Needed for Diagnostic Imaging Services					
	SickKids	**CHEO**	**Children's Hospital, LHSC**	**MCH**	**Total**
HHR					
2021/22	$742,714	$782,839	$20,065	$240,268	**$1,785,886**
2022/23	$2,970,855	$3,287,925	$118,782	$1,500,862	**$7,878,423**
2023/24	$2,970,855	$3,452,321	$108,848	$1,334,829	**$7,866,853**
Capital Improvements and Equipment					
2021/22	$500,000	$940,000	$2,700,000	$6,357,000	**$10,497,000**
2022/23	-	-	$8,500,000	$115,000	**$8,615,000**
2023/24	-	-	-	$115,000	**$115,000**
Supplies					
2021/22	$85,000	$9,625	$18,987	-	**$113,612**
2022/23	$340,000	$40,250	$82,974	$27,934	**$491,158**
2023/24	$340,000	$42,263	$72,143	$27,934	**$482,339**
Other					
2021/22	-	-	$5,000	$265,044	**$270,044**
2022/23	-	-	-	-	**-**
2023/24	-	-	-	-	**-**
Total					
Total 2021/22	$1,327,714	$1,732,464	$2,744,052	$6,862,312	**$12,666,542**
Total 2022/23	$3,310,855	$3,328,175	$8,701,755	$1,643,796	**$16,984,581**
Total 2023/24	$3,310,855	$3,494,584	$180,991	$1,477,763	**$8,464,192**
Total All Years	**$7,949,424**	**$8,555,223**	**$11,626,798**	**$9,983,871**	**$38,115,315**

Appendix B: Details of funding requests by site

SickKids

Surgical

- **Funding will support 418 blocks/2090 cases per year. Weekend blocks for both daycare and inpatient cases. Using all available real estate maximizing 16 OR suites.**

	Funding for Fiscal Year 2021/2022	Notes	Funding for Fiscal Year 2022/2023	Notes	Funding for Fiscal Year 2023/2024	Notes
Human resources	$4,777,617	• *HHR (30 FTE)* • *Surgeons and anesthesiologists (33 FTEs)*	$19,110,468	• *HHR (30 FTE)* • *Surgeons and anesthesiologists (33 FTEs)*	$19,110,468	• *HHR (30 FTE)* • *Surgeons and anesthesiologists (33 FTEs)*
Equipment/supplies	$332,405	*Consumable costs associated with increased activity*	$1,329,620	*Consumable costs associated with increased activity*	$1,349,620	*Consumable costs associated with increased activity*
Other	$716,262	*Inpatient staffing and supply costs*	$2,865,048	*Inpatient staffing and supply costs*	$2,865,048	*Inpatient staffing and supply costs*
Total	**$5,826,284**	**Total**	**$23,305,136**	**Total**	**$23,325,136**	

Ambulatory

	Funding for Fiscal Year 2021/2022	Notes	Funding for Fiscal Year 2022/2023	Notes	Funding for Fiscal Year 2023/2024	Notes
Human resource	$3,534,409	• *HHR (4 FTE)* • *Physicians (34 FTE)*	$14,137,637	• *HHR (4 FTE)* • *Physicians (34 FTE)*	$14,137,637	• *HHR (4 FTE)* • *Physicians (34 FTE)*
Equipment/Supplies	$250,000	*Level scheduling software*	$50,000	*Level scheduling software (service agreement)*	$50,000	*Level scheduling software (service agreement)*
Total	**$3,784,409**	**Total**	**$14,187,637**	**Total**	**$14,187,637**	

Diagnostic Imaging

	Funding for Fiscal Year 2021/2022	Notes	Funding for Fiscal Year 2022/2023	Notes	Funding for Fiscal Year 2023/2024	Notes
Human resources	$742,714	*HHR (15.7 FTE)* *Physicians (2.2 FTE)*	$2,970,855	*HHR (15.7 FTE)* *Physicians (2.2 FTE)*	$2,970,855	*HHR (15.7 FTE)* *Physicians (2.2 FTE)*
Capital	$500,000	• *Ultrasound machines in US and IGT* • *Novel pulse sequences and software*	-		-	
Equipment/Supplies	$85,000	*Consumable costs*	$340,000	*Consumable costs*	$340,000	*Consumable costs*
Total	**$1,327,714**	**Total**	**$3,310,855**	**Total**	**$3,310,855**	

CHEO

Surgical

- **Funding will support an additional 600 cases per year.**

	Funding for Fiscal Year 2021/2022	Notes	Funding for Fiscal Year 2022/2023	Notes	Funding for Fiscal Year 2023/2024	Notes
Human resources	$835,817	*HHR (27.8 FTE)*	$3,510,431	*HHR (27.8 FTE)*	$3,685,953	*HHR (27.8 FTE)*
Capital (e.g., space)	$1,413,000	*Surgical navigation system, wheelchairs and stretchers, motorized stretcher, microsized endoscope (ultra small sized bronchoscopes), blood parameter monitor (for use in the O.R.), anaesthesia gas monitor (measure waste anaesthetic gas in surgical areas), apheresus unit (for use during ECMO procedures to remove waste products from blood stream)*	-		-	
OR supplies	$105,000	*OR drugs and supplies*	$441,000	*OR drugs and supplies*	*$463,050*	*OR drugs and supplies*
Other	$31,520	*SDU/PACU drugs and supplies*	$21,000	*SDU/PACU drugs and supplies*	*$22,050*	*SDU/PACU drugs and supplies*
Total	**$2,385,337**	**Total**	**$3,972,431**	**Total**	**$4,171,053**	

Inpatient Rehab

	Funding for Fiscal Year 2021/2022	Notes	Funding for Fiscal Year 2022/2023	Notes	Funding for Fiscal Year 2023/2024	Notes
Human resources	$179,433	*HHR (5 FTE)*	$753,619	*HHR (5 FTE)*	$791,300	*HHR (5 FTE)*
Capital	$280,000		-		-	
Total	**$459,433**	**Total**	**$753,619**	**Total**	**$753,619**	

Ambulatory

	Funding for Fiscal Year 2021/2022	Notes	Funding for Fiscal Year 2022/2023	Notes	Funding for Fiscal Year 2023/2024	Notes
Human resource	$2,541,847	*HHR (81 FTE)*	$10,125,610	*HHR (81 FTE)*	$10,575,870	*HHR (81 FTE)*
Capital	$160,000		-		-	
Equipment/Supplies	$184,269	*Drugs & medical supplies*	$733,805	*Drugs & medical supplies*	$769,045	*Drugs & medical supplies*
Other	$927,500	*Physicians (10.5 FTE)*	$3,710,000	*Physicians (10.5 FTE)*	$3,710,000	*Physicians (10.5 FTE)*
Total	**$3,813,616**	**Total**	**$14,569,415**	**Total**	**$15,054,915**	

Diagnostic Imaging

	Funding for Fiscal Year 2021/2022	Notes	Funding for Fiscal Year 2022/2023	Notes	Funding for Fiscal Year 2023/2024	Notes
Human resources	$782,839	*HHR (12 FTE)* *Physicians (3 FTE)*	$3,287,925	*HHR (12 FTE)* *Physicians (3 FTE)*	$3,452,321	*HHR (12 FTE)* *Physicians (3 FTE)*
Capital	$940,000	*Ultrasound, cardiac and diagnostic ultrasound, stretchers/crib stretchers*	-		-	
Other	$9,625	*Medical, surgical & Anesthesia supplies*	$40,250	*Medical, surgical & Anesthesia supplies*	$42,263	*Medical, surgical & Anesthesia supplies*
Total	**$1,732,464**	**Total**	**$3,328,175**	**Total**	**$3,494,584**	

Children's Hospital, London Health Sciences Centre

Surgical

- **Funding will support an additional 92 OR Blocks/644 Grid Hours or 368 cases**

	Funding for Fiscal Year 2021/2022	Notes	Funding for Fiscal Year 2022/2023	Notes	Funding for Fiscal Year 2023/2024	Notes
Human resources	$112,483	*HHR (4.4 FTE)*	$301,600	*HHR (2.1 FTE)*	-	
Capital	$410,000	*Capital equipment (e.g., microscope)*	-		-	
Equipment/supplies	$621,184	*Instruments and supplies*	-		-	
Other	$18,000	*Registered Nurse training*	-		-	
Total	**$1,161,667**	**Total**	**$301,600**	**Total**	**0**	

Ambulatory

	Funding for Fiscal Year 2021/2022	Notes	Funding for Fiscal Year 2022/2023		Funding for Fiscal Year 2023/2024	
Human resource	$687,436	*HHR (23.10 FTE), Physician (0.5 FTE)*	$2,797,865	*HHR (23.10 FTE), Physician (0.5 FTE) + inflation*	$2,846,827	*HHR (23.10 FTE), Physician (0.5 FTE) + inflation*
Capital	$216,005	*Workstation on wheels, gas machine, sweat chloride machine*	-		-	
Supplies			$17,452	*Supplies*	$17,853	*Supplies*
Other	$10,000	*Staff training*	-		-	
Total	**$913,441**	**Total**	**$2,815,317**	**Total**	**$2,864,680**	

Diagnostic Imaging

	Funding for Fiscal Year 2021/2022	Notes	Funding for Fiscal Year 2022/2023	Notes	Funding for Fiscal Year 2023/2024	Notes
Human resources MI	$9,140	*HHR (1.1 FTE)*	$44,270	*HHR (1.1 FTE)*	$36,960	*HHR (1.1 FTE)*
Equipment/Supplies	$18,987	*Supplies, equipment and PACs*	$82,974	*Supplies, equipment and PACs*	$72,143	*Supplies, equipment and PACs*
Human resources GA	$10,926	*HHR (1.6 FTE)*	$74,512	*HHR (1.6 FTE)*	$71,888	*HHR (1.6 FTE)*
Capital - 3T MRI (1)			$6,500,000	*Net new 3T MRI dedicated to Pediatric access*		
Capital - Fluoro Unit (1)			$2,000,000	*Replacement: Capital + construction*		
Capital - X-ray Unit (2)	$1,800,000	*Replacement: Capital + construction*				
Capital - Portable X-ray (1)	$150,000	*Net new: Capital equipment only dedicated to Paed access*				
Capital - US Units (3)	$750,000	*Replacement: Capital equipment only*				
Other	$5,000					
Total	**$2,744,052**	**Total**	**$8,701,755**	**Total**	**$180,991**	

McMaster Children's Hospital

Surgical

	Funding for Fiscal Year 2021/2022	Notes	Funding for Fiscal Year 2022/2023	Notes	Funding for Fiscal Year 2023/2024	Notes
Human resources	$1,533,004	*HHR (47.8 FTE)* *Physicians (12 FTE)*	$1,216,757	*HHR (46.8 FTE)* *Physicians (12 FTE)*	$7,721,622	*HHR (46.8 FTE)* *Physicians (12 FTE)*
Capital (e.g., space)	$1,155,677	*Anesthetic machine, digital visualization and recording equipment (console, cabling, monitor, lighting, camera, etc), endoscope, other increased instrumentation.*	$0		$0	
Equipment/supplies	$92,131	*Medical and surgical supplies*	$422,217	*Medical and surgical supplies*	$316,663	*Medical and surgical supplies*
Other	$43,560	*Other direct costs*	$162,480	*Other direct costs*	$121,860	*Other direct costs*
Total	**$2,824,372**	**Total**	**$9,247,789**	**Total**	**$8,160,145**	

Ambulatory

	Funding for Fiscal Year 2021/2022	Notes	Funding for Fiscal Year 2022/2023	Notes	Funding for Fiscal Year 2023/2024	Notes
Human resource	$2,049,961	*HHR (72 FTE)*	$8,363,841	*HHR (72 FTE)*	$8,531,118	*HHR (72 FTE)*
Equipment/Supplies	$175,498	*Medical Supplies/Drugs + equipment for critical areas*	$616,032	*Medical Supplies/Drugs*	$628,353	*Medical Supplies/Drugs*
Other	$62,500	*Physician funding*	$250,000	*Physician funding*	$250,000	*Physician funding*
Total	**$2,287,959**	**Total**	**$9,229,873**	**Total**	**$9,409,471**	

Diagnostic Imaging

	Funding for Fiscal Year 2021/2022	Notes	Funding for Fiscal Year 2022/2023	Notes	Funding for Fiscal Year 2023/2024	Notes
Human resources	$240,268	*HHR (1.8 FTE)* *Physicians (2.0 FTE)*	$1,500,862	*HHR (6.8 FTE)* *Physicians (2.0 FTE)*	$1,334,829	*HHR (6.8 FTE)* *Physicians (2.0 FTE)*
Capital	$6,357,000	*CArm and renovation of interventional radiology procedure room (design, construction, equipment)*	$115,000	*Repair and Mtc fees to keep the existing magnet at MUMC online*	$115,000	*Repair and Mtc fees to keep the existing magnet at MUMC online*
Other	$265,044	*MRT - accelerated training program*	$27,934	*Contrast and Consumable Supplies*	$27,934	*Contrast and Consumable Supplies*
Total	**$6,862,312**	**Total**	**$1,643,796**	**Total**	**$1,477,763**	

Holland Bloorview Kids Rehabilitation Hospital

Ambulatory

	Funding for Fiscal Year 2021/2022	Notes	Funding for Fiscal Year 2022/2023	Notes	Funding for Fiscal Year 2023/2024	Notes
Human resource	$717,460	*HHR (26.5 FTE)*	$2,869,839	*HHR (26.5 FTE)*	$2,869,839	*HHR (26.5 FTE)*
Other	$143,492	*Overhead, admin support, general/medical supplies*	$573,968	*Overhead, admin support, general/medical supplies*	$573,968	*Overhead, admin support, general/medical supplies*
Total	**$860,952**	**Total**	**$3,443,807**	**Total**	**$3,443,807**	

Inpatient Rehabilitation

	Funding for Fiscal Year 2021/2022	Notes	Funding for Fiscal Year 2022/2023	Notes	Funding for Fiscal Year 2023/2024	Notes
Human resource	$178,750	*(6.4 FTE)*	$715,000	*(6.4 FTE)*	$715,000	*(6.4 FTE)*
Capital	$45,000	*3 beds*				
Other	$53,750	*Supplies, overhead and indirect expenses*	$215,000	*Supplies, overhead and indirect expenses*	$215,000	*Supplies, overhead and indirect expenses*
Total	**$277,500**	**Total**	**$930,000**	**Total**	**$930,000**	

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Implementation Details

Expand **community-based rehabilitation and development** resources to ensure children have timely access to services within a window of opportunity to maximize each child's potential and recovery

Part of an action plan from the Children's Health Coalition to ensure hospital capacity and provide timely access to care both in the immediate pandemic response and through recovery

For more information, please contact:
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Overview

Kids with disabilities and their families have been disproportionately and negatively impacted during the COVID-19 pandemic. During this health emergency, they have been forgotten.

