AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

399 RIDOUT STREET NORTH
SIDE ENTRANCE (RECESSED DOOR)
Board of Health Boardroom

Thursday, 7:00 p.m.
2017 March 16

MISSION – MIDDLESEX-LONDON HEALTH UNIT

The mission of the Middlesex-London Health Unit is to promote and protect the health of our community.

MEMBERS OF THE BOARD OF HEALTH

Ms. Maureen Cassidy
Mr. Michael Clarke
Ms. Patricia Fulton
Mr. Jesse Helmer (Chair)
Mr. Trevor Hunter
Ms. Tino Kasi
Mr. Marcel Meyer
Mr. Ian Peer
Mr. Kurtis Smith
Ms. Joanne Vanderheyden (Vice-Chair)

SECRETARY-TREASURER

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

APPROVAL OF MINUTES

Board of Health meeting, February 16, 2017.

DELEGATIONS

7:00 – 7:15 p.m.	Mr. Ian Peer, Finance & Facilities Committee member, re: Item #1, Finance & Facilities Committee (FFC) meeting, March 2, 2017. **Receive:** March 2, 2017 FFC meeting minutes
7:15 - 7:25 p.m.	Mr. Trevor Hunter, Chair, Governance Committee, re: Item #2, Governance Committee meeting, March 16, 2017. **Receive:** January 19, 2017 Governance Committee meeting minutes
7:25 – 7:35 p.m.	Dr. Gayane Hovhannisyan, Acting Medical Officer of Health, re: Item #3, Ontario Public Health Standards Modernization.
7:35 – 7:45 p.m.	Ms. Marlene Price, Manager, Vaccine Preventable Diseases Program Overview re: Item #4.

Item #	Report Name and Number	Link to Additional Information	Delegation	Recommendation	Information	Brief Overview
Committee Reports						
1	Finance & Facilities Committee (FFC) Meeting Update, March 2, 2017 (Report No. 010-17)	March 2, 2017 FFC Agenda Minutes	x	x		To receive information and consider recommendations from the March 2 Finance & Facilities Committee meeting.
2	Governance Committee (GC) Meeting, March 16, 2017 (Verbal Update)	March 16, 2017 GC Agenda	x	x		To receive a verbal update from the March 16 Governance Committee Meeting.
Delegation and Recommendation Reports						
3	Ontario Public Health Standards Modernization (Report No. 011-17)	Appendix A	x	x		To direct staff to respond to the consultation document and nominate a Board member to attend the MOHLTC Standards Consultations on March 24, 2017.
4	Vaccine Preventable Diseases (VPD) Program Review (Report No. 012-17)	Appendix A	x		x	To provide an update on the review of the VPD Team to identify areas of imbalance between existing resources and demand for service.
5	The Legalization and Regulation of Cannabis in Canada (Report No. 013-17)	Appendix A		x		To provide an update on the federal government's commitment to legalize, regulate and restrict access to cannabis and approve staff to continue to work with partners to support the development and implementation of evidence-informed regulations.
Information Reports						
6	Summary Information Report, March 2017 (Report No. 014-17)	Appendix A			x	To provide an update on Health Unit programs and services for March 2017.
7	Acting Medical Officer of Health / Acting Chief Executive Officer Activity Report, March 2017 (Report No. 015-17)				x	To provide an update on the activities of the Acting MOH / Acting CEO for March 2017.

OTHER BUSINESS

- Next Finance & Facilities Committee meeting: Thursday, April 6, 2017 @ 9:00 a.m.
- Next Board of Health meeting: Thursday, April 20, 2017 @ 7:00 p.m.
- Next Governance Committee meeting: Thursday, April 20, 2017 @ 6:00 p.m.

CORRESPONDENCE

a) Date: 2017 February 02
Topic: Jordan's Principle
From: Peterborough Public Health
To: Mr. Jesse Helmer

Background:

At the December 2016 Middlesex-London Board of Health meeting, Jordan's Principle was adopted as a board policy to ensure that jurisdictional disputes regarding the payment of services for children do not interfere with the timely provision of services to all First Nations children.

Peterborough Public Health called upon all boards of health in Ontario to follow the lead of the Middlesex-London Health Unit and advocate that the principle be applied to locally available services.

Recommendation:

Receive.

b) Date: 2017 February 02
Topic: Health Hazards of Gambling
From: Peterborough Public Health
To: The Honourable Dr. Eric Hoskins

Background:

Gambling has been identified as a significant public health issue in Ontario and internationally with 35 percent of Ontario gambling revenues coming from those who have moderate to severe gambling problems. Peterborough Public Health endorsed a position statement of the North Bay Parry Sound District Health Unit that a public health strategy of prevention and harm reduction be recommended. The statement also articulated that municipalities should collaborate with the Health Unit to mitigate gambling related harms and to allocate resources to study gambling prevalence, determine the impact of future casino development and establish a responsible gambling program.

Recommendation:

Receive.

c) Date: 2017 February 02
Topic: Provincial Opioid Action Plan
From: Peterborough Public Health
To: Dr. David Williams

Background:

At the November 2016 Middlesex-London Board of Health meeting, the Board passed a motion recommending the College of Physician and Surgeons of Ontario (CPSO) to advise their members that when prescribing opiates, patients should also be prescribed and counselled on

use of naloxone to help prevent potentially fatal complications associated with opioid overdose.

Peterborough Public Health send correspondence of their own to the CPSO and the Chief Medical Officer of Health in this regards.

Recommendation:
Receive

d) Date: 2017 February 02
Topic: Opioid Addiction and Overdoes
From: Peterborough Public Health
To: Dr. Rocco Gerace, Registrar, College of Physicians and Surgeons of Ontario

Background:
See item (c) above.

Recommendation:
Receive

e) Date: 2017 February 02
Topic: Bill 6, Ministry of Community Social Services Amendment Act
From: Peterborough Public Health
To: Peter Tabuns, MPP, Toronto-Danforth

Background:
Peterborough Public Health supported a position statement commending the provincial government for action taken on supporting Bill 6 (An Act to amend the Ministry of Community and Social Services Act to establish the Social Assistance Research Commission) and supporting the Nutritious Food Basket as part of a set protocol in the modernized Ontario Public Health Standards.

The Middlesex-London Health Unit Board of Health made similar recommendations to the above position statement at the November 17th, 2016 Board of Health meeting.

Recommendation:
Receive.

f) Date: 2017 February 07
Topic: Marijuana controls under Bill 178, Smoke-Free Ontario Amendment Act, 2016
From: Grey Bruce Public Health
To: The Honourable Dr. Eric Hoskins

Background:
The federal government plans to introduce legislation that would legalize cannabis in Spring 2017. Grey-Bruce Public Health supported the Sudbury and District Health Unit resolution for the inclusion of marijuana (medicinal and recreational) as a prescribed product or substance under the Smoke-Free Ontario Act.

At its January 2016 meeting, the Middlesex-London Board of Health endorsed recommendations from staff to advocate for an evidence-based public health approach to cannabis legalization and to establish baseline data and mechanisms to monitor local use.

Recommendation:

Receive.

g) Date: 2017 February 09
Topic: Opioid Addiction and Overdose
From: Huron County Board of Health
To: Registrar, College of Physicians and Surgeons of Ontario

Background:
See item (c) above.

The Huron County Board of Health passed a motion to endorse correspondence from the Middlesex-London Board of Health.

Recommendation:
Receive.

h) Date: 2017 February 03 [Received 2017 February 15]
Topic: Marijuana controls under Bill 178, Smoke-Free Ontario Amendment Act, 2016
From: Windsor-Essex County Health Unit
To: The Honourable Dr. Eric Hoskins

Background:
See item (f) above.

The Windsor-Essex County Health Unit additionally recommends sustainable funding and tailored enforcement training be provided to health units.

Recommendation:
Receive.

i) Date: 2017 February 03 [Received 2017 February 15]
Topic: Opioid Addiction and Overdose
From: Windsor-Essex County Health Unit
To: The Honourable Dr. Eric Hoskins

Background:
See item (c) above.

The Windsor-Essex County Health Unit supports the Middlesex-London Health Unit's recommendations and further commends the Ontario Government on their decision to develop a comprehensive strategy to address opioid misuse and addictions.

Recommendation:
Receive.

j) Date: 2017 January 4 [Received 2017 February 15]
Topic: Requesting Support for Enactment of Legislation under the HPPA to Allow for the Inspection and Enforcement Activities of Personal Services Settings
From: Wellington-Dufferin-Guelph Public Health
To: The Honourable Kathleen Wynne

Background:
Currently, there are no infection prevention and control training requirements for personal

service setting operators. The previous changes to the Ontario Public Health Standards did not address the potential to implement legal requirements for infection prevention and control training and operator responsibility in personal service settings (PSS).

The Wellington-Dufferin-Guelph Board of Health noted complaints from the public and indicated that an expansion in the range of services provided at these premises can be accompanied by an increased risk of subsequent infection if appropriate infection prevention and control practices are not followed.

Recommendation:
Receive.

k) Date: 2017 February 23
Topic: Updated Public Health Standards
From: Linda Stewart, Executive Director
To: Board of Health Chairs

Background:
The Association for Local Public Health Association's Winter Symposium provided an opportunity to review and discuss the consultation document for the updated Standards for Public Health Programs and Services. They have requested an extension to the April 3, 2017 feedback deadline and will be providing members with a written summary of the input from the session.

The correspondence included a technical briefing, preliminary assessment and the consultation document.

Recommendation:
Receive.

l) Date: 2017 February 16
Topic: Sugar-Sweetened Beverages
From: Canadian Beverage Association
To: Dr. Gayane Hovhannisyan

Background:
At the February 2017 Middlesex-London Board of Health meeting, a motion was passed to, support the receipt of $15,000 from the Healthy Kids Community Challenge to implement a community education campaign on the health risks associated with sugary drinks and the benefits of water, direct staff to complete the online endorsement of the Stop Marking to Kids Coalition Ottawa Principles and communicate support for STOP M2K's Ottawa Principles.

The Canadian Beverage Association noted the Health Unit's focus on sugar-sweetened beverages and expressed concerns that focusing on one product category is not an effective long-term solution. They contend that the causes of serious diseases like obesity are complex and should not be reduced to any one unique contributor. Health Canada and other researchers agree that the factors associated with these issues include overall health behaviours, and broader social, environmental and biological determinants.

Recommendation:
Receive.

Copies of all correspondence are available for perusal from the Secretary-Treasurer.

CONFIDENTIAL

The Board of Health will move in-camera to consider matters regarding identifiable individuals; employee negotations, a proposed or pending acquisition of land by the Middlesex-London Board of Health; and to review confidential minutes of the February 16 Board meeting and the March 2 Finance and Facilities Committee meeting.

ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, February 16, 2017 7:00 p.m.

MEMBERS PRESENT:
Ms. Maureen Cassidy
Mr. Jesse Helmer (Chair)
Mr. Trevor Hunter
Ms. Tino Kasi
Mr. Marcel Meyer
Mr. Ian Peer
Mr. Kurtis Smith
Ms. Joanne Vanderheyden (Vice-Chair)

MEDIA:
Mr. Gerry Dewan, Reporter, CTV London News

OTHERS PRESENT:
Ms. Laura Di Cesare, Secretary-Treasurer
Ms. Elizabeth Milne, Executive Assistant to the Board of Health & Communications (Recorder)
Ms. Shaya Dhinsa, Manager, Sexual Health
Mr. Dan Flaherty, Manager, Communications
Ms. Ellen Lakusiak, Dietitian, Chronic Disease Prevention and Tobacco Control
Ms. Heather Lokko, Manager, Healthy Start
Ms. Kim Loupos, Dietitian, Chronic Disease Prevention and Tobacco Control
Mr. John Millson, Associate Director, Finance
Ms. Jennifer Pastorius, Old East Village, BIA
Ms. Linda Stobo, Manager, Chronic Disease Prevention and Tobacco Control
Mr. Stephen Turner, Director, Environmental Health & Infectious Disease
Mr. Alex Tyml, Online Communications Coordinator
Ms. Suzanne Vandervoort, Director, Healthy Living

Chair Helmer called the meeting to order at 7:02 p.m.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Helmer inquired if there were any disclosures of pecuniary of interest. None were declared.

APPROVAL OF AGENDA

It was moved by Ms. Cassidy seconded by Ms. Vanderheyden *that the **AGENDA** for February 16, 2017 Board of Health meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Smith, seconded by Mr. Peer, *that the **MINUTES** for the January 19, 2017 Board of Health meeting be approved.*

Carried

2017 Program & Budget Templates (Report 007-17FFC)

Mr. John Millson, Associate Director, Finance, presented a summary of the 2017 Budget for all programs and services, as part of the Finance and Facilities Committee update (Report No. 007-17FFC).

COMMITTEE REPORTS

1) Finance and Facilities Committee Meeting Update – January 26 and February 2, 2017 (Report No. 004-17)

Ms. Vanderheyden took over as Chair while Mr. Helmer provided a summary and update from the January 26 and February 2, 2017 Finance and Facilities Committee meetings.

Mr. Helmer reviewed and provided context to the reports outlined below:

2016 Board of Health Remuneration (Report No. 002-17FFC)

It was moved by Mr. Peer, seconded by Mr. Meyer, *that the Board of Health receive Report No. 002-17FFC re: 2016 Board of Health Remuneration for information, as recommended by the Finance & Facilities Committee.*

Carried

2017 Budget – FFC Review (Report No. 001-17FFC)

The Finance & Facilities Committee deferred the decision on this item to the final review of the Budget at its February 2, 2017 meeting.

Finance and Facilities Committee – Reporting Calendar (Report No. 003-17FFC)

It was moved by Mr. Meyer, seconded by Mr. Smith, *that the Board of Health receive Report No. 003-17FFC re: Finance and Facilities Committee – Reporting Calendar for information.*

Carried

2016 Fourth Quarter Budget Variance Report and Factual Certificate (Report No. 004-17FFC)

It was moved by Mr. Meyer, seconded by Mr. Smith, *that the Board of Health:*

1) *Receive Report No 004-17FFC re: 2016 Fourth Quarter Budget Variance Report and Factual Certificate for information; and*
2) *Fund the 2016 Dental Treatment Program deficit from the general Cost-Shared Program surplus, if required, as recommended by the Finance & Facilities Committee.*

Carried

2016 Visa/Vendor Payments (Report No. 005-17FFC)

It was moved by Mr. Meyer, seconded by Mr. Smith, *that the Board of Health receive Report No. 005-17FFC re: 2016 Vendor/VISA Payments for information.*

Carried

Public Sector Salary Disclosure Act – 2016 Record of Employees' Salaries and Benefits (Report No. 006-17FFC)

It was moved by Mr. Meyer, seconded by Mr. Smith, *that Board of Health receive Report No. 006-17FFC re: Public Sector Salary Disclosure Act – 2016 Record of Employees' Salaries and Benefits for information.*

Carried

2017 Proposed Budget (Report No. 007-17FFC)

Discussion ensued about the 1.5% increase in Ministry of Health and Long-Term Care funding and the maintenance of a 0% increase in municipal funding.

Mr. Peer and Ms. Vanderheyden, on behalf of the Finance & Facilities Committee noted the time and effort the Committee put in to reviewing the budget over multiple meetings the past month and thanked staff for the level of detail included in the budget, which contributed to a thorough review process.

It was moved by Mr. Meyer, seconded by Ms. Cassidy, *that the Board of Health:*

1) *Approve the 2017 Operating Budget in the gross amount of $35,405,626 per the appended Report No. 007-17FFC re: 2017 Proposed Budget;*
2) *Forward Report No. 007-17 to the City of London and the County of Middlesex for information; and*
3) *Direct staff to submit the 2017 Operating Budget in the various formats required by the different funding agencies.*

Carried

Mr. Helmer took over once again as Chair following the summary of the Finance and Facilities Committee reports.

DELEGATION & RECOMMENDATION REPORTS

2) Supervised Injection Services Feasibility in Middlesex-London (Report No. 005-17)

Dr. Gayane Hovahannisyan introduced this report with a presentation on both the feasibilty of Supervised Injection Services and an update on infections and unsafe injection practices in a local context.

Discussion ensued about the following items:

- Local infection rate due to unsafe injection practices, the drug use behaviours in Middlesex-London and the type of drugs being used.
- Next steps, which will include; gathering and consulting key stakeholders, local partners, and other Health Units, addressing the legislative requirements, assisting with the application for exemption under the *Controlled Drugs and Substances Act*, presenting findings to the Community Drug and Alcohol Strategy Steering Committee, drawing on the Ministry for support and working with the Ontario HIV Treatment Network to leverage additional resources.
- Additional solutions to incorporate into the harm reduction strategy such as providing addiction services, withdrawl management, counselling and treatment.
- How other models of care can be integrated into supervised injection services, how the sites will be integrated with other services and how the services will be accessed by PWID.
- The positive benefits of implementing supervised injection services, which include seeing an increase in those seeking treatment, increase in safe injection behaviours, reduction in syringe sharing and reduction in public disorder.
- The Supervised Injection Services Feasibility Study results and the limitations of the study.
- The rates of aboriginal PWID and the importance of engaging aboriginal communities and local stakeholders through the community consultation process. Need to further identify the gaps in service and continue to build links to these communities to addiction services etc.

Dr. Hovhannisyan clarified that the Community Drug and Alcohol Strategy Steering Committee will not be taking the lead on the community consultations, but rather will be consulted for feedback and that the wording for location was only included in the recommendation as it will be a parameter included in the community consultations going forward. Staff will bring updates as more information comes through the consultation process.

