



NEW YORK STATE ASSOCIATION OF COUNTY HEALTH OFFICIALS

Leading the Way to Healthier Communities

TESTIMONY OF SARAH RAVENHALL, EXECUTIVE DIRECTOR OF THE NEW YORK STATE ASSOCIATION OF
COUNTY HEALTH OFFICIALS, BEFORE THE ASSEMBLY STANDING COMMITTEES ON HEALTH, MENTAL
HEALTH, PEOPLE WITH DISABILITIES, HIGHER EDUCATION AND LABOR ON EXAMINING THE STATUS OF
THE HEALTH CARE WORKFORCE IN NEW YORK STATE

December 19, 2023

Assembly Health Committee Chair Paulin, Assembly Mental Health Chair Gunther, Assembly Committee on People with Disabilities Chair Seawright, Assembly Higher Education Committee Chair Fahy, Assembly Labor Committee Chair Joyner and members of the respective committees, I thank you for this opportunity to present testimony to you today as you look at the status of the health care workforce in New York State. My name is Sarah Ravenhall, and I am the Executive Director for the New York State Association of County Health Officials (NYSACHO).

Introduction

NYSACHO's mission is to support, advocate for, and empower local health departments in their work to promote health and wellness and prevent disease, disability, and injury throughout New York State. On behalf of the 58 local health departments in New York State, I am honored to provide information, data, and solutions to building our governmental public health workforce and infrastructure so that we can stand confident in our ability to respond to future public health emergencies across the state.

The public health workforce in New York State remains in crisis with shattered morale post pandemic. Early retirements, professionals leaving local government to work in other sectors, increased vacancy rates, shrinking budgets and other pressures continue to challenge our members. Recruiting and retaining staff, particularly public health nurses, administrative staff, and environmental sanitarians (sanitarians identify and examine hazards in food service establishments, vector control, lead poisoning

and other environmentally related areas), has presented an incredible challenge and threatens the state's local emergency response capabilities led by LHDs.

In the health field, the public health workforce faces the same critical shortages and competition occurring in the broader healthcare landscape due to both availability of qualified workers for clinical positions and in our ability to offer competitive salaries to those seeking employment.

In the local governmental public health sector, we are also challenged by structural hiring and retention barriers posed by restrictions on federal, state and local funding, civil service and other statutory and regulatory requirements that are unique to government employment.

The 2023-24 state fiscal year investment included an increase to Article 6 state aid funding, resulting in a significant step forward towards reversing decades of disinvestment in the infrastructural funding supporting local health departments' provision of the core public health services. Article 6 funding is needed to provide a base level of protection to the communities' local health departments serve.

Ongoing state reinvestment in the funding for local health departments will help retain and sustain a responsive, skilled public health workforce necessary to take prompt action in public health emergencies. However, work remains to rebuild the public health foundations that support our communities and funding local health departments cannot be a one-shot deal. It must also be coupled with strategic and targeted legislative and regulatory changes that will also help to relieve the burden faced by LHDs.

Local Health Department's Essential Role in Protecting Communities

Local health departments are the only health entities that are statutorily required by law to provide core public health services in communities across New York State. Under state public health law, local health departments must provide the following services to be eligible for state aid reimbursement: 1. family health (reduce perinatal/infant maternal mortality and morbidity); 2. Communicable disease control (mitigate infectious diseases through surveillance and epidemiology); 3. Chronic disease prevention (promoting provider activities and prevention activities); 4. Conduct a community health assessment; 5. Environmental health (drinking water, food service establishment, investigating nuisances, prevent exposure to radiation, lead); and 6. Public health emergency preparedness and response.

In 2023, the vital need for local health departments to protect their communities through core public health services remained front and center, particularly in the area of communicable disease control. In 2022, local health departments responded to three concurrent public health emergencies: the ongoing

COVID-19 pandemic and the evolving nature of the virus, an outbreak of Mpox, with an atypical route of transmission through intimate partner contact, and the identification of a case of paralytic polio and its subsequent detection in wastewater indicating its spread in unvaccinated populations in downstate counties. In 2023, with the emergency declarations over, local health departments continued to focus on raising immunization rates by ensuring students returning to school post-covid had access to state required vaccinations, and many counties saw an influx of asylum seekers, who they supported by providing vaccines, screenings, and linkages to care for health and social services.

Chronic disease prevention remains a key health priority in many communities, particularly around tobacco control and cessation. Last year, the Governor's budget included strong public health proposals aimed at addressing the marketing tactics that continue to make flavored products that target kids, communities of color and others, and importantly for civil enforcement, significantly strengthened the existing statute to remove loopholes that retailers continue to use to keep flavored products on the market. The public health statutes related to banning flavored products are focused on civil enforcement and are aimed at the sellers who continue to offer banned products for sale, never at the individuals purchasing the banned products. Providing local health departments with stronger statutory language will assure that the law can achieve the public health goals intended by its passage. Unfortunately, these proposals were not adopted in the final state budget, leaving a continued challenge for our members tackling this threat to public health.

Counties also continue to address the overdose epidemic and mental health challenges, including suicide prevention. LHDs continue to support people who use drugs and combat overdoses and deaths in their communities, particularly the continued rise in synthetic opioids, such as fentanyl and the emergence of additives such as xylazine which can have additional adverse health effects and confound opioid overdose response efforts.

Policy Priorities for NYSACHO and Local Health Departments

In recognition of these challenges, NYSACHO's 2024 legislative platform generally supports policy changes around workforce and funding that:

- Ensure any new or expanded state-imposed statutory requirements are fully funded.
- Invest in the local public health workforce and infrastructure, including competitive compensation for professional or licensed required positions.
- Ensure that policies addressing healthcare workforce shortages include public health.