Already 25,750 kids are waiting for child development and rehabilitation care in communities across Ontario: 16,250 kids are waiting for community-based rehabilitation services (Physical Therapy, Occupational Therapy, Speech Language Pathology, Social Work); another 9,500 kids are waiting to be seen in clinics to receive Botox treatment, augmentative and alternative communication services, cleft lip and palate consultation, seating and mobility services, orthotics and prosthetics services, diagnostic services and appointments with developmental paediatricians.

Child development and rehabilitation providers offer a range of specialized services and inter-professional programs to kids with developmental disabilities, kids who are recovering from illness or injury, kids with developmental challenges, and kids with complex care needs including autism, cerebral palsy, fetal alcohol syndrome, Down syndrome and other neurodisabilities. Providers offer care in hospital, at home and in the community as well as in school.

These services have a direct positive impact on kids' health and developmental outcomes, improve opportunities for participation and inclusion, and position kids with disabilities and their families to live their best lives. Children's Treatment Centre services for medically-fragile and medically-complex children can span multiple Ontario Health regions and serve as a resource to both specialty children's services centres and community hospitals.

Addressing the need for post operative rehabilitation creates a medical surge capacity that will further delay treatment for these kids. A percentage of those currently waiting — children and youth like JJ, who you can read about below — will become candidates for surgery because their conditions progress and will require more serious and more complex acute care, adding to pressures on the health care system and increasing costs to care for their care – potentially throughout their lives.

Before the COVID-19 pandemic, the child development and rehabilitation sector needed $130 million to clear wait lists for community-based rehabilitation services and school-based rehabilitation services. The Ontario government has made a commitment of $60 million; the lion's share of this targets waits for school-based rehabilitation services.

Still, 25,750 children and youth are waiting for community-based rehabilitation services and treatment in specialty clinics. Their waits continue to grow.

An investment of $79 million over two years will provide an additional 175,000 visits to another 23,000 kids to ensure their needs are addressed, and avoid potentially more serious and costly impact on Ontario's healthcare system.

A two-year plan to address the wait lists provides the runway for providers to address pressures on the continuum of care. With realistic, appropriate funding, Ontario can provide families with a system of service delivery that will not leave kids with disabilities behind.

JJ's Story

JJ is a 12-year-old boy with a diagnosis of Hereditary Spastic Paraplegia, a condition marked by muscle weakness and spasticity of the lower extremities that can be slowly progressive.

Prior to the pandemic, JJ went to school, participating in regular movement breaks as part of his IEP. He used a walker at school primarily for safety reasons when navigating the hallways; otherwise, JJ walked independently. He travelled to and from school on the school bus and did not require adapted seating or other equipment at school. At home he would go outside and engage in other activities that maintained his level of functioning and promoted his physical well-being.

With the onset of COVID-19, JJ became anxious. He experienced panic attacks and was reluctant to leave his room. He was concerned about catching COVID-19, worrying both for his own health and also the health of his family. So, JJ limited his interaction with his family members, even going as far as to only want to take meals in his room. He gained 50 lbs during the first school closure, and the weight gain further impacted his mobility. Without exercise his stiffness and weakness increased; JJ also started having more pain in his legs as well as his back.

When JJ returned to school in September 2020, the school was concerned about his physical abilities and safety, as well as the impact of his weight gain. He was no longer able to walk without a walker, he was no longer able to sit comfortably in a regular classroom chair and his desk was not wide or tall enough to provide clearance for his legs. JJ required more EA support for safe transfers, particularly navigating the steps of the school bus. At the time of the second school closures, therapists were working with the school to acquire an ergonomically correct desk and chair. It was also determined that JJ could no longer ride the regular school bus, and would now need to be transported to school using a wheelchair and riding an accessible bus. That meant he could no longer ride the bus with his friends.

JJ's stiffness and muscle weakness further increased. There are now concerns about his hips, so he has been referred to an orthopedic surgeon to determine if he may require surgery. He requires more frequent appointments with a physiatrist to monitor his condition, and has required more intensive physiotherapy to try to regain some of his mobility. JJ has also been referred to a dietician and to recreation therapy to work on his fitness.

Stories like JJ's are common across the province.

Funding Ask and Details

	Funding Jan 1 – Mar 31/22	Funding 2022/2023	Funding 2023/2024	Total
Community-Based Rehabilitation Services and Clinic Care	$9,000,000	$35,000,000	$35,000,000	**$79,000,000**

Wait List at March 31, 2021	Investment from Jan 2022 to March 31, 2024	# Kids Served/Moved Off Wait List	# FTEs Province wide	# Visits	Average Cost per Child	Average Cost per Visit
25,750	$79 M	23,000	500	175,000	$3,000	$400

Key **Access Indicators** as currently reported quarterly in MOH MIS:

1. Total # unique kids waiting at wait 1 (referral to assessment 406**10) by functional centre
2. Total # days waiting at wait 1 (referral to assessment 407**10) by functional centre
3. Total # unique kids waiting at wait 2 (assessment to service initiation 406**20) by functional centre
4. Total # days waiting at wait 2 (assessment to service initiation 407**20) by functional centre

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Implementation Details

Augment capacity for **pediatric intensive care** to right-size the system and manage upcoming pressures

Part of an action plan from the Children's Health Coalition to ensure hospital capacity and provide timely access to care both in the immediate pandemic response and through recovery

For more information, please contact:
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Overview: Pediatric Critical Care

Pediatric Critical Care is an integral component of our health care system and provides life-saving support for critically ill children and youth. Pediatric Intensive Care Unit (PICU) beds are a scarce resource for which demand frequently exceeds supply. The occupancy rates of PICUs across the province have increased steadily over the years and as critical ill needs continue to increase in volume and acuity.

With a total of approximately 90 pediatric critical care beds (Level 2 and Level 3) in the entire province, Ontario's children's hospitals have little flexibility to meet any surges in demand and the lack of capacity has resulted in transfers to out-of-region pediatric centres, refusal of referrals, and the cancellation of surgeries. Any small increases in critical care volumes can easily overwhelm the pediatric system. This is in contrast to the adult system that has over 20 times as many critical care beds and thus more ability to flex when and if needed.

In addition, based on recent reports from other jurisdictions, there is genuine concern that the combination of rising rates for COVID in the unvaccinated pediatric population, the observed re-emergence of seasonal respiratory viruses like RSV, and the province-wide return to school will result in a rapid and dramatic increased demand for pediatric critical care.

To safeguard the health and wellbeing of the children and youth in our communities and ensure our patients have access to the pediatric critical care they need, Ontario's children's hospitals require an urgent investment in critical care. This includes an increase in the number of Level 2 and Level 3 critical care beds and the creation of critical care extender beds to help alleviate pressures on acute care hospitals. This investment in pediatric critical care would further support the government's previously announced goal to build hospital capacity by up to 1,000 critical care beds and maintain the integrity of Ontario's health system.

	Additional Critical Care Funding Needed			
	Funding for Fiscal Year 2021/2022	**Funding for Fiscal Year 2022/2023**	**Funding for Fiscal Year 2023/2024**	**Total**
SickKids	$1,483,295	$5,142,500	$5,142,500	**$11,768,295**
CHEO	$2,368,454	$7,005,000	$7,005,000	**$16,378,454**
Children's Hospital London Health Sciences Centre	$904,271	$3,285,000	$3,285,000	**$7,474,271**
McMaster Children's Hospital	$747,977	$2,517,500	$2,517,500	**$5,782,977**
Holland Bloorview Kids Rehabilitation Hospital	$463,433	$1,573,306	$1,573,306	**$3,610,045**
Total	**$5,967,430**	**$19,523,306**	**$19,523,306**	**$45,014,042**

To ensure consistency with other portions of the recovery plan proposal, costing has been provided effective January 1, 2022. However, as mobilization of critical care capacity is required within wave 4, these additional beds should be implemented earlier. Based on such timing, costs would be prorated.

In alignment with the work at the Provincial Recovery Table, the proposed Children's COVID-19 Recovery and Response Table will work to develop a set of metrics to monitor and report to the Ministry of Health. Potential metrics include:

- Occupancy Rate
- Average Length of Stay (LOS)

Additional Funding Needed for Critical Care Beds (Level 2 and Level 3)

Demand for pediatric critical care services is a constant challenge for the province's children's hospitals.

- At CHEO in calendar year 2020, 10 elective cardiovascular surgeries were cancelled, including one 4-year-old patient who had her ventricular septal defect (VSD) repair postponed 8 times (4 of those due to level 3 critical care capacity), and dozens of non-elective cardiovascular, neurosurgery, and ENT cases were postponed due to level 3 critical care challenges.
- At the Children's Hospital, London Health Sciences Centre, pediatric critical care admissions have increased by 29% over the last 10 years and critical care capacity issues have led to cancellations of Operating Rooms every year for the last five years.
- The pediatric critical care unit at Children's Hospital, London Health Sciences Centre had 1884 Minor Surge hours in 2019/20 which equates to 167 shifts where occupancy exceeded 100%.

To ensure that current demand is met and there is an ability to address ongoing surges, the children's hospitals need an investment of **$41 million** in critical care (Level 2 and Level 3). The funding increases detailed below will:

- Create new Level 2 critical care capacity at The Children's Hospital at London Health Sciences Centre and CHEO who previously did not have Level-2 beds;
- Right-size historical funding shortfall for CHEO's pediatric critical care unit; and
- Augment existing pediatric critical care capacity (Level-2 and Level-3) across the province to ensure we are better able to meet the needs of our communities.

	Additional Level-3 and Level-2 Critical Care Capacity Needed	
	# Level 3 Beds	**# Level 2 Beds**
SickKids	4	3
CHEO	3*	8
Children's Hospital London Health Sciences Centre	-	6
McMaster Children's Hospital Hamilton Health Sciences	1	3
Total	**8**	**16**

**While CHEO's PICU is designated as a 10-bed Level-3 unit by Critical Care Services Ontario (CCSO), current Ministry of Health (MOH) funding only supports 7 beds. Additional funding for 3 beds is needed to address a historical funding shortfall.*

		Additional Funding Required						
		Fiscal Year 2021/2022		Fiscal Year 2022/2023		Fiscal Year 2023/2024		Total
		Level 3	Level 2	Level 3	Level 2	Level 3	Level 2	
SickKids	Operations	$875,000	$410,625	$3,500,000	$1,642,500	$3,500,000	$1,642,500	**$11,768,295**
	Training	$197,670						
CHEO	Operations	$656,250	$1,095,000	$2,625,000	$4,380,000	$2,625,000	$4,380,000	**$16,378,454**
	Training	$237,204						
	Capital	$380,000*						
Children's Hospital London Health Sciences Centre	Operations		$821,250		$3,285,000		$3,285,000	**$7,474,271**
	Training		$83,021					
McMaster Children's Hospital Hamilton Health Sciences	Operations	$218,750	$410,625	$875,000	$1,642,500	$875,000	$1,642,500	**$5,782,977**
	Training	$118,602						
Total		**$5,503,997**		**$17,950,000**		**$17,950,000**		**$41,403,997**

Amounts based on Ministry of Health funding rates for critical care nurse training ($6,589/FTE) and operational funding rates for Level-3 ($875,000/bed) and Level-2 beds ($547,500/bed). The increase in beds will also require adjustments to Physician Human Resources.The costing for these adjustments has not yet been calculated and is not included.
**Capital equipment, including high frequency ventilators, beds/cribs, POCT ultrasound*

Creating Critical Care Extender Beds at Holland Bloorview to Alleviate Pressure on Acute Care

In order to expand capacity, rehabilitation/complex continuing care (CCC) programs at Holland Bloorview Kids Rehabilitation Hospital (Holland Bloorview) can also play a larger role in caring for more medically complex patient populations by adding critical care extender beds. The pandemic has led to unprecedented collaboration across the health system including a more collaborative relationship between acute care and rehabilitation/CCC providers, and adult rehabilitation/CCC providers have successfully cared for more medically complex patients that they would not have previously received. The Extender Beds model of care is a similar approach in pediatrics.

The added capacity at Holland Bloorview will support patient flow, free up beds at pediatric and community acute care hospitals by accepting new populations (e.g., high-risk patients requiring BIPAP), and provide rehabilitation care for post-COVID patients.

Adding critical care extender beds at Holland Bloorview will not only relieve pressure on acute care, freeing up those beds for patients with higher care needs, but it improves quality of care for pediatric patients, ensuring they get the right care, in the right place.

An investment of **$3.6 million** is needed to create **4 critical care extender beds** at Holland Bloorview.