It was moved by Mr. Smith, seconded by Ms. Cassidy that the Board of Health:

1. *Receive Report No. 005-17 re: "Supervised Injection Services (SISs) Feasibility in Middlesex-London" for information;*
2. *Endorse recommendation number 1 from the Ontario Integrated Supervised Injection Services (SIS) Feasibility Study for London, Ontario; and*
3. *Direct staff to explore the next steps in assessing the feasibility of the integrated SIS model in London and potential locations.*

Carried

3) City of London Beverage Vending Machine Review and Opportunity for Further Action on Sugary Drinks (Report No. 006-17)

It was moved by Mr. Peer, seconded by Ms. Cassidy that the Board of Health:

1. *Receive Report No. 006-17 re: City of London Beverage Vending Review and Opportunity for Further Action on Sugary Drinks;*
2. *Support the receipt of $15,000 from the Healthy Kids Community Challenge fund from the City of London's Child and Youth Network to implement a community education campaign on the health risks associated with sugary drinks and the benefits of water;*
3. *Direct staff to complete the online endorsement of the Stop Marketing to Kids Coalition's (Stop M2K) Ottawa Principles to communicate its support to restrict food and beverage marketing to children and youth 16 years of age and younger; and*
4. *Communicate support for STOP M2K's Ottawa Principles by sending Report No. 006-17 re: City of London Beverage Vending Review and Opportunity for Further Action on Sugary Drinks, and its appendices to other Boards of Health in Ontario.*

Carried

INFORMATION REPORTS

4) Summary Information Report, February 2017 (Report No. 007-17)

It was moved by Ms. Cassidy seconded by Mr. Meyer *that the Board of Health receive Report No. 007-17 re: Summary Information Report for February 2017 for information.*

Carried

5) Acting Medical Officer of Health / Acting Chief Executive Officer Activity Report, February 2017 (Report No. 008-17)

It was moved by Ms. Cassidy seconded by Ms. Vanderheyden *that the Board of Health receive Report No. 008-17 re: Acting Medical Officer of Health / Acting Chief Executive Officer Activity Report, February 2017.*

Carried

OTHER BUSINESS

Mr. Meyer provided an update on his position with the Middlesex-London Food Policy Council and advised the Board that he was nominated to Chair the Executive Committee. This would likely increase the number of meetings by one to two additional meetings per month however the cost would be shared by both nominating bodies, the County of Middlesex and the Middlesex-London Board of Health.

It was moved by Ms. Cassidy, seconded by Mr. Peer *that Mr. Meyer let his name stand for Chair of the Middlesex-London Food Policy Council Executive Committee.*

Carried

Next meetings:

- Next Finance and Facilities Committee Meeting: Thursday, March 2, 2017 at 9:00 a.m.
- Next Governance Committee Meeting: Thursday, March 16, 2017 at 6:00 p.m.
- Next Board of Health Meeting: Thursday March 16, 2017 at 7:00 p.m.

Ms. Vanderheyden and Ms. Cassidy advised they are unable to attend the March 16 Board of Health and Governance Committee meetings.

CORRESPONDENCE

It was moved by Ms. Cassidy, seconded by Mr. Smith *that the Board of Health receive items a) through k).*
Carried

CONFIDENTIAL

At 8:22 p.m., Chair Helmer invited a motion to move in camera to discuss matters regarding identifiable individuals, a proposed or pending acquisition of land by the Middlesex-London Board of Health and to review confidential minutes from its January 19, 2017 meeting and February 2, 2017 Finance & Facilities Committee meeting.

At 8:22 p.m. it was moved by Mr. Hunter, seconded by Ms. Vanderheyden *that the Board of Health move in camera to discuss matters regarding identifiable individuals, a proposed or pending acquisition of land by the Middlesex-London Board of Health and to review confidential minutes from its January 19, 2017 Board of Health meeting and February 2, 2017 Finance & Facilities Committee meeting.*
Carried

At 8:23 p.m. all visitors and Health Unit staff, except Ms. Laura Di Cesare, Dr. Gayane Hovhannisyan and Ms. Elizabeth Milne left the meeting.

At 8:35 p.m. it was moved by Mr. Hunter, seconded by Mr. Meyer *that the Board of Health rise and return to public session.*
Carried

At 8:35 p.m. the Board of Health returned to public session.

It was moved by Mr. Meyer, seconded by Ms. Vanderheyden *that the Board of Health receive the January 26, 2017 Finance and Facilities Committee meeting minutes.*
Carried

It was moved by Mr. Meyer, seconded by Ms. Vanderheyden *that the Board of Health receive the February 2, 2017 Finance and Facilities Committee meeting minutes.*
Carried

It was moved by Mr. Peer, seconded by Mr. Meyer *that the Board of Health approve the lease extension for the leased space at Sherwood Forest Mall.*
Carried

ADJOURNMENT

At 8:36 p.m., it was moved by Ms. Vanderheyden seconded by Mr. Meyer *that the meeting be adjourned.*
Carried

JESSE HELMER	**LAURA DI CESARE**
Chair	**Secretary-Treasurer**

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
MIDDLESEX-LONDON BOARD OF HEALTH
50 King Street, London
Middlesex-London Health Unit – Room 3A
2017 March 2, 9:00 a.m.

COMMITTEE MEMBERS PRESENT:	Mr. Jesse Helmer Mr. Marcel Meyer Mr. Ian Peer Ms. Joanne Vanderheyden
REGRETS:	Ms. Trish Fulton (Chair)
OTHERS PRESENT:	Ms. Lynn Guy, Executive Assistant to the Medical Officer of Health & CEO (Recorder) Ms. Laura Di Cesare, Secretary-Treasurer Mr. Jordan Banninga, Manager, Strategic Projects Dr. Gayane Hovhannisyan, Acting Medical Officer of Health Mr. John Millson, Associate Director, Finance Ms. Suzanne Vandervoort, Director, Healthy Living Mr. Chimere Okoronkwo, Manager, Dental Services

At 9:04 a.m., Chair Vanderheyden called the meeting to order.

DISCLOSURES OF CONFLICTS OF INTEREST

Chair Vanderheyden inquired if there were any conflicts of interest. None were declared.

Chair Vanderheyden noted that neither she or Marcel Meyer were involved in any of County meetings regarding the MLHU Relocation Project.

APPROVAL OF AGENDA

It was moved by Mr. Peer, seconded by Mr. Meyer, *that the AGENDA for the March 2, 2017 Finance & Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Ms. Vanderheyden, seconded by Mr. Meyer, *that the MINUTES of the February 2, 2017 Finance & Facilities Committee meeting be approved.*

Carried

NEW BUSINESS

4.1 Financial Controls Checklist (Report No. 009-17FFC)

John Millson provided an overview of the report.

Board members noted that this report was well written and highlights the Health Unit's efforts to ensure that good financial controls are in place and that they comply with Ministry of Health and Long-Term Care regulations.

It was moved by Mr. Meyer, seconded by Mr. Helmer, *that the Finance & Facilities Committee receive Report No. 009-17FFC re: Financial Controls Checklist for information.*

Carried

4.2 Impact of Consent Process on Dental Screening Outcomes (Report No. 010-17FFC)

Mr. Okoronkwo attended the meeting to discuss the impact of consent process on dental screening outcomes. He noted that there are two processes used among the four school boards in the Middlesex-London area. Those being, passive consent and active consent. Currently the Thames Valley District School Board uses a process of active consent for its dental screening. This means that children are not screened by Health Unit staff unless the parents have directly communicated their consent to the school to have their children screened. The evidence shows that this has led to a higher rate of "Child in need of Urgent Care" cases.

Ms. Vandervoort noted that the TVDSB sought legal advice in 2007 to move away from passive consent to active consent. This was done in regards to privacy issues. The Health Unit followed up with legal advice from Lerner's Law Firm. Ms. Di Cesare added that privacy legislation has changed since 2007 therefore the Health Unit will revisit the issue.

Next steps will include bringing this FFC report as well as the report written in 2007 to the next FFC meeting for further review and input.

It was moved by Mr. Peer, seconded by Mr. Helmer, *that the Finance & Facilities Committee;*

1) *receive Report No. 010-17FFC comparing screening practices between school boards within the jurisdiction of the Health Unit and Ontario for information; and*
2) *Direct staff to bring this report and the report from 2007 forward to the next FFC meeting for review and input.*

Carried

OTHER BUSINESS

5.1 Next meeting: Thursday, April 6, 2017 @ 9:00 a.m.

5.2 Ms. Di Cesare noted that depending on what reports need to go to FFC, there may not be a need for an April meeting.

5.3 Mr. Peer discussed his attendance, on behalf of the Board of Health, at the cross country tour to discuss the legalization and regulation of cannabis. Parliamentary Secretary, Bill Blair is leading these engagement sessions. Board Members discussed potential costs for the Health Unit should this initiative not be funded, concerns regarding enforcing the regulations and the unknown factors.

CONFIDENTIAL

At 9:33 a.m., it was moved by Mr. Meyer, seconded by Mr. Helmer, *that the Finance & Facilities Committee move in-camera to discuss matters regarding identifiable individuals and a proposed or pending acquisition of land by the Middlesex-London Board of Health.*

Carried

At 10:15 a.m., it was moved by Mr. Peer, seconded by Mr. Meyer, that the Finance & Facilities Committee return to public session.

Carried

ADJOURNMENT

It was moved by Mr. Helmer, seconded by Mr. Peer, *that the Finance & Facilities Committee adjourn the meeting.*

Carried

At 10:25 a.m., Chair Vanderheyden *adjourned the meeting*.

_____ _____

JOANNE VANDERHEYDEN
Vice-Chair, Board of Health

LAURA DI CESARE
Secretary-Treasurer

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH
Governance Committee
399 Ridout Street, London
Middlesex-London Board of Health Boardroom
Thursday, January 19, 2017 5:00 p.m.

Committee Members Present:	**Mr. Trevor Hunter (Chair)** Mr. Ian Peer Mr. Kurtis Smith
Regrets:	Mr. Jesse Helmer
Others Present:	Mr. Marcel Meyer Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications (Recorder) Mr. Jordan Banninga, Manager, Strategic Projects Ms. Laura Di Cesare, Director, Corporate Services

Chair Hunter called the meeting to order at 5:00 p.m.

DISCLOSURES OF CONFLICT(S) OF INTEREST

Chair Hunter inquired if there were any disclosures of conflict of interest to be declared. None were declared.

APPROVAL OF AGENDA

It was moved by Mr. Peer, seconded by Mr. Smith, *that the AGENDA for the January 19, 2017 Governance Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Smith, seconded by Mr. Peer, *that the MINUTES of the December 8, 2016 Governance Committee meeting be approved.*

Carried

NEW BUSINESS

4.1 2017 Governance Committee Reporting Calendar and Meeting Dates (Report No. 001-17GC)

Chair Hunter flagged the initiation of the MOH/CEO Performance Appraisal, which will be completed in Q2 for 2017.

Chair Hunter flagged the March meeting and advised that it will be determined pending approval of the Board of Health meeting schedule for 2017.

It was moved by Mr. Peer, seconded by Mr. Smith, *that the Governance Committee:*

1) *Receive Report 001-17GC re: 2017 Governance Committee Reporting Calendar; and*
2) *Approve the 2017 Governance Committee Reporting Calendar and Meeting Dates (Appendix A).*

Carried

4.2 2017 Board of Health Self-Assessment (Report No. 002-17GC)

Chair Hunter introduced and provided context for the report.

Discussion ensued around members' ability to complete the survey electronically, or complete it on paper before leaving the meeting; the ability to self-rank items in Question 9; and how the questions and categories were developed (based on the Ontario Public Health Standards).

Mr. Meyer arrived at 5:07 p.m.

It was moved by Mr. Smith, seconded by Mr. Peer, *that the Governance Committee:*

1) *Receive Report No. 002-17GC re: 2017 Board of Health Self-Assessment;*
2) *Approve the Board of Health Self-Assessment Tool (Appendix A); and*
3) *Initiate the Board of Health Self-Evaluation Process for 2017.*

Carried

4.3 2017 Board of Health Orientation (Report No. 003-17GC)

Mr. Hunter introduced and provided context for the report, and Ms. Di Cesare advised that the tentative orientation date is set for February 7, from 11:30 a.m. to 2:30 p.m. Orientation will be open to all BOH members.

Discussion ensued around the following items:

- Having staff provide a summary and update on their team's programs and services, including any legislated components.
- Having a fifteen-minute Board information update at each meeting to review all services, since there is so much material. This could include summarizing information from the Program and Budget Templates.
- Holding quarterly updates. We already do quarterly town halls, so this info could be put together and provided to the Board.
- Staff will look into these ideas and present the committee with options and ideas for updating the Board on staff programs and services.

It was moved by Mr. Peer, seconded by Mr. Smith, *that the Governance Committee receive Report No. 003-17GC re: "2017 Board of Health Orientation" for information.*

Carried

OTHER BUSINESS

5.1 Policy Review (Continued)

Chair Hunter provided a summary of where policy review last left off. A discussion followed on policies G-270, G-280, G-290, G-300, G-350, G-370, G-380, G-470, G-480 and G-490. It was clarified that no policies would be brought to the Board for review or approval tonight. Staff will review the Committee's discussion and recommended changes, and will send the Committee an updated draft prior to going to the Board for approval.

Further discussion ensued about the following items:

- Further review of the minimum attendance for meetings (outlined in Appendix A of G-270) and clarification of the role of the Executive Committee (Appendix B).
- Clarification of the difference between being absent from a meeting versus sending regrets. Staff will review the process and wording of other, similar policies (such as the City of London's) and will also consider this with regard to the Code of Conduct.
- Clarification of the Governance Committee's role in assessing the needs of the Board; communicating those needs both to appointing bodies and to potential Board members.
- Clarification of the Reporting Calendar, current practices and plans for Board Orientation and current practices.
- Revision to the Appendix: Items D and E should be check boxes, merely a continuation of the list.
- The responsibility to declare conflicts of interest, both annually and at every meeting of the Board of Health and its Standing Committees.
- Identification and inclusion of the Board Chair in Policy G-480.
- Consideration of the wording of walk-on reports outlined in policy G-490.

Mr. Banninga clarified that from the staff perspective, all staff who work in areas corresponding to any updated policies will be consulted as the new policies are approved.

Ms. Di Cesare advised that staff will try to update and revise policies based on this evening's discussion as soon as possible, and will distribute the updated policies to the Committee in advance of the next meeting.

5.2 Next Meeting

To be determined pending approval of the Board of Health meeting schedule.

Carried

ADJOURNMENT

At 6:17 p.m. it was moved by Mr. Smith, seconded by Mr. Peer, *that the meeting be adjourned.*

Carried

TREVOR HUNTER Chair	LAURA DI CESARE Secretary-Treasurer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 010-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 March 16

FINANCE AND FACILITIES COMMITTEE MEETING - MARCH 2

The Finance and Facilities Committee met at 9:00 a.m. on Thursday March 2, 2017. A summary of the discussion at each of these meetings can be found in the minutes.

The following reports were reviewed at the meeting and recommendations made:

Reports	Recommendations for Board of Health's Consideration and Information
Financial Controls Checklist **(Report No. 009-17FFC)**	It was moved by Mr. Meyer, seconded by Mr. Helmer, *that the Finance & Facilities Committee receive Report No. 009-17FFC re: Financial Controls Checklist for information.* Carried
Impact of Consent Process on Dental Screening Outcomes **(Report No. 010-17FFC)**	It was moved by Mr. Peer, seconded by Mr. Helmer, *that the Finance & Facilities Committee;* *1) Receive Report No. 010-17FFC comparing screening practices between school boards within the jurisdiction of the Health Unit and Ontario for information; and* *2) Direct staff to bring this report and the report from 2007 forward to the next Finance and Facilities Committee meeting for review and input.* Carried

The next Finance and Facilities Committee meeting will be Thursday, April 6, 2017 at 9:00 a.m.

This report was submitted by the Office of the Medical Officer of Health.

Dr. Gayane Hovhannisyan, MD, MHSc, CCFP, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 011-17

TO: Chair and Members of the Governance Committee

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 March 16

ONTARIO PUBLIC HEALTH STANDARDS MODERNIZATION

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 011-17 for information;***
2) ***Direct Health Unit Staff to prepare a written submission in response to the consultation document for Board of Health approval; and***
3) ***Nominate a Board Member to attend the Ministry of Health and Long-Term Care Standards Consultations on March 24, 2017, from 1 p.m. to 4 p.m.***

Key Points

- The Ministry of Health and Long-Term Care's (MOHLTC) Patients First strategy includes Public Health Transformation and the modernization of the Ontario Public Health Standards as one of its major components.
- The Standards for Public Health Programs and Services consultation document was released to health units in February to provide an opportunity for review and feedback.
- Staff members have been reviewing the proposed modernized standards and will attend a further MOHLTC consultation session on March 24 in an effort to prepare a response. This response will be brought to the Board of Health for approval at the April 20 meeting.

Background

In February 2015, the Ontario government released "Patients First: Action Plan for Health Care," which outlines policy directions for the health system. These strategies include stronger links between public health and other health sectors and agencies, such as LHINs. The Patients First strategy focuses on the structural changes necessary to achieve an improved, integrated and efficient health system in Ontario—a system oriented toward being more person-centred. Within this strategy, Public Health Transformation is one of five listed goals.

Standards for Public Health Programs and Services

One part of this Public Health Transformation is the modernization of the Ontario Public Health Standards (OPHS), which establish the minimum requirements for fundamental public health programs and services to be delivered by Ontario's thirty-six boards of health. These requirements include assessment and surveillance, health promotion and policy development, disease and injury prevention, and health protection.

On February 17, 2017, the MOHLTC released a consultation document regarding the updated standards, titled "Standards for Public Health Programs and Services" (Appendix A), and asked that health units provide feedback on issues relating to implementation and clarification of the draft standards.

Association of Local Public Health Agencies – Winter Symposium

At the alPHa Winter Symposium held at the end of February, the MOHLTC provided a technical briefing regarding the Standards for Public Health Programs and Services. alPHa enlisted Dr. Brent Moloughney, a Public Health Consultant, to assist with a preliminary assessment of the revised standards and their potential impacts on public health units.

MOHLTC Consultation

Following the release of the consultation document, Middlesex-London Health Unit staff members have been reviewing the Standards for Public Health Programs and Services to assess:

- New program/service requirements
- Opportunities for greater discretion or program changes
- Areas with reduced expectations
- Areas with enhanced expectations
- Other risks or feedback important for MOHLTC consideration

This input from each team is being collated and will be used at the MOHLTC consultation session to be held in St. Thomas on March 24. Each board of health in Southwestern Ontario is invited to send their Senior Leadership Team and a board representative.

Next Steps

Feedback from staff and additional information from the consultation will be used to formulate a response from the Middlesex-London Health Unit. This response will be brought to the Board of Health for approval at its April 20 meeting, and then forwarded to the MOHLTC for the April 21 deadline.

This report was prepared by the Strategic Projects Team, Corporate Services Division.

