AGENDA
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, February 27, 2020, 7:00 p.m.
399 Ridout Street North, London, Ontario
Side Entrance, (recessed door)
MLHU Boardroom

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 (Chair)
Ms. Aina DeViet (Vice-Chair)
Mr. John Brennan
Mr. Michael Clarke
Ms. Kelly Elliott
Ms. Tino Kasi
Ms. Arielle Kayabaga
Mr. Ian Peer
Mr. Bob Parker
Mr. Matt Reid

SECRETARY-TREASURER

Dr. Christopher Mackie

DISCLOSURE OF CONFLICTS OF INTEREST

APPROVAL OF AGENDA

MINUTES

Approve: January 23, 2020 – Board of Health meeting

Receive: February 6, 2020 – Finance & Facilities Committee Meeting
February 13, 2020 - Finance & Facilities Committee Meeting

Item #	Delegation	Recommendation	Information	Report Name and Number	Link to Additional Information	Overview and Lead
Reports and Agenda Items						
1	x	x	x	Finance & Facilities Committee Meeting Update: February 6 and 13, 2020 (Report No. 005-20A & 005-20B)	2020 Annual Service Plan (Final) February 6, 2020 Agenda Minutes February 13, 2020 Agenda Minutes	To provide an update on the February 6 and 13, 2020 Finance & Facilities Committee meetings. Lead: Kelly Elliott, Chair, Finance & Facilities Committee
2	x	x	x	Governance Committee Meeting Update: February 27, 2020 (Verbal)	February 27, 2020 Agenda	To provide an update on the February 27, 2020 Governance Committee meeting. Lead: Chair, Governance Committee
3		x	x	Public Health Modernization – Board of Health Submission (Report No. 006-20)	Appendix A	To request approval to forward the Middlesex-London Health Unit's Public Health Modernization submission to the Ministry of Health. Lead: Dr. Alex Summers, Associate Medical Officer of Health
4	x		x	Service-Seeking Client Experience Survey Results (Report No. 007-20)	Appendix A	An update on the results from the Client Experience Survey and next steps for monitoring experience and ensuring action plan implementation. Lead: Heather Lokko, Director, Healthy Start, Brooke Clark, Community Health Nursing Specialist, Michelle Sangster Bouck, Program Evaluator
5		x	x	Initial Results of Modification of Eligibility Criteria for the Healthy Babies Healthy Children (HBHC) Program (Report No. 008-20)	Appendix A Appendix B	To request approval to continue with the current modified eligibility criteria for the HBHC program and endorse communication with the Ministry of Children, Community and Social Services regarding the intent to modify eligibility criteria for an additional six months. Lead: Heather Lokko, Director, Healthy Start

6				Laptop Purchases – Contract Award (Report No. 013-20)		To request approval to enter into a contractual agreement with Insight Canada for the purchase of laptop computers. Lead: Joe Belancic, Manager, Procurement and Operations
7			**x**	Vector-Borne Disease Program: Summary Report (Report No. 009-20)	Appendix A Appendix B	To provide an update on the increased prevelance of blacklegged ticks in Middlesex-London, and the identification of a Lyme disease risk area within a 20 km radius of Komoka. Lead: Stephen Turner, Director, Environmental Health & Infectious Diseases
8			**x**	Critical Injury Investigation Results and Follow-up (Report No. 010-20)	Appendix A	To provide an update on a critical injury of a worker that occurred on January 29, 2020 outside of Citi Plaza. Lead: Cynthia Bos, Manager, Human Resources
9			**x**	Summary Information Report for February (Report No. 011-20)	Appendix A	To provide an update on Health Unit programs and services for February. Lead: Linda Stobo, Manger, Chronic Disease Prevention and Tobacco Control
10			**x**	Medical Officer of Health / CEO Activity Report for February (Report No. 012-20)		To provide an update on the Medical Officer of Health/CEO activities for February. Lead: Dr. Chris Mackie, Medical Officer of Health/CEO.
11			**x**	Verbal Update: Novel Coronavirus		To provide an update on Novel Coronavirus. Lead: Dr. Alex Summers, Associate Medical Officer of Health
Correspondence						
12			**x**	February 2020 Correspondence		To receive correspondence items a) though p). To endorse item q) re: Sufficient Public Health Funding (*resolution to be submitted to the Association of Local Public Health Agencies annual general meeting in June*).

OTHER BUSINESS

- Annual Confidentiality Declaration
  Lead: Nicole Gauthier, Manager, Privacy, Risk and Governance

- Next Finance and Facilities Committee Meeting: March 5, 2020 @ 9:00 a.m.
- Next Board of Health Meeting: March 19, 2020 @ 7:00 p.m.
- Next Governance Committee Meeting: June 18, 2020 @ 6:00 p.m.

CONFIDENTIAL

The Board of Health will move in-camera to consider matters regarding identifiable individuals, litigation or potential litigation, including matters before administrative tribunals, affecting the Middlesex-London Health Unit, a trade secret or financial information, supplied in confidence to the local board, which if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with contractual or other negotiations of a person, group of persons or organization, and a trade secret or financial information that belongs to the municipality or local board and has monetary value, to approve confidential minutes from the January 23, 2020 Board of Health meeting and to receive minutes from the February 6, 2020 Finance & Facilities Committee meeting.

ADJOURNMENT

PUBLIC SESSION – MINUTES
MIDDLESEX-LONDON BOARD OF HEALTH

Thursday, January 23, 2020, 7:00 p.m.
399 Ridout Street North, London, Ontario
Side Entrance (recessed door)
MLHU Boardroom

MEMBERS PRESENT:	Ms. Maureen Cassidy (Chair) Ms. Aina DeViet (Vice-Chair) Mr. Ian Peer Ms. Arielle Kayabaga Mr. Matt Reid Mr. John Brennan Ms. Kelly Elliott Mr. Bob Parker
REGRETS:	Ms. Tino Kasi Mr. Michael Clarke
OTHERS PRESENT:	Dr. Christopher Mackie, Medical Officer of Health/CEO (Secretary-Treasurer) Ms. Elizabeth Milne, Executive Assistant to the Board of Health and Communications Coordinator (Recorder) Dr. Alexander Summers, Associate Medical Officer of Health Ms. Laura Di Cesare, Director, Healthy Organization Ms. Mary Lou Albanese, Manager, Infectious Disease Mr. Joe Antone, Manager, Health Equity and Indigenous Reconciliation Mr. Dan Flaherty, Communications Manager Ms. Heather Lokko, Director, Healthy Start Mr. Alex Tyml, Online Communications Coordinator Mr. Stephen Turner, Director, Environmental Health and Infectious Disease Mr. Brian Glasspoole, Manager, Finance Ms. Cheryl Tung, Public Health Inspector Ms. Alison Locker, Epidemiologist Mr. Stephen Parker, Director, Foodborne Disease and Antimicrobial Resistance Surveillance Division, Health Canada

Dr. Mackie called the meeting to order at 7:02 p.m.

Ms. Kayabaga arrived at 7:03 p.m.

Dr. Mackie welcomed everyone to the inaugural meeting of the Board of Health and opened the meeting by acknowledging the Indigenous Peoples of this land and the First Nations within Middlesex and London. Dr. Mackie then introduced Mr. Joe Antone, Manager, Indigenous Reconciliation and Health Equity, who led a traditional ceremony and smudging.

Dr. Mackie noted the difference between ceremonial tobacco and commercial tobacco, and thanked Mr. Antone for leading the ceremony this evening.

DRAFT

MEETING PROCEDURES

Election of 2020 Board of Health Executive and Other Procedures **(Report No. 001-20)**

Dr. Mackie opened the floor to nominations for the position of Chair of the Board of Health for 2020.

It was moved by Mr Peer, seconded by Ms. Kayabaga, *that Ms. Maureen Cassidy be nominated for Chair of the Board of Health for 2020.*

Carried

Ms. Cassidy accepted the nomination.

Dr. Mackie invited nominations three more times. Hearing none, it was moved by Mr. Peer, seconded by Ms. Kayabaga, *that*

1) *Nominations for the position of Chair be closed; and*
2) *Ms. Maureen Cassidy be acclaimed as Chair of the Board of Health for 2020.*

Carried

Ms. Cassidy took over as Chair and welcomed Mr. Bob Parker to the Board of Health, appointed by the Province of Ontario earlier this month.

DISCLOSURE OF CONFLICT OF INTEREST

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

APPROVAL OF AGENDA

It was moved by Ms. DeViet, seconded by Mr. Peer, *that the **AGENDA** for the January 23, 2020 Board of Health meeting be approved as amended.*

Carried

Ms. Cassidy acknowledged the outgoing Chair, Ms. Trish Fulton, thanking her for her time and acknowledging her service to the Board of Health.

Chair Cassidy opened the floor to nominations for the position of Vice-Chair of the Board of Health for 2020.

It was moved by Mr. Brennan, seconded by Mr. Peer, *that Ms. Aina DeViet be nominated for Vice-Chair of the Board of Health for 2020.*

Ms. DeViet accepted the nomination.

Chair Cassidy invited nominations three more times. Hearing none, it was moved by Mr. Brennan, seconded by Mr. Peer, *that*

1) *Nominations for the position of Vice-Chair be closed; and*
2) *Ms. DeViet be acclaimed as Vice-Chair of the Board of Health for 2020.*

Carried

Chair Cassidy opened the floor to nominations for the position of Secretary-Treasurer of the Board of Health for 2020.

It was moved by Mr. Reid, seconded by Ms. DeViet, *that Dr. Christopher Mackie be nominated for Secretary-Treasurer of the Board of Health for 2020.*

Carried

Dr. Mackie accepted the nomination.

Chair Cassidy invited nominations three more times. Hearing no further discussion or nominations, it was moved by Mr. Reid, seconded by Ms. DeViet, *that Dr. Mackie be elected Secretary-Treasurer by acclaimed vote.*

Carried

Establishment of 2020 Standing Committees

It was moved by Mr. Reid, seconded by Ms. Elliott, *that the Board of Health establish the Finance & Facilities Committee and the Governance Committee, and recognize the Relocation Advisory Committee.*

Carried

Dr. Mackie outlined the membership composition of the Relocation Advisory Committee (RAC), an ad-hoc committee of the Board of Health. He noted that the RAC's Chair, Mr. Ian Peer, was appointed at the Committee's first meeting to serve until the RAC ceases to exist. All additional RAC members, including individuals previously appointed (Mr. Michael Clarke, Mr. Matt Reid, and Mr. John Brennan), must be reappointed. The newly appointed Chair of the Board of Health will also sit on the RAC Committee.

Chair Cassidy invited a motion to reappoint the members of the Relocation Advisory Committee for 2020, and reviewed the Committee's terms of reference.

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

1) *Maintain the current composition of the Relocation Advisory Committee; and*
2) *Reappoint all previously appointed members for the duration of the committee.*

Carried

Thus, the membership of the Relocation Advisory Committee for 2020 consists as follows:

1) Ms. Maureen Cassidy (Board Chair and City Representative)
2) Mr. Ian Peer (RAC Chair and Provincial Representative)
3) Mr. Michael Clarke (Provincial Representative)
4) Mr. Matt Reid (City Representative)
5) Mr. John Brennan (County Representative)

Chair Cassidy invited nominations for members of the Finance & Facilities Committee for 2020, and reviewed the Committee's terms of reference.

It was remarked that the Chair and Vice-Chair of the Board of Health sit on the Finance & Facilities Committee automatically.

It was moved by Mr. Reid, seconded by Ms. Kayabaga, *that Mr. Ian Peer be nominated to the Finance & Facilities Committee for 2020.*

Mr. Peer accepted the nomination.

It was moved by Mr. Peer, seconded by Ms. Kayabaga, *that Ms. Tino Kasi be nominated to the Finance & Facilities Committee for 2020.*

It was noted that Ms. Kasi had advised Mr. Peer, in advance of the meeting, that she would accept nomination to the Committee.

It was moved by Mr. Brennan, seconded by Ms. DeViet, *that Ms. Kelly Elliott be nominated to the Finance & Facilities Committee for 2020.*

Ms. Elliott accepted the nomination.

DRAFT

Chair Cassidy invited nominations three more times. Hearing none, it was moved by Mr. Brennan, seconded by Ms. DeViet, *that nominations be closed and that Mr. Peer, Ms. Kasi, and Ms. Elliott be appointed to the Finance & Facilities Committee for 2020.*

Carried

Thus, the membership of Finance & Facilities Committee for 2020 consists as follows:

1) Ms. Maureen Cassidy (Chair and City Representative)
2) Ms. Aina DeViet (Vice-Chair and County Representative)
3) Mr. Ian Peer (Provincial Representative)
4) Ms. Tino Kasi (Provincial Representative)
5) Ms. Kelly Elliott (County Representative)

Chair Cassidy invited nominations for members of the Governance Committee for 2020, and reviewed the Committee's terms of reference.

It was moved by Mr. Peer, seconded by Ms Elliott, *that Mr. Bob Parker be nominated to the Governance Committee for 2020.*

Mr. Parker accepted the nomination.

It was moved by Mr. Brennan, seconded by Ms. DeViet, *that Mr. Matt Reid be nominated to the Governance Committee for 2020.*

Mr. Reid respectfully declined the nomination.

It was moved by Ms. DeViet, seconded by Ms. Elliott, *that Mr. Ian Peer be nominated to the Governance Committee for 2020.*

Mr. Peer accepted the nomination.

It was moved by Mr. Brennan, seconded by Ms. Elliott, *that Ms. Arielle Kayabaga be nominated to the Governance Committee for 2020.*

Ms. Kayabaga accepted the nomination.

Chair Cassidy invited nominations three more times. Hearing none, it was moved *that nominations be closed, and that Mr. Parker, Mr. Peer, and Ms. Kayabaga be appointed to the Governance Committee for 2020.*

Carried

Thus, the membership of the Governance Committee for 2020 consists as follows:

1) Ms. Maureen Cassidy (Chair and City Representative)
2) Ms. Aina DeViet (Vice-Chair and County Representative)
3) Mr. Bob Parker (Provincial Representative)
4) Mr. Ian Peer (Provincial Representative)
5) Ms. Arielle Kayabaga (City Representative)

It was moved by Ms. Elliott, seconded by Ms. DeViet, *that the Board of Health approve the Board of Health and standing committee meeting schedule for 2020.*

Carried

APPROVAL OF MINUTES

DRAFT

It was moved by Mr. Peer, seconded by Ms. Kayabaga, *that the **MINUTES** of the December 12, 2019 Board of Health meeting be approved.*

Carried

REPORTS AND AGENDA ITEMS

FoodNet Canada Ontario Sentinel Site Update and Memorandum of Agreement (Report No. 002-20)

Dr. Mackie introduced Mr. Stephen Parker, Director, Foodborne Disease and Antimicrobial Resistance Surveillance Division, Health Canada.

Mr. Turner introduced Ms. Mary Lou Albanese, Manager, Infectious Disease Control; Ms. Cheryl Tung, Public Health Inspector; and Ms. Alison Locker, Epidemiologist. Each plays a key role in the FoodNet Ontario Sentinel site program at MLHU. Mr. Tuner also provided context to the report and its appendices.

Mr. Parker provided an overview of the FoodNet Canada program, including each of the four sentinel sites (located in Ontario, Quebec, Alberta, and British Columbia). He also outlined the role of Health Canada in supporting the sentinel sites in each province.

Discussion ensued on the following items:

- FoodNet's relationship with retailers, manufacturers, and suppliers of food products at the federal and provincial levels.
- Sampling of products from both national and provincial producers.
- Which sentinel sites sample water, and why the Ontario site does not include water in its most recent Memorandum of Agreement.
- Distribution channels and various other sites, such as farmers' markets, which could be important sources for testing products not prepared in federally inspected facilities and which could have impacts on public health.

It was moved by Ms. Elliott, seconded by Ms. Kayabaga, *that the Board of Health:*

1) *Receive Report No. 002-20 re: "FoodNet Canada Ontario Sentinel Site Update and Memorandum of Agreement"; and*
2) *Direct staff to renew the contract with FoodNet Canada for an additional one-year term.*

Carried

Medical Officer of Health/Chief Executive Officer Activity Report for January (Report No. 003-20)

It was moved by Mr. Peer, seconded by Ms. DeViet, *that the Board of Health receive Report No. 003-20 re: "Medical Officer of Health/Chief Executive Officer Activity Report for January" for information.*

Carried

CORRESPONDENCE

Ms. Cassidy mentioned a letter in the correspondence for Dr. Michael Clarke, thanking him for his term on the Board and expressing sadness at his departure.

It was moved by Mr. Reid, seconded by Mr. Parker, *that the Board of Health receive items a) through l).*

Carried

OTHER BUSINESS

Dr. Mackie invited all Board members to attend the Association of Local Public Health Agencies (alPHa) winter symposium, to be held February 20–21 in Toronto.

Chair Cassidy noted that last week's consultation with the Province was very constructive, and that a number of London City Councillors, Middlesex County Councillors and Board of Health members attended and participated. The session was facilitated by Mr. Jim Pine and attended by representatives of the Ministry of Health.

Ms. DeViet provided an update on the Minister's address at the Rural Ontario Municipal Association (ROMA) conference, which she attended earlier this week.

Chair Cassidy reviewed the next meeting dates:

- Next Finance & Facilities Committee meeting: February 6, 2020 @ 9:00 a.m.
- Special meeting of the Board of Health: February 6, 2020 @ 12:00 p.m.
- Next Governance Committee meeting: February 27, 2020 @ 6:00 p.m.
- Next regular Board of Health meeting: February 27, 2020 @ 7:00 p.m.

Verbal Update – Coronavirus

Dr. Mackie gave a verbal update and noted that much work has been done, locally and provincially, on the novel coronavirus 2019. He then invited Dr. Alex Summers, Associate Medical Officer of Health, to review at both the provincial and local level.

Dr. Summers provided some background on coronavirus and explained how this family of viruses can cause illness and be transmitted. He also outlined the history of transmission for nCoV-2019, how it has been transmitted thus far, and what the global response has been. Dr. Summers advised the Board that novel coronavirus has now been designated a reportable disease by the Minister of Health, which means that labs and physicians now have a duty to report suspect and confirmed cases to the Health Unit. MLHU will continue to monitor the situation while working closely with its community and provincial partners.

Discussion ensued on the following items:

- Case definitions for coronavirus and how someone may be identified for testing.
- That some persons are under investigation, but no confirmed cases of novel coronavirus have yet been reported in Canada.
- That the risk to residents of Ontario and Middlesex-London is low, and that flu remains the largest burden of illness in our region.

It was moved by Ms. Kayabaga, seconded by Ms. DeViet, *that the Board of Health receive the verbal update from Dr. Summers on coronavirus.*

Carried

CONFIDENTIAL

At 8:10 p.m., it was moved by Ms. Kayabaga, seconded by Mr. Brennan, *that the Board of Health move in-camera to consider matters regarding identifiable individuals and to approve confidential minutes of its December 12, 2019 meeting.*

Carried

At 8:43 p.m., it was moved by Ms. Kayabaga, seconded by Ms. Elliott, *that the Board of Health rise and return to public session.*

Carried

At 8:43 p.m., the Board of Health returned to public session.

ADJOURNMENT

DRAFT

At 8:43 p.m., it was moved by Ms. Kayabaga, seconded by Mr. Parker, *that the meeting be adjourned.*

Carried

MAUREEN CASSIDY
Chair

CHRISTOPHER MACKIE
Secretary-Treasurer

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
399 Ridout St. N.
Middlesex-London Health Unit Board Room
Thursday, February 6, 2020 9:00 a.m.