		Additional Critical Care Extender Capacity and Funding Needed			
		Fiscal Year 2021/2022	**Fiscal Year 2022/2023**	**Fiscal Year 2023/2024**	**Total**
Holland Bloorview Kids Rehabilitation Hospital	Operations	$437,077	$1,573,306	$1,573,306	**$3,610,045**
	Training	$26,356			
	Total	**$463,433**	**$1,573,306**	**$1,573,306**	

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Implementation Details

Adding **acute mental health surge capacity** in hospitals and through hospital community partnerships for children and youth in crisis

Part of an action plan from the Children's Health Coalition to ensure hospital capacity and provide timely access to care both in the immediate pandemic response and through recovery

For more information, please contact:
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Overview: Acute Mental Health Surge Capacity

For many years, the Ontario health care system has experienced year-over-year increases in hospital volumes across acute mental health needs. As well, patients returned to the hospital three times more than children with other disorders. At the same time, the COVID-19 pandemic has added a surge of unparalleled scale on hospital capacity, with an alarming rise in acuity and complexity of mental health need, spanning from high-risk behaviours to eating disorders to suicide attempts, all of which require more intensive supports.

Unfortunately, acute mental health care services were constrained well before the pandemic, with demand out-stripping system capacity. During the pandemic, as community hospitals treated COVID-19 patients, parents increasingly accessed children's hospitals for mental health care – a significant 23 per cent increase in volumes.

Children and youth with significant and complex mental illnesses require longer term and more specialized care than provided in acute care settings. However, when wait times in the community system are long or intensive treatment supports are unavailable, families in crisis often turn to hospitals because they have nowhere else to go. Also known as 'Tier 4' or 'Level 4' services (see CYMH Program Guidelines 2015), intensive treatment delivered in community-based settings has remained the most significant gap in children's mental health. Ideally, Tier 4 services should be delivered in a way that can promote and sustain treatment gains that equips the child and family for success, while also preventing the likelihood of crises, escalation in need, and re-admission to hospital.

Given these long-standing gaps and the described surge, immediate investment is needed to adequately resource and support acute mental health care capacity as well as bolster "Tier 4" community care settings, in order to address timely access to health care and preserve hospital capacity. Adding to the urgency for funding support, is the looming viral season and the potential for additional waves of the pandemic, both of which will exact pressure on already limited resources. As acute mental health needs go unaddressed (or inadequately addressed), more costly and longer-term impacts on the health system are inevitable. Ensuring that timely and appropriate acute mental health care continues through the pandemic, while addressing the backlogs in care, is critical to both the province's recovery as well as the well-being of children, youth, and families.

At the same time, and from a cost-effectiveness perspective (see CIHI/CMHO 2019 Report), sustaining acute mental health care requires intentional planning and investment in both hospital services (e.g., in-patient beds, highly trained mental health personnel), as well as community-based services to ensure that the right care is delivered at the right time and in the most appropriate setting.

The Children's Health Coalition has identified the need for an investment of $35 million over the next two years to preserve hospital capacity in children's hospitals through wave 4 and the pandemic recovery by alleviating key hospital pressures from mental illness, including eating disorders.

This investment will:

- Enhance staffing capacity within hospital settings to address backlogs and ensure that children receive care within clinically appropriate times.
- Advance clinical expertise (with interdisciplinary teams), awareness, and knowledge to address the increasing acuity and complexity of acute mental health needs.

- Expand the number of beds to facilitate care transitions and to ensure that acute mental health needs are delivered in a timely way.
- Support regional-based partnership models, between hospitals and community to enable mental health care where the right service is delivered at the right time, and within the appropriate setting.

Table A. Proposed Funding for Stabilizing and Sustaining Acute Mental Health Care Capacity

	Funding Jan 1 – Mar 31/22	Funding 2022/2023	Funding 2023/2024	Total
SickKids		$5,817,000	$5,919,000	**$11,736,000**
CHEO	$1,619,000	$2,862,000	$1,572,000	**$6,053,000**
Children's Hospital London Health Sciences Centre	$4,804,000	$4,120,000	$4,187,000	**$13,111,000**
McMaster Children's Hospital Hamilton Health Sciences	$276,000	$1,391,000	$1,410,000	**$3,077,000**
Holland Bloorview Kids Rehabilitation Hospital	$94,000	$661,000	$668,000	**$1,423,000**
Total	**$6,793,000**	**$14,851,000**	**$13,756,000**	**$35,400,000**

This funding will ensure we are able to address backlogs so that children will receive treatment/intervention within clinically appropriate times. In alignment with the work at the Provincial Recovery Table, we will monitor and report our progress through the following metrics:

- Number of emergency department visits
- Length of stay mental health beds
- Readmissions within 30 days
- One year rate of repeat hospitalizations
- Patients hospitalized for more than 30 days in a year

The proposal will outline the evidence related to acute mental health needs and the pandemic as well as solutions that will help ensure children and families across Ontario have access to critical mental health care and treatment.

Investing to build capacity in both hospitals and communities is required so that all children and families have access to care and do not end up in crisis. Adequate, sustainable funding will facilitate early intervention, in some cases prevent certain health conditions from worsening, and ultimately create the opportunity to achieve the best health outcomes for children over the long term.

Background and Current State

About Acute Mental Health Care

Common clinical profiles include:

- Self-harm and risk behaviours
- Suicide attempts
- Eating disorders
- Aggression toward others

Addressing acute mental health care needs encompasses a wide array of services, spanning both hospital and community settings. With the former, services may include psychiatric consultations, crisis support and medication management, typically with goals of stabilization and de-escalating high-risk behaviours. In the latter setting, services may include longer treatment either in a community setting or in home-based settings, depending on the risk profile of the child and family, ultimately with the goal of supporting the child and family to maintain gains and reduce acuity in need (aligned with the Stepped Model Care).

Tanushri (12) was brought to hospital due to an overdose of Tylenol. She is highly anxious and does not want to return to in-person school. Tanushri's journey in the mental health system began in May 2021 when she and her parents were connected to school mental health personnel who provide three sessions of counselling. As her needs required more care, they referred her to community-based mental health care. A full assessment was completed and her treatment plan included Dialectical Behavioral Therapy and Family Therapy. She was placed on a wait list three months ago. During that time, she has spoken to counsellors several times, however, she is still waiting for the intensive treatment she needs. She was admitted to CHEO for emergency treatment of the overdose. She was seen by an inter-professional team at the hospital who provided stabilization and care. Once the risk was at an appropriate level, she was discharged home. The community-based mental health agency was advised and increased her priority on the wait list, however, she will still be waiting another month. During that time, she is unlikely to go to school which will increase the conflict between her and her family, causing an increase in risk that she will attempt and perhaps complete suicide.

Current State

For several years, there have been clear increases in the volume of acute mental health needs among children and youth. In fact, over a 10-year period, there has been a 71 per cent increase in the rate of children and youth hospitalized for mental disorders in Ontario (CIHI 2019). Since being declared a global pandemic in March 2020, COVID-19 has led to various restrictions, including lockdowns, school closures, and physical distancing, resulting in particularly negative effects on the health and mental health of children and youth. Nearly two-thirds of youth and young people report that their mental health has worsened since the pandemic. In particular, children and youth with a pre-existing mental health need have experienced further deterioration in their mental health. And despite this need, they are not getting the care they need, when they need it:

- Before the pandemic, wait times in community mental health were as long as 2.5 years for specialized services. The average for intensive treatment services is 92 days and 67 days for counselling and therapy; well beyond the clinically appropriate wait times (CMHO, 2020). Children and youth on wait lists too often require acute stabilization. Once stabilized they are returned to wait lists and often they return to hospital yet again in crisis.
- Outpatient mental health visits to physicians are 8-10 per cent higher than pre-pandemic levels for children and youth.
- Currently at SickKids the average wait time to assessment and treatment for outpatients is eight months; on average SickKids received 14 outpatient referrals per month in 2019/20 and 21 per month in 2020/21, representing a 50 per cent year-over-year increase.
- At McMaster Children's Hospital, families have been reporting challenges over the past 18 months accessing primary care providers impacting their ability to be referred to services. Such delays can create a need for acute mental health services.
- In McMaster Children's Hospital's outpatient services, the wait list for outpatient services now sits at eight months, and for psychiatric consultation, patients can expect to wait nine months. Referral numbers have steadily increased across several programs during the pandemic, especially their psychiatric consultation program which had 100 referrals in just one month (January 2021).
- Eating disorder emergency department visits have increased 1.5 to 2.6 times expected with hospitalizations 1.5 to 1.9 times expected. Eating disorders account for a large proportion of the increase in mental health hospitalization visits, longest length of stay of any other mental illness (SickKids, 2021; ICES, 2021).

These sharp increases in demand for acute mental health care services and admissions, in addition to increasing complexity, speak to the medically compromised state that many children and youth are facing. The trend of rising need is also reflected in the demand for outpatient services in community settings which have seen similar increases. All of this is happening in a health care system that was already struggling, and with the COVID-19 pandemic and hospitals regularly operating at or over capacity, there is little to no further ability to accommodate additional demand as anticipated with the viral season-related surge (see further described below) and/or subsequent waves of the pandemic.

Example: Eating Disorders
Since the pandemic, there has been a sharp increase in demand for eating disorder services and admissions, for both inpatient and outpatient settings.

See CHC's proposal on 'The Crisis in Child and Youth Eating Disorders' for more information.

Key Challenges

Historical under-resourcing compounded by the COVID-19 pandemic has resulted in unprecedented demand for acute mental health services, lending to increasing waitlists and backlogs. While the entire health care system is under strain, there are several unique challenges confronting the pediatric population as it relates to acute mental health.

Potential double surge due to RSV/Influenza season: The potential of an earlier and extended RSV/Influenza season, converging with the unprecedented surge in demand for acute mental health care services and an ongoing pandemic, would lead to an overwhelmed pediatric acute care sector and leave scores of children and youth in crisis. Historically, medically acute patients are prioritized over patients with mental health conditions. A surge in RSV/Influenza patients will negatively impact patients with acute mental health needs who will have even less access to much needed medical stabilization. For example, at McMaster Children's Hospital (MCH), an anticipated RSV surge this year will lead to an approximate 20 per cent increase in admissions across the total pediatric capacity.

Increased acuity, complexity and risk in child and youth mental health: Across both hospital and community mental health settings, there are significant challenges with addressing the current demand and increases in acute mental health needs, including those with concurrent complex physical and mental health diagnoses (e.g., traumatic brain injuries and mental health needs). The rising acuity and complexity are further evidenced by the increases in average length of stay and bed occupancy, compared to pre-pandemic levels. For example, length of stay has in children's hospitals (e.g., at McMaster Children's Hospital, length of stay has increased on average by two days) which creates substantial pressures in a system with limited resources. In other cases, and according to McMaster Children's Hospital Consultation Liaison Psychiatry service, there have been increased levels of self-harm and suicidal ideation during the pandemic. Some of these presentations have required increased medical care (due to the severity of the attempt). The implication of these presentations impacts the sector's ability to deliver the level of evidence-based programming required.

More restrictive interventions are being implemented. At MCH, 2018-2019 monthly averages were 7.5 restrictive interventions and 1.6 Self Harm incidents per month. From July 2020 through November 2020 the average increased to 16.3 restrictive interventions and 10.3 Self Harm incidents per month.

Lack of clinical expertise to match increasing complexity and acuity: With the observed increases in acuity and complexity, it is critical to have specialized and skilled mental health clinicians and providers, but also interdisciplinary teams that can address the full scope of complexity previously described. Staff need to be well-versed and experienced on the physical/emotional/developmental needs of pediatric patients as well as the way mental illness manifests in this population. It is also necessary to demonstrate an expertise in navigating and understanding the multitude of systems, legislation, social factors and ethical considerations that need to be applied within this setting. However, in most hospital and community settings, there are few clinical staff that are trained to work with this level of complexity, largely attributable to longstanding challenges with high-turnover and staff retention.

- At McMaster Children's Hospital
    - the Consult Liaison service has experienced a significant increase in the number of cases presenting with substance use concerns.
    - an increase in patients admitted to the medical units post suicide attempt that require increased medical care due to the severity of attempt (and medical complications associated with this).
    - a significant increase in patients experiencing disruptive behaviour, mood lability, anxiety and even aggression/violence.

- At SickKids, the increasing complexity in need requires more specialized mental health clinicians in its acute mental health services. In particular, more expertise is needed to support urgent care clinics and specialized treatment programs.

- These are examples of a few children seeking care at Holland Bloorview Kids Rehabilitation Hospital
    - 13-year-old recovering from gang-related gunshot wounds
    - 12-year-old with multi-system blunt trauma following a seven-story fall with suicidal intent
    - 9-year-old with 86 per cent burns to body

  In each of these cases at Holland Bloorview Kids Rehabilitation Hospital, issues of post-traumatic stress, anxiety and involvement of child protection/justice systems can negatively affect recovery and necessitate mental health support for client's safety and emotional well-being.

Lacking resources to meet demand and needs: Given the sheer magnitude in need for acute mental health care, the respective care services in both hospitals and community need to be equipped with sufficient clinical capacity and resources (e.g., space, technological enhancements). Well-staffed services, along with interdisciplinary (and connected) teams, are required to effectively deliver the array of acute mental health care services previously described, in a timely way, but also to ensure the safety of both patients and the staff. In the absence of these resources, patients ultimately do not get the supports that they require, which hinders both the timing and quality of care, and therein, the patient's overall outcomes. Unfortunately, as acuity increases, and therein length of stay increases for example, the staffing and human resources levels will be stretched beyond capacity.

- For example, at the Children's Hospital, London Health Sciences Centre, wait times for child and youth ambulatory services are increasing and currently range from one year to 18 months to see a psychiatrist and then another year to get into group or individual treatment for a total of 2 to 2.5 years for full treatment, putting children into a completely different developmental stage and a missed opportunity for early intervention. This has proven to have led to higher acute patients upon presentation to outpatient services, and ultimately resulted in sicker patients accessing the Emergency Department and requiring admission for a much longer period of time to achieve stabilization.
- At McMaster Children's Hospital, the Outpatient Mental Health program received 10,582 referrals from August 2020 to August 2021, which is nearly double referrals from the prior year.