Dr. Gayane Hovhannisyan, MD, MHSc, CCFP, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer

Appendix A to Report No. 011-17

Ministry of Health and Long-Term Care

Standards for Public Health Programs and Services

Consultation Document

Planning and Performance Branch
Population and Public Health Division

February 17, 2017

Ministry of Health and Long-Term Care

THIS DOCUMENT IS FOR CONSULTATION PURPOSES ONLY AND IS SUBJECT TO CHANGE. THE FINAL STANDARDS FOR PUBLIC HEALTH PROGRAMS AND SERVICES MUST BE APPROVED BY THE MINISTER OF HEALTH AND LONG-TERM CARE.

Ontario

Table of Contents

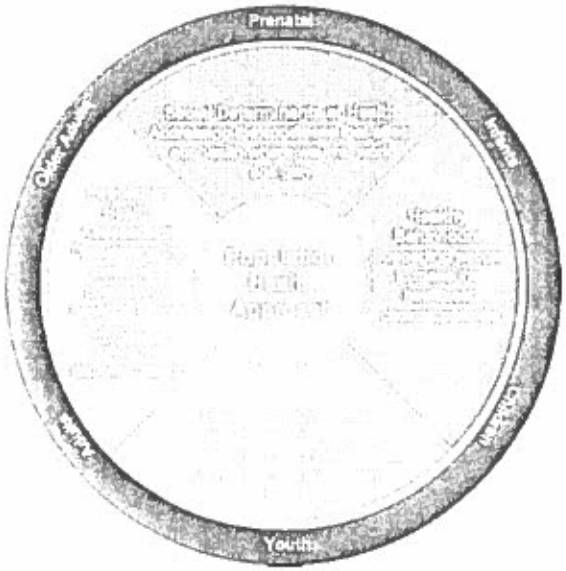
What is Public Health?

The focus of public health is on the whole population. Its work is embedded in the daily lives of the people of Ontario. Public health interventions have made the cars we drive and the food we eat safer, they have protected us from infectious diseases and environmental threats to health, and they have created healthier environments to support and inform choices about risks including those related to tobacco and alcohol. Public health also impacts communities by developing healthier built environments, responding to public health emergencies, and promoting social conditions that improve health.

Public health works through multiple channels and on multiple issues in order to have an impact on the health of the population. The work is diverse, including individual clinical service delivery, education, inspection, surveillance, and policy development among other activities. What unifies public health action is its focus on prevention, upstream interventions and societal factors that influence health.

Our public health system reflects the diversity of the Ontario population. Boards of health serve populations large and small, in urban and rural settings. Each has responsibility for delivering local public health programs and services within their geographic borders. Public health does this in partnership with many other entities including governmental, non-governmental and community organizations. Public health also builds partnerships with Indigenous communities to work together to address their public health needs.

Figure 1: What is Public Health?



Public health work is grounded in a population health approach – focused on upstream efforts to promote health and prevent diseases to improve the health of populations and the differences in health among and between groups. Health risks and priorities change as people grow and age and public health works to address health across the life course.

Defining Our Work: Policy Framework for Public Health Programs and Services

The work of public health is diverse, multi-faceted and expansive. The **Policy Framework for Public Health Programs and Services** (Figure 2) brings focus to core functions of public health and highlights the unique approach to our work. It articulates our shared goal and objectives as the sector transforms, and outlines the contribution of our work in reaching population health outcomes related to health and health equity.

Our goal is realized through the achievement of program outcomes and contributions to population health outcomes - by reducing preventable disease, injury and death and taking action on health inequities for the people of Ontario. The public health sector works in partnership with health and social sectors to contribute to these population health outcomes.

Consistent with the Ministry of Health and Long-Term Care (ministry) policy direction, public health programs and services are focused primarily in four domains:

- Social Determinants of Health
- Healthy Behaviours
- Healthy Communities
- Population Health Assessment

The population health approach assesses more than health status and the biological determinants of health but includes the social factors that influence health, including income, education, and employment. It moves beyond traditional health perspectives that focus on disease and disability, taking into account mental and social well-being and quality of life.

The work of public health is supported and shaped by a series of enabling factors. These include legislation (including the *Health Protection and Promotion Act*), funding, evidence and research, agencies such as Public Health Ontario, public health associations, municipal and federal governments, and organizations with whom we partner both provincially and locally. These enablers help us to achieve our objectives.

The public health sector achieves its objectives and ultimately improves population health outcomes through the delivery of public health programs and services. Our programs and services reach all Ontarians, with a special focus on those at greater risk of poor health outcomes. Delivering public health programs and services also requires partnering with multiple sectors both within and outside of the health system.

Figure 2: Policy Framework for Public Health Programs and Services

GOAL	To improve and protect the health and well-being of the population of Ontario and reduce health inequities
POPULATION HEALTH OUTCOMES	• Improved health and quality of life • Reduced morbidity and mortality • Reduced health inequity among population groups
DOMAINS	Social Determinants of Health Healthy Behaviours
OBJECTIVES	To reduce the negative impact of social determinants that contribute to health inequities To increase knowledge and opportunities that lead to healthy behaviours To increase policies and practices that create safe, supportive and healthy environments To increase the use of population health information to guide the planning and delivery of programs and services in an integrated health system
ENABLERS	Legislation Funding Evidence Agencies & Associations Municipal & Federal Governments Partner Organizations
PROGRAMS AND SERVICES	**GOALS** • To increase the use of public health knowledge and expertise in the planning and delivery of programs and services within an integrated health system • To reduce health inequities with equity focused public health practice • To increase the use of current and emerging evidence to support effective public health practice • To improve behaviours, communities and policies that promote health and well-being • To improve growth and development for infants, children and adolescents • To reduce disease and death related to infectious and communicable diseases of public health importance • To reduce disease and death related to vaccine preventable diseases • To reduce disease and death related to food, water and other environmental hazards • To reduce the impact of emergencies on health
PARTNERS	Health Care (including Primary, Community, Acute and Long-Term Care), Education, Housing, Children and Youth Services, Community and Social Services, Labour, Environment, Agriculture and Food, Transportation, Municipalities, Non-Governmental Agencies, Public and Private Sectors, Academia, and Indigenous communities and organizations

Pubilc Health Transformation

Transformation is happening within the public health sector, including its role in the broader health system. These changes aim to maximize public health's contributions to improve the health of the population and leverage our strengths to inform and reorient the health care system. They will strengthen the public health sector, making it more transparent, accountable, and sustainable. Alongside changes in health care, public health transformation will lead to a more integrated health system that can meet the needs of all Ontarians.

Public Health Transformation is triggered by a series of drivers.

- There are opportunities to improve the quality and delivery of public health programs and services. The evidence base for public health is growing; we know more about effective practice across the core public health functions. The work of public health needs to be responsive to this emerging evidence and Ontario's priority issues.
- There is recognition that public health is disconnected from the broader health care system. Public health's programs and services are not seamlessly integrated with those of other health sectors and public health knowledge and expertise is not a consistent part of health system planning.
- There is a call for greater efficiency across all health sectors, including public health, and a need to strengthen accountability and transparency to demonstrate the contribution and value of public health.

The Standards for Public Health Programs and Services will fulfill three main purposes:

- Incorporate emerging evidence and current accepted best practices in public health.
- Align public health programs and services with broader public health and health system changes.
- Facilitate optimal delivery of public health functions and coordinate delivery of public health programs and services across the full continuum of health.

The Standards for Public Health Programs and Services support tangible improvements in the health of all Ontarians through the delivery of public health programs and services based on the needs and contexts of local communities.

Standards for Public Health Programs and Services

Purpose

The standards define the roles of public health in a transformed system and are informed by the core public health functions which include:

- Assessment and Surveillance
- Health Promotion and Policy Development
- Health Protection
- Disease Prevention
- Emergency Preparedness

Boards of health are responsible for activities in all core function areas.

NOTE: In order to respect the board of health as the body that is accountable to the ministry while also respecting the delegation of authority for the day to day management and administrative tasks to the Medical Officer of Health (and CEO or other executive officers, where applicable), the requirements for the Standards for Public Health Programs and Services have been written as "The board of health shall..."

Scope

Boards of health are responsible for the assessment, planning, delivery, management, and evaluation of a range of public health programs and services that address multiple health needs and respond to the contexts in which these needs occur. The following standards articulate only those programs and services that all boards of health shall provide and are not intended to encompass the total potential scope of public health programming in Ontario.

The scope of these standards includes a broad range of population-based activities designed to promote and protect the health of the population as a whole and reduce health inequities. The role of boards of health is to support and protect the physical and mental well-being, resiliency and social connectedness of the local health unit population with a focus on promoting the protective factors and addressing the risk factors.

The Standards for Public Health Programs and Services identify requirements that should result in specified program outcomes and contribute to population based

outcomes and goals.[1] Boards of health shall tailor programs and services to meet local needs and work towards the achievement of specified outcomes and goals.

Many of the standards are supported by protocols that further specify how to operationalize specific requirements. Boards of health are accountable for implementing requirements articulated in these standards and protocols. Other documents referenced in the standards support planning and implementation. If the phrase 'in accordance with' precedes the document title within the text of the standards or protocols, then compliance with the document is expected.

The achievement of overall goals builds on achievements by boards of health along with those of many other organizations, governmental bodies, and community partners. Population based outcomes and goals help to qualify the collective contribution towards broader health and societal aspirations. Measurement at these levels will meet provincial reporting requirements while assisting boards of health in planning and organizing programs and services in relation to other community partners.

Statutory Basis

Section 5 of the *Health Protection and Promotion Act* (HPPA) specifies that boards of health must superintend, provide or ensure the provision of a minimum level of public health programs and services in specified areas as follows:

- Community sanitation and the prevention or elimination of health hazards;
- Provision of safe drinking water by small drinking water systems;
- Control of infectious and reportable diseases, including providing immunization services to children and adults;
- Health promotion, health protection, and disease and injury prevention;
- Family health;
- Collection and analysis of epidemiological data; and
- Such additional health programs and services as prescribed by regulations.

Section 7 of the HPPA grants authority to the Minister of Health and Long-Term Care to "publish guidelines for the provision of mandatory health programs and services, and every board of health shall comply with the published guidelines" (s.7(1)), thereby establishing the legal authority for the Standards for Public Health Programs and Services.

Where there is a reference to the HPPA within the Standards for Public Health Programs and Services, the reference is deemed to include the HPPA and its regulations.

[1] Refer to Figure 3 for a definition of program outcomes and goals.

Boards of health may deliver additional programs and services in response to local needs identified within their communities, as acknowledged in Section 9 of the HPPA.

Furthermore, boards of health should bear in mind that in keeping with the *French Language Services Act*, services in French should be made available to French-speaking Ontarians located in designated areas.

Boards of health need to be knowledgeable about their duties and responsibilities as specified in other applicable Ontario laws, including but not limited to: the *Building Code Act, 1992;* the *Child Care and Early Years Act, 2014*; the *Employment Standards Act, 2000*; the *Immunization of School Pupils Act*; the *Healthy Menu Choices Act*; the *Smoke Free Ontario Act*; the *Electronic Cigarettes Act*; the *Skin Cancer Prevention Act*; the *Occupational Health and Safety Act*; and the *Personal Health Information Protection Act, 2004*.

Format

The four principles of Need, Impact, Capacity, Partnership, Collaboration and Engagement underpin the Foundational and Program Standards. Boards of health shall us the principles to guide the assessment, planning, delivery, management, and evaluation of public health programs and services.

The Standards for Public Health Programs and Services are organized as follows:

- Four Foundational Standards:
    - Population Health Assessment
    - Health Equity
    - Effective Public Health Practice includes three sections:
        - Program Planning, Evaluation, and Evidence-Informed Decision-Making;
        - Research, Knowledge Exchange, and Communication; and
        - Quality and Transparency.
    - Emergency Preparedness, Response, and Recovery

  The Foundational Standards articulate specific requirements that underlie and support all Program Standards. Population health assessment and surveillance requirements are also included in each Program Standard.

- Eight Program Standards include requirements grouped thematically to address Chronic Diseases and Injury Prevention, Wellness and Substance Misuse; Food Safety; Healthy Environments; Healthy Growth and Development; Immunization; Infectious and Communicable Diseases Prevention and Control; Safe Water; and School Health.

Both the Foundational Standards and the Program Standards articulate broad population based goals, program outcomes, and requirements.

Although requirements are listed thematically, boards of health shall assess, plan, deliver, manage, and evaluate programs and services cohesively across thematic areas, impacting multiple settings and meeting needs across the lifespan.

A description of the Principles, the Foundational Standards, Program Standards, and related goals, program outcomes, and requirements is depicted in Figure 3.

Figure 3: Standards for Public Health Programs and Services: Description of the Principles, the Foundational Standards and the Program Standards

Principles	
Need	Boards of health shall continuously tailor their programs and services to address needs of the health unit population. Need is established by assessing the distribution of social determinants of health, health status, and incidence of disease and injury.
Impact	Boards of health shall assess, plan, deliver, and manage their programs and services by considering evidence, effectiveness of the intervention, barriers to achieving maximum health potential, relevant performance measures, and unintended consequences.
Capacity	Understanding local public health capacity required to achieve outcomes is essential to ensure the effective and efficient delivery of public health programs and services. Boards of health shall strive to make the best use of available resources to achieve the capacity required to meet the standards.
Partnership, Collaboration and Engagement	Boards of health shall engage and establish meaningful relationships with a variety of sectors, partners, communities, priority populations, and citizens, which are essential to the work of public health and support health system efficiency. Establishing meaningful relationships with priority populations includes building and further developing the relationship with Indigenous communities. These relationships may take many forms and need to be undertaken in a way that is meaningful to the community and/or organization.

Foundational Standards			
Population Health Assessment	Health Equity	Effective Public Health Practice	Emergency Preparedness, Response, and Recovery

Program Standards							
Chronic Diseases and Injury Prevention, Wellness and Substance Misuse	Food Safety	Healthy Environments	Healthy Growth and Development	Immunization	Infectious and Communicable Diseases Prevention and Control	Safe Water	School Health

Components of Each Standard		
Goal	**Program Outcomes**	**Requirements**
The goal is a statement that reflects the broadest level of results to be achieved in a specific standard. The work of boards of health, along with other parts of the health system, community partners, non-governmental organizations, governmental bodies, and community members, contribute to achieving the goal.	Program outcomes are the results of programs and services implemented by boards of health. Outcomes often focus on changes in awareness, knowledge, attitudes, skills, practices, environments, and policies. Each board of health shall establish internal processes for managing day-to-day operations of programs and services to achieve desired program outcomes.	Requirements are the specific statements of action. Requirements articulate the activities that boards of health are expected to undertake. Some requirements are core to public health practice and are expected to be adhered to consistently across the province while others are to be carried out in accordance with the local context through the use of detailed population based analysis and situational assessment. All programs and services are tailored to reflect the local context and are responsive to the needs of priority populations.[2] Protocols are named in many requirements to provide further direction on how boards of health must operationalize specific requirement(s).

Standardization and Variability

The modernized Standards for Public Health Programs and Services balance the need for **standardization** across the province with the need for **variability** to respond to local needs, priorities and contexts.

Specificity remains for those programs and services where standardization is required to protect the health of the public.

A flexible approach accommodates greater variability where there is an opportunity to plan programs to decrease health inequities and address the needs of priority populations.

[2] Priority populations as defined in the Foundational Standards.

Standards

Foundational Standards

Public health programs and services that are informed by evidence are the foundation for effective public health practice. Evidence-informed practice is responsive to the needs and emerging issues of the health unit and uses the best available evidence to address them.

- Population health assessment is integral to public health practice.
- A focus on health equity is important to the delivery of all public health programs and services in order to support people to reach their full health potential.
- Effective public health practice requires boards of health to apply skills in evidence-informed decision-making, research, knowledge exchange, program planning and evaluation, communication, with a continued focus on quality and transparency.
- Emergency preparedness, response and recovery are critical roles that boards of health play in ensuring that they have the capacity to respond to new and emerging events and cope with a range of disruptions.

Population Health Assessment

Population health assessment includes measuring, monitoring, and reporting on the status of a population's health, including determinants of health and health inequities. Population health assessment provides the information necessary to understand the health of populations through the collaborative development and ongoing maintenance of population health profiles, identification of challenges and opportunities, and monitoring of the health impacts of public health practice.

Population health assessment also includes a monitoring role, described as epidemiological surveillance. This is the systematic and ongoing collection, collation, and analysis of health-related information that is communicated in a timely manner to all who need to know, so that action can be taken. It contributes to effective public health program planning, delivery, and management. Dissemination of analyses may take the form of reports, advisories, healthy public policy recommendations, alerts, or warnings.

Goal

Public health practice responds effectively to current and evolving conditions, and contributes to the public's health and well-being with programs and services that are informed by the population's health status, including determinants of health and health inequities.

Program Outcomes

- Local public health programs and services align with the needs of the local population, as demonstrated through surveillance and assessment.
- Public health programs and services are planned and implemented to address local population health needs.
- The public, community partners, and health care providers are aware of relevant and current population health information.
- Resources are allocated to reflect public health priorities and reallocated, as feasible, to reflect emergent public health priorities.
- Planning and delivery of programs and services is tailored to meet the identified needs of priority populations.
- Local Health Integration Networks (LHIN(s)) and other relevant community partners have and use available population health information, including information on health inequities, that is necessary for planning, delivering, and monitoring health services responsive to population health needs.

Requirements

1. The board of health shall conduct surveillance, including the ongoing collection, collation, analysis, and periodic reporting of population health information, as required by the *Health Protection and Promotion Act* and in accordance with the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
2. The board of health shall interpret and use surveillance data to communicate information on risks to relevant audiences in accordance with the *Healthy Environments Protocol, 2017* (to be drafted); the *Infectious Diseases Protocol, 2016* (or as current); and the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
3. The board of health shall assess current health status, health behaviours, preventive health practices, health care utilization relevant to public health, and demographic indicators, including the assessment of trends and changes, in accordance with the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
4. The board of health shall use population health, determinants of health and health inequities information to assess the needs of the local population, including the identification of populations at risk, to determine those groups that would benefit most from public health programs and services (i.e., priority populations).[3]

[3] Priority populations are identified by surveillance, epidemiological, or other research studies. They are those populations that are at risk and for which public health interventions may be reasonably considered to have a substantial impact at the population level.