MEMBERS PRESENT: Ms. Kelly Elliott (Chair)
Ms. Aina DeViet
Ms. Tino Kasi
Mr. Ian Peer

REGRETS: Ms. Maureen Cassidy

OTHERS PRESENT: Mr. Bob Parker, Board of Health Member
Dr. Christopher Mackie, Secretary-Treasurer
Ms. Lynn Guy, Executive Assistant to the Medical Officer of Health (Recorder)
Ms. Laura Di Cesare, Director, Corporate Services
Mr. Brian Glasspoole, Manager, Finance
Mr. Joe Belancic, Manager, Procurement and Operations
Mr. Jordan Banninga, Manager, Program Planning and Evaluation
Ms. Cynthia Bos, Manager, Human Resources
Ms. Kendra Ramer, Manager, Strategic Projects
Ms. Nicole Gauthier, Manager, Privacy, Risk and Governance
Ms. Rhonda Brittan, Manager, Healthy Communities and Injury Prevention
Mr. Jeff Cameron, Manager, IT
Dr. Alex Summers, Associate Medical Officer of Health
Ms. Heather Lokko, Director, Healthy Start

At 9:00 a.m., Dr. Mackie called the meeting to order and opened the floor to nominations for Chair of the Finance & Facilities Committee for 2020.

It was moved by Ms. DeViet, seconded by Mr. Peer, *that Ms. Elliott be nominated for Chair of the Finance & Facilities Committee for 2020*.

Carried

Ms. Elliott accepted the nomination.

Dr. Mackie called three times for further nominations. None were forthcoming.

It was moved by Ms. DeViet, seconded by Mr. Peer, *that Ms. Elliott be acclaimed as Chair of the Finance & Facilities Committee for 2020.*

Carried

Chair Elliott reviewed the Committee's membership to ensure quorum.

DISCLOSURES OF CONFLICT OF INTEREST

Chair Elliott inquired if there were any disclosures of conflict of interest. None were declared.

APPROVAL OF AGENDA

DRAFT

It was moved by Ms. DeViet, seconded by Mr. Peer, *that the **AGENDA** for the February 6, 2020 Finance & Facilities Committee meeting be approved.*

Carried

APPROVAL OF MINUTES

It was moved by Mr. Peer, seconded by Ms. DeViet, *that the **MINUTES** of the December 5, 2019 Finance & Facilities Committee meeting be approved.*

Carried

NEW BUSINESS

4.1 2020 Terms of Reference and Annual Reporting Calendar (Report No. 001-20FFC)

The Terms of Reference and Reporting Calendar were attached to this report to help guide Committee members throughout the year.

It was moved by Mr. Peer, seconded by Ms. Kasi, *that the Finance & Facilities Committee approve Report No. 001-20FFC re: "Terms of Reference and Reporting Calendar."*

Carried

4.2 2020 Proposed Budget (Report No. 002-20FFC)

Dr. Mackie noted that the Annual Service Plan (ASP) is the tool that the Health Unit uses to report its budget to the Ministry of Health.

Dr. Mackie provided a Program Budget Marginal Analysis (PBMA) overview. Recognizing that all programs and activities are valuable, the PBMA process asks staff to consider opportunities for investment and/or disinvestment in their programs to provide the best possible delivery of programs and services to clients while ensuring the least negative impact.

Mr. Glasspoole provided an overview of the 2020 budget considerations, including inflationary pressures related to cost-of-living increases for staff; incremental premises cost in connection to the relocation to Citi Plaza, and PBMA-related disinvestments of $493,388.

Mr. Glasspoole provided a three-year (2018–20) budget overview. He noted that the overall proposed budget for 2020 shows an increase of $707,034 over last year. Components of this increase include: an increase of $2,561,400 for the 100%-funded Ontario Seniors Dental Care Program, an increase of $166,846 from the City of London to support local cannabis enforcement and education, and a decrease of $2,096,759 from MCCSS for children's screening programs.

There was discussion in regard to projecting how the municipalities' contributions may change. Mr. Glasspoole said he didn't feel that it would be a double-digit increase. Dr. Mackie noted that the City and the County have not put increased amounts in their budgets, but are reporting it as unknown.

Mr. Banninga reviewed the Divisions, including the teams and their respective programs. He explained the grouping of public health interventions into programs as related to specific diseases, topics, or populations. These interventions assist the program in achieving the desired outcomes. He noted that today the Finance & Facilities Committee would be looking at programs and interventions.

Mr. Peer mentioned the great amount of work that has gone into developing the ASP document. As most attendees had not had time to read through the entire document, Dr. Mackie asked that the focus today be on changes to the FTE count and budget. Staff will speak to each of these topics as required.

DRAFT

Dr. Mackie discussed the changes in Emergency Management, under the Emergency Management Standard, and noted that the reduction in one FTE resulted from not replacing an exiting Program Assistant. The remaining duties will now be performed by the Administrative Assistant to the Director.

The Communications Program, which falls under the Effective Public Health Practice Standard, experienced no significant changes. Discussion ensued on how to measure outcomes for this program and the increase in social media use, especially Instagram.

Program Planning and Evaluation (PPE) also falls under the Effective Public Health Practice Standard. Mr. Banninga reviewed the PPE Program. He noted that there were no significant changes to report.

The Quality and Transparency Program also reported no significant changes.

Mr. Banninga noted that the Research and Knowledge Exchange Program had seen a significant budget increase due to amalgamation of two programs. There was no change to service delivery.

Under the Health Equity Standard, Ms. Lokko provided the review for the Health Equity and Indigenous Public Health Practice programs. There was a question in regard to the first indicator as to teams consulting with HEART. Ms. Lokko said she would check the data provided to ensure accuracy.

Under the Population Health Assessment Standard, Dr. Summers provided the Population Health Assessment and Surveillance Program update. He reported no major changes and advised that the program remains stable and consistent.

Ms. Brittan provided updates for the Chronic Disease Prevention and Well-Being Team's programs, reportable under the Chronic Disease Prevention and Well-Being Standard. These programs include: Healthy Eating Behaviours; Oral Health; Physical Activity and Sedentary Behaviours; Mental Health Promotion; and Ultraviolet Radiation and Sun Safety.

There was discussion in regard to Oral Health indicators. When the indictor numbers are available for 2019, they will be brought to the Board. Ms. Brittan advised that she would contact the program manager to obtain the data.

Dr. Summers reviewed the Food Safety Program, which is within the the Food Safety and Healthy Environments Team and reportable under the Food Safety Standard. Also reviewed, from this team, was the Health Hazard Response Program and the Healthy Environments and Climate Change Program.

Under the Healthy Growth and Development Standard, Ms. Lokko reviewed several programs in the Healthy Start Division: Breastfeeding and Infant Feeding; Growth and Development; Healthy Pregnancies; Mental Health Promotion; and Preconception Health.

Under the Healthy Growth and Development Standard, Dr. Summers reviewed the Healthy Sexuality Program in the EHID Division. Committee members requested more information on performance/service level indicators. Dr. Summers will ask why the 2020 target for youth accessing Birth Control Clinic services (3,000) is lower than for the previous year.

At 10:50 a.m., Chair Elliott asked for a motion to take a five-minute break.

It was moved by Ms. DeViet, seconded by Ms. Kasi, *that the FFC take a five-minute break*.

At 10:55 a.m., Chair Elliott called the meeting to order.

It was moved by Mr. Peer, seconded by Ms. DeViet, that the meeting proceed.

Dr. Summers updated the Committee on the programs reportable under the Infectious and Communicable Diseases Prevention and Control Standard, beginning with the Infection Prevention and Control (IPAC) Program and continuing with the other programs: Rabies and Zoonotic Disease; Respiratory, Enteric, and Other Infectious Disease; Sexually Transmitted and Blood-Borne Disease; Tuberculosis; and Vector-Borne Disease.

Dr. Summers continued his update for the EHID Division, under the Immunization Standard. The Division's programs include: Adverse Vaccine Events and Safety; Vaccine Inventory Management; and Vaccine Preventable Disease.

Ms. Brittan introduced the School Health Standard, and reviewed the Comprehensive School Health, Oral Health, and Vision programs. There was discussion in regard to mental health services available in schools, which are provided via the Comprehensive School Health Program.

The Immunization Program, also reportable under the School Health Standard, is in the EHID Division. This update was given by Dr. Summers. A Board Member asked if mandatory indicators could be highlighted in the document? Dr. Mackie noted that the mandatory indicators are not current and will shift as Public Health Modernization proceeds.

Ms. Brittan provided the update for the Substance Use and Injury Prevention Standard, beginning with the Alcohol and Cannabis Program in the Health Living Division.

Chair Elliott noted that due to limited time, the ASP review will continue at the February 13, 2020 FFC meeting.

Carried

4.3 Staff Reimbursement – Mileage (Report No. 003-19FFC)

Mr. Glasspoole noted that the mileage reimbursement rates have not been adjusted since 2014.

It was moved by Ms. DeViet, seconded by Mr. Peer, *that the Finance & Facilities Committee make recommendation to the Board of Health to approve increases to employee mileage reimbursement rates, effective January 1, 2020, to $0.55/km for the first 5,000 km and $0.50/km thereafter.*

Carried

OTHER BUSINESS

Next meeting: February 13, 2020.

CONFIDENTIAL

At 11:30 a.m., it was moved by Ms. Kasi, seconded by Mr. Peer, *that the Finance & Facilities Committee move in-camera to consider matters regarding a trade secret or financial information, supplied in confidence to the local board, which if disclosed, could reasonably be expected to prejudice significantly the competitive position, or interfere significantly with contractual or other negotiations, of a person, group of persons, or organization, and a trade secret or financial information that belongs to the municipality or local board and has monetary value.*

Carried

At 11:53 a.m., it was moved by Mr. Peer, seconded by Ms. Kasi, *that the Finance & Facilities Committee return to public session.*

Carried

At 11:54 a.m., the Finance & Facilities Committee returned to public session.

DRAFT

ADJOURNMENT

At 11:55 a.m., it was moved by Mr. Peer, seconded by Ms. DeViet, *that the meeting be adjourned.*

Carried

At 11:56 a.m., Chair Elliott *adjourned the meeting*.

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KELLY ELLIOTT
Chair

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CHRISTOPHER MACKIE
Secretary-Treasurer

DRAFT

PUBLIC MINUTES
FINANCE & FACILITIES COMMITTEE
399 Ridout St. N.
Middlesex-London Health Unit Board Room
Thursday, February 13, 2020 9:00 a.m.

MEMBERS PRESENT:	Ms. Kelly Elliott (Chair) Ms. Aina DeViet Mr. Ian Peer
REGRETS:	Ms. Maureen Cassidy Ms. Tino Kasi
OTHERS PRESENT:	Dr. Christopher Mackie, Secretary-Treasurer Ms. Lynn Guy, Executive Assistant to the Medical Officer of Health (Recorder) Mr. Brian Glasspoole, Manager, Finance Mr. Jordan Banninga, Manager, Program Planning and Evaluation Ms. Cynthia Bos, Manager, Human Resources Ms. Kendra Ramer, Manager, Strategic Projects Ms. Nicole Gauthier, Manager, Privacy, Risk and Governance Ms. Rhonda Brittan, Manager, Healthy Communities and Injury Prevention Mr. Jeff Cameron, Manager, IT Dr. Alex Summers, Associate Medical Officer of Health Ms. Heather Lokko, Director, Healthy Start

At 9:00 a.m., Chair Elliott called the meeting to order.

DISCLOSURES OF CONFLICT OF INTEREST

Chair Elliott inquired if there were any disclosures of conflict of interest. None were declared.

APPROVAL OF AGENDA

The walk-on report "One-Time Funding Requests to the Ministry of Health" (Report No. 002-20FFC) was added to the agenda.

It was moved by Ms. DeViet, seconded by Mr. Peer, *that the amended* ***AGENDA*** *for the February 13, 2020 Finance & Facilities Committee meeting be approved.*

Carried

BUSINESS

4.1 2020 Proposed Budget (continued from the February 6 meeting) **(Report No. 002-20FFC)**

The committee continued its review of the 2020 Annual Service Plan (ASP), beginning on page 289. The floor was opened to discussion when requested by Board members.

Continuing under the Substance Use and Injury Prevention Standard, there was discussion in regard to the distribution of child booster seats. Ms. Brittan provided an update, noting that pre-booster seats are closely monitored and are provided to families with the most critical need.

DRAFT

The Falls Prevention and Healthy Aging Program is part of the Healthy Living Division. Chair Elliott suggested that the Health Unit consider increasing collaboration within the county, as many seniors there do not have personal support workers.

Also reportable under the Substance Use and Injury Prevention Standard is the Opioids and Other Drugs Program in the Environmental Health and Infectious Diseases Division (EHID). Chair Elliott noted that she had spoken with the fire chief in Thames Centre who advised her that they are starting to carry Naloxone kits in the fire engines. Chair Elliott suggested that program staff get in touch with lower-tier fire stations to provide more information.

In regard to the Road and Off-Road Safety, Mr. Peer asked about program funding. Ms. Brittan responded that the Health Unit might receive some funding under a newly announced grant.

Dr. Mackie reported on the Southwest Tobacco Control Area Network (SWTCAN) and noted that a rumour had been circulating recently that the TCANs would be dissolved. He advised that this is not the case and that, during the Public Health Modernization consultations, the importance of the TCANs had been noted.

Regarding the Tobacco Control and Electronic Cigarettes Program, discussion ensued on having sufficient resources to meet the program goals, perform the policy work, and meet regulations.

The Violence Prevention Program was mentioned, but it was felt that no further discussion was needed.

In regard to the Seniors Dental Program, it was noted that the program is 100% funded for this year. Dr. Mackie said it was not clear, at this time, what the funding will look like for next year.

Under the Safe Water Standard, the following programs were discussed:

Drinking Water: Travel expenses decreased over the past year due to the recently completed Public Health Inspector review. An intentional process was undertaken to make travel more efficient.
It was noted that for private well inspections, consultations are carried out on a by-request basis. Dr. Mackie provided additional information.
Chair Elliott asked that the Health Unit reach out to lower-tier municipalities to inquire whether MLHU could provide materials to be included in their mailouts, such as brochures and/or links to Facebook posts about well water, testing, consultations, etc.

Recreational Water: No additional discussion was required.

Small Drinking Water System: No additional discussion was required.

One of the many programs in the Healthy Organization Division, Strategic Projects was reviewed under the Delivery of Public Health Programs and Services Standard. No additional discussion was required.

Finance was reviewed under the Fiduciary Requirements Standard. Ms. DeViet asked Mr. Glasspoole to provide an update on capital assets.

Procurement was also reviewed under the Fiduciary Requirements Standard. Ms. DeViet asked about competitive bids and what is meant by decreasing the level of activity. It was noted that due to the relocation, the number of bids was higher than normal in 2019, but should decrease the following year.

For the Governance, Human Resources, Information Technology, Operations, and Privacy and Records programs in the Healthy Organization Division, reportable under the Good Governance and Management Practices Standard, it was felt that no additional discussion was needed.

There was some discussion related to the Risk Management program, also in the Healthy Organization Division. Dr. Mackie advised the Committee about a local cannabis vendor who had been selling vaping products contrary to regulations, and the attendant enforcement-related risks with respect to meeting the Health Unit's mandate.

It was moved by Ms. DeViet, seconded by Mr. Peer, *that the Finance & Facilities Committee recommend that the Board of Health:*

1) *Approve the 2020 Proposed Budget in the gross amount of $35,309,015, as appended to Report No. 002-20FFC re: "2020 Proposed Budget";*
2) *Forward Report No. 002-20FFC to the City of London and the County of Middlesex for information; and*
3) *Direct staff to submit the 2020 Proposed Budget to the Health Unit's funding agencies in the formats they require.*

Carried

4.2 One-Time Funding Requests to the Ministry of Health (Report No. 002-20FFC)

Dr. Mackie noted that the Ministry has two funding processes, one of them for one-time funding requests. Mr. Glasspoole provided additional information on three such requests, which will be submitted to the Ministry for consideration and which pertain to:

- Public Health Inspector practicum positions;
- Funds for replacement of furniture; and
- Funds to cover increased staffing expenditures in regard to Novel Coronavirus

These one-time funding requests will be added to the Annual Service Plan submission. It is not known when or if the funding will be received.

It was moved by Mr. Peer, seconded by Ms. DeViet, *that the Finance & Facilities Committee make recommendation to the Board of Health to:*

1) *Approve Appendix A, outlining One-Time Funding Requests totalling $511,055; and*
2) *Direct staff to submit the funding requests in the 2020 Annual Service Plan to the Ministry.*

Carried

OTHER BUSINESS

Next FFC meeting: March 5, 2020, at 9:00 a.m.

ADJOURNMENT

At 9:39 a.m., it was moved by Mr. Peer, seconded by Ms. DeViet, *that the meeting be adjourned.*

Carried

At 9:39 a.m., Chair Elliott *adjourned the meeting*.

_______________________________ _______________________________

KELLY ELLIOTT **CHRISTOPHER MACKIE**
Chair **Secretary-Treasurer**

DRAFT

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 005-20A

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2020 February 27

FINANCE & FACILITIES COMMITTEE MEETING – FEBRUARY 6, 2020

The Finance & Facilities Committee (FFC) met at 9:00 a.m. on Thursday, February 6, 2020. A summary of the Committee's discussions can be found in the draft minutes.

Reports	Recommendations for Information and the Board of Health's Consideration
2020 Terms of Reference and Annual Reporting Calendar (Report No. 001-20FFC)	*That the Finance & Facilities Committee approve Report No. 001-20FFC re: "Finance & Facilities Committee – Terms of Reference and 2020 Reporting Calendar."*
Annual Service Plan (Report No. 002-20FFC)	The review of the Annual Service Plan began, with the motion to recommend the Plan to the Board being deferred to the February 13, 2020 FFC meeting.
Staff Reimbursement – Mileage (Report No. 003-20FFC)	*That the Finance & Facilities Committee make recommendation to the Board of Health to approve increases to employee mileage reimbursement rates, effective January 1, 2020, to $0.55/km for the first 5,000 km and $0.50/km thereafter.*

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

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 005-20B

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2020 February 27

FINANCE & FACILITIES COMMITTEE MEETING – FEBRUARY 13, 2020

The Finance & Facilities Committee (FFC) met at 9:00 a.m. on Thursday, February 13, 2020, to continue the review of the Health Unit's Annual Service Plan. A summary of the Committee's discussions can be found in the draft minutes.

Reports	Recommendations for Information and Board of Health Consideration
Annual Service Plan (Report No. 002-20FFC)	*That the Finance & Facilities Committee recommend that the Board of Health:* *1) Approve the 2020 Proposed Budget in the gross amount of $35,309,015, as appended to Report No. 002-20FFC re: "2020 Proposed Budget";* *2) Forward Report No. 002-20FFC to the City of London and the County of Middlesex for information; and* *3) Direct staff to submit the 2020 Proposed Budget to the Health Unit's funding agencies in the formats they require.*
One-Time Funding Requests to the Ministry of Health (Report No. 007-20FFC)	*That the Finance & Facilities Committee make recommendation to the Board of Health to:* *1) Approve Appendix A, outlining One-Time Funding Requests totaling $531,055; and* *2) Direct staff to submit the funding requests in the 2020 Annual Service Plan to the Ministry.*

The next FFC meeting will be on Thursday, March 5, 2020, at 9:00 a.m.

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

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 006-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2020 February 27

PUBLIC HEALTH MODERNIZATION – BOARD OF HEALTH SUBMISSION

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 006-20 re: "Public Health Modernization – Board of Health Submission" for information;***
2) ***Review and approve Appendix A "Public Health Modernization – Recommendations of the Middlesex-London Health Unit"; and***
3) ***Direct staff to forward the submission in the various formats available to the Ministry of Health.***

Key Points

- In April 2019, the Ontario government proposed changes to the structure and funding of public health in the province, including amalgamations of local public health units and significant budget reductions. The government has subsequently reevaluated these changes and committed to extensive consultations across the province on how best to transform and strengthen the role of public health.
- In late November 2019, the Ministry of Health released a discussion paper which will frame the conversation about public health modernization. The Ministry has invited input and feedback through written and in-person consultation.
- The Middlesex-London Health Unit has engaged with staff, the Board of Health, and other stakeholders to formulate an organizational response to the discussion paper.

Background

In April 2019, the provincial budget proposed to significantly restructure Ontario's public health system, including the dissolution of its 35 health units and the creation of 10 new regional public health entities. New boards of health were to be established, and substantial adjustments to provincial-municipal cost-sharing were proposed, as well as a reduction of the overall budget envelope for local public health. Consultations were expected to be held by the Ministry of Health in the summer and fall of 2019.