- Provide equitable resources for all local health departments.
- Streamline administrative requirements to reduce barriers to providing public health services.
- Provide flexible funding to allow deployment of resources to meet local public health needs and threats.
- Address statutory and regulatory barriers to hiring and retaining a qualified workforce including modernization of civil service requirements; and
- Assure good stewardship of all taxpayer funds supporting the provision of public health services.
- Loan Forgiveness

NYSACHO additionally recognizes external workforce needs that are impacting the provision of services in programs administered by many local health departments. Ongoing provider shortages in the Early Intervention and Preschool Services of Children with Special Health Care Needs (PreK 4410 program) pose a significant barrier to meeting the needs of children and families eligible for these programs. Waiting lists and shortages span all provider types, with the highest area of need being speech language pathologist services. Provider shortages and competition in the health care professions serving these programs has resulted in longer waiting lists for families and children needing services, reduced frequency and scope of services and increased reliance on telehealth, despite most families stated preference for in-person services.

Legislative Solutions to the Public Health Worker Shortage in NYS

We recognize the desired focus of this hearing is to discuss non-fiscal solutions to the workforce shortage given the upcoming projected fiscal deficits in the next state budget year. However, we cannot ignore the need to invest resources into our public health system as we move forward.

Fiscally Neutral Recommendations:

1. Provide regulatory relief to local health departments by:
 - a. Urge the Governor to sign **A7365/S6641-A (Paulin/Rivera)**, which will alleviate local health departments (non-CHHA) providing limited core public health services in the home from inappropriate article 36 licensure.
 - b. Urge the Governor to sign **A.2400/S.6219 (PAULIN/RIVERA)**, which will alleviate local health departments providing limited clinical services from inappropriate article 28 regulations.

2. Introduce, support, and pass new policies that will provide workforce efficiencies for local health departments:
 - a. Pass A8232 (Paulin) which will expand eligibility for participants of local board of health, county boards of health and health service advisory boards to allow them to reside in contiguous counties so long as they provide services in the county of that board.
 - b. Introduce legislation to expand the length of time local health departments are required to submit a full county health assessment report, while allowing them more time for data collection and implementation.
 - c. Introduce and pass legislation to allow speech language pathologist assistants (SLP-As) to practice via license, registration, or certification in the EIP when working under a plan of supervision under the oversight of a licensed SLP to help expand speech service availability for children with developmental delays and disabilities in New York State
3. Protect local health departments and the work they do to protect children from exposure to lead poisoning in New York State by passing legislation to make them immune from liability when acting in good faith to provide services to the public. Chronic underfunding in lead poisoning prevention places LHDs at additional legal risk in meeting needs in this service area when new or expanded policies are passed. Pass legislation to close enforcement loopholes in state public health law that will prevent retailers from continuing to sell illicit flavored tobacco products, including those marketed to children, to help protect our communities and prevent youth from becoming addicted to these dangerous products.
4. Promote cost-savings, efficiency, and collaborations between governmental entities providing and funding transportation and other services to children to assure local governments' ability to stay within the state-imposed property tax cap.
5. Reduce the number of restrictions and requirements local health departments must adhere to when contracting with the state to provide public health services.
6. Realistically assess the fiscal impact of future policies passed at the state level and do not pass policies without the funding needed to implement locally.
7. Introduce legislative amendments to civil service system that will:
 - a. Modernize civil service testing to include ongoing, online, continuous testing to ensure a constant pool of candidates and address bias in the civil services testing system that traditionally impacts BIPOC communities to ensure adequate workforce representation;
 - b. Allow professional licensure to meet qualifications in lieu of required testing;

- c. Reconsider application of the civil service “rule of three” to instead allow the ability to hire provisional employees if they have passing grade on test or to permit provisionally appointed employees to be reachable based on qualifications, length of service, employment record, test retake option. A merit based civil service system should not weigh tests more heavily than experience and qualifications.
8. Ensure local health departments play a role in the new iteration of the Medicaid 1115 waiver program.

Monetary Requests

1. NYSACHO strongly supports and urges legislators to act this year to restore Article 6 state aid for general public health work to New York City by returning the percentage of reimbursement above the statutory base grant to 36%, in alignment with all other local health departments (LHDs).
2. Allow the cost of Medical Examiner services for pathology and toxicology services to be reimbursable under the Article 6 program and increase Article 6 appropriations to cover the state’s share of these services.
3. Reassess and fund local health departments for their contributions to lead poisoning prevention efforts, which has been regularly underfunded by the state.

Enumeration of New York State’s Public Health Workforce

NYSACHO conducts an enumeration study of local public health workforce annually, an initiative started in 2021, and updated in 2022, and with plans for annual updates moving forward. Prior to 2021, the last formal enumeration of the public health workforce occurred in 2006, prior to several factors that significantly and negatively impacted the public health workforce, including the 2007-2009 Great Recession; health delivery policy and payment changes that directed local health departments away from the delivery of clinical health care services without planning for reinvestment in public health; a state-imposed property tax cap; and continued boom and bust funding approaches to public health crises at the federal level that undermines the ability of local health departments to maintain and sustain the public health workforce infrastructure. Between 2008 and 2022, the number of public health registered nurses decreased by 165% across local health departments in New York State. During the same period, we also saw decreases in the number of administrative support staff and environmental health sanitarians.

I have attached the data and charts that I will be referencing in this part of my testimony to my written remarks as Appendix A. The data I'll be discussing here is contained in Figure 1. Among its key determinations, the LHD workforce enumeration study found that New York State's LHD workforce has seen a marked decline in the number of full-time staff employed since 2019. At first glance, the LHD workforce appears to have remained stagnant, with a slight increase in all FTEs employed (2%) since 2019. This alone would be alarming given that during this time, LHDs were responding to the largest public health threat in nearly a century. However, when looking at the data broken down by employee type (full-time, part-time, contractual, and seasonal), this finding becomes even more worrying. Between 2019 and 2021, the full-time LHD workforce decreased by 26%, while contractual employees saw a huge increase, 12,210% (Figure 2). This large influx of contractual employees partly comes from COVID-19 funding provided by the State and Federal governments for LHDs to hire contracted staff to assist with COVID-19 mitigation activities such as case-investigation, contact tracing, and vaccination. However, these employees are not permanent and when funding runs out, they will leave their positions, leaving LHDs with staffing shortfalls as they continue to fight COVID-19 and other existing and emerging public health issues, like Monkeypox and polio.