5. The board of health shall tailor public health programs and services to meet local population health needs, including those of priority populations, to the extent possible based on available resources.
6. The board of health shall provide population health information, including determinants of health and health inequities, to the public, LHIN(s), community partners, and health care providers, in accordance with the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
7. *Requirement pending:*

   **Work is currently underway to define the parameters of population health assessment and expectations for the relationship between LHIN(s), boards of health, as well as LHIN CEOs and Medical Officers of Health or their designates.*

Health Equity

Health is influenced by a broad range of factors - genetics, individual lifestyles and behaviours, and the physical, social, and economic environments in which we live. These factors contribute to health experienced by individuals and to the overall level of health in a community or population. Factors beyond an individual's biology and behaviours - those that form the conditions in which people are born, grow up, live, and work - are known as the social determinants of health. Any differences or variations in health status between groups are known as health inequalities. When health inequalities have the potential to be changed or decreased by social action, they are labelled as health inequities.

Health inequities are health differences that are:

- Systematic, meaning that health differences are patterned, where health generally improves as socio-economic status improves;
- Socially produced, and therefore could be avoided by ensuring that all people have the social and economic conditions that are needed for good health and well-being; and
- Unfair and unjust because opportunities for health and well-being are limited.

Health equity means that all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance. Boards of health shall assess the impact of the social determinants of health on population health outcomes as they consider the need for programs and services.

Indigenous Communities and Organizations

The Indigenous population in Ontario is comprised of First Nations, Métis, and Inuit people. There are many different First Nation and urban Indigenous communities across the province, each with their own histories, cultures, governance and organizational approaches.

Relationships between boards of health and Indigenous communities and organizations need to come from a place of trust, mutual respect, understanding, and reciprocity. It is important to acknowledge that as part of this relationship building, First Nations in Ontario believe that Canada, as a Treaty partner, also has an obligation to continue to contribute to the improvement of health care and health outcomes for their communities.

One important first step for boards of health in beginning to build and/or further develop their relationships with Indigenous communities is to ensure it is done in a culturally safe way. A series of tools will be made available to boards of health and will be further outlined in a Guidance Document, including opportunities for cultural safety training approaches.[4]

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[4] An accompanying Guidance Document will provide further guidance to boards of health on how Indigenous communities view these relationships and will provide some potential approaches and best practices that may be considered. It will also include a better understanding of the different Indigenous communities that may be within the geographic boundaries of the health unit.

Goal

Public health practice aims to decrease health inequities such that everyone has equal opportunities for health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances.

Program Outcomes

- Multi-sectoral collaboration informs development of local strategies to decrease health inequities.
- Community partners and the public are aware of local health inequities and their causes.
- There is an increased awareness on the part of the LHIN(s) and other community partners of the impact of social determinants of health on health outcomes and increased support for actions to decrease health inequities.
- Priority populations are meaningfully engaged in the planning of public health interventions.
- Indigenous communities are engaged in a way that is meaningful for them.

Requirements

1. The board of health shall assess and report on the health of local populations describing the existence and impact of health inequities and identifying effective local strategies to decrease health inequities.
2. The board of health shall modify and orient public health interventions to decrease health inequities by:
   a) Engaging priority populations in considering their unique needs, histories, cultures, and capacities; and
   b) Aiming to improve the health of the entire population while leveling up the health of priority populations.
3. The board of health shall engage in community and multi-sectoral collaboration with LHIN(s) and other relevant stakeholders in decreasing health inequities. Engagement with Indigenous organizations and communities shall include, but not be limited to, fostering the creation of meaningful relationships with them, starting with engagement through to collaborative partnership.
4. The board of health shall lead, support, and participate with other stakeholders in policy development, health equity analysis, and promoting decreases in health inequities.

Effective Public Health Practice

Goal

Public health practice is transparent, responsive to current and emerging evidence and emphasizes continuous quality improvement.

Program Outcomes

- Public health programs and services are reflective of local population health issues, the best available evidence, new public health knowledge, and adapted to the local context.
- Public health programs are modified to address issues related to program effectiveness.
- Public health practitioners, policy-makers, community partners, health care providers, and the public are aware of the factors that determine the health of the population.
- Public health research and knowledge exchange activities are reflective of effective partnerships with community researchers, academic partners, and other appropriate organizations.
- The public and community partners are aware of ongoing public health program improvements.
- Public health communication strategies reflect a variety of communication modalities and local needs.
- Ongoing program improvements enhance client and community partner experience and address issues identified through various means.

Program Planning, Evaluation, and Evidence-Informed Decision-Making

Program planning and evaluation are part of an ongoing and iterative cycle of program development and improvement.

A program is a plan of action intended to achieve specific outcomes. Program planning is an ongoing, iterative process that organizations use to develop and modify a program throughout its lifespan.

Program evaluation is the systematic gathering, analysis, and reporting of data about a program to assist in decision-making. It includes quantitative, qualitative, and mixed-method approaches. Program evaluation produces the information needed to support the establishment of new programs and services (needs assessment); assess whether evidence-informed programs and services are carried out with the necessary reach,

intensity, and duration (process evaluation); or document the effectiveness and efficiency of programs and services (outcome evaluation).

Evidence-informed decision-making is the process of analyzing and using the best available evidence from research, context, and experience to inform decisions on development and delivery of public health programs and services.

Evidence to inform the decision-making process may come from a variety sources including: key facts, findings, trends, and recommendations from published scientific research; data and analyses obtained from population health assessment and surveillance; legal and political environments; stakeholder perspectives; public engagement; and recommendations based on past experiences including program evaluation information.

A number of tools and resources are available to support decision-makers in making evidence-informed decisions.

Requirements

1. The board of health shall develop, implement, and make available to the public a Board of Health Annual Service Plan and Budget Submission[5] which:
   a) Demonstrates the use of a systematic process to plan public health programs and services to address the needs of the community by integrating the best available research and evaluation evidence with contextual factors such as local population health issues, priority populations, community assets and needs, political climate, public engagement, and available resources; and
   b) Describes the public health programs and services planned for implementation and the information which informed it.
2. The board of health shall routinely monitor program activities and outcomes to assess and improve the implementation and effectiveness of programs and services, including collection, analysis, and periodic reporting of indicators related to inputs, resources, implementation processes, reach, outputs, and outcomes.
3. The board of health shall consider the need for program evaluation (e.g., when new interventions are developed or implemented, or when there is evidence of unexpected operational issues or program results, to understand the linkages between inputs, activities, outputs, and outcomes) and conduct program evaluation where required.
4. The board of health shall use a range of methods to facilitate public health practitioners' and policy-makers' awareness of the factors that contribute to program effectiveness.
5. The board of health shall ensure all programs and services are informed by evidence.

[5] The Board of Health Annual Service Plan and Budget Submission will be further delineated in the Ministry-Board of Health Accountability Agreement.

Research, Knowledge Exchange, and Communication

Exploring an issue or investigating a question is accomplished through research - the organized and purposeful collection, analysis, and interpretation of data.

Research may involve the primary collection of new data or the analysis or synthesis of existing data and findings.

Knowledge exchange is collaborative problem-solving among public health practitioners, researchers, and decision-makers. It results in mutual learning through the process of planning, producing, disseminating, and applying existing or new research in decision-making.

Promoting and protecting the public's health require effective communication. Various communication strategies may be needed to ensure the greatest impact, depending on the population, local context, available resources, and local and provincial priorities.

Requirements

6. The board of health shall engage in knowledge exchange activities with public health practitioners, policy-makers, community partners, health care providers, and the public regarding factors that determine the health of the population as informed by population health assessment, surveillance, research, and program evaluation.
7. The board of health shall foster relationships with community researchers, academic partners, and other appropriate organizations including Public Health Ontario, to support public health research and knowledge exchange.
8. The board of health shall engage in public health research activities,[6] which may include those conducted by the board of health alone or in partnership or collaboration with other organizations.
9. The board of health shall use a variety of communication modalities, including social media, taking advantage of existing resources where possible, and complementing national/provincial health communications.

Quality and Transparency

A public health system with a culture of quality and transparency is safe, effective, client and community/population centered, efficient, responsive, and timely.

Requirements

10. The board of health shall ensure a culture of quality and continuous organizational self-improvement that underpins programs and services and public health practice and demonstrates transparency and accountability to clients, the public, and other stakeholders. This includes, but is not limited to:

[6] Research activities that involve personal health information must comply with the *Personal Health Information Protection Act, 2004* and specifically with Section 44 of that Act.

a) Identification and use of tools, structures, processes and priorities to measure and improve the quality of programs and services. This may include the establishment of a Quality/Practice Committee and/or the development and monitoring of a Quality Improvement Plan;

b) Measurement of client, community, and stakeholder/partner experience to inform transparency and accountability;

c) Regular review of outcome data that includes variances from performance expectations and implementation of remediation plans; and

d) Use of external peer reviews.

11. The board of health shall publicly disclose results of all inspections or information in accordance with the *Drinking Water Protocol, 2014* (or as current); the *Food Safety Protocol, 2016* (or as current); the *Electronic Cigarettes Compliance Protocol, 2016* (or as current); the *Infection Prevention and Control in Child Care Centres Protocol, 2016* (or as current); the *Infection Prevention and Control in Personal Services Settings Protocol, 2016* (or as current); the *Infection Prevention and Control Practices Complaint Protocol, 2015* (or as current); the *Recreational Water Protocol, 2016* (or as current); the *Tanning Beds Compliance Protocol, 2014* (or as current); the *Tobacco Compliance Protocol, 2016* (or as current); and the *Vaccine Storage and Handling Protocol, 2016* (or as current).

Emergency Preparedness, Response, and Recovery

Emergencies can occur anywhere and at any time. Boards of health in Ontario regularly experience new and emerging events ranging from infectious diseases such as SARS, the H1N1 influenza pandemic, and Ebola virus disease to extreme weather events and environmental hazards such as flooding and forest fires.

Effective emergency preparedness, response, and recovery ensures that boards of health are ready to cope with and recover from threats to public health or disruptions to public health programs and services. This is done through a range of activities carried out in coordination with other partners.

This planning, and its associated activities, is a critical role in strengthening the overall resilience of boards of health and the broader health system. Ministry policy and expectations to support a ready and resilient health system will be outlined separately.

Goal

To enable consistent and effective preparedness for, response to, and recovery from emergency situations.

Program Outcome

- The ongoing readiness of the board of health to respond to and recover from new and emerging events and/or emergencies with public health impacts.

Requirement

1. The board of health shall effectively prepare for emergencies to ensure timely, integrated, safe, and effective response to, and recovery from emergencies with public health impacts, in accordance with ministry policy and guidance documents.[7]

[7] The forthcoming ministry policy for a ready and resilient health system will set expectations across the broader health system. This will include direction for public health units in the establishment of an integrated program that incorporates emergency management practices.

Program Standards

Chronic Diseases and Injury Prevention, Wellness and Substance Misuse

Goal

To reduce the burden of chronic diseases of public health importance, preventable injuries, and substance misuse.[8]

Program Outcomes

- There is a reduction in population health inequities related to chronic diseases, injuries, and substance misuse.
- Population health inequities and priority populations have been identified and relevant data have been communicated to community partners.
- Public health chronic diseases, injury prevention, and substance misuse programs and services are implemented taking into account all relevant programs and services available in the health unit.
- Community partners, including policy-makers, and the public are meaningfully engaged in the planning, implementation, development and evaluation of chronic diseases, injury prevention, and substance misuse programs and services of relevance to the community.
- There is increased public awareness of the risk factors and healthy behaviours associated with chronic diseases, substance misuse, and injuries.
- There is an increased adoption of healthy living behaviours among populations targeted through chronic diseases, injury prevention, and substance misuse program interventions.
- Youth have reduced access to tobacco products, e-cigarettes and tanning beds.
- Tobacco vendors are in compliance with the *Smoke-Free Ontario Act*.

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[8] Chronic diseases of public health importance include, but are not limited to, cardiovascular diseases, respiratory disease, cancer, diabetes, and mental illness (including problematic use of alcohol and other substances, suicide, suicide attempts, and suicide ideation). Injury, both intentional and unintentional, prevention includes, but is not limited to, falls across the lifespan, road and off-road safety, and other injuries of public health importance.

- Tanning bed operators are in compliance with the *Skin Cancer Prevention Act (Tanning Beds), 2013.*
- E-cigarette vendors are in compliance with the *Electronic Cigarettes Act, 2015.*
- Community partners have knowledge of, and increased capacity to act on, the factors associated with healthy living behaviours, skills and practices, healthy policies, and supportive environments.
- Food premises are in compliance with the *Healthy Menu Choices Act, 2015.*

Requirements

1. The board of health shall collect and analyze relevant data to monitor trends over time and population inequities in outcomes, and communicate the population results in accordance with the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
2. The board of health shall implement a program of public health interventions that addresses chronic diseases and substance misuse risk factors to reduce the burden of illness from chronic diseases and substance misuse in the health unit population, informed by:
   a) An assessment of the risk and protective factors for, and distribution of, chronic diseases and substance misuse;
   b) Evidence of the effectiveness of the interventions employed;
   c) Consultation and collaboration with local stakeholders in the health, education, municipal, non-governmental and other relevant sectors including LHIN(s); and
   d) Consideration of the following topics based on an assessment of local needs:
      - Alcohol and other substance misuse (e.g., illicit drugs, including harm reduction strategies);
      - Built environment;
      - Comprehensive tobacco control (including addressing e-cigarettes and emerging products);
      - Healthy eating;
      - Healthy sexuality;
      - Mental health promotion;
      - Oral health;
      - Physical activity and sedentary behaviour;
      - Sleep;

- Suicide risk and prevention; and
- UV exposure.

3. The board of health shall implement a program of public health interventions to reduce the burden of illness from injuries in the health unit population, informed by:
   a) An assessment of the risk factors for, and distribution of, injuries;
   b) Evidence of the effectiveness of the interventions employed;
   c) Consultation and collaboration with local stakeholders in the health, education, municipal, non-governmental and other relevant sectors including LHIN(s); and
   d) Consideration of the following topics based on an assessment of local needs:
      - Concussions;
      - Falls;
      - Off-road safety;
      - Road safety; and
      - Violence.
4. The board of health shall include a description, as part of its Board of Health Annual Service Plan and Budget Submission, of its programs of public health interventions that:
   a) Address chronic diseases and substance misuse risk factors to reduce the burden of illness from chronic diseases in the health unit population; and
   b) Prevent and reduce the burden of illness from injuries in the health unit population.
5. The board of health shall implement and enforce the *Smoke-Free Ontario Act* in accordance with the *Tobacco Compliance Protocol, 2016* (or as current).
6. The board of health shall implement and enforce the *Skin Cancer Prevention Act (Tanning Beds), 2013* in accordance with the *Tanning Beds Compliance Protocol, 2014* (or as current).
7. The board of health shall implement and enforce the *Electronic Cigarettes Act, 2015,* in accordance with the *Electronic Cigarettes Compliance Protocol, 2016* (or as current).
8. The board of health shall implement and enforce the *Healthy Menu Choices Act, 2015*, in accordance with the *Menu Labelling Compliance Protocol, 2017* (or as current).

Food Safety

Goal

To prevent or reduce the burden of food-borne illnesses.

Program Outcomes

- Timely and effective detection, identification, and response to food-borne illnesses, their associated risk factors, emerging trends, and unsafe food offered for public consumption.
- Food-borne illness risks are mitigated.
- Food handlers handle and manage food for public consumption in a safe and sanitary manner.
- The public and community partners are aware of safe food-handling practices and food safety issues.
- There is reduced incidence of food-borne illnesses.

Requirements

1. The board of health shall:
   a) Conduct surveillance of suspected and confirmed food-borne illnesses, food premises, and food for public consumption;
   b) Conduct epidemiological analysis of surveillance data including monitoring of trends over time, emerging trends, and priority populations; and
   c) Respond by adapting programs and services in accordance with the *Food Safety Protocol, 2016* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
2. The board of health shall report Food Safety Program data elements in accordance with the *Food Safety Protocol, 2016* (or as current).
3. The board of health shall ensure food handlers in food premises have access to training in safe food-handling practices and principles in accordance with the *Food Safety Protocol, 2016* (or as current).
4. The board of health shall increase public awareness of food-borne illnesses and safe food-handling practices and principles in accordance with the *Food Safety Protocol, 2016* (or as current) by:

a) Adapting and/or supplementing national/provincial food safety communications strategies where local assessment has identified a need; and/or

b) Developing and implementing regional/local communications strategies where local assessment has identified a need.

5. The board of health shall inspect food premises and foods offered for public consumption and provide all the components of the Food Safety Program defined by the *Health Protection and Promotion Act* and in accordance with the Food Premises Regulation (O. Reg. 562); the *Food Safety Protocol, 2016* (or as current); and all other applicable Acts.

6. The board of health shall ensure 24/7 availability to receive reports of and respond to:

   a) Suspected and confirmed food-borne illnesses or outbreaks;

   b) Unsafe food-handling practices, food recalls, adulteration, and consumer complaints; and

   c) Food-related issues arising from floods, fires, power outages, or other situations that may affect food safety in accordance with the *Health Protection and Promotion Act*; the *Food Safety Protocol, 2016* (or as current); and the *Infectious Diseases Protocol, 2016* (or as current).

Healthy Environments

Goal

To reduce exposure to health hazards[9] and promote the development of healthy natural and built environments that support health and mitigate existing and emerging risks, including the impacts of a changing climate.

Program Outcomes

- Timely and effective detection, identification, and response to health hazards and associated public health risks, trends, and illnesses.
- The public is aware of health protection and prevention activities related to health hazards and conditions that create healthy natural and built environments.
- Community partners have the information necessary to create healthy public policies related to reducing exposure to health hazards and creating healthy natural and built environments.
- The public and community partners are aware of health hazard incidents and risks in a timely manner.
- There is reduced public exposure to health hazards.

Requirements

1. The board of health shall:
   a) Conduct surveillance of the environmental health status of the community;
   b) Conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations; and
   c) Use information obtained to inform Healthy Environments programs and services

   in accordance with the *Health Hazard Response Protocol, 2017* (to be drafted); the *Healthy Environments Protocol, 2017* (to be drafted); the *Infectious Diseases Protocol, 2016* (or as current); and the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
2. The board of health shall identify risk factors and priority health needs in the local physical and natural environments related to building a healthy environment.

[9] Health hazard, as defined in s.1(1) of the *Health Protection and Promotion Act*, means "(a) a condition of a premises, (b) a substance, thing, plant or animal other than man, or (c) a solid, liquid, gas or combination of any of them, that is likely to have an adverse effect on the health of any person."