Subsequently, the provincial government indicated that the proposed amalgamations and budgetary changes required further consideration and confirmed the need for robust and broad consultation. It has been specifically noted that there are no pre-determined outcomes from this consultation process and that all reasonable options will be considered. This work is being led by Jim Pine, Special Advisor, Alison Blair, Executive Lead for Public Health Modernization, and Dr. David Williams, the Chief Medical Officer of Health.

The consultations were launched on November 18, 2019 via a webinar and the release of a discussion paper. The Ministry has invited input and feedback through written and in-person consultations with public health and municipal stakeholders. Written responses are due for submission by February 10, 2020. The Ministry recommendations will be developed in Spring 2020.

Development of a Response to the Submission.

Previous efforts and reflections on the structure and function of local public health have informed MLHU's response during this consultative process. In July 2019, the Board of Health approved a response paper titled Keeping Middlesex-London Safe and Healthy to be forwarded to the Minister of Health, other boards of health and relevant stakeholders (Report No. 053-19). Previous reports of relevance to this process include Review of Public Health Services in Middlesex County (Report No. 055-18) and What Makes a High Performing Health Unit? A Research Report to Inform Strategic Planning (Report 01-15GC Appendix C). Additionally, in identifying themes for feedback to the Ministry, staff reviewed dozens on previous reports on public health in Ontario.

Five consultations with staff, management, and a Board of Health and Senior Leadership Team session were conducted in January 2020 to develop the MLHU response and recommendations. Over 100 staff and board members attended the consultations or emailed feedback they felt should be included. The recommendations are summarized in Appendix A – Public Health Modernization – Recommendations of the Middlesex-London Health Unit.

Next Steps

The Middlesex-London Health Unit will continue to actively engage in consultation opportunities that arise and advocate for the recommendations put forward in the submission. The province expects that decisions on public health modernization will be announced in the late spring of 2020.

This report was prepared by the Healthy Organization Division and the Associate Medical Officer of Health.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

Appendix A to Report No. 006-20

Public Health Modernization in Ontario

Recommendations from the Middlesex-London Board of Health

February 28th, 2020

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Executive Summary and Recommendations

Public health protects and promotes the health of our communities and provides a high return on investment for keeping Ontarians safe and healthy. The 2019 Ontario Budget Protecting What Matters Most threatened to roll back previous investment and place an increased burden on our already stretched health care sector.

The Middlesex-London Health Unit (MLHU) welcomed the decision to reassess and reconsider these proposed amalgamations and budgetary changes. The challenges identified in the discussion paper released November 2019 are consistent with other local and provincial reviews of public health over the last twenty years.

The 2019 budget announcement rightly highlighted the importance of independent Boards of Health. Autonomy allows such organizations to be hotbeds of innovation in programming and cost control. As the largest autonomous public health agency in Canada, the MLHU has countless concrete examples of how public health can work to serve the needs of our communities in creative and efficient ways. Developed through consultation with the board of health and staff, our recommendations for how to modernize public health are below, followed by a more in-depth elucidation of the related issues.

Public Health Mandate

• The province should retain and strengthen our unique legislative mandate of upstream population health and disease prevention.

• The province should continue to support and enhance the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability as the basis for public health programming.

Public Health Governance and Jurisdictional Size

• The province should support opportunistic and voluntary mergers for health units where there is a need to achieve critical mass in public health human resources and enable surge capacity.

• Where possible, boards should remain autonomous and locally-responsive.

• Boards should include both appointees that are skills-based and municipally elected members, and be representative of the local community.

• The province should ensure representation of urban, rural, and Indigenous communities.

• The province should consider improving or replacing the Public Appointments Secretariat and Order in Council process for provincial representatives.

• Provincial appointments should be offset from municipal elections to avoid wholesale turnover of a Board.

• Provincial support regarding governance bylaw and policy development, as well as board training and capacity building, would be highly beneficial.

Health Unit Leadership Model

• The board of health should be given the authority to determine the most appropriate leadership model.

• Regardless of the leadership model, the Medical Officer of Health must report directly to the board of health.

• The Medical Officer of Health must maintain their autonomy and legislated authority.

• Any attempt to curb independence of the Medical Officer of Health by imposing constraints centrally would be risky for the Ministry, and may require Medical Officers of Health to violate medical and public health ethics.

Local Relationships and Partnerships

• There should be a recognition that relationships require time and energy to be successful.

• Defined and purposeful partnerships are very effective and should be encouraged and supported by the province.

• Reciprocity in the mandate for relationships and partnerships should also be considered.

• Integration and collaboration with the health care system should not come at the expense of relationships with other social services and community agencies.

• The structure and boundaries of public health units can positively or negatively affect relationships with municipalities and other local organizations.

• Supports should be provided by the province to enable effective partnership and collaboration between public health units.

Public Health Programs and Services

All Programs

• For all public health programs, delivery should continue to be at the local level, and the province should support opportunities for better coordination across health units.

• The province should provide clear and actionable strategy, coordinate regional public health unit collaboration, and support local delivery wherever possible.

• Innovation happens at the local level and should be funded, supported, and championed by the province.

• The province should support the robust sharing of information across health units regarding program delivery through appropriate technology and facilitators.

• Policy development should continue to be conducted at the provincial level, and at the local level by health units in order to ensure a fit with local values and environments, and a wide variety of opportunities for innovation.

• Where there is strong consensus across communities on a public health issue, but provincial legislation or policy does not exist, the province should provide leadership.

Foundational Standards

• Communication capacity should be maintained or enhanced at the local level to ensure issues are addressed with consideration of the local culture and media landscape.

• The province should initiate broad communication strategies with topics identified and prioritized in partnership with local health units.

• Population health assessment and surveillance should be maintained or enhanced at the local level to ensure there is adequate and relevant data to inform public health program delivery.

• Local public health units require sufficient population health assessment and surveillance capacity to provide data interpretation beyond analysis.

• The province should actively engage in the development of additional population health assessment data and protocols, with topics identified and prioritized in partnership with local public health units.

• Program planning and evaluation capacity should be maintained or enhanced at the local level to ensure there is sufficient support to plan, monitor, and public health program delivery.

• Research and knowledge exchange capacity should be enhanced at the local level to ensure that research evidence can be translated and applied to public health programs.

Corporate Services

• The province should analyze and provide information related to public health expenditures to assist health units with resource allocation decisions.

- There are considerable opportunities for the province to standardize budgeting processes, practices, and systems across public health units.
- There should be an alignment of strategy between provincial, regional, and local work, with variability for local priorities.
- The province should guide the development of project management standards and support information sharing amongst health units for large scale and strategic projects.
- The province should provide an overarching information technology strategy for local public health units and support regional collaboration.
- The province should provide an overarching human resources strategy for local public health units and support regional collaboration.
- The province should provide partial delivery and coordination of human resources centrally with most service delivery at the local level.
- The province should provide support regarding records retention standards and practices.

Public Health Human Resources

- The province should ensure that health promotion, as well as health protection programs, are adequately funded to meet day-to-day needs as well as incidents that require surge capacity.
- When extraordinary capacity is required, the province should provide readily available funding for staffing, supplies, or other needs.

Role of the Ministry and Public Health Ontario

- The province, through legislation and policy, should ensure that funding for public health is stable, predictable, equitable and adequate for the full delivery of all public health programs to meet local population health needs.
- The province should ensure that boards of health have the autonomy to allocate and manage funds to meet local population health needs.
- When mandating new public health programs, the province should ensure new resources are available.
- The province should develop robust and meaningful performance indicators for all standards that public health units report on annually.
- The Ministry of Health should support a health-in-all policies approach across ministries.
- The Chief Medical Officer of Health must be independent and unconstrained to provide public health advice and guidance to the government and the public.
- Public Health Ontario should continue its strong focus on infectious diseases, while expanding its work in health promotion and chronic disease prevention, which represent a far greater burden of illness and death in Ontario.
- Public Health Ontario should guide the development of planning and evaluation standards and support information sharing amongst health units for planning and evaluation.
- Public Health Ontario, in partnership with the Ministry of Health, should conduct evaluations where programs are being implemented by all public health units with little variability across the province.
- The Ministry should allocate research and knowledge exchange capacity to local priorities.

We submit these recommendations to the Ministry for careful consideration and reflection. We share the goal of modernizing our public health system to better serve the people of Ontario and are committed to any change that will accomplish this. There are considerable opportunities at both the provincial and local level. This submission focuses on the recommendations that we feel can be best addressed by the province.

Full Report

Introduction

Public health protects and promotes the health of our communities. It is most effective when it is locally-provided, regionally-coordinated, and aligned with a clear and evidence-informed provincial strategy. Research has shown that investments in public health reduce demand on health care services. For example, Community-Based HIV Prevention helped prevent 16,672 HIV infections in Ontario between 1987 and 2011 and saved the health care system $6.5 billion (Choi et al., 2016).

In April 2019, the 2019 Ontario Budget Protecting What Matters Most proposed to significantly restructure Ontario's public health system, including the dissolution of its 35 health units and the creation of 10 new regional public health entities. This would have resulted in new boards of health, substantial adjustments to provincial-municipal cost-sharing, as well as a reduction of the overall budget envelope for local public health. These proposed changes threatened Ontario's long history of local public health leadership and may have increased the burden on our already stretched health care sector. While there some health units that could benefit from opportunistic mergers, forced amalgamations were more likely to increase costs and bureaucracy while decreasing responsiveness to local needs.

The Middlesex-London Health Unit (MLHU) welcomed the November 2019 decision to reassess and reconsider these proposed amalgamations and budgetary changes. We applaud the Ministry of Health for identifying the challenges articulated in the Discussion Paper regarding insufficient capacity, misalignment of health, social, and other services, duplication of effort, and inconsistent priority setting. These challenges are consistent with other local and provincial reviews of public health over the last twenty years. The province will find solutions through the careful contemplation of evidence and the hard-earned experience of public health professionals and boards of health. We are grateful to the Ministry for the opportunity to provide feedback during this exciting time of transformation.

As the largest autonomous public health agency in Canada, the MLHU has rich and concrete examples of how public health can work to serve the needs of our communities. We can also demonstrate our track record of accountability to the public, and the delivery of innovative and responsive solutions to ever-evolving population health challenges. These hard-earned insights come from decades of front-line service to our community. In preparation for the written and in-person responses to the Discussion Paper, we sought input and advice from staff, management, and the board of health. Extensive consultations through January 2020 identified key areas for consideration during the modernization process. These key areas are:

- Public Health Mandate
- Board of Health Governance
- Jurisdictional Size
- Health Unit Leadership Structure
- The Role of Public Health Ontario and the Ministry
- Local Relationships and Partnership
- Public Health Human Resources
- Program and Service Delivery

MLHU recognizes the Indigenous peoples that have cared for this land since the beginning, and applauds the Ministry of Health for ensuring that the modernization process includes specific consultation with Indigenous nations and organizations.

In the following pages, we provide specific recommendations from each of these critical areas that we believe will address the challenges. The evidence and experience presented by MLHU in this submission are not uniquely insightful; the parallels with previous reports on public health reform are evident. The value of a high-performing public health system and the importance of keeping Ontarians safe and healthy may be most evident during a crisis such as the threat of the novel coronavirus 2019. However, infectious disease emergencies such as Walkerton or SARS should not be the only triggers for a collective realization of the importance of a sufficiently supported public health system. Beyond disease prevention and control, public health has proven and cost-effective programs and interventions to help reduce demand on the primary, acute, and long-term care in Ontario and alleviate the challenge of *Hallway Medicine*.

Choi, S. K., Holtgrave, D. R., Bacon, J., Kennedy, R., Lush, J., McGee, F., Tomlinson, G. A., & Rourke, S. B. (2016). Economic Evaluation of Community-Based HIV Prevention Programs in Ontario: Evidence of Effectiveness in Reducing HIV Infections and Health Care Costs. AIDS and behavior, 20(6), 1143–1156. https://doi.org/10.1007/s10461-015-1109-8

Public Health Mandate

The priorities of public health are continuously shifting and evolving. Infectious and communicable diseases, chronic diseases, mental health, substance use, and demographic trends all present challenges to which we must be ready to respond.

The Health Protection and Promotion Act (HPPA) is the principal enabling and operating statute for boards of health. Boards of health must provide or ensure the provision of a minimum level of public health programs and services in the areas identified by the Ontario Public Health Standards.

The province should retain and strengthen our unique legislative mandate of upstream population health and disease prevention. We keep people healthy, prevent disease, and reduce health inequities long before people end up in primary, acute, and long-term care. We collaborate with and complement social services and other health care services by understanding our community health needs and priorities and understanding with gaps in service and inequities in health exist. This focus stands in contrast to those of health care, which focuses downstream on the need of individual patients and not entire populations.

The province should continue to support and enhance the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability as the basis for public health programming. The Standards are a critical document that guides the work of public health units and provides direction on how to deliver on our mandate. Significant changes to the standards and its population health focus required and benefit from fulsome consultation with local and front-line public health.

Board of Health Governance and Jurisdictional Size

The Middlesex-London Health Unit (MLHU) is the largest autonomous health unit in Canada, serving a population of over 450,000 people in a mixed rural-urban geography of 3300 square kilometres. This structure and geography is a unique position from which to provide feedback to the province during this modernization process. MLHU is in the sweet spot for jurisdictional size. Research has found that a larger jurisdiction size, up to a maximum of 500,000 people, was a positive predictor of performance (Mays et al., 2006).

The province should support opportunistic and voluntary mergers for health units where there is a need to achieve critical mass in public health human resources and enable surge capacity. Merging health units to serve larger populations and geographies will make it difficult to understand the communities that are served and to adjust programs and interventions to meet local needs. The geographic size and people served by any future health unit should seek to optimize the competing demands of efficiencies of scale with the need to remain responsive to the specific needs of communities.

Transformative Innovation: Expanding Regional Cooperation

Effective regional partnering processes must be replicated in new areas. Currently, Tobacco Control Area Networks (TCANs) ensure that all public health units provide consistent, high-quality tobacco programming. Key ingredients are a modest amount of human resources, and an oversight process that includes input from all health units in a given region. This approach would have great benefits if expanded to other areas, such as falls prevention, school health, and promotion of healthy eating and physical activity.

Where possible, boards should remain autonomous and locally-responsive as there are risks to being integrated within local governments. Research in Ontario has shown that independent health units behave more in alignment with provincial expectations than those integrated within municipalities (Lyons, 2016). Additionally, autonomous governance ensures that a trusted, accountable, and independent public health voice is present in a community.

Boards should include appointees that are both skills-based and municipally elected members, and be representative of the local community. Representatives should be from the local community and appointed by the province and municipalities with consideration of skills and the diversity of the population the board serves.

The province should ensure representation of urban, rural, and Indigenous communities on Boards. The Middlesex-London Board of Health feels that the current

Mays, G. P., McHugh, M. C., Shim, K., Perry, N., Lenaway, D., Halverson, P. K., & Moonesinghe, R. (2006). Institutional and economic determinants of public health system performance. American journal of public health, 96(3), 523–531. https://doi.org/10.2105/AJPH.2005.064253

mix of five provincial appointees, three City of London appointees, and three Middlesex County appointees has adequately balanced the voices of the residents that the board serves. Any future state must consider the representation of Indigenous communities on the board.

The province should consider improving or replacing the Public Appointments Secretariat and Order in Council process for provincial representatives. There have been considerable challenges in the past with the prompt recruitment of appointees. Steps should also be taken to enhance the transparency, independence of appointments, and the promotion of vacancies to attract suitable candidates.

Provincial appointments should not be offset from municipal elections to avoid wholesale turnover of a Board. There can be substantial board turnover because of municipal elections. Having provincially appointed members provide continuity of board functioning is highly beneficial.

Provincial support regarding governance bylaw and policy development, as well as board training and capacity building, would be highly beneficial. There is considerable opportunity to reduce duplication of effort that occurs with boards of health when they individually develop bylaws and policies. Additionally, standardized training would enhance board governance and reduce the burden of that training on public health unit staff.

Health Unit Leadership Model

There is considerable variability across Ontario in how public health units establish their leadership model and report to the board of health. Some have Medical Officers of Health as the Chief Administrator while others do not. MLHU has always had a harmonized MOH/CEO position, and the Middlesex-London Board of Health values this unified leadership model for this agency. The Health Unit also values the role of the Chief Nursing Officer as a senior leader in the organization.

The board of health should be given the authority to determine the most appropriate leadership model. This model should be considerate of the size and complexity of the organization.

Regardless of the leadership model, the Medical Officer of Health must report directly to the board of health. This reporting relationship ensures that the board has direct access to public health expertise and holds the Medical Officer of Health accountable as an employee of the board.

The Medical Officer of Health must maintain their autonomy and legislated authority. This autonomy and legislative authority are critical for Medical Officer of Health to best advocate for the community health needs and priorities and to have a platform and public voice when communicating issues of public health importance.

Lyons J. (2016). The Independence of Ontario's Public Health Units: Does Governing Structure Matter?. Healthcare policy, 12(1), 71–83.

Any attempt to curb independence of the Medical Officer of Health by imposing constraints centrally would be risky for the Ministry, and may require Medical Officers of Health to violate medical and public health ethics.

Local Relationships and Partnerships

The Discussion Paper focuses on strengthening relationships with primary care and the health care system. In addition to this admirable goal, it is critically important for public health to maintain and strengthen its relationships with the other services that influence the social determinants of health, such as housing, education, and regional planning. Furthermore, to effectively address health equity, public health must be empowered to build relationships with communities that are not necessarily represented in formal structures or organizations. These relationships are paramount and essential to achieve public health's unique upstream population health and disease prevention mandate.

There should be a recognition that relationships require time and energy to be successful. It has taken years of deliberate action by health units to establish strong local relationships and partnerships. Amalgamations have the potential to negatively disrupt these relationships and partnerships, and they will not be easily rebuilt.

Defined and purposeful partnerships are very effective and should be encouraged and supported by the province. Examples of these defined partnerships in Middlesex-London include the HIV Leadership Table that includes representation across the health and social services sector working in collaboration to address HIV, as well as a partnership like the dental clinic being offered in health unit space by the Southwest Aboriginal Health Access Centre.

Reciprocity in the mandate for relationships and partnerships should also be considered. For example, in the Ontario Public Health Standards, public health units are mandated to collaborate with school boards. However, there is no reciprocal mandate that requires school boards to work with public health units. This gap can present challenges in delivering public health programs and interventions that rely on schools for successful implementation. Other scenarios include the lack of mandated data sharing between local emergency medical services, police, and hospitals.

Transformative Innovation: Partnering with Primary Care

MLHU uses an academic detailing approach to partner with primary care providers. A public health nurse visits each clinic to speak directly with clinicians in their environment on their terms about how we can work together on prevention and health promotion. Uptake is excellent, and strong relationships are leveraged in times of crisis such as the current Coronavirus outbreak.

Integration and collaboration with the health care system should not come at the expense of relationships with other social services and community agencies. Public health acts as a nexus between the health care system and broader community, focusing attention on needs that have been identified through population health assessments and community engagement.

The structure and boundaries of public health units can positively or negatively affect relationships with municipalities and other local organizations. These boundaries should be considerate of the range of stakeholders and partners with the understanding that larger health units (in both size and population) will have more difficulty cultivating these relationships.

Supports should be provided by the province to enable effective partnership and collaboration between public health units. One example that has been praised is the Tobacco Control Area Network (TCAN) structure. This initiative has a provincial strategy, regional coordination, and local public health service delivery, which is very useful in reducing duplication of effort.

Other examples of exceptional partnerships include:

- Active and Safe Routes to School
- Nurse-Family Partnership Advisory Committee
- Health Care Provider Outreach
- Child and Youth Network
- HIV Outreach
- Community Drug and Alcohol Strategy
- Temporary Overdose Prevention Site
- Hospital Screening and the Healthy Babies Healthy Children Program
- Municipalities
    - Mayors Poverty Panel
    - Newcomer Settlement
    - Road Safety

Public Health Program and Service Delivery

At MLHU, we continuously strive for program and service delivery excellence by optimizing evidence-informed planning and evaluation, fostering strategic integration and collaboration, and addressing the social determinants of health. We do this to maximize the value and impact of our resources and to ensure our residents receive the programs and services that best meet community health needs.