Additionally, as seen in Figure 2, LHDs have seen a marked increase in vacancy rates since 2019. Overall, LHDs reported a 20% average vacancy rate for their departments, compared to 12% in 2019. Licensed practical or vocational nurses (39%), supervising public health nurses (26%), community health workers (24%), health educators (24%), and public health nurses (23%) were the positions with the highest vacancy rates. Respondents indicated that nursing positions, including public health nurses, were frequently vacant for more than a year. Public health physicians and health educators were the other positions that were most frequently reported to be vacant for long periods of time. Long vacancy periods leave LHDs without the full staffing required to be readily available to respond to emerging public health crises. High vacancy rates also increase the risk of existing staff becoming overworked and burnt-out, leading to turnover and further vacancies.

Moreover, compounding the existing staff shortage, all LHD respondents, regardless of size, reported facing high impending retirements, with 990 FTEs (almost 10% of the current workforce) planning to retire within the next three years. Since the start of the pandemic, 47% of LHD leaders (Commissioners/Directors) have retired or left their departments. Each retirement, or exodus of a key leadership position, equates to decades of institutional governmental public health knowledge leaving a department and the community they serve.

Barriers to Building an Adequate Public Health Workforce

To further understand the drivers of staffing changes as we move into the post-COVID era, NYSACHO conducted a follow-up qualitative study in 2023, to identify what major barriers and/or solutions exist to the hiring and retention of qualified public health workers. Our study identified both state and local level barriers, and my testimony will focus on the areas within our preliminary findings where state-level legislative actions could be considered.

Regardless of whether an LHD experienced an increase or decrease in their workforce, the drivers of change and reasons for people leaving the health department were similar. Retirement was a frequent issue with some employees even opting to retire early, especially during the pandemic. Issues that emerged due to the pandemic, like burnout or loss of COVID-specific staff, contributed to attrition and turnover within departments.

Counties that reported staffing increases in their workforce typically credited increases to being able to fill positions that had been vacant for extended periods and recovering from staffing shortages post-COVID, so these are less new staff but rather are fills of existing staffing gaps.

Retirement is a critical consideration for policymakers. The local government public health workforce that has recently, or will soon, retire is doing so under retirement benefits that contributed significantly to their longevity in the government workforce as a balance to traditionally lower compensation than private sector jobs. The younger workers coming into the field receive retirement benefits more comparable to private sector retirement, so those benefits no longer serve as an incentive to remain in public service. While we recognize that higher retirement benefits come at a significant cost to the taxpayers, we feel that this is an issue that must be addressed.

The impact on services due to staffing changes most often resulted in a shift of focus, with a common theme being that there was a shift from what LHDs wanted to do to what they had to do. With limited resources and residual pressures from COVID-19, the available resources, including increased staffing, had to be diverted to necessities rather than more costly services that didn't bring in revenue, such as maternal child health nursing visits in the home setting.

This trend is important for policymakers in terms of the on the ground ability of local health departments to implement any new or expanded state mandates. Simply stated, new requirements cannot be accomplished without funding and without other steps to remove those barriers to recruitment and retention of the staff necessary for policy implementation.

Civil Service

Among all counties interviewed, the Civil Service Exam was cited as a specific deterrent to candidates applying to positions or a reason why candidates decided to withdraw from the hiring process. One challenge is that Civil Service Exams are offered infrequently, and so employees hired on a provisional basis must eventually take the Civil Service Exam and score within the top 3 of test takers to retain their position. All counties interviewed mentioned the need to modernize the Civil Service System to assure that it is an aid rather than barrier to hiring. NYSACHO recognizes and supports the need to assure a strong merit-based system remains in place for public sector hiring but that must be balanced to assure that the same system does not constitute barriers to hiring to the extent the public services cannot be adequately delivered. Our primary barriers to hiring under the current civil service requirements include: the length of time between test dates; length of time it takes to score tests resulting in a loss of candidates during the waiting period; inability to hire a provisional appointment employee after they score poorly on a test despite their on-the-job excellence and requiring licensed professionals to take tests beyond their qualifications (e.g. social workers, engineers, pharmacists, etc.).

We support a state-level policy consideration that would allow professions that require external licensing to have that license serve as the qualification rather than an additional Civil Service test. In addition, there must be more frequent test taking opportunities, online testing, and real-time results and continuous review of public sector title requirements to address workforce shortages are other areas for consideration.

Salaries

Non-competitive salaries have made hiring difficult for LHDs. In positions that have a highly competitive marketplace, like nursing, this has resulted in positions being posted for extended periods of time without sufficient applicants or applicants that are not qualified. Offering a salary that can attract interest for nurses or other clinical positions has been difficult, as the counties must compete with hospitals and other county offices that are able or willing to offer higher salaries that take LHDs out of contention for applicants. Hospitals can offer sign-on bonuses and higher wages to nurses and other clinical positions that a LHD cannot compete with. In one instance, a county was able to raise wages for their EMTs and the commercial ambulance companies promptly raised theirs. Raises and cost of living adjustments are potential solutions to counties ability to hire competitive positions.

Any state-level action regarding bonuses, wage increases, and other incentives must ensure that the public sector is also eligible for incentives and that incentives also recognize that the public health sector includes non-clinical titles.

Finding Qualified Candidates

Recruiting qualified candidates for positions like nursing, and other clinical positions, has proven difficult for counties to accomplish. Outside of a better work-life balance, counties, especially small and rural ones, are being out-competed on every other front, such as pay, benefits, and location. Rural counties mentioned that people who grew up or attended college in the area rarely stayed in the area to work. Another challenge is stringent position requirements that must be met. External county offices, rather than the LHD, are often the ones making the determination of whether requirements are met. For example, if an open position requires a bachelor's degree, any candidate who lacks a bachelor's degree is automatically rejected without the LHD being able to review the candidate holistically.

The COVID-19 response demonstrated that when there is a need, all levels of credentialed clinical professionals can step in and fill demand. The lessons learned during COVID should be used to explore where scope of practice can be expanded with appropriate training and oversight.