3. The board of health shall develop effective strategies in collaboration with community partners to reduce exposure to health hazards and promote healthy natural and built environments in accordance with the *Health Hazard Response Protocol, 2017* (to be drafted) and the *Healthy Environments Protocol, 2017* (to be drafted).
4. The board of health shall, as part of its strategy to reduce exposure to health hazards and promote healthy natural and built environments, effectively communicate with the public by:
   a) Adapting and/or supplementing national/provincial health communications strategies where local assessment has identified a need;
   b) Developing and implementing regional/local communications strategies where local assessment has identified a need; and
   c) Addressing the following topics based on an assessment of local needs:
      - Built environment;
      - Climate change;
      - Exposure to chemical contamination;
      - Exposure to hazardous environmental contaminants and biological agents;
      - Exposure to radiation;
      - Extreme weather;
      - Indoor air pollutants;
      - Outdoor air pollutants; and
      - Other measures as emerging health issues arise.
5. The board of health shall assess and inspect facilities where there is an elevated risk of illness associated with exposures that are known or suspected to be associated with health hazards in accordance with the *Health Hazard Response Protocol, 2017* (to be drafted).
6. The board of health shall investigate potential health hazards and respond by preventing or reducing exposure to health hazards in accordance with the *Health Hazard Response Protocol, 2017* (to be drafted).
7. The board of health shall ensure 24/7 availability to receive reports of and respond to health hazards in accordance with the *Health Protection and Promotion Act* and the *Healthy Environments Protocol, 2017* (to be drafted).

Healthy Growth and Development

Goal

To achieve optimal maternal, newborn, child, youth, and family health.

Program Outcomes

- There is a reduction in health inequities related to healthy growth and development.
- Increased community partner knowledge about the factors associated with, and effective programs for, the promotion of healthy growth and development and managing the stages of the family life cycle.
- Increased collaboration among community partners, children, youth, emerging adults, and parents in the planning, development, implementing, and evaluation of programs, services, and policies which positively impact healthy families and communities.
- Individuals and families have increased knowledge, skills and access to local resources related to healthy growth and development to effectively manage the different life stages and their transitions (e.g., maternal, newborn, child, and youth).
- Increased public knowledge about the importance of creating safe and supportive environments that promote healthy growth and development.
- Increased awareness among youth and emerging adults about contraception and healthy pregnancies.
- Families are aware of community resources and tools available to assess children's health and development.

Requirements

1. The board of health shall collect, obtain, and analyze relevant data to monitor trends over time in outcomes, in healthy growth and development and population inequities, and communicate the population results in accordance with the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
2. The board of health shall implement a program of public health interventions to support healthy growth and development in the health unit population, informed by:
   a) An assessment of risk and protective factors that influence healthy growth and development;

b) Evidence of the effectiveness of the interventions employed;

c) Consultation and collaboration with local stakeholders in the health, education, municipal, non-governmental, social, and other relevant sectors with specific attention to:

- School boards, principals, educators, parent groups, student leaders, and students;
- Child care providers and organizations that provide child care services, such as Community Hubs and Family Centres;
- Health care providers and LHIN(s);
- Social service providers; and
- Municipalities.

d) Consideration of the following topics based on an assessment of local needs:

- Breastfeeding;
- Growth and development;
- Healthy pregnancies;
- Healthy sexuality;
- Mental health promotion;
- Preconception health;
- Preparation for parenting; and
- Positive parenting.

3. The board of health shall include a description, as part of its Board of Health Annual Service Plan and Budget Submission, of its programs of public health interventions to support healthy growth and development.

4. The board of health shall provide all components of the Healthy Babies Healthy Children Program in accordance with the *Healthy Babies Healthy Children Protocol, 2012* (or as current) (Ministry of Children and Youth Services).

Immunization

Goal

To reduce or eliminate the burden of vaccine preventable diseases through immunization.

Program Outcomes

- There is reduced incidence of vaccine preventable diseases.
- Timely and effective detection and identification of children susceptible to vaccine preventable diseases, their associated risk factors, and emerging trends.
- Timely and effective detection and identification of priority populations facing barriers to immunization, their associated risk factors, and emerging trends.
- Health care providers are knowledgeable of and adhere to improved practices related to proper vaccine management, including storage and handling and inventory management.
- There is reduced vaccine wastage.
- Target coverage rates for provincially funded immunizations are achieved.
- Effective outbreak management related to vaccine preventable disease outbreaks is achieved.
- The public and community partners are aware of the importance of immunization.
- Health care providers report adverse events following immunization to the board of health.
- Children have up-to-date immunizations according to the current Publicly Funded Immunization Schedules for Ontario, and in accordance with the *Immunization of School Pupils Act*, and the *Child Care and Early Years Act, 2014*.

Requirements

1. The board of health shall assess, maintain records, and report on:
   a) The immunization status of children enrolled in child care centres as defined in the *Child Care and Early Years Act, 2014*; and
   b) Immunizations administered at board of health-based clinics as required in accordance with the *Immunization Management Protocol, 2016* (or as current) and the *Infectious Diseases Protocol, 2016* (or as current).

2. The board of health shall conduct epidemiological analysis of surveillance data for vaccine preventable diseases, vaccine coverage, and adverse events following immunization, including monitoring of trends over time, emerging trends, and priority populations[10] in accordance with the *Infectious Diseases Protocol, 2016* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
3. The board of health shall work with community partners to improve public knowledge and confidence in immunization programs and services by:
   a) Adapting and/or supplementing national/provincial health communications strategies where local assessment has identified a need;
   b) Developing and implementing regional/local communications strategies where local assessment has identified a need; and
   c) Addressing the following topics based on an assessment of local needs:
      - The importance of immunization;
      - Diseases that vaccines prevent;
      - Recommended immunization schedules for children and adults and the importance of adhering to the schedules;
      - Introduction of new provincially funded vaccines;
      - Promotion of childhood and adult immunization, including high-risk programs and services;
      - The importance of maintaining a personal immunization record for all family members;
      - Immunization for travelers;
      - The importance of reporting adverse events following immunization;
      - Reporting immunization information to the board of health as required;
      - Vaccine safety; and
      - Legislation related to immunizations.
4. The board of health shall provide consultation to community partners on immunization and immunization practices based on local needs and as requested.
5. The board of health shall promote and provide provincially funded immunization programs and services to eligible persons in the health unit, including underserviced and priority populations.

[10] Priority populations as defined in the Foundational Standards.

6. The board of health shall have a contingency plan to deploy board of health staff capable of providing vaccine preventable diseases outbreak management and control, such as mass immunization, in the event of a community outbreak.
7. The board of health shall provide a comprehensive information and education strategy to promote optimal vaccine management, including storage and handling practices, among health care providers in accordance with the *Vaccine Storage and Handling Protocol, 2016* (or as current). This shall include:
   a) Training at the time of cold chain inspection;
   b) Distributing information to new health care providers who handle vaccines; and
   c) Providing ongoing support to existing health care providers who handle vaccines.
8. The board of health shall ensure that the storage and distribution of provincially funded vaccines, including to health care providers practicing within the health unit, is in accordance with the *Vaccine Storage and Handling Protocol, 2016* (or as current).
9. The board of health shall promote vaccine inventory management in all premises where provincially funded vaccines are stored in accordance with the *Vaccine Storage and Handling Protocol, 2016* (or as current).
10. The board of health shall:
    a) Promote reporting of adverse events following immunization by health care providers to the local board of health in accordance with the *Health Protection and Promotion Act*; and
    b) Monitor, investigate, and document all suspected cases of adverse events following immunization that meet the provincial reporting criteria[11] and promptly report all cases.

[11] The provincial reporting criteria are under development at the Federal/Provincial/Territorial level.

Infectious and Communicable Diseases Prevention and Control

Goal

To reduce the burden of communicable diseases and other infectious diseases of public health importance.[12,13]

Program Outcomes

- Timely and effective detection, identification, and management of exposures and local cases/outbreaks of infectious and communicable diseases of public health importance, including reportable diseases, their associated risk factors, and emerging trends.
- The public, health care providers, and other relevant partners, including emergency service workers are aware of the epidemiology, associated risk and protective factors, and practices related to the prevention and control of infectious and communicable diseases of public health importance.
- Effective partnerships support actions to prevent and control the spread of infectious and communicable diseases of public health importance.
- Effective case management results in limited secondary cases.
- Priority populations have access to harm reduction services and supports necessary to adopt healthy behaviours and practices that prevent exposure to and the transmission of sexually transmitted infections and blood-borne infections.
- There is reduced transmission of infections and communicable diseases including reduced progression of tuberculosis (TB).

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[12] Infectious diseases of public health importance include, but are not limited to, those specified reportable diseases as set out by Regulation 559/91 (as amended) under the *Health Protection and Promotion Act* and include zoonotic and vector-borne diseases. Emerging infectious diseases may be considered of public health importance based on a variety of criteria, including their designation as an emerging disease by international, Federal, and/or Provincial/Territorial health authorities, their potential for preventability or public health action, and the seriousness of their impact on the health of the population and potential spread.

[13] Communicable diseases are a subset of infectious diseases and defined in the legislation as set out by Regulation 558/91 (as amended) under the *Health Protection and Promotion Act.*

- The public, community partners, and health care providers report all suspected rabies exposures.
- Public health risks associated with infection prevention and control lapses are managed and mitigated effectively and efficiently.
- Settings that are required to be inspected are aware of and use infection prevention and control practices.

Requirements

1. The board of health shall conduct population health assessment and surveillance regarding infectious and communicable diseases and their determinants. These efforts shall include:

   a) Reporting data elements in accordance with the *Health Protection and Promotion Act*; the *Infectious Diseases Protocol, 2016* (or as current); the *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2013* (or as current); the *Rabies Prevention and Control Protocol, 2013* (or as current); and the *Tuberculosis Prevention and Control Protocol, 2008* (or as current);

   b) Conducting surveillance and epidemiological analysis, including the monitoring of trends over time, emerging trends, and priority populations[14] in accordance with the *Infectious Diseases Protocol, 2016* (or as current); the *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2013* (or as current); the *Rabies Prevention and Control Protocol, 2013* (or as current); the *Tuberculosis Prevention and Control Protocol, 2008* (or as current); and the *Population Health Assessment and Surveillance Protocol, 2016* (or as current);

   c) Responding to international, Federal, Provincial/Territorial and local changes in diseases epidemiology by adapting programs and services; and

   d) Using the information obtained through assessment and surveillance to inform program development regarding communicable diseases and other infectious diseases of public health importance.

2. The board of health shall provide public education to increase awareness related to infection prevention and control measures, including respiratory etiquette, and hand hygiene. These efforts shall include:

   a) Adapting and/or supplementing national/provincial health education/communications strategies where local assessment has identified a need; and/or

[14] Priority populations as defined in the Foundational Standards.

b) Developing and implementing regional/local communications strategies where local assessment has identified a need.

3. The board of health shall work with community partners and service providers to determine and address the need for knowledge translation resources and supports in the area of infection prevention and control. These efforts shall include:

   a) Adapting and/or supplementing national/provincial health education/communications strategies where local assessment has identified a need; and/or

   b) Developing and implementing regional/local communications strategies where local assessment has identified a need.

4. The board of health shall use health promotion approaches to increase adoption of healthy behaviours among the population regarding sexual practices and injection drug use to prevent and reduce exposures to sexually transmitted and blood-borne infections by collaborating with and engaging health care providers, community and other relevant partners, and priority populations.

5. The board of health shall collaborate with health care providers and community partners, including school boards, to create supportive environments to promote healthy sexual practices[15] and access to sexual health services and harm reduction programs and services for priority populations.

6. The board of health shall participate on committees, advisory bodies, or networks that address infection prevention and control practices[16] and policies of, but not limited to, hospitals and long-term care homes in accordance with the *Institutional/Facility Outbreak Prevention and Control Protocol, 2016* (or as current).

7. The board of health shall work with appropriate partners to increase awareness among relevant community partners, including correctional facilities, health care, and other service providers, of:

   a) The local epidemiology of communicable diseases and other infectious diseases of public health importance;

   b) Infection prevention and control practices; and

   c) Reporting requirements for reportable diseases, as specified in the *Health Protection and Promotion Act*.

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[15] Healthy sexual practices include, but are not limited to, contraception, pregnancy counselling, and the prevention and/or management of sexually transmitted infections and blood-borne infections.

[16] Infection prevention and control practices that may be addressed could include having current evidence-informed infection prevention and control policies and conducting regular staff education sessions to communicate and enhance awareness about the content of the policies.

8. The board of health shall provide public health management of cases, contacts and outbreaks to minimize the public health risk in accordance with the *Infectious Diseases Protocol, 2016* (or as current); the *Institutional/Facility Outbreak Prevention and Control Protocol, 2016* (or as current); the *Tuberculosis Prevention and Control Protocol, 2008* (or as current); the *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2013* (or as current); and the *Rabies Prevention and Control Protocol, 2013* (or as current).
9. The board of health shall receive reports of complaints regarding infection prevention and control practices and respond to and/or refer to appropriate regulatory bodies, including regulatory colleges[17], in accordance with applicable provincial legislation and in accordance with the *Infection Prevention and Control Practices Complaint Protocol, 2015* (or as current).
10. The board of health shall receive and evaluate reports of complaints regarding infection prevention and control practices in settings for which no regulatory bodies or regulatory colleges exist, particularly personal services settings. This shall be done in accordance with the *Infection Prevention and Control in Personal Services Settings Protocol, 2016* (or as current) and the *Infection Prevention and Control Practices Complaint Protocol, 2015* (or as current).
11. The board of health shall communicate, in a timely and comprehensive manner, with all relevant health care providers and other partners about urgent and emerging infectious diseases issues.
12. The board of health shall, based on local epidemiology, supplement provincial efforts in managing risk communications to appropriate stakeholders on identified risks associated with infectious diseases and emerging diseases of public health importance.
13. The board of health shall collaborate with health care providers and other relevant partners to ensure access to, or provide, based on local assessment, clinical services for priority populations to promote and support healthy sexual practices, contraception, pregnancy counselling, and the prevention and/or management of sexually transmitted infections and blood-borne infections.
14. The board of health shall collaborate with health care providers and other relevant community partners to achieve a comprehensive and consistent approach, based on local assessment and risk surveillance, to address and manage sexually transmitted infections and blood-borne infections in accordance with the *Sexual Health and Sexually Transmitted Infections Prevention and Control Protocol, 2013* (or as current).

[17] For the purposes of requirements 9 and 10, a "regulatory college" means the college of a health profession or group of health professions established or continued under a health professions Act named in Schedule 1 to the *Regulated Health Professions Act, 1991*.

15. The board of health shall receive and respond to all reported cases of suspected rabies exposures received from the public, community partners and health care providers in accordance with the *Health Protection and Promotion Act* and the *Rabies Prevention and Control Protocol, 2013* (or as current).

16. The board of health shall address the prevention and control of rabies threats as per a local Rabies Contingency Plan and in consultation with other relevant agencies[18] and orders of government, in accordance with the *Rabies Prevention and Control Protocol, 2013* (or as current).

17. The board of health shall develop a local vector-borne management strategy based on surveillance data and emerging trends in accordance with the *Infectious Diseases Protocol, 2016* (or as current).

18. The board of health shall inspect settings associated with risk of infectious diseases of public health importance in accordance with the *Infection Prevention and Control in Child Care Centres Protocol, 2016* (or as current); the *Infection Prevention and Control in Personal Services Settings Protocol, 2016* (or as current); and the *Healthy Environments Protocol, 2017* (to be drafted).

19. The board of health shall ensure 24/7 availability to receive reports of and respond to:

    a) Infectious diseases of public health importance in accordance with the *Health Protection and Promotion Act*; the *Mandatory Blood Testing Act, 2006*; the *Infectious Diseases Protocol, 2016* (or as current); and the *Institutional/Facility Outbreak Prevention and Control Protocol, 2016* (or as current); and

    b) Suspected rabies exposures in accordance with the *Health Protection and Promotion Act* and the *Rabies Prevention and Control Protocol, 2013* (or as current).

[18] Currently these agencies include the Ministry of Natural Resources and Forestry (MNRF), the Canadian Food Inspection Agency (CFIA) and the Ontario Ministry of Agriculture, Food and Rural Affairs (OMAFRA).

Safe Water

Goals

- **To prevent or reduce the burden of water-borne illnesses related to drinking water.**
- **To prevent or reduce the burden of water-borne illnesses and injuries related to recreational water use.**

Program Outcomes

- Timely and effective detection, identification, and response to water contaminants and illnesses, their associated risk factors, and emerging trends, including levels of fluoride outside the recommended range.
- Water-borne illness risks are mitigated.
- Members of the public who use private wells, cisterns, and rain or lake water are aware of how to safely manage their own drinking-water systems.
- The public is aware of drinking water safety.
- Owners/operators of recreational water facilities and owners/operators of small drinking-water systems operate in a safe and sanitary manner.
- The public is aware of potential risk of illnesses and injuries related to public beach use.
- Public exposure to recreational water-related illnesses and hazards is reduced.

Requirements

1. The board of health shall report Safe Water Program data elements in accordance with the *Drinking Water Protocol, 2014* (or as current) and the *Recreational Water Protocol, 2016* (or as current).
2. The board of health shall:
   a) Conduct surveillance of:
      - Drinking water sources and systems and of drinking water illnesses of public health importance, their associated risk factors, and emerging trends;
      - Public beaches and public beach water-borne illnesses of public health importance, their associated risk factors, and emerging trends; and
      - Recreational water facilities;

b) Conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations; and

c) Use the information obtained to inform Safe Water programs and services

in accordance with the *Drinking Water Protocol, 2014* (or as current); the *Infectious Diseases Protocol, 2016* (or as current); the *Recreational Water Protocol, 2016* (or as current); and the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).

3. The board of health shall provide information to private citizens who operate their own wells, cisterns, and rain or lake water systems to promote awareness of how to safely manage their own drinking-water systems.
4. The board of health shall ensure the provision of education and training for owners/operators of drinking-water systems in accordance with the *Drinking Water Protocol, 2014* (or as current).
5. The board of health shall increase public awareness of water-borne illnesses and safe drinking water by working with community partners and by:

   a) Adapting and/or supplementing national/provincial safe drinking water communications strategies where local assessment has identified a need; and/or

   b) Developing and implementing regional/local communications strategies where local assessment has identified a need.
6. The board of health shall ensure the provision of education and training for owner/operators of recreational water facilities in accordance with the *Recreational Water Protocol, 2016* (or as current).
7. The board of health shall provide all the components of the Safe Water Program in accordance with all applicable statutes and regulations, and the *Drinking Water Protocol, 2014* (or as current) to protect the public from exposure to unsafe drinking water.
8. The board of health shall inform the public about unsafe drinking water conditions and provide the necessary information to respond appropriately in accordance with the *Drinking Water Protocol, 2014* (or as current).
9. The board of health shall reduce risks of public beach and recreational water facilities use in accordance with the *Recreational Water Protocol, 2016* (or as current).
10. The board of health shall review drinking water quality reports for its municipal drinking water supply(ies) where fluoride is added. These reports shall be reviewed at least monthly and, where necessary, action shall be taken in accordance with the *Protocol for the Monitoring of Community Water Fluoride Levels, 2014* (or as current).