All Programs

For all public health programs, delivery should continue to be at the local level, and the province should support opportunities for better coordination across health units. There are no local public health programs that could be delivered more effectively at the provincial level. However, these programs could be enhanced through provincial coordination and support.

The province should provide clear and actionable strategy, coordinate regional public health unit collaboration, and support local delivery wherever possible. A helpful model of coordinated programming and integration is the Smoke-Free Ontario Strategy wherein regional tobacco control area networks support local service delivery. This allows for local variability and innovation with information sharing enabled through a formal network and coordination. Another example is the Shared Library Services Partnership, which provides research and knowledge exchange capacity to health units that do not have those resources in-house.

Innovation happens at the local level and should be funded, supported, and championed by the province. There are thousands of variations in programs being delivered across the province that act as natural experiments. The province should have a fulsome understanding of this variability in program delivery, promote the sharing of information, and assist with scaling up effective interventions across health units.

The province should support the robust sharing of information across health units regarding program delivery through appropriate technology and facilitators. An profound amount of time is spent by Ontario public health units trying to learn and apply best practices to their local jurisdiction. Current information sharing is done in an ad hoc way. It is often dependent on professional associations and other workgroups who should be focusing on professional development rather than gathering provincial data.

Policy development should continue to be conducted at the provincial level, and at the local level by health units in order to ensure a fit with local values and environments, and a wide variety of opportunities for innovation. Often, local priorities and policies drive more substantive and expansive policy efforts – indoor smoking bans being one such example. Municipalities should continue to provide leadership on healthy public policy that can then be scaled up to the provincial policy arena.

Where there is strong consensus across communities on a public health issue, but provincial legislation or policy does not exist, the province should provide leadership. For issues such as water fluoridation or vaccine hesitancy, it is inefficient for each health unit to engage in policy discussions. In these cases, the province could provide leadership through enacting province-wide legislation.

Foundational Standards

Communications

Communication capacity should be maintained or enhanced at the local level to ensure issues are addressed with consideration of the local culture and media landscape. Often, the provincial standardization of communications can come at the expense of local appropriateness. The more locally relevant public health communications are, the more effective those messages will be.

The province should initiate broad communication strategies with topics identified and prioritized in partnership with local health units. There are cost-saving opportunities that are available through bulk media buys and the development of communications material. These initiatives should intersect with and complement local communication strategies.

Population Health Assessment and Surveillance

Population health assessment and surveillance should be maintained or enhanced at the local level to ensure there is adequate and relevant data to inform public health program delivery. Localized and real-time data

most effectively guides local public health action. This data requires relationships and data sharing agreements with organizations such as local police, emergency medical services, and hospitals.

Local public health units require sufficient population health assessment and surveillance capacity to provide data interpretation beyond analysis. Due to capacity constraints and the lack of appropriate local data from the province, most population health assessment, and surveillance capacity is taken up with analysis and reporting. Additional capacity for data interpretation will ensure that public health action is reflective of population health outcomes.

The province should actively engage in the development of additional population health assessment data and protocols, with topics identified and prioritized in partnership with local public health units. For example, there is a shortage of information on public attitudes, perceptions, and behaviours, particularly relating to opioids, vaping, and vaccine hesitancy. These gaps in data limit public health effectiveness.

Program Planning and Evaluation

Program planning and evaluation capacity should be maintained or enhanced at the local level to ensure there is sufficient support to plan, monitor, and public health program delivery. There are considerable capacity constraints that limit robust program planning, implementation, and evaluation. This capacity should be enhanced at the local level to improve programs that are being delivered with variability from health unit to health unit.

Research and Knowledge Exchange

Research and knowledge exchange capacity should be enhanced at the local level to ensure that research evidence can be translated and applied to public health programs. This translation to practice requires access to research literature, library professionals, and capacity beyond front-line service delivery to support this work.

Corporate Services

Finance

The province should analyze and provide information related to public health expenditures to assist health units with resource allocation decisions. There are considerable reporting requirements for public health units such as the Annual Service Plan and Standards Activity Reports that are submitted to the province with little or no further follow-up. This data is invaluable to enhance the management of public health units that should be analyzed, followed-up on, and shared.

There are considerable opportunities for the province to standardize budgeting processes, practices, and systems across public health units. Examples that are ripe for standardization include procurement, payroll system, variance reporting and analysis, Program Budgeting and Marginal Analysis, and the establishment of a uniform chart of accounts. Standardization would improve health unit interoperability and reduce the duplication in identifying needs, selecting and implementing processes, practices, and systems.

Transformative Innovation:
Budgeting for Maximum Impact

Since 2013, MLHU has used a budget reallocation process to shift resources out of lower impact areas into high impact areas. Using criteria linked to the Ontario Public Health Standards, disinvestment and investment proposals are scored, with the best ones moving forward. This has freed up over $7 million of resources for re-investment into high priority work.

Strategic Planning and Projects

There should be an alignment of strategy between, provincial, regional, and local work, with variability for local priorities. The province should articulate a clear public health system strategy on a regular basis to drive improvements across all public health programs. This approach for public health priority setting should not be top-down or bottom-up; instead, it should be reflective of the diverse needs at each level. This alignment requires strategic planning capacity at all levels.

The province should guide the development of project management standards and support information sharing amongst health units for large scale and strategic projects. Examples of this would include the provisions of standards, guides, tools, and templates to establish consistent practices across the province or through the development of an online repository where project plans and status updates could be shared.

Information Technology

The province should provide an overarching information technology strategy for local public health units and support regional collaboration. Regional collaboration could include joint strategy and management of services as well as the procurement of infrastructure, hardware, and software. End-user support will always be required at the local level.

Human Resources

The province should provide an overarching human resources strategy for local public health units and support regional collaboration. The provincial strategy should ensure that there is a pipeline of trained and competent staff that is being developed in post-secondary education, preceptorships, residencies, and fellowships, as well as local and regional strategies to address specific local needs. This strategy should be done in collaboration with public health professional associations.

The province should provide partial delivery and coordination of human resources centrally with most service delivery at the local level. Some of the aspects of human resources that could benefit from province leadership include collective bargaining, job descriptions, core competencies, job advertising, administrative policy development, provincially-legislated training, vulnerable sector screening, and employee performance management systems. Aspects that require local delivery include employee relations, recruitment, and occupational health and safety.

Privacy and Records

The province should provide support regarding records retention standards and practices. Currently, each health unit develops and implements a records management strategy to meet the same legislative requirements. Duplication of work could be avoided through the development of standardized policies and practices.

Technology

The province should conduct regular audits and inventories, and support information sharing for technologies that are employed for public health program delivery. This information could help to establish consistent technology usage and practice across the province.

The province should provide standardized information technology solutions to public health units were similar needs are identified. This standardization would enhance health unit collaboration, interoperability, and create significant efficiencies from a procurement, training, and implementation perspective. Examples that could benefit from this approach include electronic client records, inspection reporting (like hedgehog), iPHIS, emergency messaging services, human resource and financial information systems, website platforms, and online community of practice portals.

The province should support pilot testing of solutions at the local level to scale up systems into common province-wide platforms whenever possible. This pilot testing would allow for innovation and the development of new practices that complement existing provincial infrastructure.

Processes

The province should provide leadership and coordination of public health medical directives to ensure consistency and interoperability across public health units. Medical directives that enable the work of public health staff under the direction of the Medical Officer of Health are specific to the jurisdiction in which they are employed. There is considerable variability in medical directives across health units, and this results in duplication of effort as well as challenges in responding to cross-jurisdictional public health issues. The province could provide support by standardizing common medical directives, providing practice guidelines or protocols, or by enabling public health units to more readily share their practices.

Public Health Human Resources

The staffing of public health professionals accounts for approximately 80 percent of public health expenditures in Ontario. Any reduction in funding would have a considerable negative impact on addressing the challenges that were identified in the Discussion Paper relating to lack of critical mass and surge capacity. Given the breadth of the Ontario Public Health Standards and the unquenchable need for public health programs, there will always be capacity constraints.

The province should ensure that health promotion, as well as health protection programs, are adequately funded to meet day-to-day needs as well as incidents that require surge capacity. The work of health protection and health promotion are highly complementary within health units. Staff who work in upstream health promotion programs can provide surge capacity in the event of a public health emergency. While necessary for the long-term health of the population, health promotion activities can be suspended for a short period of time during public health emergencies to provide much-needed surge capacity.

When extraordinary capacity is required, the province should provide readily available funding for staffing, supplies, or other needs. With the emergence of several acute and ongoing public health challenges, health units have had to rapidly deploy resources from other programs with more upstream focus to address these crises. However, given the sustaining nature of these crises, over time this has led to a shift from programs focused on chronic public health issues to those that are more acute. Additional provincial resources are necessary to sustain ongoing upstream work that will, in time, decrease these acute population health challenges.

Role of the Ministry and Public Health Ontario

The Ministry of Health and Public Health Ontario will play critical roles in addressing the challenges identified in the Discussion Paper. Local public health units have attempted, individually and collectively, to address insufficient capacity, misalignment of health and social services, duplication of efforts, and inconsistency. The work of the COMOH ISPA Working Group to standardize the interpretation of grace periods is an example of this type of collaboration. However, local public health units are often not ideally positioned to coordinate or address issues of provincial standardization; this is the role of provincial authorities. Provincial leadership is critical in supporting local public health in being more efficient, effective, and innovative.

The province, through legislation and policy, should ensure that funding for public health is stable, predictable, equitable and adequate for the full delivery of all public health programs to meet local population health needs. Public health funding provides an excellent return on investment compared to dollars and reduces demand on primary and acute care in Ontario.

The province should ensure that boards of health have the autonomy to allocate and manage funds to meet local population health needs. Recent funding announcements have often been earmarked for specific public health programming or needs with little increase to the cost-shared component of the budget. It is important to ensure that boards of health retain their autonomy to set and manage their resources as they are most attuned to local need. This autonomy includes the ability to establish and hold reserves, as well as carry-over budget surplus from year-to-year with appropriate financial controls.

When mandating new public health programs, the province should ensure new resources are available. The need for existing programming does not diminish when new public health issues arise, but public health units are often asked to do more with the same or less funding. New mandates without new resources position local public health for failure in achieving the desired objectives.

The province should develop robust and meaningful performance indicators for all standards that public health units report on annually. There is considerable variation and duplication of effort in developing performance indicators for each standard. This reporting process should facilitate improvements at the program level through the provision of feedback from the province, and information sharing across health units about what is working well.

The Ministry of Health should support a health-in-all policies approach across ministries. Given the importance of the social determinants of health, the Ministry of Health should not be the only Ministry that affects change in population health. There should be mechanisms for shared priority setting and policy across all levels of government.

The Chief Medical Officer of Health must be independent and unconstrained to provide public health advice and guidance to the government and the public. The primary objective of the CMOH is to protect and promote the health of Ontarians. This advice and guidance will often, but may not always, align with the agenda of the government of the day. Previous provincial reports have provided guidance on mechanisms and structures that would ensure the autonomy of the CMOH. These recommendations should be implemented. Additionally, to support the work of the CMOH, additional deputy CMOH positions should be filled.

Public health units should help to set the priorities of Public Health Ontario to ensure that the expertise and support being provided is meeting local public health needs and overarching provincial priorities. Public Health Ontario is a critical and essential resource. Their expertise is essential for Ontario's public health system to achieve its world-class, high-quality aspirations. There should be a willingness for the province to engage and hear from public health units to inform government action and ensure that Public Health Ontario is meeting the needs of public health units.

When appropriate, Public Health Ontario should be enabled and empowered to provide definitive guidance on the evidence for healthy public policy and public health practice. Public Health Ontario's mandate clearly limits its role in setting policy; this is the job of the Ministry. However, where the evidence exists, Public Health Ontario should provide fulsome and conclusive health public policy analyses. This is a gap in the current services provided by Public Health Ontario that has been filled by local public health units with relatively limited capacity. It is also an explanation for some of the observed duplication across the province.

Each standard in the Ontario Public Health Standards should have a provincial strategy that is supported by technical expertise at the Ministry of Health and Public Health Ontario. Examples of this include the Scientific Advisory Committee Reports (led by PHO), which compiled interventions and provided evidence from white and grey literature for Tobacco Control. This information is invaluable for helping to guide local action.

Public Health Ontario should continue its strong focus on infectious diseases, while expanding its work in health promotion and chronic disease prevention, which represent a far greater burden of illness and death in Ontario.

Public Health Ontario should guide the development of planning and evaluation standards and support information sharing amongst health units for planning and evaluation. Examples of this would include the provisions of standards, guides, tools, and templates to establish consistent practices across the province or through the development of an online repository where program plans, monitoring plans, or evaluations could be shared.

Public Health Ontario, in partnership with the Ministry of Health, should conduct evaluations where programs are being implemented by all public health units with little variability across the province. An example of this would be the Low-Income Seniors Dental Program. Where there is local variability in program delivery, evaluations should be conducted locally and shared provincially.

Ministry should allocate research and knowledge exchange capacity to local priorities. Amongst health units, there is periodically duplication of work like literature and evidence reviews or jurisdictional scans. Some of this duplication is necessary and reflects variation in local needs and realities. Some could be avoided through provincial leadership and investment in answering questions that are relevant to local public health practices. Additionally, the coordination and support of local research activities could be much more effective with provincial leadership. The establishment of the Public Health Ontario Ethics Review Board is one such example that has been highly beneficial.

Conclusion

The Middlesex-London Health Unit shares the goal of creating a modernized and resilient public health system that supports the health and well-being of all people in Ontario. The recommendations detailed in this submission reflect the lessons learned across MLHU's long history and the shared experience and expertise of our board and public health professionals.

There is an opportunity to address challenges that have continued to be present in public health since the early 2000's at both the provincial and the local level. This submission focuses on the recommendations that we feel the province is best situated to provide leadership on, but the feedback we collected will also be used to inform local action.

We eagerly await the findings of Mr. Pine, Ms. Blair, and Dr. Williams in the spring of 2020 and look forward to actively engaging with the implementation efforts of the Ministry.

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REPORT NO. 007-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2020 February 27

SERVICE-SEEKING CLIENT EXPERIENCE SURVEY RESULTS

Recommendation

It is recommended that Report No. 007-20 re: "Service-Seeking Client Experience Survey Results" be received for information.

Key Points

- Measuring client, community, and community partner experiences to support a culture of excellence and quality of care is identified by the Ontario Public Health Standards and is identified as a priority in MLHU's Balanced Scorecard under Client and Community Confidence.
- Overall, the 2019 Service-Seeking Client Experience Survey findings indicate that MLHU staff providing interventions to service-seeking clients achieved a high degree of adherence to client-centred practices, with opportunities for improvement.
- Action plans will be developed collaboratively to enhance adherence to client-centred practices.

Background

Public health is directed via the Ontario Public Health Standards (2018) to support a culture of excellence and quality through practices such as measuring client, community, and community partner experience. In alignment with the Health Unit's current strategic plan and these organizational requirements, a priority area on the MLHU's 2015–20 Balanced Scorecard is "Client and Community Confidence," with the objectives of:

- seeking and responding to community input;
- ensuring that clients and the community know and value our work; and
- delivering client-centred services.

This strategic initiative, focused on assessing client, community, and community partner experience, addresses the third objective boe, and has been divided into four phases. This report focuses on the first phase—the Client Experience Survey—which measured service-seeking clients' experiences. An update about the Client Experience Survey was previously shared with the Board of Health in Report No. 024-19.

Algoma Client-Centred Care Tool

In 2018, the Algoma Client-Centred Care Tool (ACCCT) (Boston et al., 2013) was selected to measure service-seeking clients' experience in recognition of the strong alignment between the measurement of adherence to client-centred principles in the ACCCT and the value placed on client experience by MLHU. The ACCCT is based on the work of Carl Dunst and Carole Trivette and their model of family-centred care (Dunst & Trivette, 2005). This tool measures client-centred practices—both relational and participatory practices—along with self-efficacy, program loyalty, and social validity.

Methods

The service-seeking interventions that were incorporated in the survey included: home visits, group programs, telephone support, and drop-in, from the Healthy Start Division; children and adult dental clinics, from the Healthy Living Division; and the Immunization Clinic, the Sexual Health Clinic, the Family Planning Clinic, needle exchange, and outreach, from the Environmental Health and Infectious Disease Division. Staff and managers were responsible for setting up the data collection process to survey clients in their interventions.

Results

In total, 1,181 client survey responses were collected between January and November 2019, primarily through paper-based surveys but also online. Participating clients received a $5 grocery gift card as an honorarium.

The benchmark for adherence to client-centred principles, established by Dunst and Trivette (2005), is 85%. Overall, aggregated results show that MLHU staff achieved 79% adherence to client-centred practices, as measured by clients responding that MLHU staff "always" exhibited expected client-centred behaviour. The majority of other respondents indicated that MLHU staff "usually" met these expectations. Results also indicate that adherence to client-centred practices appears to be influencing participants' self-efficacy beliefs in the expected direction. Furthermore, additional baseline measures of program loyalty and social validity were collected and will be monitored over time. A comprehensive report on survey findings is available in Appendix A.

Next Steps

These scores indicate that MLHU staff are following client-centred care principles and that some room remains for improvement. As a next step, the Program Evaluator and Community Health Nursing Specialist will share the survey results with appropriate managers and staff. Action plans will be developed collaboratively, with managers and directors responsible for ensuring implementation. These additional efforts to support adherence by MLHU staff to client-centred principles could improve clients' overall health outcomes. An update regarding action plans will be shared with the Board of Health in fall of 2020.

The next phases of the Client Experience Project will focus on mandated clients, non-English- and non-French-speaking clients, and community partners. Monitoring client, community, and community partner experiences will be an ongoing process at MLHU. Obtaining quality feedback will support Health Unit employees to enhance and optimize interactions with clients and community partners, and to exemplify MLHU's values more effectively.

This report was prepared by the Office of the Chief Nursing Officer and the Healthy Organization Division.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

CLIENT EXPERIENCE SURVEY

Service-Seeking Clients

Middlesex-London Health Unit Overall Results

February 20, 2020

CLIENT EXPERIENCE SURVEY

Service-Seeking Clients

Project Sponsor

Heather Lokko
Chief Nursing Officer & Director, Healthy Start Division

Initial Project Team

Christine Brignall
Program Evaluator

Brenda Marchuk
Community Nursing Specialist

Angela Armstrong
Program Assistant

Jordan Banninga
Manager, Program Planning & Evaluation

Meena Ume
Health Promoter

Current Project Team

Michelle Sangster Bouck
Project Evaluator

Brooke Clark
Community Nursing Specialist

Angela Armstrong
Program Assistant

Jordan Banninga
Manager, Program Planning & Evaluation

Management Advisory Committee for Phase One Planning

Mary Lou Albanese
Manager, Infectious Disease Control

Deb Shugar
Manager, Reproductive Health

David Pavletic
Manager, Food Safety and Healthy Environments

Darrell Jutzi
Manager, Child Health

Donna Kosmack
Manager, Southwest Tobacco Control Area Network

Tracey Gordon
Manager, Vaccine Preventable Diseases

Sean Bertleff
Manager, Emergency Preparedness

Acknowledgements

Carolynne Gabriel
Librarian

Bernie Lueske
Data Analyst

Client Experience Survey

Service-seeking Clients - MLHU Overall Results

Background

In 2019, The Algoma Client Centred Care Tool (ACCCT)[i] was implemented as the data collection tool for measuring service-seeking[1] clients' experience as part of the MLHU strategic initiative for *Client and Community Confidence*. The selection of this tool was made specifically for service-seeking clients by the Program Evaluator and Community Health Nursing Specialist leading the project work, in consultation with the project's Management Advisory Committee. There was recognition of the strong alignment between the measurement of adherence to client-centred principles in the ACCCT and the MLHU values for client experience. This alignment would provide the MLHU with an understanding of service-seeking clients' experience. The purpose of this survey was to determine the extent to which public health staff in service-seeking programs were delivering client-centred care. This tool provides an opportunity to monitor service-seeking clients' experiences over time.