Recruitment of Public Health Practitioners

A lack of colleges in some counties was cited exclusively by LHDs who experienced a decrease in staffing, which may play a role in the counties' ability to recruit the new graduates as well as build relationships with academic partners. In contrast, a public health program being offered at local colleges was mentioned exclusively by counties who experienced an increase in staffing.

Increased opportunities for support for academic field placements in public sector settings, as well as review of state supported degree programs to assure that they are aligned with the current needs of the public health professions, are potential avenues to explore. As a balance to the lower public sector salaries, state-supported public health loan forgiveness programs are a potential benefit that can assure that public service jobs are not simply unaffordable for recent graduates with significant student debt. This can also address equity issues in hiring where public sector jobs with low entry level salaries may be unaffordable for graduates from lower-income backgrounds.

Administering Contracts/Grants and Maximizing Funding

All counties had issues with utilizing grant funds. Multiple counties cited a burdensome administrative component as a barrier to utilizing grant funds. Neither grant nor state aid money could be used to provide bonuses to the public health workforce, making it difficult to support the existing workforce and impossible to bolster the workforce. Years of flat funding, and the elimination of state-level cost of living adjustments for state grants, are also a barrier to staff retention.

Prompt contracting laws for state grants to municipalities, like those currently in statute for nonprofits, could address this hiring barrier.

New York State's Early Intervention Program for Children Ages 0-3

The Early Intervention Program (EIP) provides critical developmental services to infants and toddlers (ages 0- 3 years) with developmental delays or disabilities, and their families, at a time when these services can have the greatest impact. Stagnant and inadequate service rates have produced major provider capacity issues in the EIP. Provider capacity issues contribute to growing service waitlists and pose a barrier to infants and toddlers with special needs receiving this critical service and stagnant provider reimbursement rates continue to contribute to a lack of ability or interest on the part of providers in providing services under this program. In New York State, counties, primarily through the local health departments are responsible for administration and oversight of the early intervention program locally.

The data related to EI can be seen in Figures 3 – 8 in Appendix A. As of August 2023, there are 7,360 children across New York State waiting for Early Intervention Services. This is a 28% increase in children waiting for services since 2022, and an over 500% increase since 2020. In 2023, across all regions, speech (2418), occupational therapy (1055), special education (1404), and physical therapy (877) had the most children waiting for services. Services with the largest increases in children waiting were evaluations (+113%), service coordination (+166%), special education (+42), nutrition (+58%), and developmental pediatricians/evaluators (+130%). From 2020 to 2022, there was an over 400% increase in the number of children on EI waitlists, equaling thousands of children waiting to receive services across New York State. In-person services entail a therapist traveling to see patients in their homes. In the EIP, telehealth removes a significant burden – the time, effort, and expense of travel – from the therapists. Since providers receive the same rate for providing telehealth services as in-person services, many EI service providers continue to deny requests for in- person services due to the additional effort required.

The EIP is a family-centered program. Family choice and family rights are mandated by New York State Public Health and Regulations at every step of the process, including the method of service delivery. A survey conducted in Spring 2022 found that 95% of children on waiting lists for EI services are waiting for in-person services, compared to 5% who specifically requested telehealth services, showing a strong preference by EI families for in-person services, which is not being met by providers.

Due to continued provider shortages in the EIP, NYSACHO strongly recommends that NYS EI rates include a differential between telehealth and in-person services to create an incentive for in-person service delivery. An 11% rate increase for in-person service delivery is appropriate due to the additional time and travel required by therapists to provide in-person services. Additionally, it will help to prevent inequities between communities that receive in-person services and those that receive only teletherapy.

Use of Speech Language Pathology Assistants (SLP-A)'s in the Early Intervention Program

According to the American Speech-Language-Hearing Association, a speech-language pathology assistant (SLPA) is support personnel who, following academic coursework, fieldwork, and on-the-job training, performs tasks that are prescribed, directed, and supervised by a certified and/or licensed speech-language pathologist. These professionals may have the opportunity to work in a variety of settings including schools, home health, clinics, private practice, and Early Intervention, as determined by state laws and regulations. Currently in New York State, Speech Language Pathologists (SLPs) are required to perform all evaluations and services for speech/language in the Early Intervention Program (EIP); and speech services are repeatedly the number one referred service for Early Intervention across New York State.

New York State is experiencing dire shortages of qualified professionals to provide speech language pathology and audiology services to children with developmental delays and disabilities in the EIP; and children in the EIP are going unserved or underserved due to the shortage of SLPs available to provide services. According to a survey of 48 county health departments, over 2,000 children were waiting for speech services in the summer of 2022.

At least 40 other states allow SLPAs to practice via license, registration, or certification. Shifting service delivery for some of the most common speech issues to qualified assistants would result in a more effective use of limited SLPs by allowing SLPs to work at the top of their license and focus on services that only they are qualified to provide, such as feeding services and other services for high needs children.

Allowing SLPAs to practice via license, registration, or certification in the EIP, when working under a plan of supervision under the oversight of a licensed SLP, will help expand speech service availability for children with developmental delays and disabilities in New York State. Further, the New York State Department of Health should aid in identifying any barriers to EIP services provided by SLPAs working under a plan of supervision being reimbursed by Medicaid and move forward with actions to ensure such services are Medicaid reimbursable.

NYSACHO's Position on an 11% Provider Rate Increase for Early Intervention Program Providers

NYSACHO represents the 58 local health departments across New York State where Early Intervention Officials are employed to help work with families and providers and SUPPORTS an 11% rate increase for providers, assuming the TOTAL COST of this increase does not impact county budgets. Counties are NOT

able to absorb the cost associated with such an increase due to the property tax cap restrictions set by the state and legislature outside of NYC. One way to protect counties from this increase is to increase the cost of the current covered lives assessment by the TOTAL COST of an 11% provider rate increase OR to utilize unallocated covered lives pool funding (state's portion) to fund the increase. NYSACHO requests the state take the following steps to help counties aid in delivering early intervention services to families:

1. Immediately pay counties the money they are owed from the EI covered lives pool enacted in 2021;
2. Establish a county escrow payment schedule through 2027 and set up a separate payment stream which will flow from covered lives pool to county escrow through 2027;
3. Increase early intervention provider rates by 11%; and
4. Protect counties from these increases by maintaining cost neutrality for counties.