11. The board of health shall ensure 24/7 availability to receive reports of and respond to:

   a) Adverse events related to safe water, such as reports of adverse drinking water of drinking water systems, governed under the *Health Protection and Promotion Act* or the *Safe Drinking Water Act, 2002*;

   b) Reports of water-borne illnesses or outbreaks;

   c) Safe water issues arising from floods, fires, power outages, or other situations that may affect water safety; and

   d) Safe water issues relating to recreational water use including public beaches in accordance with the *Health Protection and Promotion Act*; the *Drinking Water Protocol, 2014* (or as current); the *Infectious Diseases Protocol, 2016* (or as current); and the *Recreational Water Protocol, 2016* (or as current).

School Health

Goal

To achieve optimal health of children and youth in schools through partnership and collaboration with school boards and schools.

Program Outcomes

- School boards and schools are aware of relevant and current population health needs impacting students in their schools.
- School boards and schools are meaningfully engaged in the planning, development, implementation, and evaluation of public health programs and services relevant to children and youth.
- School-based initiatives relevant to healthy living behaviours are informed by effective partnerships between boards of health, school boards, and schools.
- There is an increased adoption of healthy living behaviours among children and youth.
- Children, youth, and emerging adults have increased knowledge about, and skills for healthy growth and development.
- There is an increased awareness among youth and emerging adults about contraception and healthy pregnancies.
- Oral health of children and youth from low-income families is improved by enabling access to oral health care.
- There is an increase in the number of children screened for visual health concerns.
- Children have up-to-date immunizations according to the current Publicly Funded Immunization Schedules for Ontario and in accordance with the *Immunization of School Pupils Act*.

Requirements

1. The board of health shall collect, obtain and analyze relevant data to monitor trends over time in outcomes, in the health of children and youth in schools and population inequities, and communicate the population results in accordance with the *Population Health Assessment and Surveillance Protocol, 2016* (or as current).
2. The board of health shall provide population health information, including determinants of health and health inequities, relevant to the school population to school boards and schools to identify public health needs in schools.

3. The board of health shall develop and implement a program of public health interventions to improve the health of children and youth in schools, informed by:
   a) An assessment of the local population, including the identification of priority populations in schools as well as school communities at risk for increased health inequities and negative health outcomes;
   b) Evidence of the effectiveness of the interventions employed;
   c) Consultation and collaboration with school boards, principals, educators, parent groups, student leaders, and students; and
   d) A review of other relevant programs and services delivered by the board of health.
4. The board of health shall include a description, as part of its Board of Health Annual Service Plan and Budget Submission, of its programs of public health interventions to improve the health of children and youth in school.
5. The board of health shall offer support to school boards and schools to assist with the implementation of health-related curricula and health needs in schools, based on need and considering, but not limited to:
   a) Alcohol and other substance misuse (e.g., illicit drugs, including harm reduction strategies);
   b) Comprehensive tobacco control (including addressing e-cigarettes and emerging products);
   c) Concussions and injury prevention;
   d) Healthy eating and food safety;
   e) Healthy sexuality;
   f) Mental health promotion;
   g) Oral health;
   h) Physical activity and sedentary behaviour;
   i) Road and off-road safety;
   j) Suicide risk and prevention;
   k) UV exposure; and
   l) Violence and bullying.

Oral Health

6. The board of health shall conduct surveillance of children in schools and report in accordance with the *Oral Health Assessment and Surveillance Protocol, 2016* (or as current) and the *Population Health Assessment and Surveillance Protocol*, 2016 (or as current).
7. The board of health shall conduct oral screening in accordance with the *Oral Health Assessment and Surveillance Protocol, 2016* (or as current).
8. The board of health shall provide the Healthy Smiles Ontario (HSO) Program in accordance with the *Healthy Smiles Ontario (HSO) Program Protocol, 2016* (or as current).

Vision

9. The board of health shall provide, in collaboration with community partners, visual health supports and vision screening services in accordance with the *Child Visual Health and Vision Screening Protocol, 2017* (to be drafted).

Immunization

10. The board of health shall enforce the *Immunization of School Pupils Act* and assess the immunization status of children in accordance with the *Immunization Management Protocol, 2016* (or as current).
11. The board of health shall work with school boards and schools to identify opportunities to improve public knowledge and confidence in immunization for school-aged children by:
    a) Adapting and/or supplementing national/provincial health communications strategies where local assessment has identified a need;
    b) Developing and implementing regional/local communications strategies where local assessment has identified a need; and
    c) Addressing the following topics based on an assessment of local needs:
        - The importance of immunization;
        - Diseases that vaccines prevent;
        - Recommended immunization schedules for children and the importance of adhering to the schedules;
        - Introduction of new provincially funded vaccines;
        - Promotion of childhood immunization, including high-risk programs and services;
        - The importance of maintaining a personal immunization record for all family members;

- The importance of reporting adverse events following immunization;
- Reporting immunization information to the board of health as required;
- Vaccine safety; and
- Legislation related to immunizations.

12. The board of health shall promote and provide provincially funded immunization programs to eligible students in the health unit through school-based clinics.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 012-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 March 16

VACCINE PREVENTABLE DISEASES PROGRAM REVIEW

Recommendation

It is recommended that Report No. 012-17 re: Vaccine Preventable Diseases Program Review be received for information.

Key Points

- The Vaccine Preventable Diseases (VPD) Team conducted a review of its programs due to an identified imbalance between existing resources and demand for service.
- The review yielded sixteen recommendations, five of which are in the process of being implemented.
- As a result of the recent change in eligibility criteria announced by the MOHLTC, the Health Unit is no longer administering Tuberculin skin tests (TSTs) to those who require them for admission to educational institutions.

Background

Over the past few years, changes to the provincial vaccination program have placed increased demands on the MLHU's Vaccine Preventable Diseases Team. Implementation of the Panorama provincial immunization database, changes to the Immunization of School Pupils Act, including an increase in the eligible cohort for several vaccinations such as HPV, and new recommendations from the Province's Immunization 2020 document, led the team to conduct a program review to identify opportunities to better balance the services provided with the resources available.

Review Components

The VPD program review explored several objectives, including:

- Reviewing the alignment of VPD program activities to the Ontario Public Health Standards and related protocols.
- Exploring the reasons why individuals and families seek immunization services from the Health Unit rather than from their primary Health Care Provider (HCP) or community clinics.
- Exploring the reasons why individuals seek tuberculin skin testing (TST) services from the Health Unit rather than from their HCP or community clinics.
- Assessing the impact of reportable disease case investigations on the VPD Team's work.
- Exploring the alignment of current Team practices of refugee immunization with best-practice clinical guidelines (Refugee Screening Guidelines).

Key Findings

Among the program review's key findings was the identification of services provided by the VPD Team that could be provided by HCPs or community clinics. Tuberculin skin tests (TSTs) and immunizations are offered to eligible clients in the community through the Health Unit's Immunization Clinic in order to

provide enhanced access to these services. Additionally, TSTs are offered to several groups on a fee-for-service basis, including clients requiring the test for school, work, or volunteer activities. In a survey of clients, more than half of those requesting TSTs stated they required the test for admission to an educational program, and more than eighty percent of those seeking immunizations stated that they currently had an HCP. The full summary of key findings from the review can be found in Appendix A (Section A).

Recent Development: Tuberculin Skin Testing

Via a memorandum from the Ministry of Health and Long-Term Care sent February 10, 2017, the MLHU was notified that Tubersol (the solution used for TSTs) was now publicly funded for several population groups, including students who require the test as a condition of enrolment. The MLHU charges a fee for providing this test to recover costs, both of the Tubersol itself and the staffing cost of administering the test. Now that Tubersol is publicly funded for students, the MLHU need no longer charge a fee for providing this service to students, and therefore cannot recover the associated staffing costs. While the MLHU will no longer be able to provide this service to students, it is anticipated that there will be a resultant increase in community capacity to provide this service, as HCPs are able to bill OHIP and will now be provided the Tubersol for this cohort without charge.

Recommendations and Next Steps

In total, the review yielded sixteen recommendations, which may be found in Appendix A (Section B). The following actions have been prioritized as staff begin to implement the recommendations:

- The Health Unit is no longer administering TSTs for admission or continuation in educational institutions, as there is now increased capacity in the community, and no Health Unit mandate or resources, to provide this service.
- Follow-up of reportable diseases is being transferred to the Infectious Diseases Control Team effective June 1, 2017.
- Individuals and families with HCPs are being encouraged to seek immunization and TST services from their primary HCP.
- Staff have begun to discuss strategies to engage HCPs to identify their needs and barriers, and to provide support to enhance their capacity.
- Work has also begun to identify priority populations and collect data to determine the reach of the immunization clinic.

Other recommendations will be prioritized once the above recommendations have been implemented and assessed for their impact.

This report was submitted by the Program Planning and Evaluation Team, Foundational Standards Division and the Vaccine Preventable Diseases Team, Environmental Health and Infectious Diseases Division.

Dr. Gayane Hovhannisyan, MD, MHSc, CCFP, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer

Appendix A : Evidence Summary

Key Findings

1. Alignment with OPHS

The Ontario Public Health Standards (OPHS) incorporate the ISPA and the Child Care and Early Years Act (CCEYA) legislations and are supported by two protocols (Immunization Management Protocol and the Vaccine Storage and Handling Protocol**)** which provide direction to the Board of Health (BOH) on how to operationalize the specific requirement(s) identified in the standard. The current activities of the VPD program were compared to the OPHS and Immunization Management Protocol. The Vaccine Storage and Handling Protocol was considered outside the scope of this review.

a. There are 13 requirements under the Vaccine Preventable Disease Standard
- 7 requirements are met, 4 requirements are partially met, and 2 requirements are not met

b. There are 35 elements under the Immunization Management Protocol
- 5 out of the 35 elements are not met
- 1 out of the 35 elements is partially met

More complete compliance with the ISPA and CCEYA, enhanced data entry, improving the public's knowledge and confidence in immunization programs and providing education to health care providers related to Adverse Effects Following Immunization (AEFI) were identified as areas where improvements could be made. It was identified that the provision of Tuberculin Skin Tests (TST) exceeds the requirements of the OPHS.

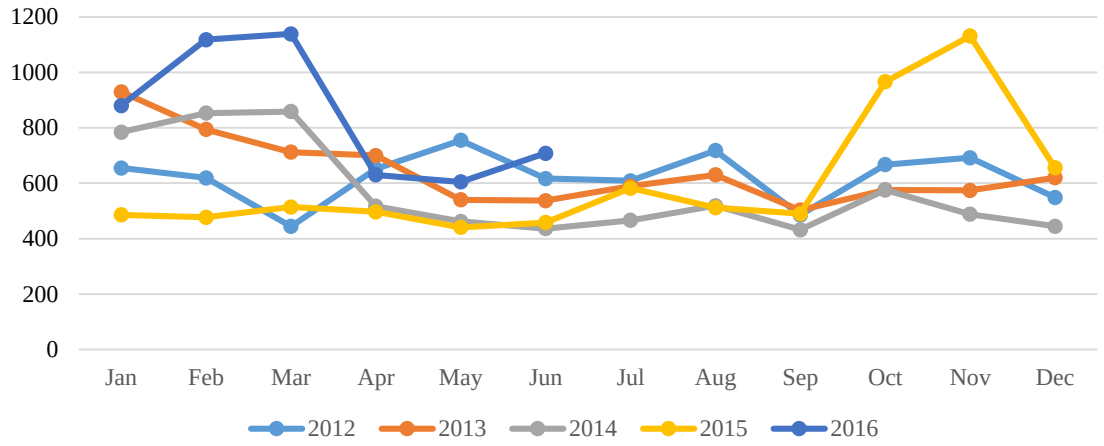
2. Immunization Clinic

The Immunization Clinic offers publicly funded and paid vaccines. The 50 King Street Clinic operates on an appointment and walk-in basis on Mondays, Wednesdays and Fridays. The Strathroy site operates on a walk-in basis on the first Tuesday of every month.

Clinic Trends

- Client demographics and volume were assessed to characterize the population seen in the Immunization clinics. In the first six months of 2016, the total number of visits to the Immunization Clinic was 5,080, which was 43% higher than the total number of visits in the first six months of 2015 (n=2,873) (Figure 1). School aged children accounted for 58% of 2016 visits compared to 46% of 2015 visits. The increased proportion of school aged children attending the clinic in 2016 is at least partially due to ISPA-related screening and suspension activities.

Figure 1. Number of Immunization Clinic vists by month, January 2012- June 2016



Clinic Survey

- The survey was conducted at the 50 King Street Immunization Clinic between September and November 2016. The purpose of the survey was to understand the reasons why individuals and families visited the Immunization Clinic rather than their HCP or a community clinic.

- Overall, 343 clients were approached to participate in the survey; the response rate was 93% (319/343). Not being fluent in English was the most commonly reported reason clients declined to participate in the survey.

- Majority (96%, 300/312) of the respondents indicated residing in the MLHU catchment area.

- The most commonly reported ways in which clients reported hearing about the Immunization Clinic was through their HCP, the MLHU website and word of mouth.

- Routine immunization was the most common (76%, 237/312) reason why respondents were receiving immunizations. One-tenth of respondents (34/312) reported receiving immunizations to meet the requirements of an organization or placement. Other reasons clients reported were due to an injury, travel or recommended by their HCP.

- Most of the respondents who attended the Clinic during the survey period reported having a valid health card (97%, 294/304) and a HCP (86%, 269/313).
    - Most clients (79%, 213/269) with a HCP reported they were aware that they could receive immunizations through their HCP.

- Clients with a HCP were also asked to specify their reasons for choosing the Immunization Clinic over their HCP for their immunization needs. The three most commonly reported reasons were that the immunization was not available from their HCP, flexibility to walk-in fit with their schedule and the location of the Immunization Clinic was accessible.

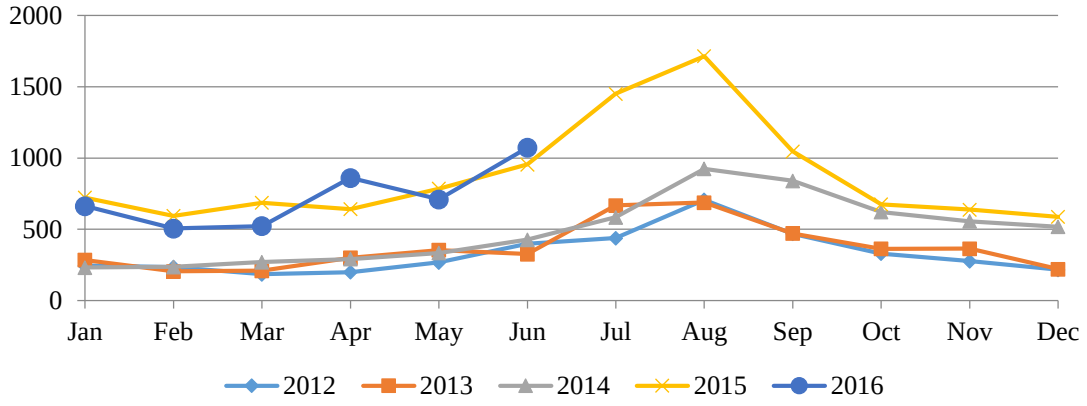
3. Tuberculin Skin Test (TST) Clinic

Clinic Trends

The TST Clinic offers tuberculin skin tests, with the option of appointments. Clients receiving a TST are also assessed to ensure their immunizations are up to date. The TST Clinic is cost-neutral, and is staffed by causal nurses. No TST services are offered by the Health Unit at the Strathroy site.

- Changes made to the criteria for publically-funded Tubersol in 2014 contributed to an increase in TST administered by the Health Unit for educational purposes.
- The number of TST administered and read each year by MLHU has increased from a total of 3,969 client interactions in 2012 to 10,499 in 2015. In the first six months of 2016, 4,335 client interactions have occurred. August has consistently been the month with the most client interactions (Figure 2).

Figure 2. Number of TB skin tests and reads (interactions) at MLHU by month and year, January 2012-June 2016



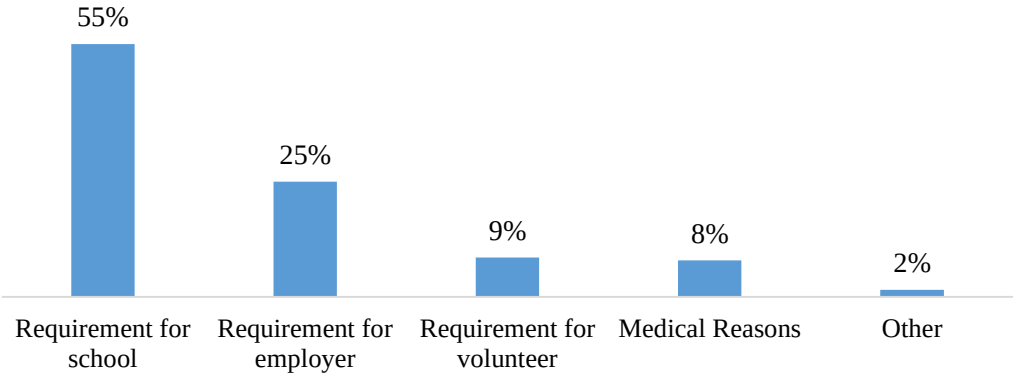
- Two thirds (66%) of TSTs administered in 2014 and 2015 were required for educational purposes

TB Clinic Survey

- Overall, 343 clients were approached to participate in the survey between August and November 2016. The response rate was 94% (327/347). Language was the most commonly reported reason clients declined to participate in the survey.

- The most frequently reported reason for requiring a TST was educational purposes (Figure 3). The majority (83.5%, 152/182) of clients receiving a TST for educational purposes were enrolled at a post-secondary institution in the Middlesex-London area.