Relationship between the client-centred care and client outcomes

The ACCCT is based on the work of Carl Dunst and Carole Trivette and their model of family-centred care.[ii] Their research found that client-centred practice was an important determinant of self-efficacy beliefs, and self-efficacy beliefs were in turn an important determinant of health outcomes.[ii] At its essence, this survey tool measures how much staff follow client-centred principles when delivering care.

Methods

The service-seeking interventions in which this survey was implemented included: Home Visiting, Group Programs, Telephone Support and Drop-In from the Healthy Start Division, Children and Adult Dental Clinics from the Healthy Living Division, and the Immunization Clinic, Sexual Health Clinic, Family Planning Clinic, Needle Exchange, and Outreach interventions in the Environmental Health and Infectious Disease Division. For each intervention, staff and managers were responsible for setting up their data collection process. In most cases, staff and managers choose to use paper surveys, although on-line surveys were used in some interventions. A five-dollar grocery gift card[2] was distributed in the paper survey package or sent to on-line respondents that provided their contact information as an honourarium. In some areas, administrative assistants distributed the survey package, whereas in other areas the survey was distributed by the service provider.

Clients were eligible to complete the survey if they were 16 years of age or older and spoke English or French. Parents completed the survey for children under the age of 16. With some interventions, there were other specific eligibility criteria to ensure inclusion of service-seeking clients. Non-English and non-French speaking clients will be included in a future phase. This report includes the overall health unit results, with the aggregated survey results from all service-seeking interventions. Analysis followed the suggested program evaluation protocol by Dunst and colleagues.[iii]

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[1] Service-seeking clients include those that independently pursue and consent to our programs and services. Their engagement is optional.

[2] Five dollars cash was used instead of a gift card for Outreach clients.

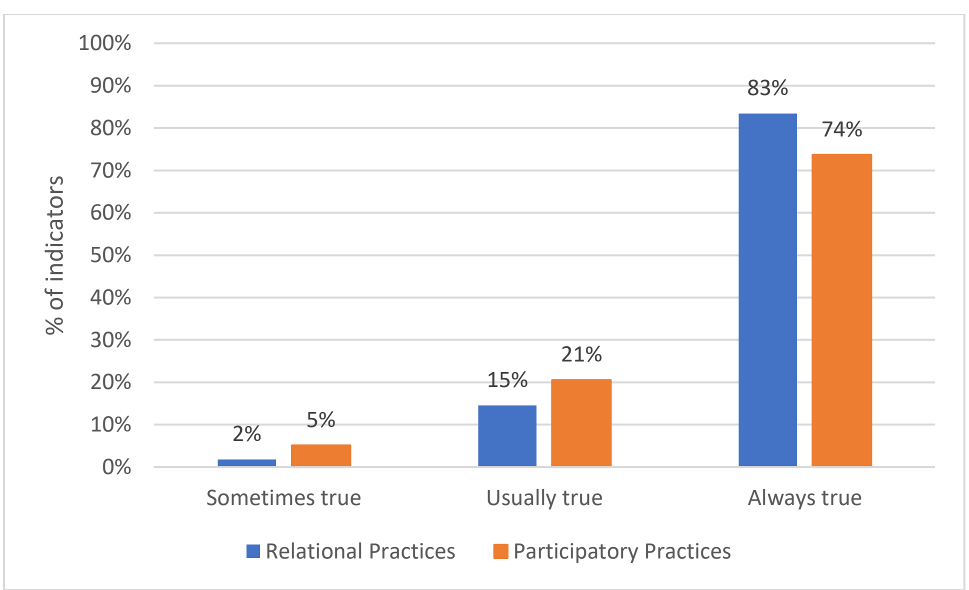
Results

In total, 1181 client survey responses were collected from January to November 2019. The survey measured client-centred practice (relational practice and participatory practice), self-efficacy, program loyalty and social validity. Participant demographics were also measured. In the results below, the measures are defined, aggregated results are presented, and brief interpretation notes are included.

Client-centred principles

Client-centred principles have been defined along two dimensions: relational and participatory practices. **Relational practices** are behaviors associated with good clinical practice and include active listening, compassion, empathy, respect and positive beliefs about clients' strengths and capabilities. **Participatory practices** are behaviours that involve clients in the decision-making. Participatory practice is individualized, flexible and responsive to family concerns and priorities.

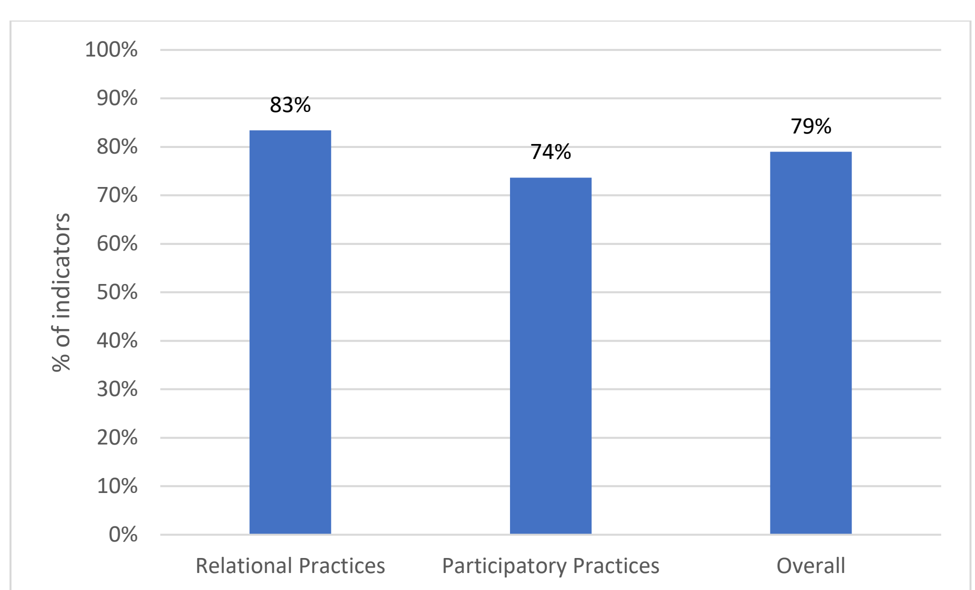
Figure 1: Percentage of indicators by rating for the client-centred principles of relational and participatory practices (n=1181).



Interpretation Notes – Figure 1

- Figure 1 presents the percentage of indicators given different ratings on the scales for relational and participatory practices for all participants taken together.
- Almost all responses to the relational and participatory practice items were rated "usually true" or "always true".
- Not all ratings are included on the chart due to the very small number of responses in the lowest ratings of "not at all true" and "rarely true."
- Typically, relational practices score higher than participatory practices. However, participatory practices are the types of capacity-building experiences that have empowering effects for clients and can have greater impact on health outcomes[ii].
- Individual item scores for the five relational practice items and the five participatory practice items are included in Appendix B.

Figure 2: Staff adherence to client-centred principles of relational and participatory practices (n=1181).



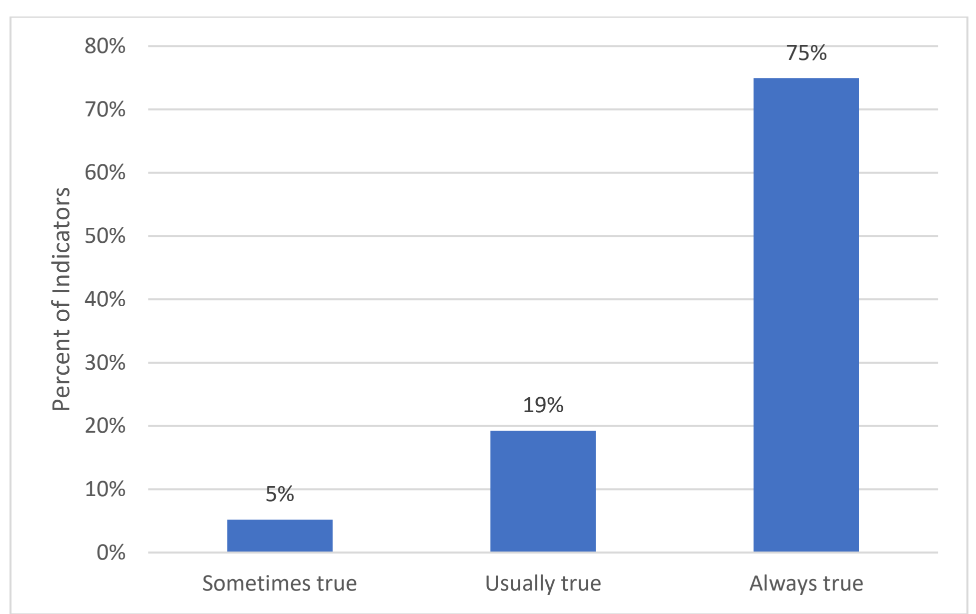
Interpretation Notes – Figure 2

- Figure 2 presents staff adherence to client-centred principles of relational and participatory practices as well as an overall score.
- These adherence scores have been calculated by determining the percentage of indicators receiving the highest rating of 5 or "always true" for all clients taken together following the evaluation protocol described by Dunst et al.[iii]
- Dunst and Trivette have indicated that programs should aim for scores of 85% adherence to client-centred principles. They established this as the liberal criteria to claim that adherence to client-centred principles has been attained. In some cases, they have applied the more stringent criteria of 90% adherence. This level of adherence is consistent with consumer loyalty research that indicates most indicators must receive the highest rating[ii]. In their technical manual describing their evaluation work with Family Support Programs in North Carolina, relational and participatory scores often ranged from 60% to 90%. In some years, participatory measures in some locations were under 40%[ii].
- There are structural aspects of programs that demonstrate differences in adherence scores. Typically, one-on-one interventions delivered in the home score higher than group programs offered in a community setting[ii]. These differences are expected; however, each intervention type can try to improve upon their baseline results and work towards the established benchmark over time.
- Adherence to client-centred care practices can be difficult to attain and maintain. Consistent attention to the principles of relational and participatory practices is required[ii]. Routine collection of this data, along with reflection and action planning about how these approaches may be effectively applied in day-to-day interactions, can support efforts to achieve client-centred practice.

Self-efficacy

Self-efficacy is the belief that an individual can take control; a measure of one's own beliefs about executing a course of action to produce a desired result. These questions ask participants to indicate the extent to which they can take control of the assistance, supports and resources provided to accomplish the desired tasks. According to the work of Dunst and Trivette, as the extent to which staff deliver client-centred care increases, self-efficacy scores should also increase. Furthermore, the desired health outcomes should also improve.[ii]

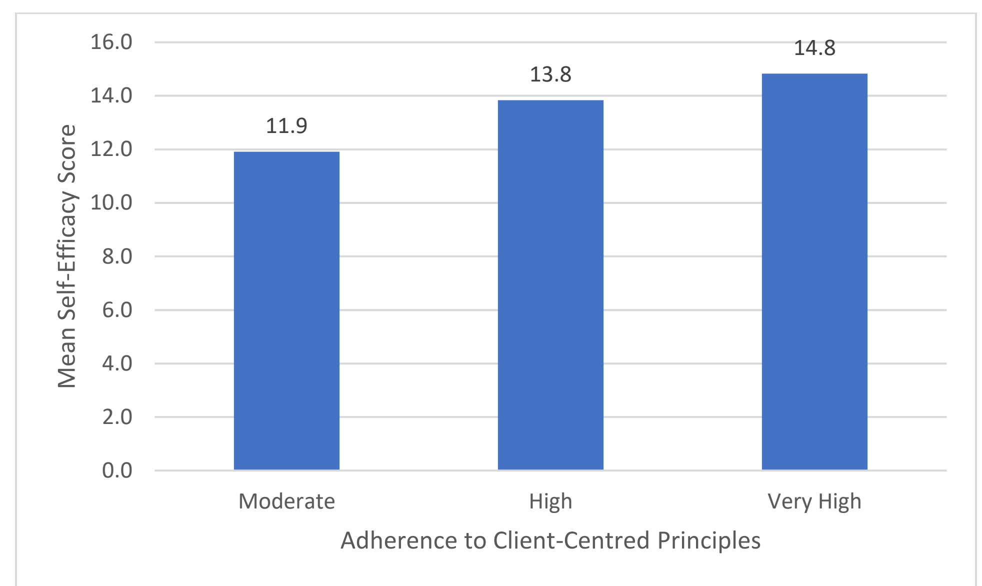
Figure 3: Percentage of indicators by rating for the self-efficacy scale (n=1181).



Interpretation Notes – Figure 3

- Figure 2 presents the percentage of indicators given different ratings on the self-efficacy scale for all participants together[ii].
- If clients feel a sense of empowerment, the largest percentages of indicators should receive the highest rating of "always true".
- Not all ratings are included on the chart due to very small percentages in the lowest ratings of "not at all true" and "rarely true." Therefore, the percentages do not add up to 100.
- Self-efficacy measures will be monitored for improvement over time.
- Individual item scores for the three self-efficacy questions are included in Appendix B.

Figure 4: Mean self-efficacy score by level of adherence to client-centred principles (n=1066)



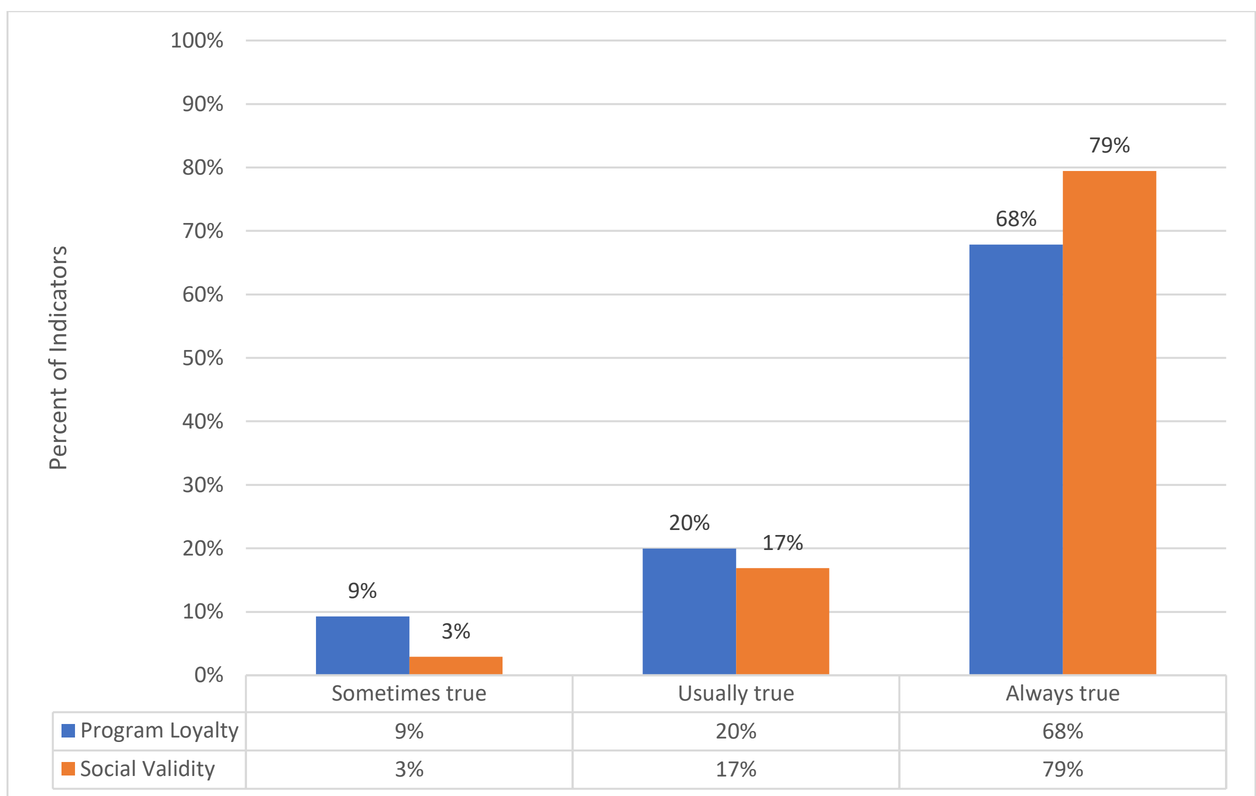
Interpretation Notes – Figure 4

- Figure 3 graphically presents the relationship between client-centred care and self-efficacy beliefs.
- In this figure, program participants were divided into different groups according to their client-centred care ratings and then the mean self-efficacy belief score for each group was calculated[ii].
- Clients in the "Very High" category scored 5 on all 10 client-centred measures, therefore having a client-centred care score of 50 (n=521). The 'High" category was every client that scored 43-49 which represents a rating of reaching the set benchmark of 85% (n=412). Clients in the moderate category scored 29-42, representing a rating below the benchmark (n=133).
- The maximum self-efficacy belief score is 15.
- According to the theory of Dunst and Trivette, the group with the highest adherence scores should have the highest self-efficacy score. This figure shows that this is indeed the case with the MLHU data. This is a simple way of checking to see if client-centred practices are influencing self-efficacy beliefs in the expected direction.
- Only clients that answered all 10 client-centred care questions were included in this analysis (n=1066).

Program Loyalty and Social Validity

Program loyalty is the degree to which clients desire interactions with the staff, have a positive attitude toward the staff, and consider the staff to be helpful when the need for support arises. Social validity is the degree to which clients feel their involvement with the organization is worthwhile. According to the work of Dunst and Trivette, as the extent to which staff deliver client-centred care increases, self-program loyalty should also increase.

Figure 5: Percentage of indicators by rating for program loyalty and social validity (n=1181).



	Sometimes true	Usually true	Always true
Program Loyalty	9%	20%	68%
Social Validity	3%	17%	79%

Interpretation Notes - Figure 4

- Figure 4 presents the percentage of indicators given different ratings on the program loyalty and social validity questions for all participants together[ii].
- If clients desire interactions with staff (program loyalty) and feel their involvement with MLHU is worthwhile (social validity), the largest percentages of indicators should receive the highest rating of "always true".
- Not all ratings are included on the chart due to very small percentages in the lowest ratings of "not at all true" and "rarely true." Therefore, the percentages do not add up to 100.
- Program loyalty and social validity measures will be monitored for improvement over time.
- Individual item scores for program loyalty and social validity questions are included in Appendix B.

Qualitative Comments

At the end of the survey tools, survey participants had the opportunity to provide any comments. Approximately, one-quarter of respondents provided comments, and an overwhelming majority of comments were positive. Many participants remarked on the friendly, caring and informative staff.

> *Great service. Thankful it was provided. The nurses were amazing. Very helpful.*

> *We really appreciated the service and staff! Professional, helpful and kind!*

There was no consistency across the few negative comments received about client experience. One participant expressed frustration in having to answer sensitive questions multiple times because staff didn't read the information provided. Another indicated the information provided was not consistent across staff members. A third participant brought attention to assumptions that can be made by some staff members.

> *'When you get married and pregnant' - question statement on behalf of public health - suggests shaming for those unmarried and pregnant. Also had no idea if I was married or not.*

In other cases, the negative comments received did not reflect the client experience, rather the client's desires for the program structure (e.g. disappointment when program cancelled, requests to expand services). There were a few suggestions for the survey tool itself including a suggestion to add a "not-applicable" option to each question.

Participant Characteristics

Survey participant characteristics are detailed in Figure 5 and Table 1 below. Table 1 presents the participant demographics including age, gender, ethnicity and place of birth across the whole sample. Figure 5 presents the length of involvement that survey participants had in their specific intervention. The length of involvement varied across the participants and this is not surprising given the varied interventions included in this survey.