Pressures are intensified by lack of transitions, outpatient programs or safe pathways for discharge:

Prior to COVID-19, the most significant gap in the mental health system was for children with the most serious issues; this gap, unfortunately, has been exacerbated by the pandemic. Paired with increasing need and demand for mental health care, the current system is stretched well beyond its current capacity. More specifically, several inpatient programs are operating at full bed capacity with long wait lists. Additionally, many providers have experienced pressures in procuring discharge supports or outpatient beds;

At McMaster Children's Hospital, waitlist for outpatient services now sits at 8 months and for psychiatric consultation patients, the wait time is now 9 months.

this means that a patient may have an extended bed occupancy in the interim, thereby adding to the backlog of patients that are waiting for said care. Given current demands, capacity pressures ultimately lead to patients being discharged early, many without a plan, in order to free-up beds for others. During COVID-19, wait lists for outpatient services have nearly doubled in the number of referrals received. Unfortunately, this leads to a rise in re-admissions as needs are not appropriately met.

- At McMaster Children's Hospital, the inpatient program has experienced pressures in finding adequate discharge supports/environments. Many group homes/community resources have had reduced services during the pandemic due to the institution of IPAC (Infection Prevention and Control) measures which decreased capacity significantly. This results in challenges setting up appropriate discharge plans and environments. As a result, McMaster Children's Hospital temporarily increased support within its Day Hospital Program to accommodate additional patients.

The Solution: A Partnership Model for Acute Mental Health Care

In this request, the Children's Health Coalition has identified a need for an urgent one-time investment of **$34 million** to increase both hospital and community capacity for acute mental health care, through a partnership model, for the next two years. Investment is necessary to ensure that a system chronically underfunded and stretched prior to the COVID-19 pandemic, does not fail children, youth, and families in their time of greatest need. This investment will:

- **Enhance Staffing Capacity**

To address backlogs and ensure that children and youth receive care within clinically appropriate times

An increase in funding is urgently needed to reduce the enormous backlog that pre-dated the COVID-19 pandemic but has now escalated to critical levels. This funding will help to bolster the capacity of acute mental health care providers (in both hospital and community) to hire additional staff and extend hours, both of which will help to reduce the backlogs. Additional funding for physical space, supplies, as well as technological advances that will optimize clinic processes, are all critical to creating more capacity in the system to address the current backlog and anticipated, ongoing need. In doing so, we can ultimately ensure that children receive care within clinically appropriate wait times.

- **Advance Clinical Expertise and Interdisciplinary Teams**

To address the increasing acuity and complexity of mental health needs

In parallel with hiring more staff and resources, additional funding is needed to ensure that staff are trained and equipped to work with the aforementioned increasing acuity and complexity. Accordingly, an investment is needed for creating interdisciplinary teams and practice models, and facilitating training opportunities, that can equip our hospitals and communities to meet these more complex needs. For example, at McMaster Children's Hospital there has been a significant increase in referrals for patients with substance use needs, in particular**,** for the assessment and treatment of acute

withdrawal syndromes for opioids and benzodiazepines. In this example, specialized models of care and treatment delivery (between pediatric medicine and psychiatry) were needed so that patients experiencing substance withdrawal could be managed safely in an evidence-informed manner. As demonstrated, supporting interdisciplinary teams is critical to being able to effectively meet the acute mental health needs of children and youth.

- **Expand Hospital Beds**

To facilitate care transitions and to ensure timely access to acute mental health services

By investing in the expansion of in-patient beds, more children will be able to get timely access to the care and intervention they need. In addition to funding in-patient beds, and in alignment with the continuum of care, further investment is urgently needed for post-intervention care, such as outpatient services, which are critical to supporting discharge plans and sustaining treatment gains and outcomes. In the absence of this investment, long wait lists for outpatient services will only serve to have a compounding effect on the health care system; this has already been observed by the rise in hospital re-admissions across the province. This funding will help to expand bed capacity and outpatient services, within both hospital and community settings. Through this investment: (i) waitlists can be reduced and will equip hospitals with the ability to meet the current and anticipated demand; and (ii) the provision of transitions to other levels of care can be more readily facilitated for patients at the appropriate time of need. This also helps to reduce the current pressures on in-patient beds.

- **Support regional-based partnership models between hospitals and community**

To enable mental health care where the right service is delivered at the right time, and within the appropriate setting

Intensive or Tier 4 mental health care services within community settings have consistently been under-equipped to meet the needs of children, youth and families. It is well understood that hospitals alone are not the most appropriate, nor most cost-effective setting for these ongoing treatment needs (see CIHI/CMHO 2019 paper). To sustain Ontario's acute mental health care capacity, it is critical to provide parallel investments in community settings that are eager and prepared to build up their intensive treatment capacity. Promoting and investing in partnership models on a regional basis is a critical success factor for addressing the long-standing gaps in acute mental health care. These partnership models will help reduce existing bottlenecks and pressures, but also means that early and appropriate intervention can be prioritized in a way that ultimately leads to better outcomes for children, youth and families. This investment can be delivered to hospitals, who can then use the earmarked dollars to support capacity building with their community partners.

Proposal Summary

In summary, there is increasing need for acute mental health services in the province, especially given the COVID-19 pandemic and additional anticipated challenges that will only serve to further constrain the limited resources available. Many hospitals and community providers are experiencing challenges in delivering timely care, in addition to managing increasingly acute and complex needs. As these acute mental health needs go unaddressed (or inadequately addressed), more costly and longer-term impacts

on the health system become inevitable.

Investing in children's health care services will ensure timely access to critical child and youth mental health care for those with more acute and intensive needs. The Ontario government can address current delays and backlogs for acute mental health care with an investment of **$34 million** over the next two years. Due to regional variations in both pressures and relationships between community and hospital care across the province, as well as local initiatives underway, the requests for funding (see Appendix) vary across sites and reflects the needs of their local communities.

This funding will help avert the worst of the potential crisis scenarios for children's hospitals and community mental health providers. With an added focus of a partnership model, this funding will help enhance pathways and care models to develop a system of care that ensures the appropriate level of care is delivered in the appropriate setting, lending to better outcomes for children, youth, and families.

Appendix – Details of funding requests by site

Children's Hospital, London Health Sciences Centre

	Funding for Fiscal Year 2021/2022 Jan 1 to March 31	Funding for Fiscal Year 2022/2023	Funding for Fiscal Year 2023/2024
# of additional beds		3	3
Cost per patient day *As of July 31, 2021, this is our cost per Inpatient Day combined on both D4 and B8 geographic locations*		$ 782	$782
HHR (total salary and benefits) *Inpatient Areas: 8.4 FTEs Registered Practical Nurses, 4.2 FTEs Registered Nurses, 5.2 FTEs Child & Youth Counsellors, 2.0 FTE Child Life Specialists, 1.0 FTE Occupational Therapist, 1.0 FTE Child Psychiatrist, 1.0 FTE Manager* *Outpatient Trauma & Addictions: 1.0 FTE Social Worker, 1.0 FTE Child & Youth Counsellor* *Outpatient Tertiary Care: 2.0 FTEs Registered Nurses* *Outpatient General Ambulatory Services: 3.0 Social Workers, 1.0 FTE Ambulatory Clerk/Clinic Aide*	$779,861	$3,249,649 *Assume 1.75% inflation*	$3,306,518 *Assume 1.75% inflation*
Knowledge Translation		$285,631	$285,631
Supplies and equipment	$57,084	$234,599	$239,995
Overhead/admin costs	$83,695	$348,425	$354,651
Other costs *Renovations for footprint of both CAMH IP areas to be on one floor (over 17 months)*	$3,883,305		
Total Costs	**$4,803,945**	**$4,119,631**	**$4,187,631**

About Children's Hospital, London Health Sciences Centre Funding Ask

The funding will be used to intervene early and quickly, keeping children, youth and their families out of crisis. This will be achieved by increasing resources within the ambulatory program, allowing more clinicians to provide more in-depth and earlier care/treatment, including more family therapy sessions. This inpatient ask will bring all children and youth requiring inpatient stays together, in one space, while also providing a pediatric-focused lens, with all pediatric trained staff. This is to be done in partnership with our community partners, in addition to providing education and training to those that serve this population within the community. This funding will lend to building better partnerships and care models that can wraparound the patient and their families, while also facilitating appropriate step-up/step-down care models. In summary, this investment will help to ensure that there are no gaps in care while in hospital but also when in community treatment and within their schools and home.

McMaster Children's Hospital

	Funding for Fiscal Year 2021/2022 Jan 1 to March 31	Funding for Fiscal Year 2022/2023	Funding for Fiscal Year 2023/2024
HHR (total salary and benefits) *7.4 FTEs: Psychologist 2.0, Nurse Practitioner 0.4, Social Worker 3, Intake Coordinator (CYC) 0.5, Business Clerk 0.5, Service Navigator 1.0*	$237,400	$949,600	$966,218
Supplies and equipment *Desktop computers, licence, laptops*	$13,750	$55,000	$56,265
Knowledge Translation		$285,631	$285,631
Overhead/admin costs	$25,115	$100,460	$102,248
Total Costs	**$276,265**	**$1,390,631**	**$1,409,631**

About McMaster Children's Hospital's Funding Ask

The pressures in CYMH are related to level of acuity in our inpatient unit and less about needing more beds. What is required are more supports to address children/youth in crisis and to augment our outpatient services to avoid crisis and admission to inpatient unit. Therefore, this funding ask is primarily focused on building our resources and capacity to addressing the current and expected demand for acute care services. More specifically, this funding ask would provide us with the ability to recruit and hire clinical staff resources to: (i) reduce our wait list (current state); (ii) be more responsive post pandemic (research indicates significant likelihood of ongoing and increasing demands on mental health services); (iii) support children/youth that are presenting with symptoms exacerbated by the pandemic and lock downs; and (iv) continue to provide a range of services including individual, family, group, outreach.

Holland Bloorview Kids Rehabilitation Hospital

	Funding for Fiscal Year 2021/2022 Jan 1 to March 31	Funding for Fiscal Year 2022/2023	Funding for Fiscal Year 2023/2024
HHR (total salary and benefits) *Psychologist 2.0*	$85,250	$341,000	$346,968
Knowledge Translation		$285,631	$285,631
Overhead/admin costs	$8,525	$34,100	$34,697
Total Costs	**$93,775**	**$660,631**	**$667,631**

About Holland Bloorview's Funding Ask

Psychologist for Specialized Orthopedic and Developmental Rehabilitation Inpatient Unit: The specialized orthopedic and developmental rehabilitation (SODR) inpatient unit accepts referrals from across the province. This unit has the only funded specialized pediatric orthopedic rehabilitation beds in Ontario. There has been a sharp rise in patients requiring mental health services including patients experiencing the involvement of the Children's Aid Society.

- Approximately 25% of clients on this unit have a new traumatic or life-altering event or diagnosis e.g., a spinal cord injury resulting in paralysis, severe burns altering appearance or new metastasis while undergoing rehabilitation for complications of a tumor or tumor resection.
- Last year, 40% of SODR clients were flagged as requiring psychology services, e.g., rehabilitation from orthopedic surgery post-attempt suicide. With no dedicated resource available, those clients had an unacceptable clinical wait for the services they needed.
- 30% of clients have a pre-existing condition such as intellectual disability or autism spectrum disorder. 10% are diagnosed during their admission with a new anxiety disorder or depression.

In some instances, admission from an acute care hospital is delayed because Holland Bloorview does not have the resources to address the mental health comorbidity resulting in a prolonged acute care admission / ALC designation and delayed access to rehabilitation. In the worst cases, Holland Bloorview may decline an admission due to mental health comorbidities with further upstream impacts.

Increased availability of psychology services on SODR will:

- reduce wait times for mental health interventions for clients with speciality rehabilitation needs;
- remove the need for referrals that increase wait lists at other hospitals' and community-based mental health services;
- allow for meaningful rehabilitation intervention through improving coping skills and reducing emotional distress during hospital admission; and

- enhance transition to community and safe discharge without unnecessary delays through increased readiness to access appropriate services upon discharge either at Holland Bloorview (in person or through virtual care) or in other community settings.

CHEO

	Funding for Fiscal Year 2021/2022 Jan 1 to March 31	Funding for Fiscal Year 2022/2023	Funding for Fiscal Year 2023/2024
HHR (total salary and benefits) *Hiring of 2 Social Workers FTE, 1 Nurse Practitioner FTE, 1 Psychologist 0.8 FTE, 1 Pediatrician FTE, 1 Psychiatrist FTE*	$ 306,000	$1,224,000	$1,233,000
Knowledge Translation		$ 285,631	$ 285,631
Overhead/admin costs	$ 13,108	$ 52,431	$ 53,348
Other Costs *4 bed addition to inpatient Psychiatry* *10 bed renovation to add capacity for eating disorder program*	$1,300,000	$1,300,000	
Total Costs	**$1,619,108**	**$2,862,062**	**$1,571,979**

About CHEO's Funding Ask

Given the increasing demand and need for CHEO's acute care services, this funding ask will reduce the current wait times to weeks versus months. The addition of new clinical staff will enhance our capacity to support more children and youth, and in a timely way. The proposed additions will lead to in increase in the number of new patients, as described below:

- Psychologist - 50-150 new patients, 36-48 outpatients and 1-2 therapy groups
- Social workers - 150 children/youth Nurse Practitioner 350-400 children/youth

The Consultation Liaison Service provides mental health and addiction consults to all medical, surgical and intensive care patients. Since the onset of the COVID-19 pandemic, there has been a steady increase in referrals to Psychiatry and Health Psychology waiting lists, resulting in delays in the provision of timely services to children and youth with complex medical and mental health and addiction conditions. These delays in care include children/youth triaged as "red" who are at highest need due to their mental health/addiction issues impacting their medical care and health outcomes. The Consultation Liaison team has also been supporting the multiple Eating Disordered patients admitted on medical floors. It is important to note that the team has also seen a dramatic increase in the number of overdose admissions to the medical floors whom are not medically stable to be admitted to inpatient psychiatry. A nurse practitioner can bridge these patients between our medical floors and inpatient psychiatry to support the current psychiatry shortage. Outpatient mental health and addiction social workers are greatly needed to help with the ever growing wait list in outpatient to both provide support and counselling but also to liaise with our community mental health and addictions partners to create

care pathways to addictions services. Also, social workers will be trained to see the less severe Eating Disordered patients that are currently being seen in outpatient Mental Health.