Conclusion

There has never been a more pivotal time to take a stand in support of public health and the work local health departments partner with their communities to provide. I thank you for inviting the New York State Association of County Health Officials to provide you with this information and our thoughts and ideas on the status of the health care workforce in New York State.

Appendix A

Figure 1. Trends in FTEs between 2008 and 2022 in the public health workforce.

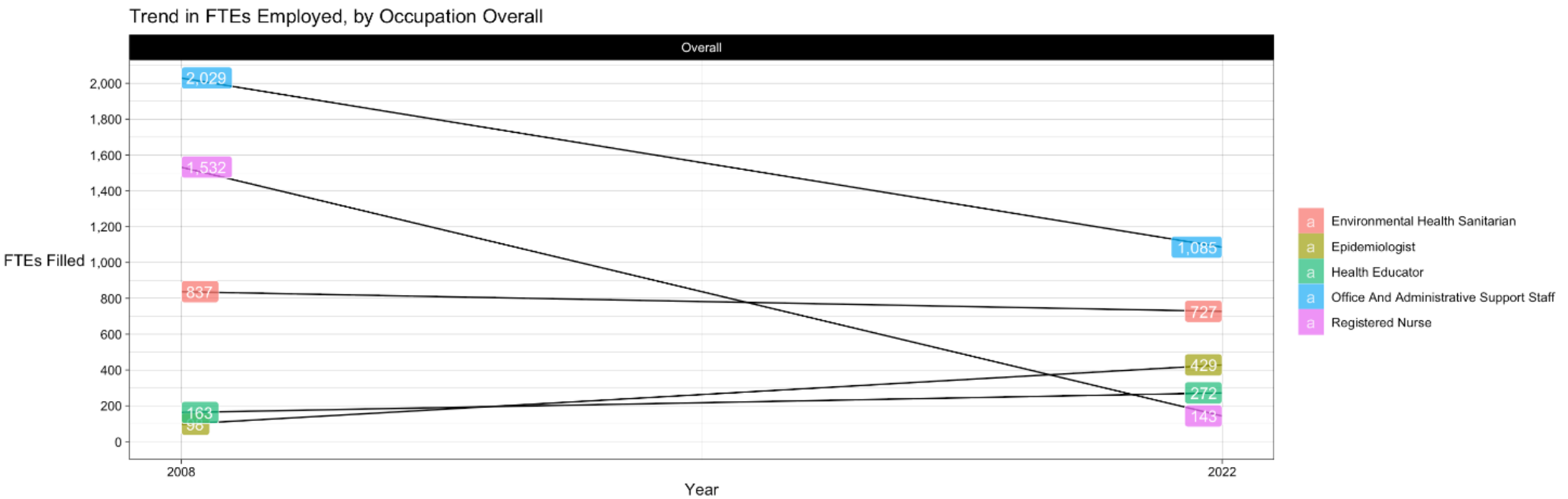


Figure 2: Changes in FTEs Employed in LHDs from 2019 to 2021, By Employee Type

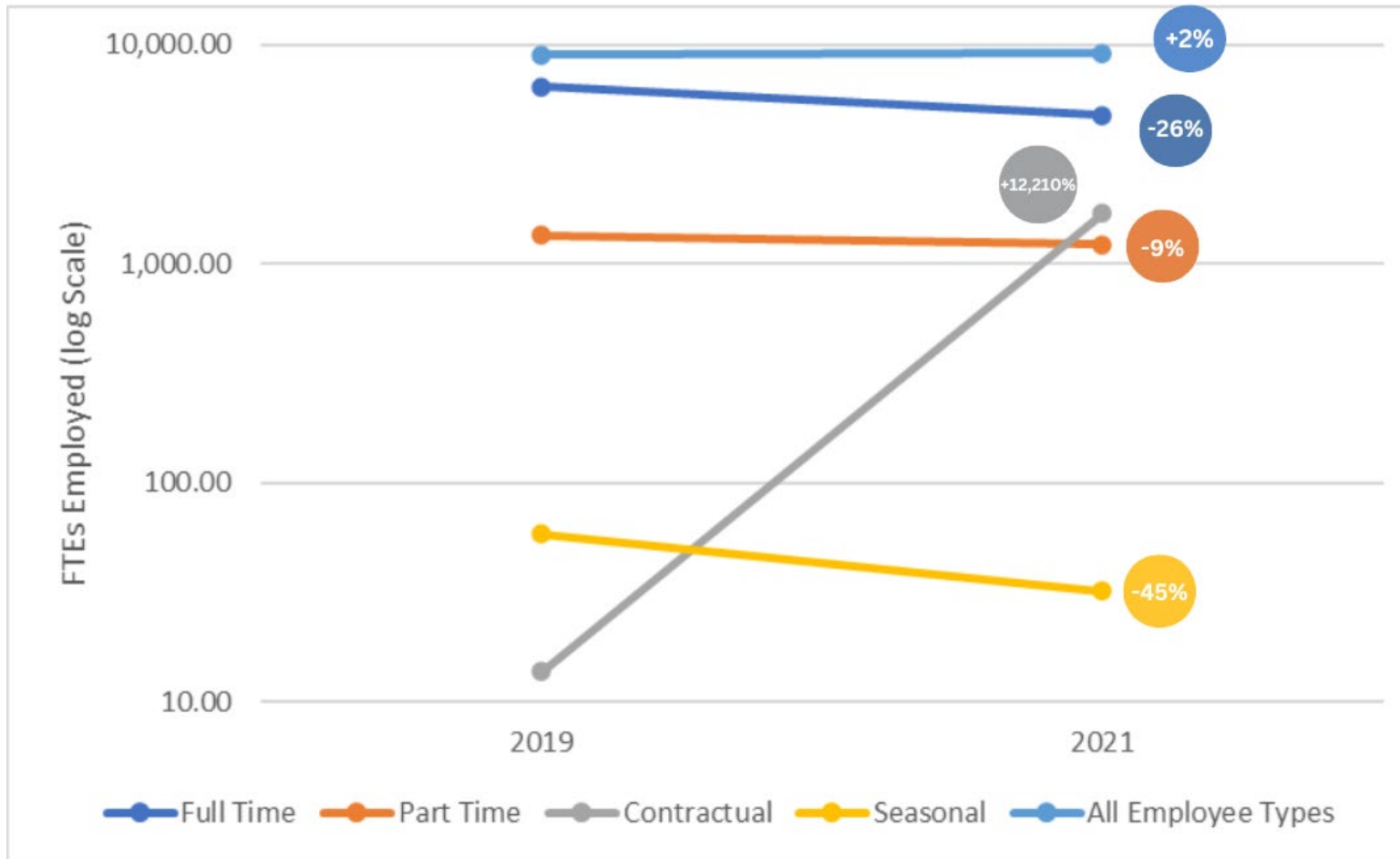


Figure 3. Change in Children Waiting for Any Amount of EI Service Types 2020-2023 (All NYS Regions)

Change in Children Waiting for Any Amount of All EI Service Types 2020-2023 (All Regions)

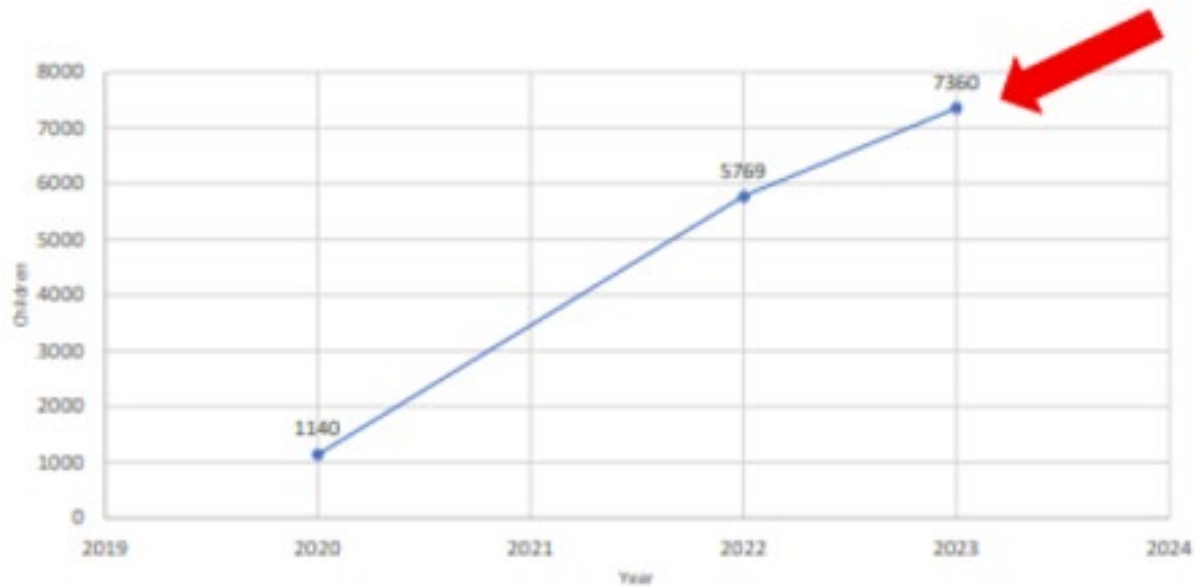


Figure 4. Total Children Waiting for Any Amount of EI Services by Service Type (All NYS Regions)

Total Children Waiting for Any Amount of EI Services by Service Type (All Regions)