Figure 5: Survey respondents' length of involvement in intervention (n=1181)

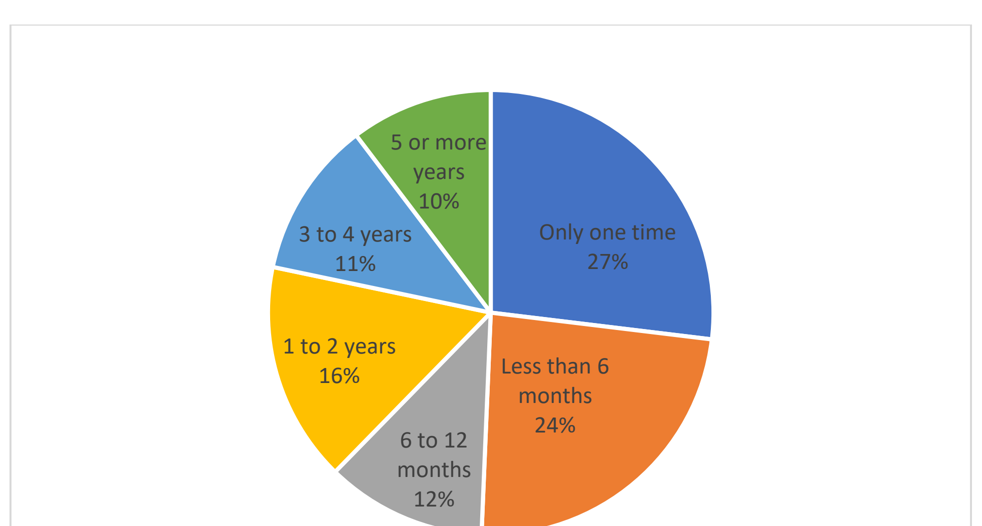


Table 1: Participant Demographics (n=1181)		
Age	Less than 20 years	7% (88)
	20 to 24 years	11% (132)
	25 to 29 years	20% (236)
	30 to 39 years	39% (455)
	40 to 49 years	12% (143)
	50 to 59 years	5% (64)
	60 or more years	1% (17)
	No Response	4% (46)
Gender	Female	71% (836)
	Male	25% (300)
	Other	1% (7)
	No Response	3% (38)
Ethnicity	Asian – East	4% (43)
	Asian – South	5% (61)
	Asian – South East	2% (20)
	Black -African	1% (14)
	Black - Caribbean	1% (14)
	Black - North American	0.5% (6)
	First Nations	4% (45)
	Metis	0.5% (6)
	Latin American	5% (62)
	Middle Eastern	7% (83)
	White European	20% (235)
	White North American	41% (480)
	Mixed Heritage	3% (34)
	Other	1% (14)
	No Response	5% (64)
Place of Birth	Born in Canada	68% (806)
	Born Outside Canada	28% (330)
	No Response	4% (45)
Years in Canada	< 5 years	26% (86)
For those Born Outside Canada	> 5 years	50% (165)
(n=330)	No response	24% (79)

Discussion

The intent of implementing the ACCCT, which monitors staff adherence to client-centred practice, with the service-seeking programs was to have a measure of client experience at MLHU. Aggregated together, our service-seeking interventions are close to achieving the established benchmark for relational practices, and more work is required to reach the benchmark for participatory practices. That said, it appears that the benchmarks established by the research of Dunst and Trivette for relational and participatory practices are fair and challenging for the service-seeking interventions at MLHU. Typically, relational practices score higher than participatory practices.[ii] Nevertheless, participatory practices are the types of capacity-building experiences that are more likely to have empowering effects for clients.[ii]

Another notable result is that adherence to client-centred practices appear to be influencing self-efficacy beliefs in the expected direction. The research of Dunst and Trivette has shown that adhering to client-centred principles impacts self-efficacy, which in turn impacts the health outcomes trying to be achieved. The higher MLHU clients rated staff adherence with client-centred principles, the higher their self-efficacy scores. Additional actions to support adherence to client-centred principles, and specifically participatory practices, by MLHU staff could improve client self-efficacy and overall health outcomes.

From this experience of implementing the ACCCT, there are additional baseline measures of program validity and social validity which can also be monitored over time. Full benefit of the results will be realized at the level of individual intervention where staff and managers can see their results and identify ways to strengthen adherence to client-centred principles and practices. Indeed, just the process of measuring and discussing the results with staff and managers can bring attention to these client-centred principles.

Limitations

There are several limitations to the data collected that may impact the final scores and interpretation of findings:

Response rate

Methods used did not allow for calculation of response rates. In team debriefings following data collection, some areas estimated that a significant number of clients declined to complete the survey (e.g. Immunization Clinic) whereas other areas indicated the response rate was very high (e.g. Home Visiting). Knowing response rates can help us understand the quality of data collected. For example, low response rates indicate there could be selection bias in the responses. The inability to calculate response rates also makes it impossible to evaluate the effectiveness of providing a five-dollar gift card as an honourarium.

Bias

In many programs, the staff members providing the service were responsible for asking clients to participate in the survey, which can result in staff consciously or unconsciously selecting which clients to ask to participate. In debriefings with staff, it was acknowledged that this selection bias was sometimes taking place. Survey implementation appeared to be more efficient and with less selection bias in settings where clinical assistants/administrative staff were responsible for distributing surveys to clients. Other types of bias may also have been present (e.g. seasonal bias, social desirability bias). The bias introduced into this sample likely elevates the client-centred scores.

Question wording

The question “How often do you use this program/ service?” experienced a high percentage of “other” responses that were difficult to categorize. As a result, this question was eliminated from the analysis. In our debriefings with staff following data collection, this same question was highlighted as difficult to answer given the episodic nature of many of the programs.

Next Steps and Recommendations for Future Data Collection:

At this stage, managers and staff will be reviewing results and developing action plans for their specific areas, with the support of the Community Health Nursing Specialist. Action plans will be developed collaboratively, and managers and directors will be responsible for ensuring action plan implementation. It is challenging to institutionalize program practices related to client-centred principles as there are many factors that can disrupt staff intentions including new staff members, setting changes, new knowledge, and changes to policy.[ii] It is suggested that planned actions increase staff attention to these principles.[ii]

Routine collection of this data ensures there is a match between perceived and actual client-centred service delivery and allows for timely actions to be organized.[ii] In recognition of the value in routine data collection and monitoring to bring attention to client-centred practices, recommendations for future data collection are outlined below.

Recommendation 1: Move towards intervention reporting

The results from the survey are most useful to staff and managers at the intervention level. When results for a division or program area with multiple interventions are combined, intervention staff are unable to directly determine how clients perceive their services. There are privacy concerns in programs with a small number of staff members, but it is hoped that overtime, staff members will recognize the value in this tool monitoring their adherence to client-centred practices.

Recommendation 2: Develop a more consistent process to implement the survey

There was significant variation in how surveys were implemented creating opportunities for selection bias, delays in data collection and inability to calculate response rates. Debriefings with staff also suggested that the data collection process can be made more efficient with reduced confusion by selection of one type of survey method. Opportunities to facilitate routine data collection should be explored (e.g. random selection of participants from electronic client record, increased involvement of administrative staff and decreased involvement of service delivery staff) that can decrease selection bias and ensure response rates can be calculated.

Recommendation 3: Revisit sample size and quotas

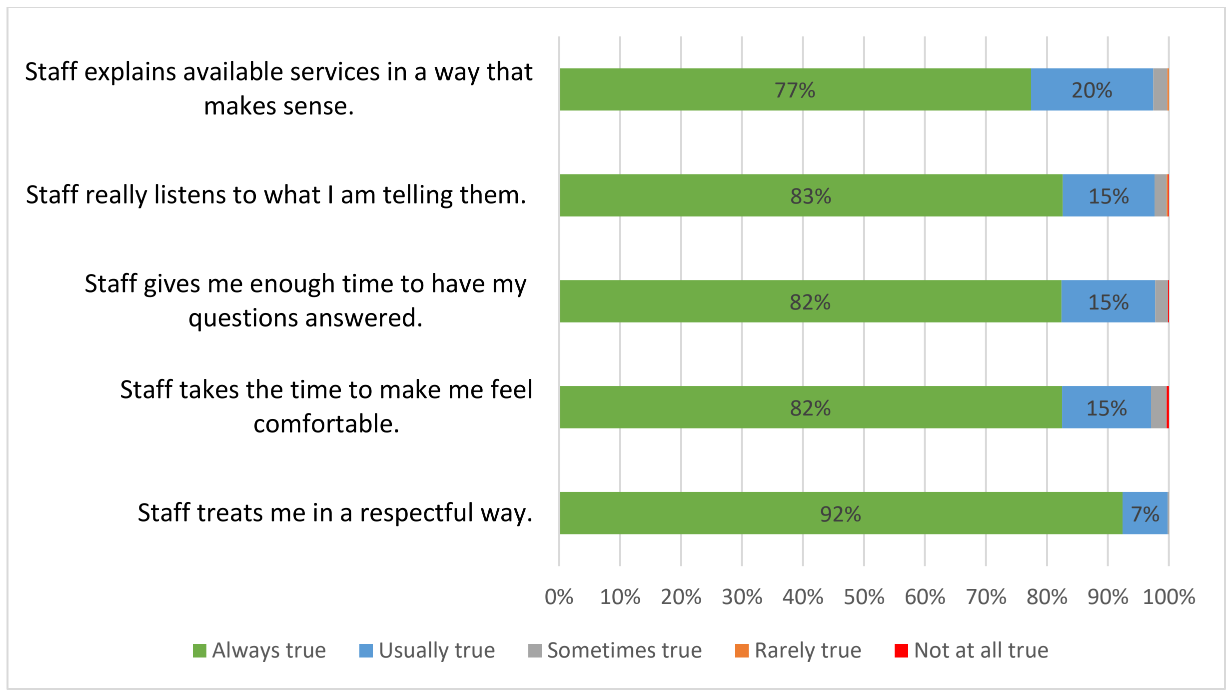
The sample size calculations for program/intervention reporting should be based on the actual number of clients seen by that program over a specified period (e.g. one year). This will require client population estimates and sample size calculations to be completed for each individual intervention.

Appendix A

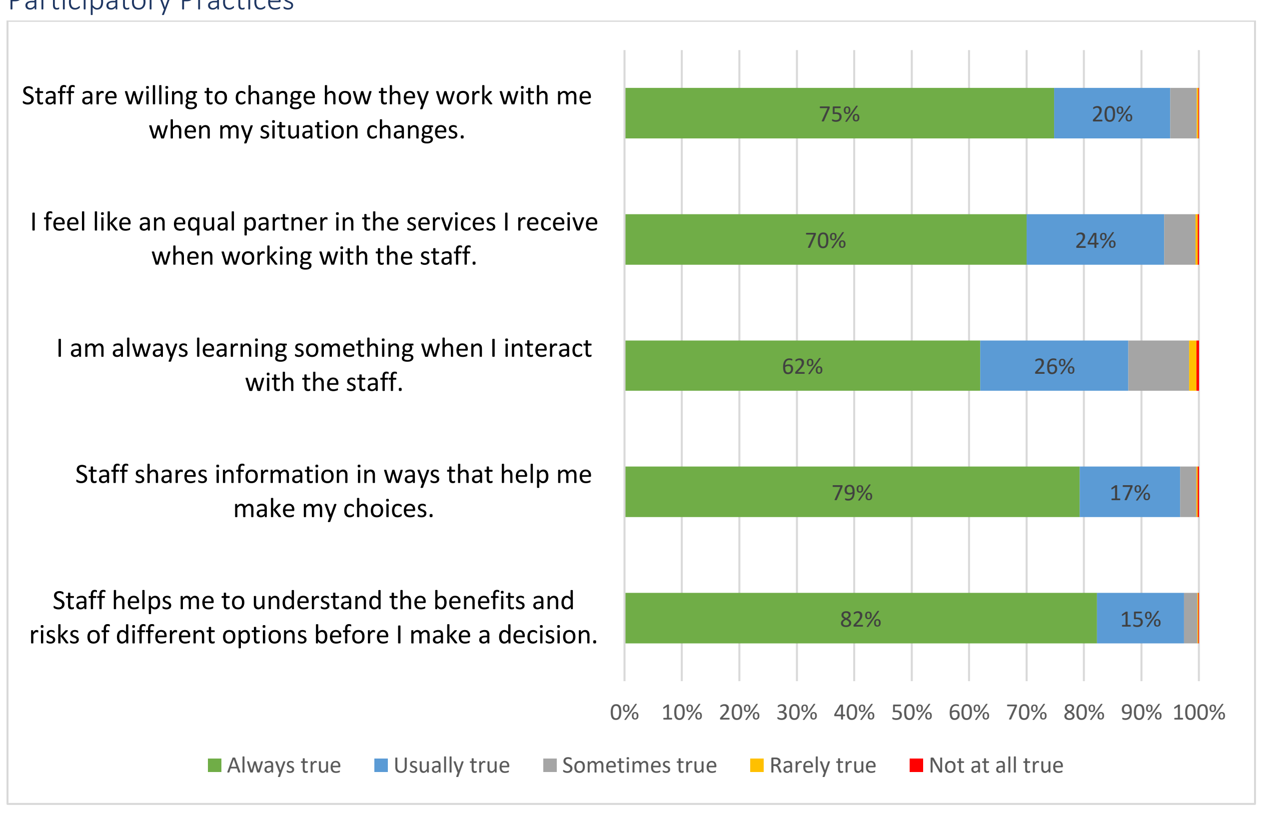
Adherence to client-centred practices

Below are charts with the individual item scores for both relational and participatory practices.

Relational Practices



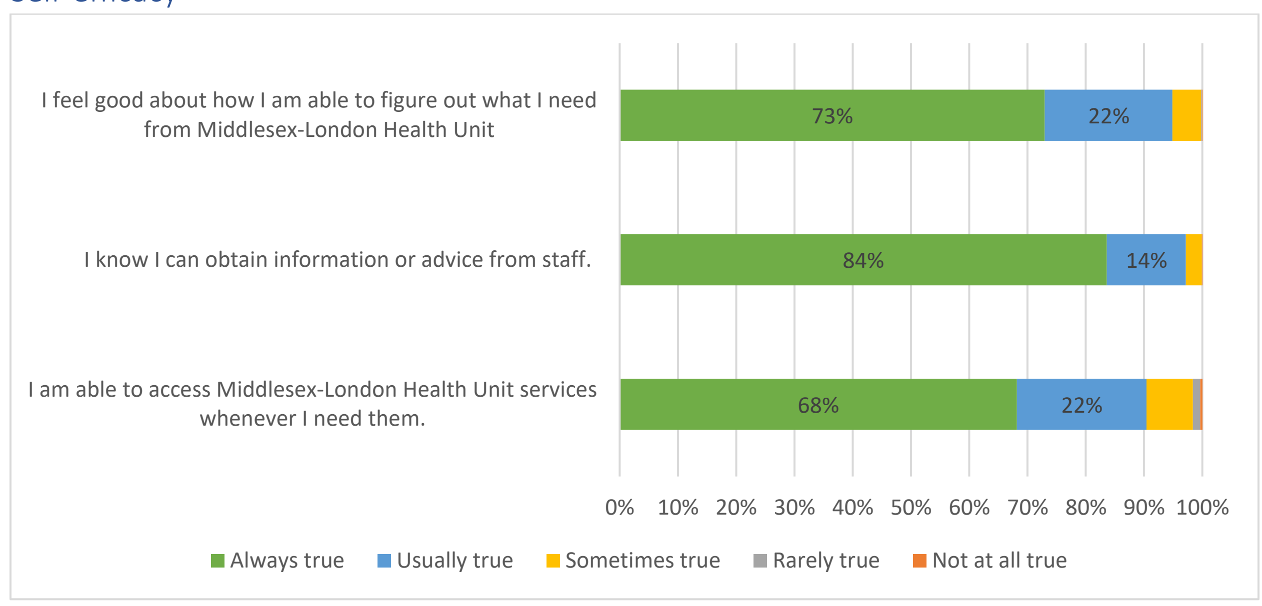
Participatory Practices



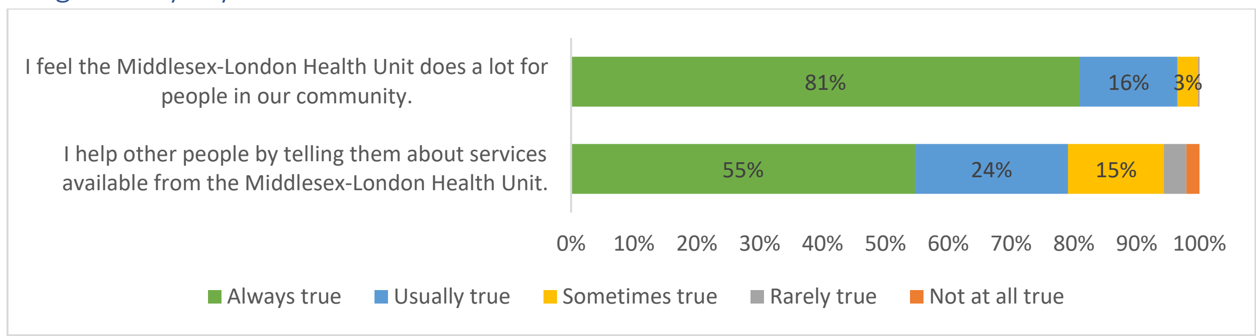
Appendix B

Below are charts with the individual item scores for self-efficacy, program loyalty and social validity

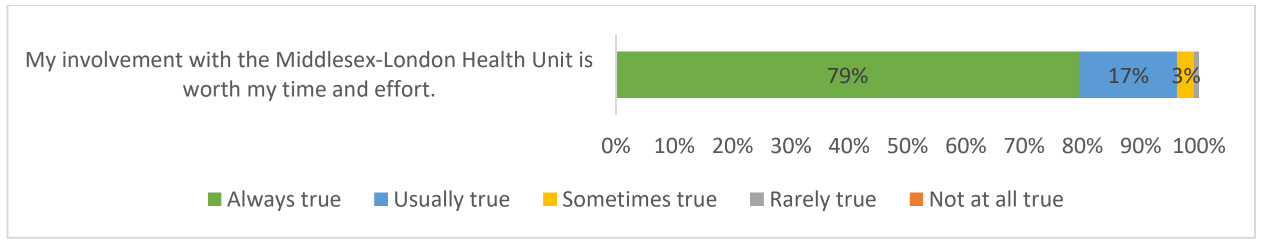
Self-efficacy



Program Loyalty



Social Validity



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References

[i] Boston, S., Zimmerman, G., Trivette, C. M., & Dunst, C. J. (2013). Algoma Client-Centred Care Tool: An evaluation scale for assessing staff use of client-centred practices. *Practical Evaluation Reports*, *5*(2), 1-12.

[ii] Dunst, C.J., & Trivette, C.M. (2005). Measuring and Evaluating Family Support Program Quality. Winterberry Press Monograph Series. Asheville, NC: Winterberry Press.

[iii] Dunst, C.J., Trivette, C.M., & Hamby, D.W. (2006). Family Support Program Quality and Parent, Family and Child Benefits. Winterberry Press Monograph Series. Asheville, NC: Winterberry Press.

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 008-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2020 February 27

INITIAL RESULTS OF MODIFICATION OF ELIGIBILITY CRITERIA FOR THE HEALTHY BABIES HEALTHY CHILDREN (HBHC) PROGRAM

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 008-20 re: "Initial Results of Modification of Eligibility Criteria for the Healthy Babies Healthy Children (HBHC) Program" for information;***
2) ***Endorse continuing with the current modified eligibility criteria for the HBHC Program for six months to gather additional data and explore the suitability of further modification; and***
3) ***Endorse communication with the Ministry of Children, Community and Social Services regarding the intent to modify eligibility criteria for the Healthy Babies Healthy Children program for six months.***

Key Points

- The HBHC Screen is a 36-item validated tool used to identify families who would benefit from the Blended Home Visiting program.
- Pilot modification of the Screen's eligibility criteria for the HBHC program in the context of a significant waitlist, resulted in the conversion approximately one third of "with risk" postpartum screens to "without risk." Virtually all received support from other Healthy Start programs.
- Proposed next steps include communication with MCCSS and continued modification of the HBHC screening criteria for the next six months, with enhanced data collection to assess implications.