SICKKIDS

	Funding for Fiscal Year 2021/2022 Jan 1 to March 31	Funding for Fiscal Year 2022/2023	Funding for Fiscal Year 2023/2024
HHR (total salary and benefits) *Hiring of Psychologist 4* *Nurse Practitioner 2* *Child and youth counsellor 10.7* *Registered nurse 3.5* *Social worker 15* *Intake coordinator 1* *Behavioural therapist 1* *Clinical Team Lead Manager 2* *Advanced practice clinician 2* *Admin assistant 1* *Dietitian 0.5*		$5,002,729	$5,095,275
Knowledge Translation		$285,631	$285,631
Overhead/admin costs		$528,836	$538,091
Total Costs		**$5,817,196**	**$5,918,997**

About SickKids' Funding Ask

SickKids hospital has identified that across the hospital there remain significant unmet resource needs for our mental health populations inclusive of those patients with primary acute, complex psychiatric disorders and those with concurrent complex physical and mental health diagnoses. Specialized mental health clinicians are required in our growing Rapid Access Urgent Care Clinic and outpatient specialized Mental Health treatment service lines. Resources to support acute patients from both populations on evenings and weekends within the emergency department and across the hospital are required to ensure the safety of both patients and the staff. As a tertiary and quaternary specialized site, with the resources of the SickKids Centre for Community Mental Health and additional knowledge translation capacity, SickKids is uniquely positioned to develop and deliver curriculum and resources for the broader province, building capacity for a better system response to the rising needs across mental health.

MAKE
KIDS
COUNT

Implementation Details

Prevent children and youth with mental health issues from requiring hospital care and ensure step down care is promptly available by investing in **community-based child and youth mental health** treatment and innovative partnership models

Part of an action plan from the Children's Health Coalition to ensure hospital capacity and provide timely access to care both in the immediate pandemic response and through recovery

For more information, please contact:
Children's Mental Health Ontario
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Overview: Community Child and Youth Mental Health

Before the pandemic, there were too many children going to hospital unnecessarily due to service gaps in community-based care. With new data and research predicting that children's mental health has significantly deteriorated as a result of the pandemic, we are at a crisis point. Addressing the significant service gaps in community-based care is critical to preserving capacity in our hospitals.

Long wait times were a challenge for families prior to COVID-19 with 28,000 children and youth waiting for mental health care. For children and youth with serious and intensive needs, wait times could be as long as long as 2.5 years. Now, the situation is worse. Leading international and Ontario researchers are sounding the alarm and warning that children and youth are experiencing significant mental health deterioration and for those that had mental health and addiction issues before the pandemic, the issue is worse. Providers of child and youth mental health care are observing increased client complexity and acuity through the pandemic.

Social isolation, school closures, job losses, grief and a loss of supports through the pandemic is leading to increased mental health needs and often more serious mental health issues. The effects are even more profound for low-income families, children and youth with disabilities, and for racialized, marginalized and vulnerable families. An entire generation of children are at risk if we do not act now to ensure they can access the mental health care and services they need.

Mental health system capacity for children is at risk. Investments are urgently needed now to ensure the system is equipped to manage the current and projected increases in demand for mental healthcare arising from wave 4. And even prior to the pandemic, there were too many preventable visits to hospital for mental health care. We have to do everything we can to prevent as many children as possible from requiring hospitalization, preserve hospital capacity and also, allow for quick discharge to home or other community-based mental health services.

The significant rise of eating disorder cases in hospitals underscores the community-based service gaps that need to be urgently addressed. Children with eating disorders require long-term treatment, along with family supports. This is best provided in community-based settings, however, it has been identified as a service gap for many years. Inaction by multiple governments to build the services required in the community has led to the capacity issues that hospitals now face. Simply building more acute care capacity does not address the real issue, which is the lack of community-based, long-term treatment services where children with ongoing mental health needs are best served.

Every day matters in the life of a child. Timely and equitable access is critical for children's mental health care services. Delays in treatment puts kids at risk over the long term and has life-long consequences and costs to the health care system. As the province faces wave 4 of the pandemic and through recovery planning, the urgency of improving access to children's mental health care must be a top priority of the government.

The Children's Health Coalition has identified the need for an investment of $15,650,000 in 2021/2022, $57,045,000 in 2022/2023 and $58,044,000 in 2023/24 to prevent children and youth with mental health issues from requiring hospital care and ensuring step down care is promptly available by investing in community-based child and youth mental health treatment and innovative partnership models. This investment will:

- Build **intensive treatment and specialized consultation services** to ensure timely access to care by tackling long wait times and gaps in care, with an immediate focus on those with the most serious and intensive needs
- Increase access to **psychotherapy & counselling**, including walk-in therapy, single session and brief services, as well as long-term counselling and psychotherapy. These services are important enablers to preventing needs from worsening or becoming more acute over time
- Increase **family therapy and supports** so that plans of care are as effective as possible when supporting and treating children and youth in the context of their families and caregivers
- Scale 24/7 **crisis support services** to ensure children and youth experiencing a crisis have an alternative to going to the emergency department, thereby preserving hospital capacity for when its needed most
- Enable **key processes and functions** in the delivery of mental health treatments and services including, **coordinated access, service coordination, prevention**

Investments in these areas will ensure that **innovative partnership models** are possible between hospital and community when supporting mental health needs on the continuum of care. This is especially critical as children and youth "step down" or transition from hospital to community for their ongoing treatment through wave 4 and beyond.

Table A. Proposed Funding for Community-Based Mental Health to Reduce Pressure on Acute Care and Prevent Hospitalizations

	Funding for Fiscal Year 2021/2022 Jan 1 – March 31	**Funding for Fiscal Year 2022/2023**	**Funding for Fiscal Year 2023/2024**	**Total**
Intensive treatment & specialized consultation services	$7,689,000	$20,012,000	$20,362,000	$48,064,000
Psychotherapy & counselling,	$5,151,000	$22,514,000	$22,908,000	$50,573,000
Family therapy & supports	$877,000	$3,940,000	$4,009,000	$8,826,000
Crisis support services	$350,000	$1,396,000	$1,420,000	$3,166,000
Key processes and functions				
Coordinated access	$980,000	$5,141,000	$5,231,000	$11,352,000
Service coordination	$341,000	$1,350,000	$1,374,000	$3,065,000
Prevention	$262,000	$2,692,000	$2,740,000	$5,694,000
Total	**$15,650,000**	**$57,045,000**	**$58,044,000**	**$130,739,000**

This funding will ensure we **prevent children and youth with mental health issues from requiring hospital care and ensure timely access to community services are available and step down care is promptly available by investing in community-based child and youth mental health treatment**. Appendix A: Funding required by service area provides a detailed breakdown of the proposed investments in the province's service areas for child and youth mental health.

In alignment with the work at the Provincial Recovery Table, we will monitor and report our progress through the following metrics:

- Wait times by core service
- Wait lists by core service

This proposal will outline emerging data related to mental health needs in the context of the pandemic as well as solutions that will help ensure children, youth and families across Ontario have timely access to critical mental health care and treatment.

Children's health and health care services are intricately connected, and services are delivered in multiple sectors (e.g., hospital, community, home, school). Changes and pressures in one part of the system have profound impacts throughout the system. For example, a lack of timely access to community-based child and youth mental health care for a child with mental illness leads to increased pressures on hospitals as families turn to emergency departments in crisis.

Investing to build capacity in both hospitals and communities now is required so that all kids and families have access to mental health care/treatment and do not end up in crisis. Moving forward, adequate and sustainable funding will facilitate early intervention, in some cases prevent certain health conditions from worsening, and ultimately create the opportunity to achieve the best health outcomes for kids over the long term.

Pandemic Challenges and Impacts on Child and Youth Mental Heath

Hospital and community service providers have noted that there has been both a sharp increase in demand and acuity. Before the pandemic, 28,000 children and youth were waiting as long as 2.5 years for mental health care (CMHO 2020). Since the beginning of the pandemic, indicators of more serious mental health issues are emerging and greater needs have been reported by youth, parents and service providers. Our review of current research also predicts a significant increase in demand that we will continue to see beyond the pandemic.

The mental health needs of children, youth and families have never been higher, and a generation of children are at risk:

- **Pre-Pandemic wait times** in community-based mental health can extend up to 2.5 years for specialized services and the average is 92 days for intensive treatment services and 67 days for counselling & therapy; well beyond the clinically appropriate wait times (CMHO, 2020).
- **Overall greater mental health needs** with nearly two-thirds of youth and young people surveyed, reported that their mental health had gotten worsen since the pandemic. Youth from

low-income families and Northern and remote communities reported even worse declines in their mental health (Ramdomski et al, 2020).

- **Pre-Existing mental heath diagnoses,** along with socioeconomic and ethnic vulnerabilities predict family financial instability, parental stress and poor parent and child mental health (Sick Kids, 20201).
- **Parents (59%) reporting behavioural changes in their child** ranging from outbursts or extreme irritability to drastic changes in mood, behavior or personality and difficulty sleeping/altered sleeping patterns as well as persistent sadness and more (Ipsos Survey, 2020).
- **Prolonged impacts:** Evidence indicates that the social, emotional, and educational impacts of the pandemic, including prolonged isolation, repeated school closures, hours of screen time and increased stress and fears about the virus, have all had a dramatic effect on both physical and mental health in children and youth (Tombeau Cost et al., 2021; Public Health Ontario, 2020).
- **Increased Needs, but less help sought,** students reported increased feelings of loneliness (55%), boredom (73%), stress (43%) and anxiety (38%). Only 4% reported seeking mental health support (PHO-Compass, 2021).

Current State

Child and youth mental health centres are doing everything they can to provide care for families in their communities. New investments of $83 million over the past few years have enabled great advances in expanding child and youth mental health walk-in clinics and progress towards what is needed to address long wait times and expand access to services. Over the past year, tremendous gains have been made in innovation by pivoting to online and virtual mental health care options to address public health concerns and directions during the pandemic.

However serious challenges remain for families who are trying to access care. Long wait times persist, and there are huge gaps in care for those with serious and complex mental health issues including eating disorders, as well as for racialized, marginalized and underserved families. Sector funding has fallen by almost 40% in real terms over the past 25 years, and as a result, wait times continue to get worse, especially for children and youth with more serious mental health needs. The pandemic has also exacerbated health human resource challenges in child and youth mental health. Given labour shortages, a system-wide view on new investments is required to ensure we are using our limited specialized workforce where the needs are most urgent.

Our Vision

We envision a future where community child and youth mental health services are equipped to meet kids and families where they are and is well connected with other children's systems including acute mental health care. Services should be co-designed and built up to meet the needs of children, youth and families that are particularly underserved, marginalized and oppressed – including Black families, Indigenous families, Racialized families, Francophone families, low-income families, LGBTQ+ children and youth, and those from rural, remote and Northern communities.

All new investments and actions should prioritize service system building to include a quality common experience with equitable access that puts the mental health needs of infants, children, youth and families at the centre and is built on:

- **Family and youth voice and engagement:** Youth and families voices with lived or living experience of mental illness or addiction contributing to the development of recommendations for service providers and government, that reflect and respond to family experiences of the service system
- **Equity:** Every infant, child, youth and family should have access to care that is culturally relevant and safe. All system change must be achieved through an equity based, anti-racist and anti-oppressive lens.
- **Social determinants of health:** Addressing the social determinants of health appropriately, including housing, is foundational and fundamental to mental health.

The Solution: Building Community-Based Capacity to Preserve Hospital Capacity

The Children's Health Coalition has identified the critical importance of preventing children and youth with mental health issues from requiring hospital care and ensuring step down care is promptly available by investing in community-based child and youth mental health treatment.

An investment of **$15,650,000 in 2021/2022, $57,045,000 in 2022/2023 and $58,044,000 in 2023/24** acknowledges the critical connection between community and acute mental health care in supporting kids with the most intensive and serious mental health needs. Success in preserving acute mental health capacity in hospitals during wave 4 and beyond is also about ensuring capacity in the community for effective and ongoing mental health care is delivered in the community.

Aligned with the government's vision to build a connected health care system, including mental health and addictions, this will also help build a well-organized and high-quality system that meets the needs of children, youth, and families. Investment is necessary to address gaps that were there persistent prior to the pandemic. This investment will:

1) Build intensive treatment services and specialized consultation

Ensure timely access to care to tackle long wait times and gaps in care, with an immediate focus on those with the most serious and Intensive needs

Children and youth with significant and complex mental health challenges often require longer term and more intensive, specialized support. Before the pandemic wait times for intensive treatment in the community were too long or not available at all leaving many families turning to hospitals with nowhere else to go, or worse, in a mental health crisis. It is well understood that hospitals alone are not the most appropriate, nor most cost-effective setting for these ongoing treatment needs (see CIHI/CMHO 2019 paper).

*Service gaps in community for intensive treatment can be alleviated by opening Tier 4 beds at the **Syl Apps Youth Centre**. This would create additional capacity in the system for children and youth with the most serious and significant mental health needs*

Expanding and scaling intensive and live-in treatment for those with the most serious and complex mental health challenges would fill a major gap in the community system now. The most significant gaps in the mental health system for children and youth are in Tier 4 which is predominantly provided by mental health professionals in the community. There also needs to be a special focus on building services in remote, rural, and northern parts of the province that have been particularly underserved making it challenging to consistently and comprehensively meet the needs of young people and their families. For those who have to travel far from home to get treatment or are left waiting many months before they can get into services, needs can further intensify and prospects for positive outcomes diminish.