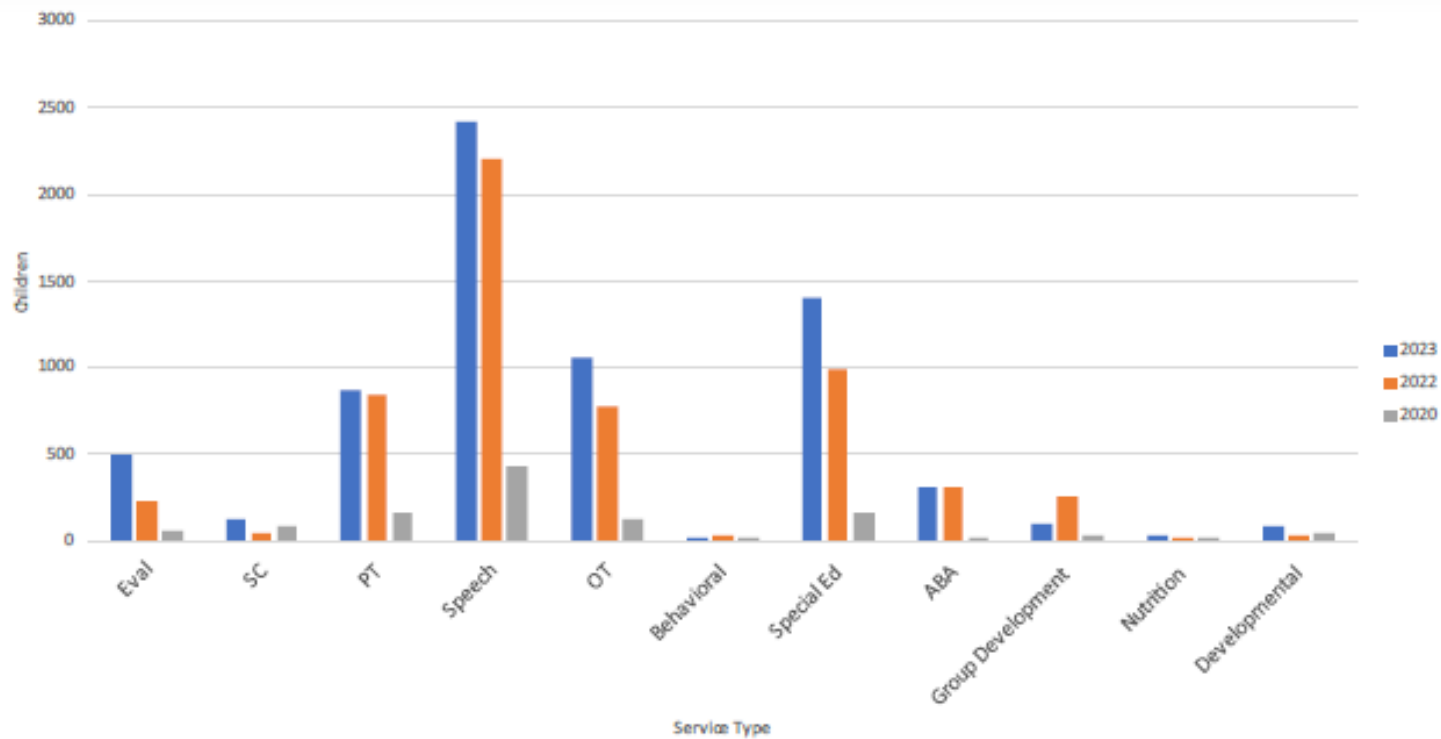


Figure 5. For most service types, more than 50% of children waiting for services are receiving no services during that time, as opposed to receiving some number of services, but not the full