Background

The Ministry-mandated HBHC screening tool is used to identify families and children experiencing challenges that may increase their risk of compromised healthy child development, and who may benefit from an in-depth assessment. The HBHC Screen (Appendix A) is a 36-item validated tool, which can be used universally during three stages: prenatal screening (before a baby is born); postpartum screening (prior to discharge from the hospital); and early childhood screening (any time from six weeks until school entry). At the Health Unit, the HBHC program had an intermittent waitlist from April 2017 to February 2018, and a continuous waitlist from February 2018 to the present (Report No. 018-18). In June 2019, the Board approved exploration of HBHC program eligibility criteria revision in order to ensure that the most vulnerable clients were receiving care (Report No. 046-19).

The HBHC Screen assesses risk factors in the following areas: pregnancy and birth, family, parenting, and infant/child development. A risk score is tallied from the responses, and those scoring 2 or more are considered "with risk." Each "yes" on the screen is assigned a score of 1, except question 36. Question 36 examines the health care professional's concern(s) and observations of the client and family, and is automatically scored as 2 with a "yes" response. Postpartum clients who score 2 or higher on the HBHC Screen are referred to the HBHC program for further assessment and follow-up. Clients who score less than

2 are provided with information related to the postpartum period and referred to the Early Years Team for breastfeeding support, as needed.

Further Analysis

Following Board of Health approval in June 2019, managers contacted other health units that had revised HBHC program eligibility criteria to more fully understand the analyses they had completed and their rationale in making decisions. Subsequently, further analysis of postpartum HBHC screening results was conducted using data from 2013 to 2017, and 2017 to 2018. Analysis of postpartum HBHC screenings and in-depth assessments (IDA), HBHC scores by IDA rating, IDA risk rating by HBHC screen question, and risk factor combinations with an HBHC screen score of 2, was completed; limitations of the data were considered. These data were then used to analyze the potential impact of seven alternate screening strategies. These strategies were considered, and one selected for piloting. Support and expertise from the Population Health Assessment and Surveillance Team were critical to this analysis and planning work.

Results of Modified Screen

Per the selected strategy for HBHC eligibility criteria modification, any answer of "yes" to questions 1–7 and 9 was scored as 0; this essentially meant these questions were no longer included when calculating the final screening score. Scoring for the remainder of the screen remained unchanged.

Piloting of this modification was initiated on December 24, 2019. Data from this date until February 3, 2020, were used to complete an initial analysis of the implications of the modified criteria. During this period, there were 252 postpartum screens, with 161 scoring "with risk," 72 scoring "without risk," and 19 with no information using the original eligibility criteria. Of the 161 "with risk," 57 (35%) were no longer considered "with risk" when using the revised criteria. This finding was consistent with what had been predicted when considering this alternate screening approach. Of the 57 screens that converted from "with risk" to "without risk," 55 clients consented to a follow-up postpartum phone call from a Public Health Nurse on the Early Years Team, and 18 went on to receive a home visit for breastfeeding support. Only one was referred to the Best Beginning Team for assessment of need for the HBHC program. Analysis of screens that converted from an original score of 2, 3, or 4 ("with risk") to a score of 0 or 1 ("without risk") was also completed. None of the converted screens scored "yes" on more than one of the questions highlighted in yellow (Appendix B).

Next Steps

With approval from the Board of Health, the Healthy Start Division will share the results of the modified eligibility pilot with MCCSS, and will continue with this alternate screening approach for the next six months. During this time, data will continue to be collected to enable further analysis of the implications of this approach. Steps will also be taken to explore whether there are any additional items on the HBHC Screen that could reasonably be included with those items that score 0 with a "yes" response. Should any indications arise, during the six months, that clients are experiencing negative impacts from this alternate screening approach, eligibility will revert to the original criteria.

This report was submitted by the Healthy Start Division.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health/CEO

Healthy Babies Healthy Children Referral

FAX: 519-663-8243

Appendix A to Report No. 008-20

Name (Parent or Mother): ______

Address: ______

______ Postal Code: ______

Telephone No.: (   ) ______ - ______

D.O.B (Mother or Parent) ______

Health Connection use only:

Self-Referral ☐ NOC discussed ☐

PHN Initials ______

Referred by:

Name: ______ Agency: ______

Phone: ______ - ______ - ______

TO BE SIGNED BY PARENT:

Healthy Babies Healthy Children (HBHC) is a voluntary program to support all expectant mothers and families from childbirth to the transition to school. I will ask you a series of questions about your pregnancy, birth, parenting, and your family history. This information will be sent to your local health unit so that a Public Health Nurse can contact you.

I want to participate in the Healthy Babies Healthy Children Program and I understand that a copy of the personal information on this form will be shared with my local health unit.

Client Signature ______ Date: ______

CHILD:

DOB: ______ Name: ______

Gestation: wks ______ Birth Wt: ______gms Sex: M☐ F☐ Delivery: Vaginal ☐ C-Section ☐

MOTHER:

Marital Status: S ☐ M ☐ Common-law ☐ GTPAL: ______ EDB: ______

Mother's Maiden Name: ______ *Partner's name:* ______

Family Physician: ______ Language: English ☐ Other: ______

REASON FOR REFERRAL:

☐ Prenatal Support ☐ Infant Feeding ☐ Child Behaviour

☐ Growth & Development ☐ Nutrition ☐ Safety

☐ Perinatal Mood Disorder (PPD) ☐ Infant / Child Health ☐ Other ______

Notes:

______

______

______

______

______

Cont'd on Page 2

Healthy Babies Healthy Children Screen

MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com
FAX: 519-663-8243

Ontario

Name (Parent or Mother): ____________________

Reason for no response:

A requires further assessment, B client declined to answer, C unable to assess

Section A: *Pregnancy & Birth*

	Yes/No	Reason for no response
1) Multiple birth?	Y☐ N☐	A☐ B☐ C☐
*2) Premature? *(born at less than 37 weeks gestation)*	Y☐ N☐	A☐ B☐ C☐
*3) Was the birth weight less than 1500g?	Y☐ N☐	A☐ B☐ C☐
*4) Was the birth weight more than 4000g?	Y☐ N☐	A☐ B☐ C☐
*5) Apgar score of less than 5 at five minutes?	Y☐ N☐	A☐ B☐ C☐
6) Health conditions/medical complications during pregnancy that impact infant? *eg. diabetes*	Y☐ N☐	A☐ B☐ C☐
	Please List :	
*7) Complications during labour and delivery? *(e.g. scheduled caesarean, emergency caesarean, infant trauma or illness such as respiratory distress syndrome, difficult vaginal birth including forceps or vacuum*	Y☐ N☐	A☐ B☐ C☐
	Please List :	
8) Maternal smoking of cigarettes during pregnancy?	Y☐ N☐	A☐ B☐ C☐
9) Maternal smoking of more than 100 cigarettes (5 packs) in her lifetime prior to pregnancy?	Y☐ N☐	A☐ B☐ C☐
10) Maternal alcohol use during pregnancy?	Y☐ N☐	A☐ B☐ C☐
11) Maternal drug use during pregnancy? *(Include information on illegal drug use and prescription drugs that impact on activities of daily living or are teratogenic)*	Y☐ N☐	A☐ B☐ C☐
	Please List :	
12) No prenatal care before sixth month?	Y☐ N☐	A☐ B☐ C☐

Section B: *Family*

Mother		
13) Is less than 18 years old?	Y☐ N☐	A☐ B☐ C☐
14) Was less than 18 years old when first child was born?	Y☐ N☐	A☐ B☐ C☐
15) Experienced a previous loss? (pregnancy or baby)	Y☐ N☐	A☐ B☐ C☐
16) Is a single parent?	Y☐ N☐	A☐ B☐ C☐
17) Mother and child do **NOT** have a designated primary care provider?	Y☐ N☐	A☐ B☐ C☐
18) Does **NOT** have an OHIP number?	Y☐ N☐	A☐ B☐ C☐
19) Did **NOT** complete high school?	Y☐ N☐	A☐ B☐ C☐
Infant/Child		
20) Congenital or Acquired Health Challenge?	Y☐ N☐	A☐ B☐ C☐
Please *List:*		
*21) Maternal separation from infant greater than 5 days?	Y☐ N☐	A☐ B☐ C☐
Please specify reason:		
Partner/Father/Support Person		
22) Father/partner/support person is **NOT** involved with care of baby?	Y☐ N☐	A☐ B☐ C☐

Section C: *Parenting*

	Yes/No	Reason for no response
23) Client cannot identify support person to assist with parenting of the baby/child?	Y☐ N☐	A☐ B☐ C☐
24) Client cannot identify support person to assist with care of the baby/child?	Y☐ N☐	A☐ B☐ C☐
25) Client or family in need of newcomer support?	Y☐ N☐	A☐ B☐ C☐
26) Client has concerns about money to pay for housing/rent and family's food, clothing, utilities and other basic necessities?	Y☐ N☐	A☐ B☐ C☐
27) Client or parenting partner has a history of depression, anxiety, or other mental illness?	Y☐ N☐	A☐ B☐ C☐
28) Client or parenting partner has a disability that may impact parenting?	Y☐ N☐	A☐ B☐ C☐
29) Client expresses concern about their ability to parent child/baby?	Y☐ N☐	A☐ B☐ C☐
30) Client expresses concern about their ability to care for baby/child?	Y☐ N☐	A☐ B☐ C☐
31) Client's relationship with parenting partner is strained? (evidence of relationship stress observed)	Y☐ N☐	A☐ B☐ C☐
32) Client or parenting partner has been involved with Child Protection Services as a parent?	Y☐ N☐	A☐ B☐ C☐
*33) Client expresses that his/her child is difficult to manage?	Y☐ N☐	A☐ B☐ C☐
*34) Client's response patterns are inconsistent or inappropriate to the baby's child's cues? *(evidence of inappropriate responses observed)*	Y☐ N☐	A☐ B☐ C☐

Section D: *Infant/Child Development*

*35) Parent(s) identified a risk factor? *(e.g., hearing, speech and language, communication skills, social development, emotional development behaviour, motor skills, vision, cognitive development, self help skills)*	Y☐ N☐	A☐ B☐ C☐

Section E: *Health Care Professional Observations*

36) Health care professional has concerns about the wellbeing of client and/or baby?	Y☐ N☐	A☐ B☐ C☐

Additional Comments:

Signature(s) of health care professional(s) completing Screen with client:

____________________ Date: __________

Please print name: ____________________

Professional Title: ☐RN ☐RPN ☐NP ☐Midwife ☐MD Other__________

The Personal Information on this Healthy Babies, Healthy Children Screen is being collected under the authority of the *Health Protection and Promotion Act* and the Ontario Public Health Standards, 2008 (Reproductive Health). This information will be used to identify families and children with risks to healthy child development and to determine eligibility for participation in the HBHC Program. Any questions about the collection of this information should be directed to the HBHC Manager, 519-663-5317 ext. 2280.

January 2016

HEALTHY BABIES HEALTHY CHILDREN SCREENING TOOL

Instructions, Definitions, Additional Information for Care Providers

Regular Screening of Families

Health care providers are in a unique position to have an impact on positive childhood development outcomes by virtue of their ongoing contact with patients and families over time. Completed screens need to be sent to your local public health department's Healthy Babies Healthy Children Program so that families can receive the supports and services needed. This screen is intended to identify with risk families who may benefit from the Healthy Babies Healthy Children home-visiting program during the prenatal, postnatal or early childhood periods.

Instructions for Completion

Please provide ONE response for each question: If a yes/no response cannot be provided, please indicate the reason for no response in the right-hand column. Reason for no response: ***A.*** Individual completing the screen may have concerns or suspect a risk but needs more information in order to confidently identify this item as a risk. ***B.*** indicates that the client declined to answer the question. ***C.*** unable to assess or unable to ask the client (for example, client was in distress, there was no opportunity for a private discussion about the risk, etc.).

For all questions, a "Yes" indicates a risk. Some items have been reversed, questions 17, 18, 19 and 22, so that a "yes" indicates a risk. For example, "Mother does NOT have an OHIP number". The more "yes" responses, the more likely a family is at risk.

This HBHC Screen should be used for prenatal, postnatal and early childhood clients:

Screening of prenatal clients:

- Conception to birth of infant.
- Answer all questions except for questions 2, 3, 4, 5, 7, 21, 33, 34, 35 (marked with an asterisk). These questions DO NOT apply when screening prenatal clients and should be left BLANK.

Screening of postnatal clients:

- Birth up to 6 weeks of age. In the case of multiple births, one screen is completed for each infant.
- Answer all questions.

Screening of early childhood clients

- From 6 weeks of age. One screen is completed for each infant/child.
- Answer all questions.

Suggested Introduction to Screening for Health Care Professionals

"As part of the Healthy Babies Healthy Children program, all families in Ontario are offered the chance to speak to someone about how they are doing (during their pregnancy, after the birth of a baby, or when their children are in early childhood).

I would like to spend some time talking to you about your family, the supports you have, and any challenges that you may face. We gather the same kind of information from all families at this stage (pregnancy, after birth, early childhood of children) and use the information to support families in getting services that they may find helpful.

If you find there are some things you don't feel comfortable talking to me about, just let me know and we will move to another topic. If you have an
y questions or concerns throughout our discussion today, please let me know. If you and your family might need some extra support. A Public Health Nurse will contact you to talk about services that may be available to you."

Additional Information for Selected Questions

All questions are grounded in evidence and are reflective of the identification of potential risk. References are available upon request.

The following provides additional tips for completing specific questions.

<u>**Section A: Pregnancy and Birth (Questions 1-12)**</u>

5) Please complete even if scores are provided.

6) Health conditions/medical complications during pregnancy that ***Impact*** Infant. *Include: diabetes, eclampsia, congenital herpes, rubella, HIV, Hepatitis B, abruption placenta.*

7) Complications during labour and delivery. *Include: labour that required mid forceps, including breech delivery or emergency caesarean due to complications. Infant trauma or distress including respiratory distress syndrome and convulsions.*

9) Evidence demonstrates that 100 cigarettes is the threshold for establishing Nicotine addiction.

10) Ask every mother about her alcohol use throughout her pregnancy. Discussing alcohol use and fetal development with all women normalizes discussion of this issue and introduces a harm reduction approach to prevention.

11) Maternal drug use during pregnancy *Include: illegal drug use during pregnancy and prescription drugs that impact on activities of daily living or are teratogenic. Exclude: non-teratogenic prescription drugs and small amounts of over-the-counter drugs.*

<u>**Section B: Family (Questions 13-22)**</u>

15) Include previous loss at any stage of pregnancy and at any age, includes loss of a twin, stillbirth, miscarriage, and abortion due to complications.

16) Include if mother identifies herself as sole primary caregiver for child (include unmarried, separated, widowed, divorced and common-law relationship less than one year).

20) Include confirmed congenital or acquired health challenge with probability of permanent disability (e.g. vision or hearing impairment, Down's Syndrome, birth asphyxia, etc.). If a suspected health challenge exists then "A" should be checked off.

21) Include mothers sent home from hospital while baby is still hospitalized (applies to postnatal period).

22) Question refers to the person that the mother identifies as the secondary caregiver to her current child and can include biological father, boyfriend, her mother, friend.

<u>**Section C: Parenting (questions 23-34)**</u>

23 & 24) Parenting refers to meeting the baby/child's emotional and social needs (e.g. providing comfort, responding to needs with warmth and sensitivity, being emotionally and physically available, and appropriate communication). Care refers to meeting the baby/child's basic physical needs (e.g. feeding, diapering, and washing).

25) A mother who is new to Canada, less than 5 years living in Canada, who lacks social supports, or is experiencing social isolation (newcomer is defined as someone new to Canada).

27) Include present or past depression, anxiety or emotional problems. Include if either mother OR father/parenting partner indicates a history of mental illness.

28) Include mental or physical challenge for mother OR father/parenting partner.

29 & 30) Parenting refers to meeting the baby/child's emotional and social needs (e.g. providing comfort, responding to needs with warmth and sensitivity, being emotionally and physically available, and appropriate communication). Care refers to meeting the baby/child's basic physical needs (e.g. feeding, diapering, and washing).

31) Include distress or conflict between parenting partners (e.g. separation, frequent arguments, presence of physical, verbal, emotional or sexual abuse in the home). This could be broadly defined as either by direct observation or expressed by the client.

Note: Screening questions related to partner violence should not be asked with partner present with client.

32) Include family's past or present involvement with Child Protection Services. Exclude involvement of client or parenting partner with Child Protection Services when they were a child.

33) Consider client's perception of difficulty managing the baby/child's behavior *(eg. Temper tantrums, excessive crying, biting, etc.)*

34) Include inappropriate or lack of response when baby/child is in need of comfort, lack of eye contact or physical contact. This could be broadly defined as either by direct observation or expressed by the client.

<u>**Section D: Infant/Child Development (Question 35)**</u>

35) This question should be answered in direct response to a developmental concern specifically raised by the parent and should not include parent concerns or questions about the normal care of a newborn or child. Areas of development include vision, hearing and communication, gross and fine motor, cognitive, social/emotional, and self-help. Parental concerns may be identified through the Nipissing Developmental District Screening TM (NDDS) tool that assists parents and caregivers to monitor child development. More information on the NDDS can be found at www.ndds.ca

<u>**Section E: Health Care Professional Observations (Question 36)**</u>

36) Health care professional's concern(s) includes professional observations of the client and family.

<u>**Consent:**</u>

The check box for consent refers to verification by the health care provider that the necessary consent has been obtained (as described in PHIPA). Client consent refers to both consent to disclose personal information and personal health information, and consent to participate in the HBHC Program. If client declines further participation in the HBHC Program, cross out participation only.

<u>**Signature:**</u>

The screen should be signed by the individual who obtains consent from the mother and completes the Screen. If additional information is completed by another practitioner, this individual should provide their initial and signature with designation on the Screen, and initial the responses collected.

Appendix B to Report No. 008-20

HBHC Screening Questionnaire

HBHC Screening Question	BORN SCORE		
	2 N=35	3 N= 11	4 N= 4
1. Multiple birth	1	1	
2. Premature (born less than 37 weeks gestation)	4	1	2
3. Birth weight less than 1500g			
4. Birth weight more than 4000g	9	3	1
5. Apgar score less than 5 at 5 minutes			
6. Health conditions/medical complications during pregnancy that impact infant	12	8	4
7. Complications during labour and delivery	19	8	4
8. Maternal smoking of cigarettes during pregnancy			
9. Maternal smoking of more than 100 cigarettes (5 packs) in her lifetime prior to pregnancy			
10. Maternal alcohol use during pregnancy			
11. Maternal drug use during pregnancy			
12. No prenatal care before sixth month			
13. Mother is less than 18 years old			
14. Mother was less than 18 years old when first child was born			
15. Experienced a previous loss	12	2	2
16. Single parent			
17. Mother and/or child does not have a designated primary care provider	1	1	1
18. Mother does not have an OHIP number			
19. Mother did not complete high school			
20. Infant/child has a congenital or acquired health challenge		1	1

HBHC Screening Question	BORN SCORE		
	2 N=35	3 N= 11	4 N= 4
21. Maternal separation from infant greater than 5 days			
22. Father/partner/support person is not involved with care or baby/child			
23. Client cannot identify support person to assist with parenting of the baby/child			
24. Client cannot identify support person to assist with care of the baby/child			
25. Client or family in need of newcomer support	1	1	
26. Client has concerns about money to pay for housing/rent and family's food, clothing, utilities and other basic necessities			
27. Client or parenting partner has a history of depression, anxiety, or other mental illness	11	1	
28. Client or parenting partner has a disability that may impact parenting			
29. Client expresses concern about their ability to parent baby/child			
30. Client expresses concern about their ability to care for baby/child			
31. Client's relationship with parenting partner is strained			
32. Client or parenting partner has been involved with Child Protection Services as a parent			
33. Client expresses that baby/child is difficult to manage			
34. Client's response patterns are inconsistent or inappropriate to the baby's/child's cues			
35. Parent(s) identified a risk factor			
36. Health care professional has concerns about the wellbeing of client and/or baby/child			

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 013-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health/ CEO

DATE: February 27, 2020

LAPTOP PURCHASES - CONTRACT AWARD

Recommendation

It is recommended that the Board of Health:

1) ***Receive Report No. 013-20 for information; and***
2) ***Approve entering into a contractual agreement with Insight Canada for the purchase of laptop computers***

Key Points
- MLHU staff examined requirements for the purchase of technology to support staff working both internally at Citi Plaza and externally in the community.
- Quotes were prepared for the purchase of laptops compatible with the current technology infrastructure and 3 bids were received. The lowest acceptable bid was received from Insight Canada for $77,882 + HST.