Figure 3: Reported Reason for TST (n=327)



Note: Percentages were calculated based on the total number of respondents each month. Because respondents were able to choose multiple options, the sum of the percentages exceeds 100%.

- The most frequently reported ways in which clients heard about the TST Clinic was through their HCP, word of month, and the MLHU website.

- An identified barrier was that although most clients reported having a HCP, the test was not available through their HCP. There was also low awareness of availability of TST services outside of the Health Unit. Of those that were aware of community clinics, cost was identified as a barrier.

- Consultations with HCP offices identified cost, lack of interest, and low awareness of the purchase and administration processes of providing TSTs as barriers.

Refugee Clinic

The Health Unit collaborates with the London InterCommunity Health Centre (LIHC) and the Cross Cultural Learner Centre (CCLC) to provide immunization screening and administration to refugees. From January 1, 2012 to June 30, 2016, the Immunization Clinic has held 63 immunization clinics for refugees. A review of best practices of screening and immunizing refugees was conducted to align with the Evidence Based Clinical Guidelines for Immigrants and Refugees document. Collaboration will continue with community partners to provide immunization services to this population.

Reportable Disease Follow-up

Discussions with the team have highlighted that the rotational structure does not allow of follow-up to be performed efficiently. Since the team works off-site and on-site, the PHNs rotate to complete team activities. This arrangement results in case management and follow-up to be passed on from one Public Health Nurse (PHN) to another, reducing the consistency of care and

follow-up. In addition, because reportable disease follow-up is a small component of the team's work, this was also described to be time intensive and requiring additional staff to work together to best proceed with the follow-up. These challenges have resulted in delaying the follow-up and timely reporting of the reportable disease to the Ministry. In addition, this also has implications on other program activities (e.g. screening, immunization clinic) that the team is mandated to provide.

Recommendations

Based on the information gathered, recommendations were developed in consultation with the VPD team. These recommendations have been further refined in consultation with the Environmental Health and Infectious Disease Director and Associate Medical Officer of Health.

1. **Collaborate with the Health Care Provider Outreach Team to develop a coordinated strategy to engage HCPs**
   - Developing a coordinated strategy to engage physician would allow the team to:
     - Assess the information needs (e.g. immunization schedules, AEFIs, ISPA screening letters, appropriate diagnostic test for a suspected disease) and provide education around the identified areas
     - Identify the challenges and barriers to administering immunizations and provide ongoing support as needed.

2. **Enhance partnership with HCPs and provide on-going support to enable them to administer immunizations**
   - Enhancing partnerships will allow HCPs to be supported in administering immunizations to their clients. In addition, it is important that partnerships are established with HCPs in light of the Immunization 2020 strategy, as HCPs will be required to report client immunizations to the Health Unit.
   - This will include targeted outreach to HCPs who direct clients to the Health Unit for immunization services

3. **Screen clients while booking appointments to identify those with a HCP and redirect them back to their HCP for their immunization and TST needs**

4. **Identify priority populations and collect data to determine the reach of the Immunization Clinic**
   - As part of requirement 2 of the OPHS, the Health Unit is responsible for conducting epidemiological analysis to identify priority populations that may face barriers to immunization. Currently there are information gaps which limit the ability to assess if the Immunization Clinic is reaching the appropriate priority populations.

5. **Develop a strategy to meet the legislative requirements**
   - The Health Unit is not fully compliant with the ISPA and CCEYA legislations. A strategy is warranted to meet the legislative requirements as compliance will be monitored under the Immunization 2020 strategy.

6. **Consider realignment of reportable disease follow up to Infectious Disease Control Team**
   - Challenges were identified that limited or delayed the follow-up of reportable diseases. Realignment of reportable disease follow-up to a team that is more equipped can improve consistency of how reportable diseases are followed-up.

7. **Gather the perspectives of those with a language barrier to identify challenges to seeking immunization and TST services from their HCP.**
   - Investigation of those with a language barrier will help identify challenges to receiving immunizations and TSTs in primary care clinics and determine how public health can play a role in reducing the challenges.

8. **Consider offering designated immunization clinics for school aged children**
   - Following the assessment of immunization records, there is an increase in school aged children attending the Immunization Clinic. Designated clinics may need to be explored to manage client volume and ensure that client needs are met.

9. **Engage post-secondary institutions to understand the challenges and capacity of providing TSTs to their students**

10. **Increase awareness of community clinics that offer TSTs**

11. **Further explore the need for TST services in the County**

Update: The recommendations 9, 10 and 11 have been impacted by the MOHLTC changes to the criteria for publicly funded Tubersol.

12. **Maintain an on-going relationship with LIHC**
    - Collaborate with LIHC around the exchange of immunization information for children from refugee families and the feasibility of incorporating LTBI screening in refugee assessment clinics.

13. **Explore measures to enhance the quality of clinic data to support the proposed recommendations and future decision making**

14. **Revise client registration form to identify language barriers and clients with a HCP**

15. **Investigate feasibility of Interferon Gamma Release Assay (IGRA) as an alternative to TSTs in refugees**

16. **Develop a communication plan to communicate the changes made to the Immunization Clinic as a result of the Program Review**

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 013-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 March 16

THE LEGALIZATION AND REGULATION OF CANNABIS IN CANADA

Recommendation

It is recommended that the Board of Health:

1. ***Receive Report No. 013-17 re: "The Legalization and Regulation of Cannabis in Canada" for information; and***
2. ***Direct staff to continue to work with partners at the local and provincial levels to advocate for and support the development and implementation of evidence-informed regulations.***

Key Points

- In its December 2015 Throne Speech, the federal government set out its commitment to "legalize, regulate, and restrict access" to cannabis.
- The Federal Task Force on Cannabis Legalization and Regulation released a report that contains recommendations to the government for a framework to legalize, regulate and restrict access to cannabis.
- On February 28, Mr. Bill Blair, Parliamentary Secretary to the Minister of Justice and Attorney General of Canada, met with invited local stakeholders, including representatives from the Health Unit and the Board of Health, to gather input and feedback.
- Enabling legislation will be tabled in spring 2017 to provide parliamentary approval to proceed with the development of the framework to support legalization and regulation of cannabis by 2019.

A Public Health Approach to the Regulation of Cannabis

Criminal prohibition of cannabis has resulted in well-documented health and social harms. Despite prohibition, Canada has one of the highest rates of recreational cannabis use worldwide. In July 2015, the Board of Health was advised that staff would be bringing forward an evidence-based position on cannabis policy (Report No. 047-15). A comprehensive report was prepared and presented to the Board of Health in January 2016 (Report No. 003-16 and Appendix A). At that time, the Board of Health authorized staff to advocate for an evidence-based public health approach to cannabis legalization, including strict regulation for non-medicinal use and a legislative framework that enacts strict controls on the production, distribution, promotion and sale of cannabis.

Federal Government Commitment to Legalize and Regulate Cannabis

In its December 2015 Throne Speech, the federal government committed to "legalize, regulate, and restrict access" to cannabis. In June 2016, the government created a nine-member Task Force on Cannabis Legalization and Regulation to consult and provide advice on the requirements of a new legislative and regulatory framework for legal access to cannabis. Nine principal objectives guided the Task Force's work, chief among these being "keeping cannabis out of the hands of children and keeping profits out of the hands of organized crime." The Task Force has incorporated lessons learned from other jurisdictions that have already legalized cannabis (e.g., Colorado, Washington state) to inform recommendations for the Canadian government. The Task Force engaged with provincial, territorial and municipal governments, experts,

patients, advocates, Indigenous governments and representative organizations, and industry, and reviewed over 30,000 online submissions from individuals and organizations, including the Canadian Public Health Association, the Canadian Medical Association and the Centre for Addiction and Mental Health. The Health Unit provided input as a member of the Ontario Public Health Unit Collaboration on Cannabis (the Collaborative), a group of substance misuse professionals from thirty-two public health units who are working together as a unified voice to recommend a comprehensive public health approach.

The Task Force's report, "A Framework for the Legalization and Regulation of Cannabis in Canada," was released on November 30, 2016, and contains recommendations in five key areas: minimizing harms of use; establishing a safe and responsible supply chain; enforcing public safety and protection; medical access; and implementation. Task Force recommendations are summarized in Appendix A. The Task Force recognizes that successful implementation of the framework will take time and require federal, provincial and municipal governments to work together to meet a number of challenges regarding capacity and infrastructure, oversight, coordination and communications.

Stakeholder Consultations

On February 28, as part of a cross-country tour, Mr. Bill Blair, Parliamentary Secretary to the Minister of Justice and Attorney General of Canada, convened a meeting with representatives from the Health Unit and the Board of Health, the Thames Valley District School Board, the Mayor's office, London City Council, Addiction Services of Thames Valley and local Members of Parliament Kate Young and Peter Fragiskatos. Blair met separately with the London Police Service. The meeting served to give context to the impending legalization and its proposed timelines; to discuss Task Force recommendations; and to hear concerns and suggestions from invited participants. Enabling legislation will be tabled in the spring of 2017 to provide parliamentary approval to proceed with the development of the framework to support legalization and regulation of cannabis by 2019. According to Mr. Blair, the creation of this system will take time. Reducing public health and social harms is the sole motivation behind legalization, not revenue generation and economic benefits through taxation. The Health Unit commented specifically on the Task Force's recommended minimum age of purchase of cannabis (18 years) and the recommendations related to personal cultivation, encouraging the federal government to weigh the evidence carefully and consider the impact that these policy directions could have on youth and young adult brain development and on normalization of the cannabis culture. The Health Unit expressed caution that changes to cannabis policy may have unintended consequences on infant and maternal health outcomes. The Health Unit expressed the need for ethical distribution of revenues generated from cannabis sales and reinvestment in health promotion, prevention of substance misuse, treatment and enforcement. Last, the Health Unit emphasized the need for investing in baseline surveillance systems and research, and the importance of a comprehensive policy monitoring and evaluation framework.

Boards of Health are mandated under the Ontario Public Health Standards to reduce the frequency, severity and impact of substance misuse; criminal prohibition of cannabis is a barrier to meeting these objectives effectively. A public health approach acknowledges that cannabis is not a benign substance and that policy built upon evidence-based regulations and controls is the best approach to minimize the risks and harms associated with use. Federal government policy should be restrictive enough that it minimizes the risks and harms associated with normalization and use of cannabis, while being adaptable in the event that changes are required to mitigate unintended consequences of policy change.

This report was by the, Chronic Disease Prevention and Tobacco Control Team; and the Healthy Communities and Injury Prevention Team, Healthy Living Division.

Dr. Gayane Hovhannisyan, MD, MHSc, CCFP, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer

This report addresses the following requirements of the Ontario Public Health Standards (revised May 2016): Foundational Standard; Chronic Disease Prevention; Prevention of Injury and Substance Misuse.

Table of Recommendations from report "A Framework for the Legalization and Regulation of Cannabis in Canada: The Final Report of the Task Force on Cannabis Legalization and Regulation"

Minimizing Harms of Use	
Minimum Age	Set a national minimum age of purchase of 18, acknowledging the right of provinces and territories to harmonize it with their minimum age of purchase of alcohol
Promotion, Advertising and Marketing Restrictions	Apply comprehensive restrictions to the advertising and promotion of cannabis and related merchandise by any means, including sponsorship, endorsements and branding, similar to the restrictions on promotion of tobacco products
	Allow limited promotion in areas accessible by adults, similar to those restrictions under the Tobacco Act
	Require plain packaging for cannabis products that allows the following information on packages: company name, strain name, price, amounts of delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD) and warnings and other labelling requirements
	Impose strict sanctions on false or misleading promotion as well as promotion that encourages excessive consumption, where promotion is allowed
	Require that any therapeutic claims made in advertising conform to applicable legislation
	Resource and enable the detection and enforcement of advertising and marketing violations, including via traditional and social media
Cannabis-based edibles and other products	Prohibit any product deemed to be "appealing to children", including products that resemble or mimic familiar food items, are packaged to look like candy, or packaged in bright colours or with cartoon characters or other pictures or images that would appeal to children
	Require opaque, re-sealable packaging that is childproof or child-resistant to limit children's access to any cannabis products
	Additional, for edibles: • Implement packaging with standardized, single serving, with a universal THC symbol • Set a maximum amount of THC per serving and per product
	Prohibit mixed products, for example cannabis-infused alcoholic beverages or cannabis products with tobacco, nicotine or caffeine
	Require appropriate labelling on cannabis products, including: • Text warning labels (e.g., "KEEP OUT OF REACH OF CHILDREN") • Levels of THC and CBD • For edibles, labelling requirements that apply to food and beverage products
	Create a flexible legislative framework that could adapt to new evidence on specific product types, on the use of additives or sweeteners, or on specifying limits of THC or other components
THC Potency	Provide regulatory oversight for cannabis concentrates to minimize the risks associated with illicit production
	Develop strategies to encourage consumption of less potent cannabis, including a price and tax scheme based on potency to discourage purchase of high-potency products

	Require all cannabis products to include labels identifying levels of THC and CBD
	Enable a flexible legislative framework that could adapt to new evidence to set rules for limits on THC or other components
	Develop and implement factual public education strategies to inform Canadians as to risks of problematic use and lower-risk use guidance
Tax and Price	Conduct the necessary economic analysis to establish an approach to tax and price that balances health protection with the goal of reducing the illicit market
	Work with provincial and territorial governments to determine a tax regime that includes equitable distribution of revenues
	Create a flexible system that can adapt tax and price approaches to changes within the marketplace
	Commit to using revenue from cannabis as a source of funding for administration, education, research and enforcement
	Design a tax scheme based on THC potency to discourage purchase of high-potency products
Public Education	Implement as soon as possible an evidence informed public education campaign, targeted at the general population but with an emphasis on youth, parents and vulnerable populations
	Co-ordinate messaging with provincial and territorial partners
	Adapt educational messages as evidence and understanding of health risks evolve, working with provincial and territorial partners
Prevention and Treatment	In the period leading up to legalization, and thereafter on an ongoing basis, governments invest effort and resources in developing, implementing and evaluating broad, holistic prevention strategies to address the underlying risk factors and determinants of problematic cannabis use, such as mental illness and social marginalization
	Governments commit to using revenue from cannabis regulation as a source of funding for prevention, education and treatment
Workplace Safety	Facilitate and monitor ongoing research on cannabis and impairment, considering implications for occupational health and safety policies
	Work with existing federal, provincial and territorial bodies to better understand potential occupational health and safety issues related to cannabis impairment
	Work with provinces, territories, employers and labour representatives to facilitate the development of workplace impairment policies

Establishing a safe and responsible supply chain	
Production	Regulate the production of cannabis and its derivatives (e.g., edibles, concentrates) at the federal level, drawing on the good production practices of the current cannabis for medical purposes system
	Use licensing and production controls to encourage a diverse, competitive market that also includes small producers
	Implement a seed-to-sale tracking system to prevent diversion and enable product recalls

	Promote environmental stewardship by implementing measures such as permitting outdoor production, with appropriate security measures
	Implement a fee structure to recover administrative costs (e.g., licensing)
	Regulate CBD and other compounds derived from hemp or from other sources
Distribution	The Task Force recommends that the wholesale distribution of cannabis be regulated by provinces and territories and that retail sales be regulated by the provinces and territories in close collaboration with municipalities.
Retail	Retail sales be regulated by provinces and territories in close collaboration with municipalities
	The Task Force further recommends that the retail environment include: • No co-location of alcohol or tobacco and cannabis sales, wherever possible. When co-location cannot be avoided, appropriate safeguards must be put in place • Limits on the density and location of storefronts, including appropriate distance from schools, community centres, public parks, etc. • Dedicated storefronts with well-trained, knowledgeable staff • Access via a direct-to-consumer mail-order system
Personal Cultivation	The Task Force recommends allowing personal cultivation of cannabis for non-medical purposes with the following conditions: • A limit of four plants per residence • A maximum height limit of 100 cm on the plants • A prohibition on dangerous manufacturing processes • Reasonable security measures to prevent theft and youth access • Oversight and approval by local authorities

Enforcing Public Safety and Protection	
Illegal activities	Implement a set of clear, proportional and enforceable penalties that seek to limit criminal prosecution for less serious offences. Criminal offences should be maintained for: • Illicit production, trafficking, possession for the purposes of trafficking, possession for the purposes of export, and import/export • Trafficking to youth
	Create exclusions for “social sharing”
	Implement administrative penalties (with flexibility to enforce more serious penalties) for contraventions of licensing rules on production, distribution, and sale
	Consider creating distinct legislation—a “Cannabis Control Act”—to house all the provisions, regulations, sanctions and offences relating to cannabis

Personal Possession	Implement a limit of 30 grams for the personal possession of non-medical dried cannabis in public
	A corresponding sales limit for dried cannabis
	Develop equivalent possession and sales limits for non-dried forms of cannabis
Place of Use	The Task Force recommends that jurisdictions: • Extend the current restrictions on public smoking of tobacco products to the smoking of cannabis products and to cannabis vaping products • Be able to permit dedicated places to consume cannabis such as cannabis lounges and tasting rooms, if they wish to do so, with no federal prohibition. Safeguards to prevent the co-consumption with alcohol, prevent underage use, and protect health and safety should be implemented
Impaired driving	Invest immediately and work with the provinces and territories to develop a national, comprehensive public education strategy to send a clear message to Canadians that cannabis causes impairment and that the best way to avoid driving impaired is to not consume. The strategy should also inform Canadians of: • the dangers of cannabis-impaired driving, with special emphasis on youth; and • the applicable laws and the ability of law enforcement to detect cannabis use
	Invest in research to better link THC levels with impairment and crash risk to support the development of a per se limit
	Determine whether to establish a per se limit as part of a comprehensive approach to cannabis-impaired driving, acting on findings of the Drugs and Driving Committee, a committee of the Canadian Society of Forensic Science, a professional organization of scientists in the various forensic disciplines
	Re-examine per se limits should a reliable correlation between THC levels and impairment be established
	Support the development of an appropriate roadside drug screening device for detecting THC levels, and invest in these tools
	Invest in law enforcement capacity, including Drug Recognition Experts and Standardized Field Sobriety Test training and staffing
	Invest in baseline data collection and ongoing surveillance and evaluation in collaboration with provinces and territories
	Governments in Canada consider the use of graduated sanctions ranging from administrative sanctions to criminal prosecution depending on the severity of the infraction. While it make take time for the necessary research and technology to develop, the Task Force encourages all governments to implement elements of a comprehensive approach as soon as feasible, including the possible use of administrative sanctions or graduated licensing with zero tolerance for new and young drivers

Medical Access	
Medical Access	Maintain a separate medical access framework to support patients
	Monitor and evaluate patients' reasonable access to cannabis for medical purposes through the implementation of the new system, with action as required to ensure that the market provides reasonable affordability and availability and that regulations provide authority for measures that may be needed to address access issues

	Review the role of designated persons under the ACMPR with the objective of eliminating this category of producer
	Apply the same tax system for medical and non-medical cannabis products
	Promote and support pre-clinical and clinical research on the use of cannabis and cannabinoids for medical purposes, with the aim of facilitating submissions of cannabis-based products for market authorization as drugs
	Support the development and dissemination of information and tools for the medical community and patients on the appropriate use of cannabis for medical purposes
	Evaluate the medical access framework in five years

Implementation	
Capacity	Take a leadership role to ensure that capacity is developed among all levels of government prior to the start of the regulatory regime
	Build capacity in key areas, including laboratory testing, licensing and inspection, and training
	Build upon existing and new organizations to develop and co-ordinate national research and surveillance activities
	Provide funding for research, surveillance and monitoring activities
Oversight	Establish a surveillance and monitoring system, including baseline data, for the new system
	Ensure timely evaluation and reporting of results
	Mandate a program evaluation every five years to determine whether the system is meeting its objectives
	Report on the progress of the system to Canadians
Coordination	Take a leadership role in the co-ordination of governments and other stakeholders to ensure the successful implementation of the new system
	Engage with Indigenous governments and representative organizations to explore opportunities for their participation in the cannabis market
Communication	Provide Canadians with the information they need to understand the regulated system
	Provide Canadians with facts about cannabis and its effects
	Provide specific information and guidance to the different groups involved in the regulated cannabis market

	Engage with Indigenous communities and Elders to develop targeted and culturally appropriate communications
	Ensure that Canada shares its lessons and experience with the international community

MIDDLESEX-
LONDON HEALTH UNIT

REPORT NO. 014-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 16 March 2017

SUMMARY INFORMATION REPORT FOR MARCH 2017

Recommendation

It is recommended that Report No. 014-17 re: Summary Information Report for March 2017 be received for information.