amount. Exceptions to this are applied behavior analysis and nutrition.

Percentage of Children Waiting for Any Amount of EI Services Who Are Receiving No Services

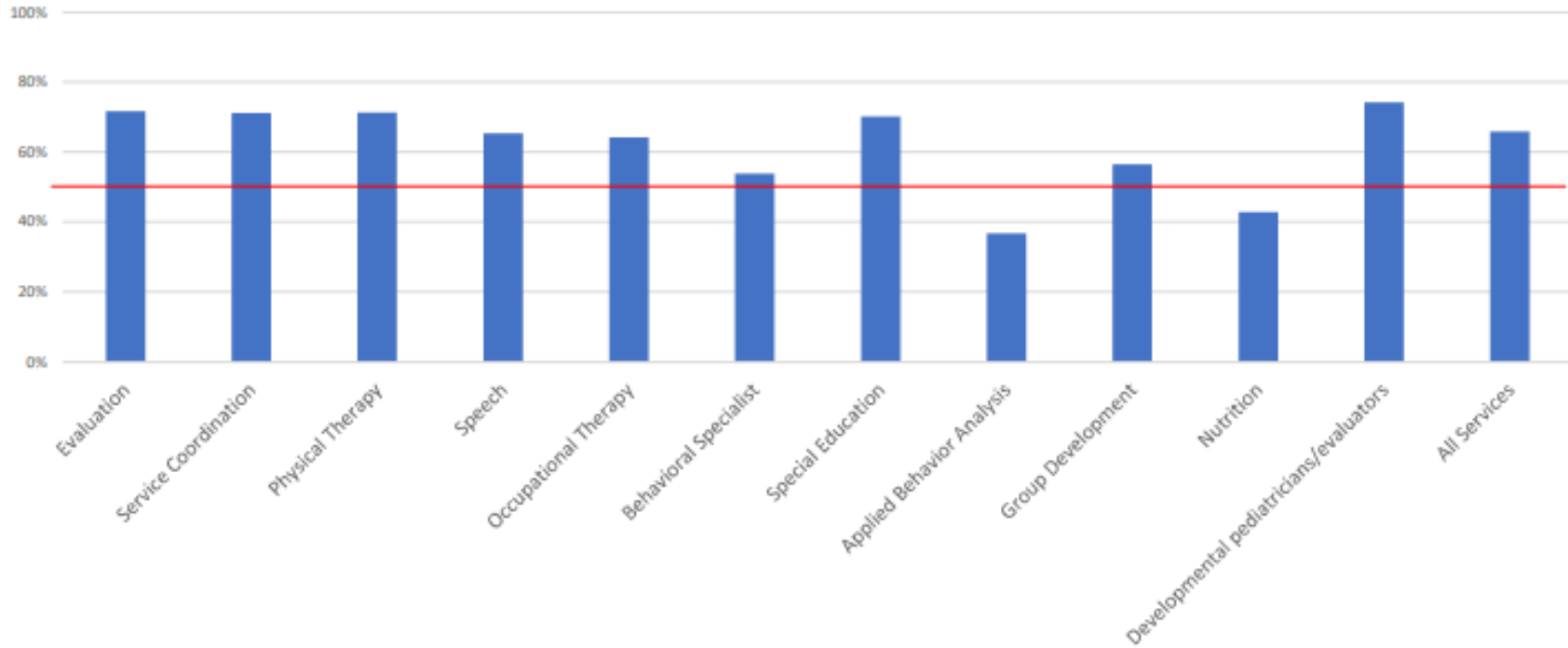
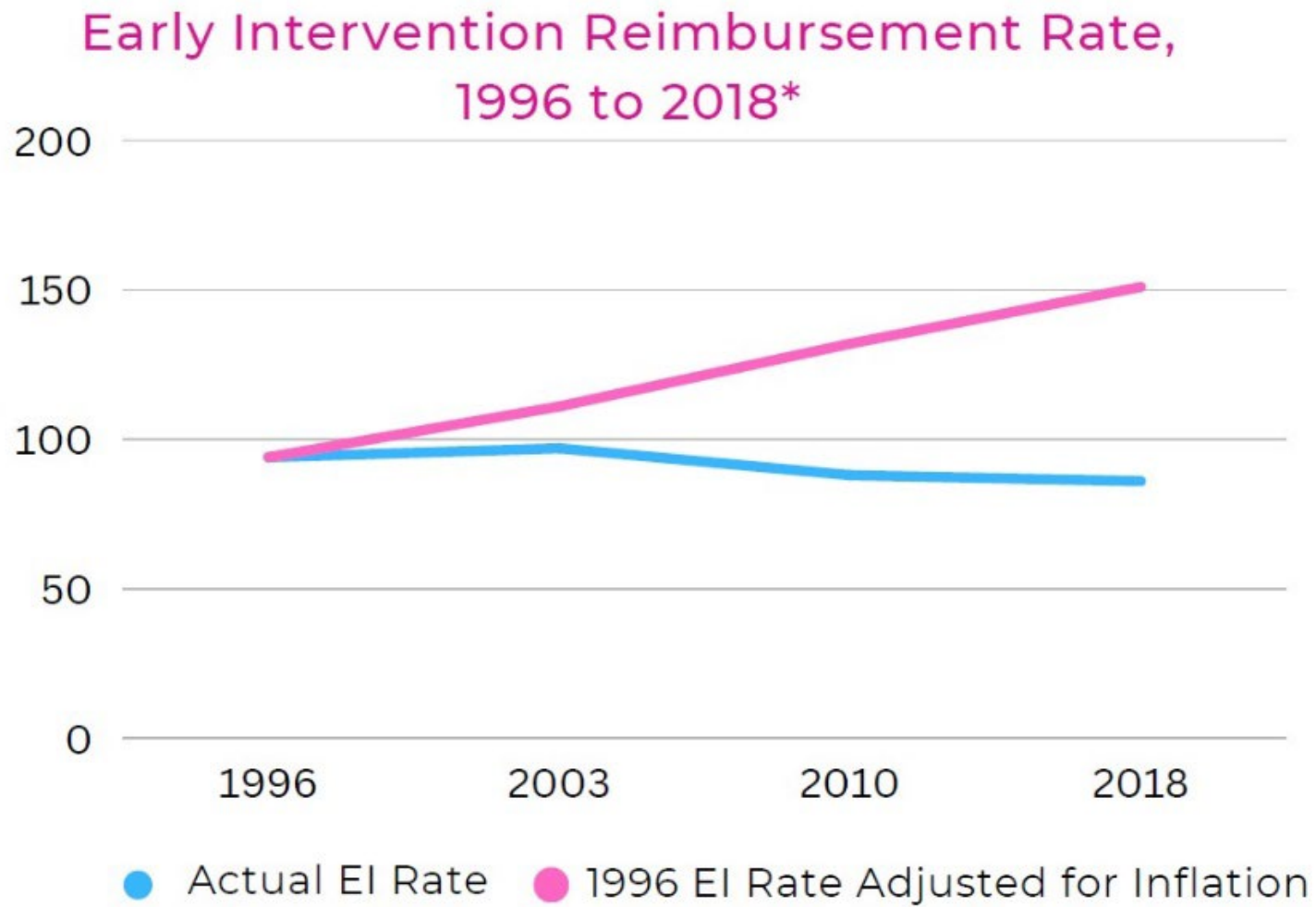