At the same time, planning work to is required over the longer-term to build the system of intensive with a particular focus on live-in-treatment programs, which are often a step down from hospital.

2) Increase Access to Psychotherapy and Counselling, including Walk-In Therapy

*Increase access to **Psychotherapy & counselling**, including walk-in therapy, single session and brief services, as well as long-term counselling and psychotherapy. These services are important enablers to preventing needs from worsening or becoming more acute over time.*

Investments to support service delivery will not only address long wait times and preserve hospital capacity over the short term but will also improve access to support the best outcomes possible over the long term. For children and youth with moderate to severe needs to those requiring more intensive, ongoing treatment, there is an urgent need to expand front line services.

Building staffing capacity of mental health professionals in community to deliver critical treatment services families rely on is essential. The range of specialized expertise in child and youth mental health includes psychologists, social workers, child and youth mental health workers, among others, providing inter-professional care to children and youth. Supporting the delivery of counselling and therapy also has lifelong impacts when a need is identified.

Walk-in services are also an important access mechanism in reducing wait times for treatment. Early identification and interventions through walk-in services can prevent needs from worsening or becoming more complex or acute. Child and youth mental health centres have worked to develop responsive and innovative models to provide more timely access to service. Over the last several years, more than 80 child and youth mental health walk-in clinics have opened across Ontario.

A walk-in model is a family's first step into the services that child and youth mental health offers. It provides brief or a single therapy session to children, family and youth who need support and where appropriate, it also offers referrals to other programs and services. Walk-In clinics offer accessible, barrier-free ways to meet the needs of families, with flexible hours and availability and important access mechanism into the system so children and youth get the support they need right time and place. The *Roadmap to Wellness* also prioritizes improving and ensuring easier access as an important part of its plan to build the mental health system. Access is also a provincial priority in the sector as an important

indicator of system quality. Currently the system is building innovation by developing a provincial "Virtual Mental Health Walk-In Clinic", to provide a virtual option to access walk in services so families will be able to easily access community child and youth mental health services. This will be even more important as needs and demand are increasing now throughout the global pandemic.

3) Building Family Therapy and Supports

*Increase **family supports** so that plans of care are as effective as possible when supporting and treating children and youth in the context of their families and caregivers*

With increased more acute needs being seen in mental since the start of the Covid-19 pandemic, it has never been more important to consider the context of family in the delivery of services. Addressing child and youth well-being and mental health exists within families and also broader support systems. That is why team-based care in child and youth mental health facilitates a wholistic and bio-psycho-social approach, which allows for the delivery of a diversity of services.

SUPPORTING FAMIILIES & CAREGIVERS

Build innovative family models to expand capacity for families and caregivers through models like peer support or wrap around supports. This would create additional capacity in the system for children and youth with the most serious and significant mental health needs

Child and youth mental health agencies strive to understand and address the social determinants of health and other external factors impacting wellbeing, while also providing family-centred care, which supports the needs of the whole family. This approach also requires strong intersectoral collaborations to wholistically meet the needs of clients and families. As a result, increasing family supports in the context of child and youth mental health will help achieve the best mental health outcomes over the long term. As a core service provided in the service system, increased investment will aid in the delivery of evidence-based approaches and intervention supporting the family.

4) Crisis Support Services

*Scale 24/7 **crisis support services** to ensure children and youth experiencing a crisis have an alternative to going to the emergency department, thereby preserving hospital capacity when its needed most*

Mental health challenges present at varying levels of urgency. Yet we know that when youth are in crisis, they need support urgently. When crisis support services are insufficient in the community, children, youth, and families turn to the hospital emergency department.

Over the last 10 years, there has been a 71% increase in rate of child and youth mental health hospitalizations and 64% increase in rate of ED visits for children and youth. At same time the rate of hospitalization for every other condition fell by 26% (CIHI, 2020). Yet kids could be served more appropriately and cost-effectively served in community-based settings.

Investment in crisis services in the community is an important part of preserving hospital capacity and ensuring kids have access when needs are urgent.

5) **Coordinated Access and Service Coordination and Prevention**

Enable key processes and functions in the delivery of mental health treatments and services including, ***coordinated access, service coordination, prevention***

Support for key processes and functions enable the delivery of mental health treatment in community child and youth mental health. These services and processes are a critical part of the delivery of all core services. With heightened awareness about mental health needs increasing, access points to children's mental health services also increase as more youth and families reach out.

Increasing support and coordination at the “front door” is an important part of creating access and efficiency to services or pathways to care and treatment. At the same time, targeted prevention helps children and youth remain mentally healthy. By targeting prevention efforts, we can address things like specific risk factors, needs and focus on specific populations.

Proposal Summary:

In summary, there is increasing need build community-based capacity in child and youth mental heath in the province to preserve hospital capacity. This is especially needed in the context of the COVID-19 pandemic and additional anticipated challenges that will only serve to further constrain the limited resources available. Many hospitals and community-based providers are experiencing challenges in delivering timely mental health care, in addition to managing increasingly acute and complex needs.

Appendix A – Summary of Detailed Funding Request by Budget Year, Service Area and Service

Provincial Overview by Year and Service

Service	Detail Codes	Jan 1 - Mar 31/22	2022/23	2023/24	Totals
Intensive Treatment & Specialized Consultation	A353, A355	7,689,151	20,011,424	20,361,624	48,062,199
Psychotherapy & counselling	A348, A349	5,150,898	22,514,129	22,908,126	50,573,153
Family Support & Therapy	A351	877,351	3,940,253	4,009,207	8,826,811
Crisis Services	A350	349,885	1,395,590	1,420,013	3,165,487
Coordinated Access	A352	980,466	5,141,196	5,231,167	11,352,829
Service Coordination	A354	340,545	1,350,206	1,373,835	3,064,586
Prevention	A356	261,822	2,692,497	2,739,616	5,693,935
		15,650,118	**57,045,295**	**58,043,588**	**130,739,000**

Jan 1, 2022 to March 31, 2022											
Service Area	Region	A348 - Brief Services	A349 - Counselling & Therapy	A350 - Crisis	A351 - Family/Caregiver Capacity Building & Support	A352 - Coordinated Access & Intake	A353 - Intensive Treatment Services	A354 - Case Management & Service Coordination	A355 - Specialized Consultation & Assessment	A356 - Targeted Prevention	
Sudbury/Manitoulin	Northern Ontario	-	37,500	-	-	-	37,500	-	-	-	
Nipissing/Parry Sound/Muskoka	Northern Ontario	58,750	42,500	20,000	20,000	-	-	-	15,000	-	
Cochrane/Timiskaming	Northern Ontario	16,750	11,250	-	-	88,250	61,250	88,250	-	-	
*Algoma**	*Northern Ontario*	15,100	28,250	9,000	4,000	17,650	34,750	17,650	3,000	-	
Kenora	Northern Ontario	-	-	-	-	-	-	-	-	-	
Thunder Bay	Northern Ontario	-	50,000	25,000	-	-	75,000	-	-	-	
Lanark/Leeds/Grenville	Eastern Ontario	47,233	47,233	-	-	-	-	-	-	-	
Renfrew	Eastern Ontario	25,000	50,000	-	-	-	60,000	-	-	-	
Ottawa	Eastern Ontario	-	118,687	-	71,316	329,141	1,432,018	-	-	-	
Prescott & Russell	Eastern Ontario	10,000	106,250	-	15,000	-	17,500	-	-	-	
Frontenac/Lennox and Addington	Eastern Ontario	-	101,976	-	-	-	-	-	-	33,992	
Hastings/Prince Edward/Northumberland	Eastern Ontario	-	46,838	-	-	-	-	-	-	-	
Stormont/Dundas/Glengarry	Eastern Ontario	-	31,250	-	18,750	-	200,000	-	-	-	
Dufferin/Wellington	Central	28,370	78,420	25,494	25,494	79,588	109,816	131,040	30,044	-	
Haliburton/Kawartha Lakes/Peterborough	Central	41,607	296,775	20,804	-	-	-	-	-	-	
York	Central	-	146,675	-	24,175	-	62,500	21,643	-	18,750	
Peel	Central	-	388,898	-	127,200	13,113	3,204,655	-	-	25,625	
Durham	Central	-	66,750	-	-	-	-	-	-	-	
Halton	Central	49,885	205,500	45,750	31,350	51,250	89,000	5,500	125,162	18,205	
Simcoe	Central	82,573	109,500	-	-	29,790	-	-	-	-	
Waterloo	Central	-	286,975	71,098	90,275	-	491,756	875	61,785	39,000	
Huron Perth	Western Ontario	21,000	47,750	-	56,250	-	29,500	-	20,000	-	
Middlesex	Western Ontario	31,000	216,250	50,000	254,500	22,750	479,750	5,500	5,750	44,750	
Hamilton	Western Ontario	25,000	44,500	-	-	161,680	127,500	3,250	-	-	
Chatham/Kent	Western Ontario	6,250	50,000	18,750	-	-	25,000	6,250	-	-	
Haldimand/Norfolk	Western Ontario	-	50,000	23,750	31,250	-	-	-	-	-	
Essex	Western Ontario	89,279	371,930	25,827	78,341	50,714	171,664	-	-	-	
Elgin/Oxford	Western Ontario	29,425	101,225	-	10,000	77,291	21,838	46,838	19,895	22,500	
Brant	Western Ontario	-	61,975	14,413	19,450	19,250	52,825	13,750	-	12,000	
Lambton	Western Ontario	-	23,500	-	-	-	20,013	-	-	-	
Grey Bruce	Western Ontario	-	64,500	-	-	-	-	-	7,500	-	
Niagara	Western Ontario	43,602	43,602	-	-	-	21,801	-	-	-	
Toronto	Toronto	817,000	386,618	-	-	40,000	494,132	-	81,250	47,000	
		1,437,823	3,713,075	349,885	877,351	980,466	7,319,766	340,545	369,386	261,822	15,650,118

**extrapolated, outstanding data*

April 1 , 2022 - March 31, 2023											
Service Area	Region	A348 - Brief Services	A349 - Counselling & Therapy	A350 - Crisis	A351 - Family/Caregiver Capacity Building & Support	A352 - Coordinated Access & Intake	A353 - Intensive Treatment Services	A354 - Case Management & Service Coordination	A355 - Specialized Consultation & Assessment	A356 - Targeted Prevention	
Sudbury/Manitoulin	Northern Ontario		150,000				150,000				300,000
Nipissing/Parry Sound/Muskoka	Northern Ontario	235,000	170,000	80,000	80,000				60,000		625,000
Cochrane/Timiskaming	Northern Ontario	67,000	45,000	-	-	353,000	245,000	353,000	-	-	1,063,000
*Algoma**	*Northern Ontario*	60,400	113,000	36,000	16,000	70,600	139,000	70,600	12,000	-	517,600
Kenora	Northern Ontario	-	-	-	-	-	-	-	-	-	-
Thunder Bay	Northern Ontario		200,000	100,000			300,000	-	-	-	600,000
Renfrew	Eastern Ontario	100,000	200,000				230,000				530,000
Ottawa	Eastern Ontario		467,980		285,263	2,329,543	5,714,535				8,797,321
Lanark/Leeds/Grenville	Eastern Ontario	184,625	184,625								369,250
Prescott & Russell	Eastern Ontario	40,000	360,000	-	-	-	-	-	-	-	400,000
Frontenac/Lennox and Addington	Eastern Ontario		346,788							115,596	462,384
Hastings/Prince Edward/Northumberland	Eastern Ontario	-	187,353	-	-	-	-	-	-	-	187,353
Stormont/Dundas/Glengarry	Eastern Ontario		125,000		75,000		800,000				1,000,000
Dufferin/Wellington	Central	109,763	304,968	98,028	98,028	313,316	437,235	524,183	116,849	-	2,002,370
Haliburton/Kawartha Lakes/Peterborough	Central	166,427	1,187,099	83,214							1,436,740
York	Central		586,700		96,700		250,000	86,570		75,000	1,094,970
Peel	Central	-	3,039,186	-	997,599	104,900	2,253,661	-	-	201,000	6,596,346
Durham	Central		267,000								267,000
Halton	Central	199,540	822,000	183,000	125,400	205,000	356,000	22,000	500,649	72,820	2,486,409
Simcoe	Central	574,058	758,000			206,817					1,538,875
Waterloo	Central	-	1,147,900	284,391	361,101		1,967,023	3,500	247,138	156,000	4,167,053
Huron Perth	Western Ontario	86,000	195,000		225,000		122,000		80,000		708,000
Middlesex	Western Ontario	126,000	899,000	200,000	1,024,000	137,000	1,911,000	23,000	23,000	174,000	4,517,000
Hamilton	Western Ontario	100,000	165,000			672,000	521,000				1,458,000
Chatham/Kent	Western Ontario	25,000	200,000	75,000	-	-	100,000	25,000	-	-	425,000
Haldimand/Norfolk	Western Ontario		200,000	95,000	125,000						420,000
Essex	Western Ontario	357,114	1,487,719	103,307	313,362	202,855	686,654	-	-	-	3,151,011
Elgin/Oxford	Western Ontario	117,699	404,898		40,000	309,165	87,353	187,353	79,581	90,000	1,316,049
Brant	Western Ontario	-	247,900	57,650	77,800	77,000	211,300	55,000	-	48,000	774,650
Lambton	Western Ontario		94,000				80,051				174,051
Grey Bruce	Western Ontario		258,000						30,000		288,000
Niagara	Western Ontario	264,228	172,681	.	.	.	88,076	-	-	-	524,985
Toronto	Toronto	3,268,000	1,446,478	-	-	160,000	1,887,319	-	325,000	1,760,081	8,846,878
		6,080,854	16,433,275	1,395,590	3,940,253	5,141,196	18,537,207	1,350,206	1,474,217	2,692,497	57,045,295