Key Points

- The Middlesex-London Health Unit has participated in HealthForceOntario's Nursing Graduate Guarantee Initiative (NGGI) since 2007 and hired eighteen nurses through this program. Although MLHU's experience with the NGGI has been very positive, the organization will no longer be participating in this program after April 2017 due to program requirement changes communicated by the Ministry.
- The Office of the Auditor General of Ontario will be conducting a survey of all public health units and will also be conducting on-site audit work at selected health units. MLHU staff will keep the Board up to date as the process unfolds.
- The Health Unit will continue to work on strategies to improve oral health outcomes for children and to increase participation in the school-based dental screening program.

HEALTHFORCEONTARIO'S NURSING GRADUATE GUARANTEE INITIATIVE (NGGI)

The Middlesex-London Health Unit has participated in HealthForceOntario's Nursing Graduate Guarantee Initiative (NGGI) since 2007. The NGGI is a comprehensive strategy designed by the Ministry of Health and Long-Term Care to build capacity within the healthcare system for nursing workforce planning and management. The program provides funding to healthcare organizations to create "bridge positions" for new nurse graduates for a twenty-six-week period. Under the former conditions of the agreement, Middlesex-London Health Unit (MLHU) paid an additional six weeks of salary for each nurse graduate hired through the NGGI (if MLHU was unable to offer immediate full-time employment). Nurse graduates hired by MLHU through the program were designated with temporary job status for the twenty-six weeks. Each were assigned nurse mentors, and participated in monthly orientation sessions with the Community Health Nursing Specialist to bridge public health theory and practice.

Since 2007, MLHU has placed thirty-six graduate nurses through the NGGI. Evaluation results were positive from both the new nurse and the nurse mentor perspectives. Fifty percent (eighteen) of those graduate nurses placed successfully obtained permanent full-time or part-time/job-share public health nurse positions with MLHU, ninety percent of whom remain on staff. Overall, the NGGI was highly effective in building resource capacity through fostering interest in public health nursing and contributing to a multi-generational nursing workforce. In November 2016, MLHU was advised of changes to the NGGI, commencing April 2017. Employers are now required to transition nurse graduates to permanent full-time employment within one year, or Ministry funding will be recovered. Unfortunately, as a result of the new program conditions, MLHU will no longer be in a position to participate in the NGGI, due to significant financial burden on the organization.

PUBLIC HEALTH PROGRAM AUDIT BY THE OFFICE OF THE AUDITOR GENERAL OF ONTARIO

On March 2, 2017, Health Units received notification from the Ministry of Health and Long-Term Care (MOHLTC) that the Office of the Auditor General of Ontario (OAGO) had identified the Public Health Program as a candidate for a value-for-money audit.[1] Value-for-money audits assess whether money was spent with due regard for economy and efficiency, and whether appropriate procedures were in place to measure and report on the effectiveness of government programs. Each year, the OAGO audits selected ministry or agency programs and activities, with the major ones generally audited every five to seven years. The results of these value-for-money audits are published in the Auditor General's Annual Report, and usually receive a great deal of attention from both media and public (see footnote 1, below).

The MOHLTC advised that the OAGO will conduct on-site audit work at a few public health units; however, the MOHLTC had not been informed which public health units will be contacted at this stage. The Health Unit should expect to be contacted as early as March 6, 2017. In addition, the OAGO is also planning to conduct a survey of some of the personnel at all public health units, and have requested contact information for all Board of Health members and senior Health Unit employees. The requested information was forwarded to the MOHLTC on March 6, 2017. Staff will endeavour to keep the Board informed about this process as more details become available.

MIDDLESEX-LONDON 2015–16 SCHOOL-BASED DENTAL SCREENING RESULTS

During the 2015–16 school year, the Health Unit screened 16,231 students (81%) in 131 elementary schools through the School-Based Dental Screening Program. The volume of students excluded from participating by their parents was higher than the previous year's percentage by 18%, but the volume of absent students was unchanged at 6%. The volume of students screened in Junior Kindergarten who were caries-free (i.e., have not had cavities or the removal or filling of a tooth because of tooth decay) was 76%. The volume of caries-free students in Grade 2 was 57%. Seven hundred and fifty-five students (5%) were found to have urgent dental needs, which made them clinically eligible to receive dental care through the Healthy Smiles Ontario Essential and Emergency Services Stream (HSO-EESS; formerly Children in Need of Treatment, or CINOT) funding. The Health Unit continues to work on strategies to improve oral health outcomes among children in the community, and to increase participation in the School-Based Dental Screening Program.

Please see the full report in Appendix A.

Dr. Gayane Hovhannisyan, MD, MHSc, CCFP, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer

[1] "Value-for-money Audits of Selected Government Activities," http://www.auditor.on.ca/en/content/aboutus/whatwedo.html (last modified November 15, 2016).

ANNUAL ORAL HEALTH REPORT 2015/2016 School Year

Purpose

To provide information about the findings of the Health Unit's school-based screening program from the last school year: September 2015 to June 2016.

Methodology

Publicly funded elementary schools and three private schools participated in the school-based screening program. Students in Junior Kindergarten, Senior Kindergarten, and Grade 2 at publicly funded schools were screened in accordance with the Oral Health Assessment and Surveillance Protocol of the Ontario Public Health Standards.

Based on the screening results of the Grade 2 students at each school, the school was categorized into the following levels of screening intensity: "Low", "Medium", or "High", as per the Protocol. Increased screening intensity level requires that additional grades be screened.

The parents of the students in these grades who decline to have their children screened advise their school administrators who then provide this information to Health Unit staff. Children whose parents have consented to screening but who are absent on the day of screening may be screened on a subsequent screening day.

Student level data was collected by six Registered Dental Hygienists employed by the Health Unit. The need for and urgency of dental care was recorded and the parents advised of the required follow-up. As well, indicators of previous dental caries were recorded. Data was collected and stored in accordance with the Oral Health Assessment and Surveillance Protocol, the Health Protection and Promotion Act, the Municipal Freedom of Information and Protection of Privacy Act, and the Personal Health Information Protection Act.

The Ministry of Health and Long-Term Care's Oral Health Information Support System was used to generate summary statistics from the student level data. Historical aggregate data was accessed from archived Health Unit spreadsheets. These data were further analysed using Microsoft Excel.

Key Findings

Participation. Of the 20,048 students who were offered dental screening at the schools that participated in the school-based dental screening program, 16,231 or 81% were screened (Figure 1). For the 2015-2016 school year, the Health Unit did not have parental consent to screen 2,635 (13%) students, and 1,182 (6%) were absent on the day(s) that staff were screening at their schools. The percentage of excluded students is higher than the previous year's percentage by18%, but the percentage of absent students is unchanged.

Screening intensity. Among the 128 elementary schools with Grade 2 in the Health Units jurisdiction, 95 (74%) were categorized as Low intensity, 18 (14%) as Medium intensity, and 15 (12%) as High intensity (Figure 2). Schools are categorized as per the Oral Health Assessment and Surveillance Protocol which is described in the sidebar

Dental caries. The percentages of Junior Kindergarten, Senior Kindergarten, and Grade 2 students screened who were caries-free, (i.e. have never had tooth decay or the removal or filling of a tooth because of caries) were 76%, 68%, and 57%, respectively (Figure 3). This demonstrated a decrease in percentages from the previous school year which were 78%, 71%, and 59% respectively. Slightly more than 6% of Grade 2 students screened had two or more teeth with tooth decay (Figure 4).

Urgent dental needs. Seven hundred and fifty-five (755) students or 5% of those screened were found to have Urgent dental needs which deemed them clinically eligible to receive Healthy Smiles Ontario Essential and Emergency Care (formerly Children in Need of Treatment) funding for their dental care (Figure 5). The percentage of students found to have Urgent dental needs is higher than the previous school year's. To date, six hundred and eighty-nine (689) students or 91% of those found to have Urgent dental needs were referred to local dental offices for treatment.

Next Steps

- The Health Unit will continue to work on strategies such as the school-based and daycare-based fluoride varnish programs to address the percentages of Junior Kindergarten, Senior Kindergarten, and Grade 2 students who are caries-free.
- The Health Unit continues to work with schools that require active consents to develop strategies to improve participation in the program.

Results

Figure 1. Percentages of students screened, absent and refused by school year

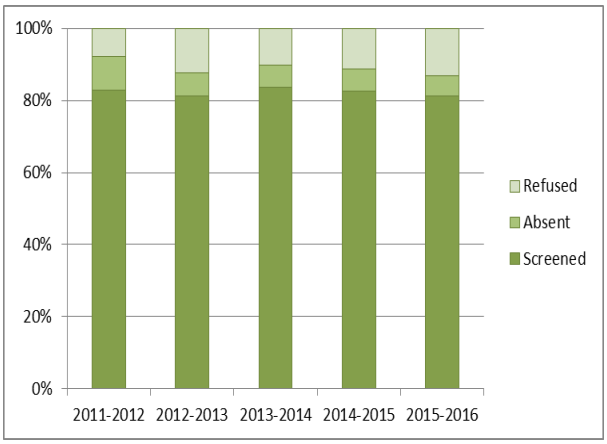


Figure 2. Screening intensity of schools by school year

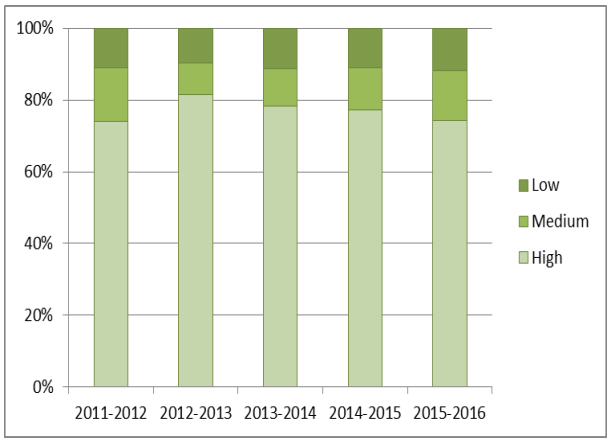


Figure 3. Percentage of students screened who were caries-free by grade for 2013-2014, 2014-2015, and 2015-2016 school years

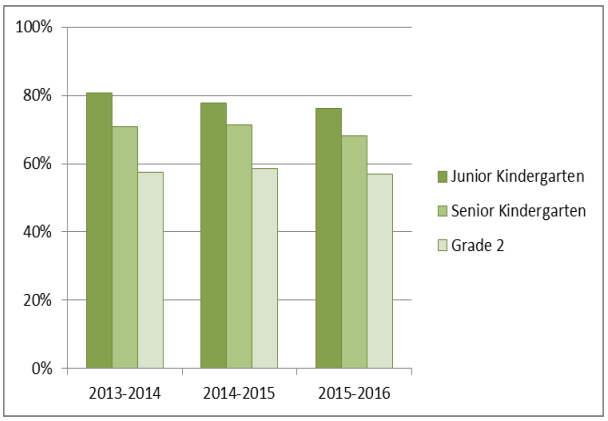


Figure 4. Percentage of Grade 2 students screened with two or more teeth affected by caries (decay, removals, or fillings) by school year

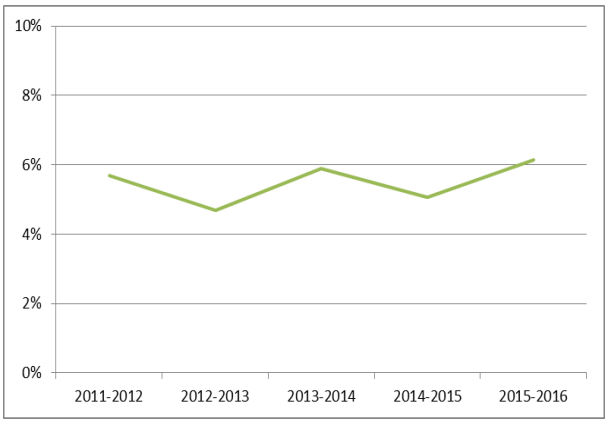
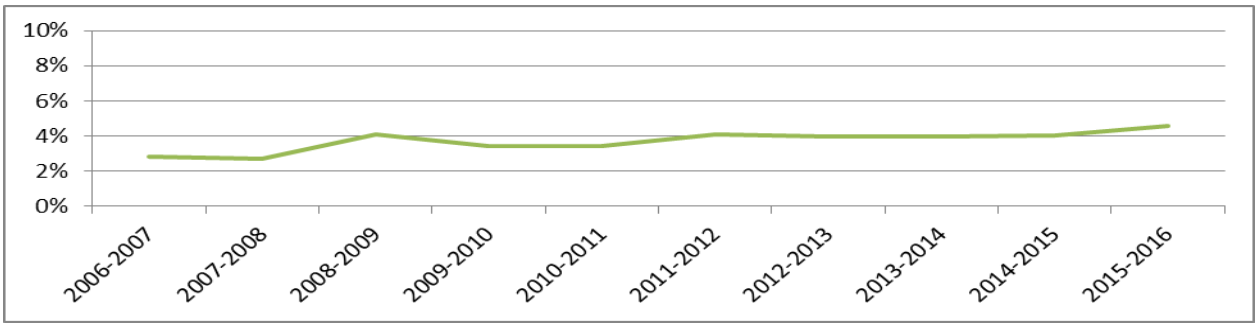


Figure 5. Percentage of students screened with Urgent dental needs by school year



MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 015-17

TO: Chair and Members of the Board of Health

FROM: Dr. Gayane Hovhannisyan, Acting Medical Officer of Health
Laura Di Cesare, Acting Chief Executive Officer

DATE: 2017 March 16

ACTING MEDICAL OFFICER OF HEALTH / ACTING CHIEF EXECUTIVE OFFICER ACTIVITY REPORT – MARCH

Recommendation

It is recommended that Report No. 011-17 re: Acting Medical Officer of Health / Acting Chief Executive Officer Activity Report – March be received for information.

The following report highlights activities of the Acting Medical Officer of Health (Acting MOH) / Acting Chief Executive Officer (Acting CEO) for the period of February 9, 2017, to March 3, 2017.

The Acting MOH / Acting CEO also attended the following events:

February 9 The Acting MOH attended the Youth Opportunities Unlimited Breakfast for YOU.

February 10 The Acting MOH and the Acting CEO met with Deb Matthews chiefly to detail and call attention to the HIV situation in London.
The Acting MOH met with Dr. Laura Lyons to discuss gaps in services available to people who inject drugs in London.

February 15 The Acting MOH met with Miriam Klassen via teleconference to discuss the February 17 SWMOH meeting.

February 16 The Acting MOH participated in the monthly Provincial / Public Health Unit conference call.
The Acting MOH and Acting CEO attended the Board of Health meeting.

February 17 The Acting MOH chaired the SWMOH teleconference meeting and the Acting CEO participated in the call.
The Acting MOH met with the Deputy Chief MOH, Dr. David McKeown, to discuss Safe Injection Services.

February 21 The Acting MOH attended a physician CME event on opioid maintenance during pregnancy and presented on the local situation in regard to injection drug use in London.

February 23–24 The Acting MOH attended the 2017 alPHa Winter Symposium in Toronto and the COMOH section meeting.

February 24 On behalf of the Acting MOH, Suzanne Vandervoort, Director of the Healthy Living Division, attended a meeting of the Community Drug and Alcohol Strategy Steering Committee.

February 28 The Acting MOH and Acting CEO, along with the Senior Leadership Team and other volunteers, cooked pancakes and sausages for Health Unit staff to celebrate Pancake Tuesday and raise funds for the United Way.
The Acting MOH attended a consultation regarding regulations around legalizing cannabis hosted by Bill Blair, Parliamentary Secretary to the Minister of Justice.
The Acting MOH met with Dr. Adam Dukelow, the city-wide Emergency Department Chief, on collaboration to enhance opioid surveillance and prevention.

March 2 The Acting MOH and Acting CEO attended the Finance & Facilities Committee meeting.
The Acting MOH and Acting CEO had an introductory meeting with Mr. Peter Develin, President of Fanshawe College.

This report was submitted by the Office of the Medical Officer of Health.

Dr. Gayane Hovhannisyan, MD, MHSc, CCFP, FRCPC
Acting Medical Officer of Health

Laura Di Cesare, CHRE
Acting Chief Executive Officer