Figure 6



**Data from The Children's Agenda, 2018*

Figure 7

Children on EI Service Waitlists for Key Services (2020-2022)

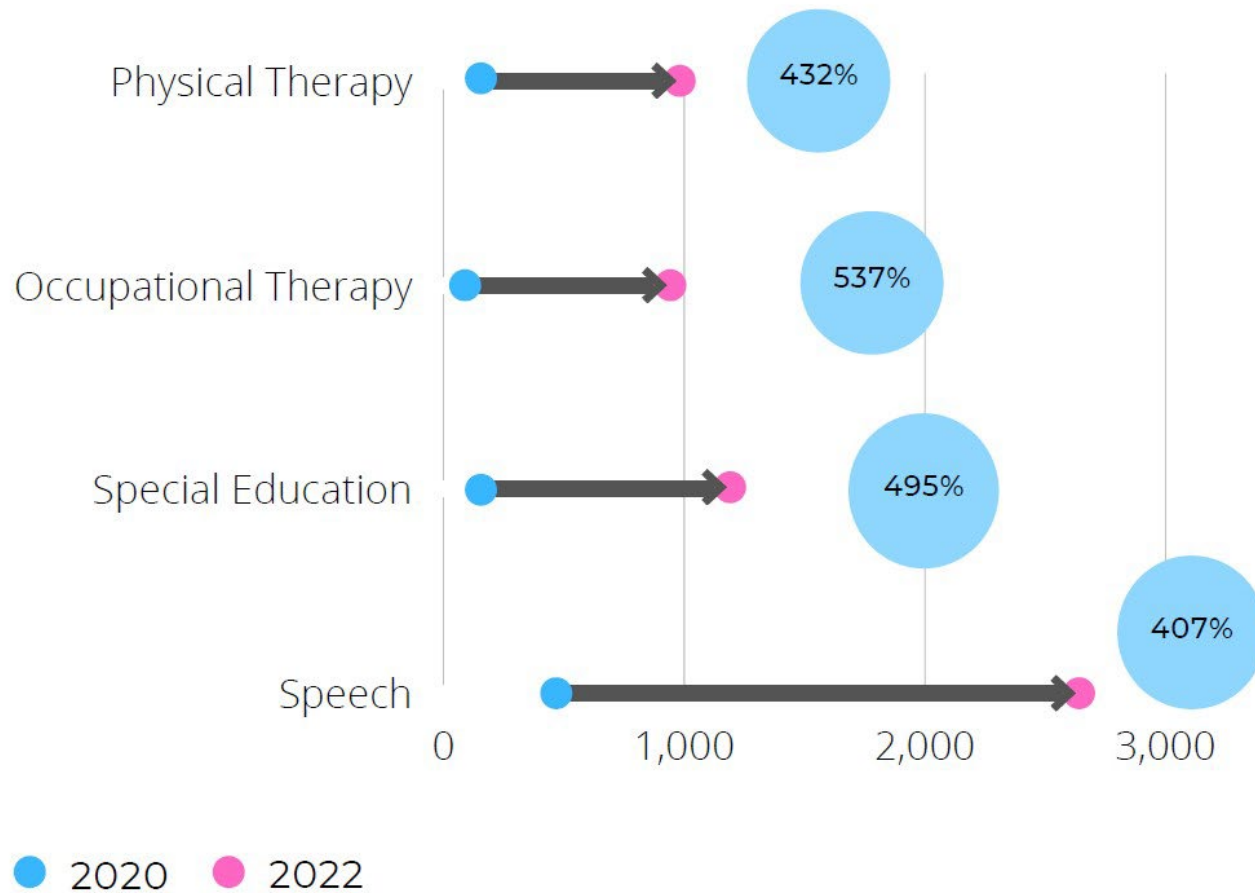


Figure 8

Children Waiting for In-Person vs Telehealth Services