**extrapolated, outstanding data*

April 1 , 2023 - March 31, 2024											
Service Area	Region	A348 - Brief Services	A349 - Counselling & Therapy	A350 - Crisis	A351 - Family/Caregiver Capacity Building & Support	A352 - Coordinated Access & Intake	A353 - Intensive Treatment Services	A354 - Case Management & Service Coordination	A355 - Specialized Consultation & Assessment	A356 - Targeted Prevention	
Sudbury/Manitoulin	Northern Ontario	-	152,625	-	-	-	152,625	-	-	-	
Nipissing/Parry Sound/Muskoka	Northern Ontario	239,113	172,975	81,400	81,400	-	-	-	61,050	-	
Cochrane/Timiskaming	Northern Ontario	68,173	45,788	-	-	359,178	249,288	359,178	-	-	
*Algoma**	*Northern Ontario*	61,457	114,978	36,630	16,280	71,836	141,433	71,836	12,210	-	
Kenora	Northern Ontario	-	-	-	-	-	-	-	-	-	
Thunder Bay	Northern Ontario	-	203,500	101,750	-	-	305,250	-	-	-	
Renfrew	Eastern Ontario	101,750	203,500	-	-	-	234,025	-	-	-	
Ottawa	Eastern Ontario	-	476,170	-	290,255	2,370,310	5,814,539	-	-	-	
Lanark/Leeds/Grenville	Eastern Ontario	187,856	187,856	-	-	-	-	-	-	-	
Prescott & Russell	Eastern Ontario	40,700	366,300	-	-	-	-	-	-	-	
Frontenac/Lennox and Addington	Eastern Ontario	-	352,857	-	-	-	-	-	-	117,619	
Hastings/Prince Edward/Northumberland	Eastern Ontario	-	190,632	-	-	-	-	-	-	-	
Stormont/Dundas/Glengarry	Eastern Ontario	-	127,188	-	76,313	-	814,000	-	-	-	
Dufferin/Wellington	Central	111,684	310,305	99,743	99,743	318,799	444,887	533,356	118,894	-	
Haliburton/Kawartha Lakes/Peterborough	Central	169,339	1,207,873	84,670	-	-	-	-	-	-	
York	Central	-	596,967	-	98,392	-	254,375	88,085	-	76,313	
Peel	Central	-	3,092,372	-	1,015,057	106,736	2,293,100	-	-	204,518	6,711,782
Durham	Central	-	271,673	-	-	-	-	-	-	-	
Halton	Central	203,032	836,385	186,203	127,595	208,588	362,230	22,385	509,410	74,094	
Simcoe	Central	584,104	771,265	-	-	210,436	-	-	-	-	
Waterloo	*Central*	-	1,167,988	289,368	367,420	-	2,001,446	3,561	251,463	158,730	
Huron Perth	Western Ontario	87,505	198,413	-	228,938	-	124,135	-	81,400	-	
Middlesex	Western Ontario	128,205	914,733	203,500	1,041,920	139,398	1,944,443	23,403	23,403	177,045	
Hamilton	Western Ontario	101,750	167,888	-	-	683,760	530,118	-	-	-	
Chatham/Kent	Western Ontario	25,438	203,500	76,313	-	-	101,750	25,438	-	-	
Haldimand/Norfolk	Western Ontario	-	203,500	96,663	127,188	-	-	-	-	-	
Essex	Western Ontario	363,363	1,513,754	105,115	318,846	206,405	698,670	-	-	-	
Elgin/Oxford	Western Ontario	119,759	411,984	-	40,700	314,575	88,882	190,632	80,974	91,575	
Brant	Western Ontario	-	252,238	58,659	79,162	78,348	214,998	55,963	-	48,840	
Lambton	Western Ontario	-	95,645	-	-	-	81,452	-	-	-	
Grey Bruce	Western Ontario	-	262,515	-	-	-	-	-	*30,525*	-	
*Niagara**	*Western Ontario*	268,852	175,703	-	-	-	89,617	-	-	-	
Toronto	Toronto	3,325,190	1,471,791	-	-	162,800	1,920,347	-	330,688	1,790,882	
		6,187,269	16,720,857	1,420,013	4,009,207	5,231,167	18,861,608	1,373,835	1,500,016	2,739,616	58,043,588
*extrapolated, outstanding data											

MAKE
KIDS
COUNT

Implementation Details

Provide immediate support for specialized tertiary **child and youth eating disorders** programs*

Part of an action plan from the Children's Health Coalition to ensure hospital capacity and provide timely access to care both in the immediate pandemic response and through recovery

For more information, please contact:
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* This proposal for emergency in year funding was originally submitted July 2021

Executive Summary

For many years, the Ontario health care system has experienced year-over-year increases in volumes across paediatric mental health and eating disorder programs. On top of already under-resourced services, the COVID-19 pandemic has added a surge of unparalleled scale, with the crisis most pronounced in the alarming rise in need for eating disorder services.

With child, youth, and family needs already outstripping current service capacity, immediate emergency investment in eating disorder services is needed. Adding to the urgency for funding support, is the looming respiratory syncytial virus (RSV)/Influenza season, which is anticipated to be earlier and more severe as public health measures relax, regular activities resume, and children and youth head back to school in September (as is being experienced in the Southern Hemisphere). Furthermore, eating disorder cases have had a historical seasonal pattern with an increase in presentations in August just before the academic year, coinciding with the expected RSV/Influenza surge.

If nothing is done to meet the scale of rising need for eating disorder services, the pressure of historical capacity shortfalls, unprecedented demand for services exacerbated by COVID-19, increase in acuity and risk, and now the likelihood of an earlier and extended RSV/Influenza season (with volumes already on the rise), will all converge to overwhelm the paediatric acute care sector and leave scores of children and youth in crisis. Unsustainable demands on limited resources are already compromising the ability to deliver evidence-based care. Eating disorders are acknowledged as being the psychiatric illness with the highest mortality rate and have multiple chronic consequences if not optimally treated. The system, already under-resourced and then further stretched beyond capacity due to COVID-19, simply cannot absorb another surge.

Ontario's children's hospitals represent a majority of the province's paediatric eating disorder inpatient capacity. Adult general hospitals and the province's specialized psychiatric hospitals are often unable to admit medically unstable paediatric patients with eating disorders (whom children's hospitals regularly admit through their Emergency Departments) and there is variation across the province in capacity to partner and/or leverage other programs. In fact, in Eastern Ontario for example, CHEO has the only paediatric inpatient eating disorder program in the region. If the children's hospitals are overwhelmed by another surge, the sickest and most vulnerable of patients may need to be sent to out-of-province and/or out-of-country providers, which will be far more costly and disruptive for patients and families, compromising the recovery process and outcomes.

In this request from the Children's Health Coalition, a collective of Ontario's leading children's health care providers, we have identified a need for an urgent one-time investment of **$8 million** to shore up existing specialized tertiary child and youth eating disorder programs during the predicted RSV/Influenza surge (September 2021 to March 2022), and avert a catastrophic crisis. Due to regional variations in both pressures and eating disorder programs across the province, as well as local initiatives underway, the requests for funding vary across the hospitals and reflect the needs of their local communities.

	CHEO	SickKids	Children's Hospital London Health Sciences Centre	McMaster Children's Hospital Hamilton Health Sciences
Funding Request (Sep. 2021 - Mar. 2022)	**$4,419,330**	**$1,919,618**	**$447,604**	**$1,282,833**
Total one-time funding of $8,069,385				

It is important to note that while this funding will help avert the worst of the potential crisis scenarios for children's hospitals over the short-term (September 2021 to March 2022), it is not meant to meet the system-wide capacity issues across paediatric mental health and eating disorder services that need to be addressed over the mid- to long-term. There are other ongoing efforts by partners across the continuum of care at the provincial and regional levels (and Ontario Health) to address gaps in community-based intensive eating disorder treatment models and hospital-based programs for children and youth struggling with eating disorders who require intensive, specialized and ongoing mental health treatment.

Background

Unprecedented Demand for Eating Disorder Services

Since being declared a global pandemic in March 2020, COVID-19 has led to various restrictions, including lockdowns, school closures, and physical distancing, resulting in particularly negative effects on the health and mental health of children and youth. Children and youth with eating disorders have been severely impacted, with early research suggesting that almost half of adolescents with pre-existing eating disorders reporting a reactivation of symptoms during the pandemic.

- Since March 2020, CHEO's eating disorder program has seen a 63% rise in inpatient admissions compared to the same period last year (2019: 41 admissions; 2020: 67 admissions). Although mandated to serve as provincial beds, the unit rarely had the capacity to offer support beyond children and youth in the immediate Ottawa area.
- For the period of October 1, 2020 to March 31, 2021, McMaster Children's Hospital's (MCH) eating disorder program saw an increase of 90% in referrals compared to the same period in 2019/20, and demand for hospital admissions via the Emergency Department are 49% higher compared to the same period.
- SickKids' mental health unit had 147 eating disorder admissions in 2019/20 and 229 in 2020/21, representing a 56% increase.
- Since June 2020, the eating disorder program at the Children's Hospital, London Health Sciences Centre (LHSC) has had an unprecedented surge in referrals and admissions. There is a 7- to 9-month waitlist for assessment, and for the first time in the history of the hospital, there is now a waitlist for treatment.

These sharp increases in demand for eating disorder services and admissions speak to the medically compromised state that many of these young people are in. The trend of rising need is also reflected in the demand for outpatient services which have seen similar increases.

All of this is happening in a health care system that was already struggling, and with the COVID-19 pandemic and hospitals regularly operating at or over capacity, there is little to no further ability to accommodate additional demand as anticipated with the RSV/Influenza surge.

Children, Youth and Families in Crisis

Hospitals are at capacity, wait times for services have increased, and patients and families are in crisis and are desperate for care. Timely access to services and earlier intervention is the solution to reduce

inpatient volumes and acuity; however, waitlists are increasing, exacerbating patient severity, and increasing the demand for resource intensive and costly inpatient services.

- At MCH, wait times for non-urgent eating disorder patients have increased from four to six months in March 2020, to over 12 months as of March 31, 2021. Volumes of referrals and corresponding outpatient therapists' caseloads have increased significantly (average 35-40 patients per therapist). This has created decreased availability of regularly scheduled evidence-based treatment appointments, increasing likelihood of inpatient admission.
- Currently at SickKids the average wait time to assessment and treatment for outpatients is eight months; on average SickKids received 14 outpatient referrals per month in 2019/20 and 21 per month in 2020/21, representing a 50% year-over-year increase.
- In the seven months following March 2020, CHEO's eating disorder program experienced a 28% increase in those requiring assessment in the Emergency Department, and a 56% increase in outpatient referrals deemed urgent. The program has had to close to all but the most urgent referrals, turning away 73% of community referrals (up 49% from the previous year).

Evidence-based care requires early intervention. The inability to address waitlists in a timely manner can result in crisis mode interventions upon first meeting, jeopardizing the therapeutic relationship and trust needed between the patient, family and healthcare team. Unsustainable demands on limited resources are compromising the ability to deliver evidence-based care and positive outcomes.

One family visited CHEO's ED eight times over the course of 1.5 years looking for support, and when finally admitted, it was to an off-service unit where they didn't receive all of the evidence-based services they required.

When patients are admitted, in many cases capacity pressures are so high that they are discharged as soon as they're stabilized in order to free-up beds for others, leading to a rise in readmissions. Eating disorder patients are also increasingly placed in generalized paediatric units (e.g., cardiac units, surgical units) that are not set up to care for eating disorder patients, compromising the ability to provide evidence-based care. All of this has led to a rise in patient and family complaints as they desperately advocate for access to evidence-based care.

One family, after struggling through 3 emergency inpatient admissions which involved anxious waits for beds to open up, and early discharges due to capacity pressures leading to repeated readmissions, is now struggling to find outpatient care.

Our journey with the hospital system began in December 2020. By March 2021 our daughter admitted that she no longer wanted to live and in April 2021 she attempted to end her life. Now we are in July 2021 and we are desperately trying to get our daughter into the Day Program at McMaster as her condition continues to deteriorate. We are told it most likely will not be till the end of September until our daughter gains admission into the program. ***10 months of suffering, 10 months of our family being turned upside down, 10 months of frustration, 10 months of begging programs to take us. Something has to give here, who's looking after our children? Programs are breaking at the seams! Our children are suffering. How many children suffering with this disorder have been left untreated because there is no room for them in the programs?***

Janet, Mom of 13-year-old

Warnings of an earlier and extended RSV/Influenza Season leading to a double surge on top of the already stretched system

The annual RSV/Influenza season typically corresponds with a surge of patients that tests the limits of an already stretched health care system. While questions remain about the severity of this year's RSV/Influenza season, many expect that with the relaxing of public health measures (which have limited exposure of children to typical childhood viruses), resumption of regular activities and the return of in-person school in September, we may experience an earlier and extended RSV/Influenza season. The experience in Australia suggests that an earlier RSV/Influenza season given the opening of schools will be a major vector of transmission for some children. In Australia, cases remained low until late Spring when a large surge was observed in New South Wales and Western Australia. The speed and magnitude of this increase was greater than the usual winter peak of RSV and this situation is now being experienced in several states across Australia.

The relaxation of COVID restrictions, which is occurring now in Ontario, leads us to believe that we will experience the same increase in RSV, with multiple paediatric Emergency Departments as of mid-July already reporting an increase in volumes (typically experienced from November to March). Reduced immunity to Influenza due to the skipped 2020 season may also result in a very severe season.

While estimates vary, hospitals are anticipating a 10-20% increase in inpatient cases above the typical 20% seasonal volume increase (which typically happen from November to March but are predicted to happen even earlier around September). This represents a potential increase of up to 40% of usual patient volumes. In addition, eating disorder cases have had a historical seasonal pattern with an increase in presentations in August just before the academic year, coinciding with the expected RSV/Influenza surge.

Adding to all of this is the ongoing COVID-19 pandemic, which will continue to loom over the health care system for the foreseeable future. Looking at the experience during Wave 3, many children's hospitals saw increased non-eating disorder activity as they admitted many more community paediatric patients and/or admitted adult critical care patients to provide relief to the adult hospitals, placing significant pressure on capacity. Shortages in community nursing care due to COVID-19 also resulted in patients staying in hospital longer and further reducing capacity. This may occur again if the RSV/Influenza season, another eating disorders surge, and a further pandemic wave were to coincide.

Currently, hospital bed occupancy levels are regularly at or over capacity, and paediatric hospitals have already had to divert patients to non-specialized general paediatric units to try and meet the demand for eating disorder services. This significantly impacts the capacity of those units to care for other acute patients and is not optimal care for eating disorder patients who require specialized care and staff. *Hospitals do not have the ability to meet a further surge of patients with eating disorders and RSV/Influenza patients.*

Rationale for Funding

The convergence of pressures from historical capacity shortfalls, unprecedented demand for services, increase in acuity and risk, and the likelihood of an early and prolonged RSV/Influenza season further impacting hospital capacity, all point to a potential catastrophic scenario for paediatric hospitals if no additional support is made available.

Potential double surge: The potential of an earlier and extended RSV/Influenza season, converging with the unprecedented surge in demand for eating disorder services and an ongoing pandemic, would lead to an overwhelmed paediatric acute care sector and leave scores of children/youth in crisis. Historically, medically acute patients are prioritized over patients with mental health conditions (even though eating disorders are life threatening and have multiple chronic consequences if not optimally treated - brittle bones, growth failure, kidney dysfunction, liver dysfunction, nutritional deficiencies). A surge in RSV/Influenza patients will negatively impact patients with eating disorders who will have even less access to much needed medical stabilization.

- Hospitals are anticipating a 10-20% increase in inpatient cases above the typical 20% seasonal volume increase earlier in the season (typically in November, with cases already on the rise), representing an unsustainable potential increase of up to 40% over usual patient volumes.

Pressures on non-specialized general paediatric units: The need to place eating disorder patients in other units such as General Paediatrics, Cardiology or Neurology/Trauma, has significantly impacted the capacity of those units to care for other acute patients. In addition, non-specialized general paediatric units are not set up to care for eating disorder patients.

> *"There are lots of things on this unit that I could kill myself with. I don't feel safe on this unit, there are too many things that make me unsafe, I could really hurt myself here."*
>
> *Eating Disorder Patient*

Caring for severely ill youth with complex medical eating disorders requires a multidisciplinary team with specialized eating disorder training in order to ensure appropriate nutritional rehabilitation and symptom containment. This requires reduced staff ratios to maintain a safe environment, provide intensive meal support, interrupt urges for symptoms and provide parent coaching. Staff on medical units do not typically have this type of training and medical staffing models do not support the necessary ratios to implement successfully. The health care teams are simply not able to deliver the highest quality, safest evidence-based care on the non-eating disorder units.

- At MCH, "off-serviced patients" to a general paediatric unit in 2019/20 was 35; for 2020/21 this number was 68, representing an increase of 97%.

- At SickKids in 2019/20, 19 patients were admitted to “off-service beds”; this number increased to 65 in 2020/21, representing a dramatic increase of 342%.

> *As the eating disorder team scrambled to rotate and extend staff in a bid to support off-service patients on up to 5 different medical units, one family shared their frustration. They had to see four different team physicians in one week. The only Child and Youth Counsellor available could only check in with the family twice per week. Environmental layout, nursing station/patient room line of sight and higher nursing to patient ratios on the medical floor meant that parents did not feel they could leave their child’s bedside – there was no assurance that the food would be eaten/replaced and that symptoms would be contained. When the family finally made it to the Eating Disorders unit and their child’s treatment progressed, they refused to go back down to the medical floor prior to discharge to make room for more acute patients. They did not feel the standard of care on the medical floor was acceptable.*

Increased acuity and risk: Eating disorders are acknowledged as being the psychiatric illness with the highest mortality rate and have multiple chronic consequences if not optimally treated - brittle bones, growth failure, kidney dysfunction, liver dysfunction, and nutritional deficiencies. Patients and families are presenting with increasingly complex medical and mental health concerns. These children, youth, and families have diverse and highly variable needs, inclusive of complex child welfare cases, legal disputes, significant language and cultural needs, social complexity, and mental health.

As a proxy measure for resource intensity and patient complexity, the table on the right presents a comparison of HBAM Inpatient Group (HIG) weights and underscores the severity and complexity of eating disorder patients.

Patient Population	HIG Weight
Eating Disorder Inpatients	**4.3***
Psychiatric Inpatients	**1.4***
Paediatric Medicine Inpatients	**1.7***
Ontario Adult COPD Patient	**0.9**
Ontario Adult Pneumonia Patient	**1.4**

**Average from SickKids and the Children’s Hospital, London Health Sciences Centre*

- The Children’s Hospital at LHSC has seen a significant increase in the complexity of eating disorder patients, the most critical one falling into self-injurious behaviour. There has been a greater than 3 standard deviations above the mean in self-harm events within the CAMH acute inpatient floor from January 2020 to June 2021.
- At CHEO, on average those who presented during the pandemic were significantly more medically unstable (65%) than those who presented the year before (35%), and they are attaining this medically compromised state in shorter periods of time (less than 6 months in 2020 versus 12 months in 2019).
- In order to maximize patient flow and free up beds for the large number of eating disorder patients requiring acute care, patients at CHEO are currently being discharged at lower weights

and degrees of medical fragility, and are being offered fewer opportunities to practice eating outside of hospital prior to discharge through the use of passes in order to actively attempt to shorten lengths of stay (while risking likelihood of readmission).
- MCH has seen an increase in the complexity and level of medical compromise upon initial presentation, along with increased levels of self-harm and suicidal ideation during the pandemic. The implication of these presentations impacts the program's ability to deliver the level of evidence-based programming required.

Lack of beds and hospital capacity: Hospitals are regularly operating at or over capacity, with no ability to accommodate surges in demand. Eating disorder programs have been operating well over capacity and patients have increasingly been placed in non-specialized general paediatric units, putting further pressure on other areas.

- At CHEO, from February to June 2021, the occupancy rate of the eating disorder unit rose from 122% to 211%.
- In 2020/21, SickKids' 12-bed mental health/eating disorders unit has regularly run at a census of 14 to 17 patients representing an occupancy that is between 20% and 40% over capacity. Between October and December 2020, SickKids opened a second 6-bed unit to accommodate the high number of patients presenting for acute admission.
- The inpatient eating disorder unit at the Children's Hospital at LHSC was 50% over capacity for the first half of this year, requiring 55% more surge capacity compared to previous years.

Lengths of stay and pressure to admit: Eating disorder admissions typically have associated long lengths of stay. The surge in patients with eating disorders has resulted in a high demand for admissions, leading to some patients being discharged earlier, resulting in readmissions. The reduced length of stay is driven by unsustainable demands on limited resources rather than the required standard plan of care and positive outcomes. Patients are being discharged as soon as they are stable in order to free up beds for the sickest of the sick. This is not safe and has led to a revolving door of repeat admissions, further impacting limited bed resources.

- At MCH, since 2018/19, the average length of hospital stay has declined from 17.8 days to 11.7 days in 2020/21. This is not in the interest of the individual patient and is the result of capacity pressures necessitating an earlier-than-appropriate discharge.

Need for more capacity for care close to home: Eating disorder patients, similar to all paediatric patients with either mental or physical health diagnoses, are best served closest to home. This supports the recovery process, the family, transition to school and better outcomes. The investment in resources now will position the system to better respond to acute service demands. If the children's hospitals are overwhelmed by another surge, patients may need to be sent to out-of-province and/or out-of-country providers, which will be far more costly and disruptive for patients and families, compromising the recovery process and outcomes.

- Ontario's children's hospitals represent a majority of the province's paediatric eating disorder inpatient capacity as they are its most specialized and tertiary-level resource. Adult general hospitals and the province's specialized psychiatric hospitals are often unable to admit the medically unstable paediatric patients with eating disorders that children's hospitals regularly admit through their Emergency Departments. There is variation across the province in capacity

to partner and/or leverage other programs. In Eastern Ontario for example, CHEO has the only paediatric inpatient eating disorder program in the region.

Funding Request

In this request, the Children's Health Coalition has identified a need for an urgent one-time investment of **$8 million** to shore up existing specialized tertiary child and youth eating disorder programs from September 2021 to March 2022. Investment is necessary to ensure that a system chronically underfunded and squeezed prior to the COVID-19 pandemic, does not fail children, youth, and families in their time of greatest need.

It is important to note that while this funding will help avert the worst of the potential crisis scenarios for children's hospitals over the short-term from September 2021 to March 2022, it is not meant to meet the system-wide capacity issues across paediatric mental health and eating disorder services that need to be addressed over the mid- to long-term. There are other ongoing efforts by partners across the continuum of care (and Ontario Health) to address gaps in community-based intensive eating disorder treatment models and hospital-based programs for children and youth struggling with eating disorders who require intensive, specialized (and ongoing) mental health treatment.

This funding will enable Ontario's children's hospitals to have more capacity in the short term to support eating disorder patients who desperately need care and better position them to respond to a potential RSV/Influenza surge. Due to regional variations in both pressures and eating disorder programs across the province, and local initiatives underway, the requests for funding vary across the hospitals and reflect the needs of their local communities.

	CHEO	SickKids	Children's Hospital London Health Sciences Centre	McMaster Children's Hospital Hamilton Health Sciences
# of beds	7	5	0	2
HHR (salary and benefits)	$3,805,648	$1,484,826	$399,660	$846,696
Supplies and equipment	$139,420	$8,687	$11,029	$20,000
Overhead and miscellaneous costs	$36,000	$42,181	$16,915	$141,137
Other costs	$438,262	$383,924	$20,000	$275,000
Total per site	**$4,419,330**	**$1,919,618**	**$447,604**	**$1,282,833**
Total one-time funding requested (Sept. 2020 - Mar. 2021)	**$8,069,385**			

More details on each hospital's funding request is included in the Appendix

Appendix – Funding Request Details

CHEO				
# of beds	7	7 temporary surge beds (expanding capacity from 6 to 13 beds), plus additional Partial Hospitalization Program		
HHR (total salary and benefits)	$3,805,648	**For Inpatient Beds**	**Total Cost**	**FTE**
		RN - Registered Nurse	$894,320	12.6
		Child and Youth Counsellor	$370,251	3.7
		Patient Service Clerk	$70,071	1.0
		Social Worker	$100,689	0.8
		Staff Psychologist	$134,934	0.8
		Clinical Nurse Practitioner	$141,625	1.0
		Dietitian	$92,006	0.8
		For Partial Hospitalization Program	**Total Cost**	**FTE**
		Project Director	$90,000	1.0
		Case Coordinator	$106,592	1.0
		Administrative Assistant	$72,861	1.0
		Dietitian	$115,008	1.0
		Clinical Nurse Practitioner	$141,625	0.8
		Social Worker	$100,689	0.8
		Staff Psychologist	$134,934	0.8
		Psychometrist MA	$105,349	0.4
		Occupational Therapist	$47,917	3.2
		Child and Youth Counsellor	$320,217	6.3
		Registered Nurse	$766,560	
Supplies and equipment	$139,420	Medical equipment and drugs to support additional inpatients		
Overhead/admin costs	$36,000	Includes non-medical supplies and patient food		
Other costs	$438,262	Additional equipment including furniture and medical technology to build out additional inpatient beds		
Total Costs	**$4,419,330**			

SickKids				
# of beds	5	5 temporary surge beds (expanding capacity from 12 to 17 beds)		
HHR costs (total salary and benefits)	$1,484,826	**For Inpatient Beds** Registered Nurse Child and Youth Counsellor Patient Information Clerk Purchased Services (Security, CYCs) Paediatrician Nurse Practitioner Psychologist Dietitian	**Total Cost** $793,552 $303,924 $37,485 $51,273 $144,550 $78,949 $45,006 $30,087	**FTE** 13.1 6.6 1.1 1.1 1.0 1.0 0.5 0.5
Supplies and equipment	$8,687	Med surg, drugs and other supplies		
Overhead/admin costs	$42,181	Patient food, office supplies, housekeeping supplies, etc.		
Other costs	$383,924	Indirect overhead @25% of direct costs		
Total Costs	**$1,919,618**			

Children's Hospital, London Health Sciences Centre			
# of beds	0	Funding for resources to support ambulatory and inpatient volumes	
HHR costs (total salary and benefits)	$399,660	**Resources to span across ambulatory and inpatient** Nurse Practitioner Nurse Case Manager Child and Youth Counsellor Dietitian	**FTE** 1.0 1.0 1.0 0.5
Supplies and equipment	$11,029		
Overhead/admin costs	$16,915	**Admin resource** Clerk	**FTE** 0.3
Other costs	$20,000	• Training in CBT/DBT individual and family therapy for new staff • Education to be provided to Community agencies and Primary Care physicians to allow transition of patients throughout the continuum of care	
Total Costs	**$447,604**		

MCH			
# of beds	2	Requires funding to renovate space	
HHR costs (total salary and benefits)	$846,696	**Resources** Child Life Specialist Registered Nurse Registered Dietitian MSW Business Clerk Child and Youth Counsellor Psychologist	**FTE** 1.4 4.37 1.0 2.0 1.0 3.14 1.6
Supplies and equipment	$20,000		
Overhead/admin costs	$141,137		
Other costs	$275,000	Approximate one-time cost to renovate a space to accommodate day hospital capacity increase, and which will be clinically appropriate in a location outside of inpatient unit	
Total Costs	**$1,282,833**		