Background

A focus on technology requirements for numerous initiatives, including Enterprise Resource upgrades, the adoption of Electronic Client Records and a growing mobile workforce through Activity Based Workstations (hoteling) and the approval of Alternative Work Arrangement policies has prioritized IT expenditures on end user equipment purchases since December of 2018. This end user replacement strategy for laptops is approaching completion across the organization and to date 240 laptops and desktops have been replaced, with approximately 50 laptops remaining. The remaining fleet of laptops and desktops have reached the end of their warranty period and functional capabilities. They are due for replacement this fiscal year. The replacement strategy has been successful and helped transform the capabilities of staff across the organization. This strategy would recommend the next replacement of laptops in December 2021.

Laptop Quotation

A Request for Quotation (RFQ) was issued on February 7, 2020 for the purchase of 50 laptops to support the productivity of staff and complete the next phase of equipment upgrades. The quote includes:

1) Laptop
2) 24" Monitor
3) Ethernet adapter
4) Riser stand
5) 3-year warranty service.

The equipment selected was based on the compatibility and interchangeability with the current fleet of laptops and monitors.

The bid closed on February 21st and three quotes were received for the equipment specified. While all bidders provided equipment and services in line with the quote requirements, Insight Canada provided the lowest acceptable bid. Insight is a Fortune 500 company and has more than two decades of experience helping Canadian businesses procure and manage hardware, software and cloud products.

It is recommended that Insight Canada be awarded the contract for laptops.

Next Steps

As a result of the quote process undertaken, it is recommended that the contract for laptops be awarded to Insight Canada.

This report was prepared by Procurement & Operations Team, Healthy Organization Division.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health/CEO

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 009-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health/CEO

DATE: 2020 February 27

VECTOR-BORNE DISEASE PROGRAM: SUMMARY REPORT

Recommendation

It is recommended that Report No. 009-20 re: "Vector-Borne Disease Program: Summary Report" be received for information.

Key Points

- The increased prevalence of blacklegged ticks (Lyme disease vectors) in Middlesex-London, primarily caused by climate change, has led Public Health Ontario to identify a Lyme disease "risk area" within a 20-kilometre radius of Komoka.
- The elevated incidence of locally acquired blacklegged ticks may contribute to an increase in the number of Lyme disease infections in Middlesex and London residents.

Background

In 2019, the Vector-Borne Disease (VBD) Team's passive and active tick surveillance identified the presence of blacklegged ticks in the Komoka area. Blacklegged ticks are known vectors of Lyme disease (LD). While active surveillance did not identify LD-positive blacklegged ticks, one LD-positive tick was submitted from a human in this area. Because of the discovery of this tick species in the Komoka area during spring and fall surveillance activities, the region now meets Public Health Ontario criteria for the establishment of a Lyme disease "risk area."

Since 2015, the term "risk area" has been used to describe locations in Ontario where there is an increased risk of encountering LD-infected ticks. For the past four years, the northern part of Middlesex County has been identified as a LD risk area, since it was within a 20-kilometre radius of Pinery Provincial Park, where blacklegged ticks are known to be present. Public Health Ontario uses the 20-kilometre radius measure as it accounts for the movement of animals upon which ticks travel. This movement of animals is attributable to the expansion of tick populations across the province.

As blacklegged ticks were identified in Komoka, applying the 20-kilometre radius measure from their point of identification will result in most of the City of London's geographical area falling within the newly identified risk area, in addition to Middlesex Centre, Strathroy-Caradoc, the Munsee-Delaware Nation, the Oneida Nation of the Thames, and the Chippewas of the Thames First Nation (refer to Appendix A).

Activities

The VBD team uses passive and active tick surveillance throughout the Middlesex-London region to monitor the risk of LD infection and to help identify establishing tick populations. Passive tick surveillance occurs when health care providers, veterinarians, and residents submit ticks to the Health Unit for identification. Active surveillance occurs when MLHU staff deploy in the field to search for ticks using a technique called tick dragging (see Appendix B). Location selection for this activity is guided by results from passive tick surveillance. Active surveillance helps to identify trends in the tick population across our region over multiple years. Finding multiple ticks in a single location may be indicative of an established tick population.

As climate change and animal movement can expand the range of tick habitat, active tick surveillance will be expanded to communities near the identified risk area to determine if the risk area is expanding. The risk of human cases of LD increases in areas where infected blacklegged tick populations are established.

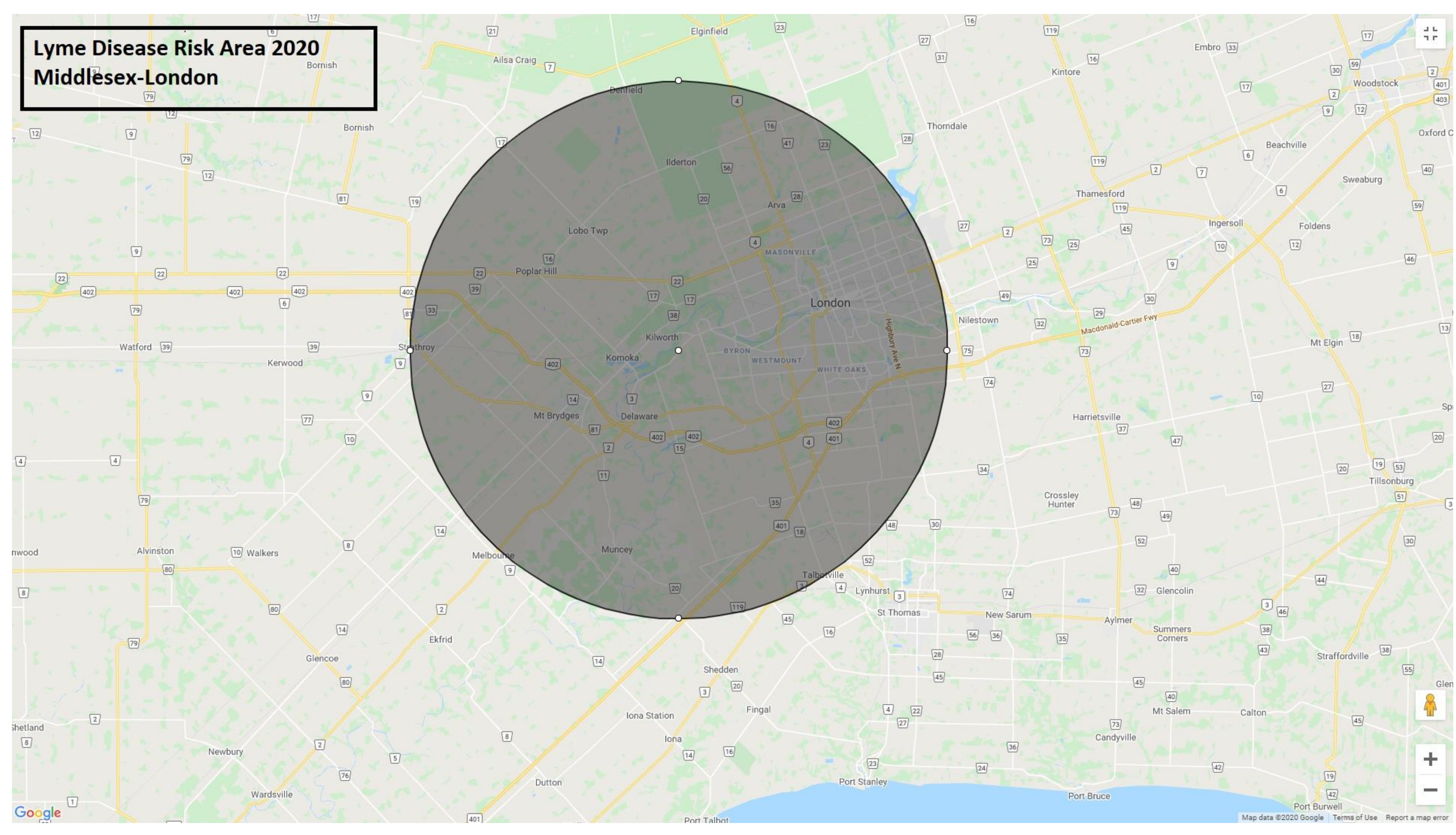
Next Steps

The combination of LD-positive ticks and the continued rise in the number of blacklegged ticks found in our region demonstrates the need for continued passive and active surveillance, testing, and public education. Although the number of locally acquired human cases of LD has been historically low, the number of local blacklegged ticks identified through active and passive surveillance is anticipated to continue to increase across Middlesex-London. The newly established risk area in Komoka has been added to Public Health Ontario's LD risk area map. This new designation will help local health care providers make more efficient and informed assessments of their patients and deliver more consistent treatment. Moving forward, the VBD Team will alert local health care providers and continue to support residents by promoting personal protection, enhancing public education campaigns, and working with community partners.

This report was prepared by the Safe Water, Rabies and Vector-Borne Disease Team in the Environmental Health and Infectious Diseases Division.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

Appendix A to Report No. 009-20



	2017	2018	2019
Ticks Submitted to the Middlesex-London Health Unit			
# of Non-Vector Ticks Submitted	349	237	357
# of Blacklegged Ticks Acquired Within Middlesex-London	34	29	63
# of Blacklegged Ticks Acquired Outside of Middlesex-London	48	46	80
Active Tick Surveillance in Middlesex-London			
Number of Blacklegged Ticks Found Through Tick Dragging	0	0	31*
Lyme Disease Cases in Middlesex-London			
Number of Probable Human Lyme Disease Cases in Middlesex-London With No Travel History	4	3	0

*all from the Komoka region

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 010-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2020 February 27

CRITICAL INJURY INVESTIGATION RESULTS AND FOLLOW-UP

Recommendation

It is recommended that Report No. 010-20 re: "Critical Injury Investigation Results and Follow-Up" be received for information.

Key Points

- A critical injury of a worker occurred on January 29, 2020, at Citi Plaza, which required an investigation and notification of the Ministry of Labour, Skills and Training Development.
- The Board of Health is accountable for ensuring that the *Occupational Health and Safety Act* (OHSA) requirements, in regard to notification and investigation of critical injuries, are conducted.
- The Ministry of Labour, Skills and Training Development conducted a field visit at Citi Plaza on February 6, 2020, to review the investigation documentation and the actions taken by MLHU to prevent a recurrence. The inspector issued no orders to MLHU.

Background

On the evening of January 29, 2020, a worker slipped, tripped, and fell outside of Entrance Five at Citi Plaza, while ending their workday and returning to their vehicle. The worker sustained a fractured elbow in the fall, meeting the threshold for a critical injury as defined by the *Occupational Health and Safety Act, Regulation 834: Critical Injury – Defined*. In response to the written notification of the critical injury, a Ministry of Labour, Skills and Training Development inspector attended the Citi Plaza offices to conduct a field visit to review the investigation documentation. The inspector completed their investigation, praised the work that had been completed in preparation for the field visit, and issued no orders (see Appendix A).

Incident Investigation and Follow-Up

A critical injury must be reported under section 51 of the *Occupational Health and Safety Act* if there is a connection between the hazard that gave rise to the injury and worker health and safety. Per Administrative Policy 8-040, as well as requirements under the *Occupational Health and Safety Act*, the following parties were notified of the incident: Board of Health, Senior Leadership Team, Joint Occupational Health and Safety Committee (JOHSC), and the trade unions.

After being notified of the incident, the management representative from JOHSC investigated, which included discussing the event with the injured worker, reviewing training and other awareness records associated with slips, trips, and falls, and taking photos of the incident site.

The incident was also reported to the City of London as well as Avison Young, the Citi Plaza building management company. The City of London made repairs to the incident site by filling cracks with concrete on February 3, 2020.

Due to the nature of the injury, the worker received medical attention and missed time from work, requiring further reporting to the Workplace Safety and Insurance Board (WSIB). MLHU has since been notified that the claim for WSIB coverage was denied as the injury was not sustained during work time or in the workplace.

Following the incident, a communiqué was sent to all employees to notify them of the present hazard to prevent a recurrence and to remind them of precautions for preventing slips, trips, and falls.

MLHU continues to monitor the workplace health and safety conditions, making recommendations and changes where necessary to ensure the employer is taking every reasonable precaution to protect workers.

This report was prepared by the Human Resources team, Healthy Organization Division.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

Ministry of Labour **Safe At Work Ontario**

Operations Division — Occupational Health and Safety

Field Visit Report

Appendix A to Report No. 010-20

OHS Case ID: **02817PCNT676**
Field Visit no: **02817PCWP677** Visit Date: **2020-FEB-06**

Workplace Identification: **MIDDLESEX-LONDON HEALTH UNIT**
355 WELLINGTON STREET, LONDON, ON, CANADA N6A 3N7

Notice ID:

Telephone:	JHSC Status:	Work Force #:	Completed %:
(519) 663-5317	**Active**	**150**	

Persons Contacted: **LISA KELLIHER WORKER CO- CHAIR JHSC,LILKA YOUNG MANAGER CO- CHAIR JHSC,LAURA DI CESARE ,DIRECTOR HEALTHY ORGANIZATION , TIM HUGGINS OPERATIONS MANAGER FOR AVISON YOUNG PROPERTY MANAGEMENT**

Visit Purpose: **FRACTURED ELBOW WHILE EXITING THE WORKPLACE.**

Visit Location: **MEETING ROOM- INCIDENT AREA REVIEWED.**

Visit Summary: **NO ORDERS**

Detailed Narrative:

This is the location of the Middlesex -London Health Unit.
Location of the incident Citi Plaza Mall, Side walk at the corner of King St and Clarence St, 355 Wellington St, London, ON N6A 3N7

INCIDENT:
On January 29/2020 a worker was exciting the Citi Plaza Mall to go to their car located in the Impark parking lot adjacent to 186 King Street London.
The worker fell at the corner of King Street and Clarence Street at entrance 5 of Citi Plaza. The worker sustained a fractured elbow when her right foot caught on a raised piece of pavement on the City of London sidewalk.
Video of the incident was provided to the Middlesex -London Health Unit by Tim Huggins Operations Manager for Avison Young Property Management .
The video was reviewed by all workplace parties and this Inspector. The employer is retaining the disk as part of their accident investigation.
The video supports the employer's investigative findings.

NOTIFICATIONS:
Notifications of the MOL,JHSC and Trade Unions was conducted on January 30/2020.

TRAINING:
All workers get trained on the prevention of slips, trips and falls in orientation.Workers receive updates regarding the prevention of slips, trips and falls throughout the year via email blasts,posters and intranet postings.

PHOTOGRAPHS :
The employer took 3 pages of pictures of the incident area on January 30/2020 post incident and pre repair of the area by the City of London.

Recipient	Inspector Data	Worker Representative
Name: Lilka Young	**TERESA BOWEN** OCCUPATIONAL HEALTH & SAFETY INSPECTOR PROVINCIAL OFFENCES OFFICER 217 York Street, 5th Floor London, ON N6A 5P9 **Tel: (226) 980-5534** **Fax: (519) 672-0268**	Name: Lisa Kelliher
Title: Mgmt co-chair JHSC		Title: Worker rep - Co Chair
Signature: [signature]	Signature: [signature]	Signature: [signature]

You are required under the Occupational Health and Safety Act to post a copy of this report in a conspicuous place at the workplace and provide a copy to the health and safety representative or the joint health and safety committee if any. Failure to comply with an order, decision or requirement of an inspector is an offence under Section 66 of the Occupational Health and Safety Act. You have the right to appeal any order or decision within 30 days of the date of the order issued and to request suspension of the order or decision by filing your appeal and request in writing on the appropriate forms with the Ontario Labour Relations Board, 505 University Ave., 2nd Floor, Toronto, Ontario M5G 2P1. You may also contact the Board by phone at (416) 326-7500 or 1-877-339-3335 (toll free), mail or by website at http://www.olrb.gov.on.ca/english/homepage.htm for more information.

Do you have a comment or feedback about your inspection? Call the Ministry of Labour Contact Centre 1-877-202-0008

Ministry of Labour **Safe At Work Ontario**

Operations Division — Occupational Health and Safety

Field Visit Report

OHS Case ID: **02817PCNT676**
Field Visit no: **02817PCWP677** Visit Date: **2020-FEB-06** Field Visit Type: **INITIAL**
Workplace Identification: **MIDDLESEX-LONDON HEALTH UNIT** Notice ID:
355 WELLINGTON STREET, LONDON, ON, CANADA N6A 3N7

The employer took 2 pages of pictures of the incident area on February 5/2020 of repairs to the area where the worker tripped and fell.

REVIEWED AND RECEIVED:
The employer took 3 pages of pictures of the incident area on January 30/2020 post incident and pre repair of the area by the City of London.
The employer took 2 pages of pictures of the incident area on February 5/2020 of repairs to the area where the worker tripped and fell.
Middlesex -London Health Unit Critical Injury/Fatality Report Form - 2 pages.
Middlesex -London Health Employee Injury /Incident Report Form -5 pages.
Notification e mails to January 30/2020 to JHSC including Unions - 2 pages.
Notification e mails to January 30/2020 to Senior Leadership - 2 pages.
Notification e mails to January 30/2020 to Board of Health - 2 pages.
Injured Worker training record- 1 page.
Training Winter Weather Updated January 25/2019 -1 -page.
Post Incident Staff Communication ,Slips,trips and falls -1 -page.
Awareness documents for slips,trips and falls - 6 pages.

Recipient	Inspector Data	Worker Representative
Name ______	**TERESA BOWEN** OCCUPATIONAL HEALTH & SAFETY INSPECTOR PROVINCIAL OFFENCES OFFICER 217 York Street, 5th Floor London, ON N6A 5P9 **Tel: (226) 980-5534** **Fax: (519) 672-0268**	Name ______
Title ______		Title ______
Signature	Signature	Signature

You are required under the Occupational Health and Safety Act to post a copy of this report in a conspicuous place at the workplace and provide a copy to the health and safety representative or the joint health and safety committee if any. Failure to comply with an order, decision or requirement of an inspector is an offence under Section 66 of the Occupational Health and Safety Act. You have the right to appeal any order or decision within 30 days of the date of the order issued and to request suspension of the order or decision by filing your appeal and request in writing on the appropriate forms with the Ontario Labour Relations Board, 505 University Ave., 2nd Floor, Toronto, Ontario M5G 2P1. You may also contact the Board by phone at (416) 326-7500 or 1-877-339-3335 (toll free), mail or by website at http://www.olrb.gov.on.ca/english/homepage.htm for more information.

Do you have a comment or feedback about your inspection? Call the Ministry of Labour Contact Centre 1-877-202-0008

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 011-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2020 February 27

SUMMARY INFORMATION REPORT – FEBRUARY 2020

Recommendation

It is recommended that Report No. 011-20 re: "Summary Information Report – February 2020" be received for information.

Key Point

- Health Canada is seeking input on its proposed *Vaping Products Promotion Regulations* to address the rapid uptick in vaping and to reduce harms from vapour product use. The Health Unit's submission is attached as Appendix A.

Federal *Vaping Products Promotion Regulations*

On December 21, 2019, Health Canada published the *Vaping Products Promotion Regulations* (VPPR), in the Canada Gazette, Part I. The proposed regulations intend to address the rapid increase in youth vaping, to raise awareness about the harms of vapour product use, and to mitigate the impact of vaping product promotion on young persons and non-users of tobacco products. The proposed regulations, if enacted, would: prohibit advertising that can be seen or heard by young people; prohibit the display of vaping products that can be seen by youth at point of sale; and require that all vaping product advertisements convey a health warning. The Health Unit submitted feedback (attached as Appendix A) commending Health Canada for its continued attention to vaping and vapour product regulation, along with some recommendations (here in summary) to further strengthen the VPPR:

- Apply the same regime as is used to restrict the promotion and advertising of commercial tobacco products, prohibiting all forms of advertising for vaping products except informational signs in adult-only venues and publications sent to named, consenting adults;
- Ensure that the "List of Health Warnings for Vaping Product Advertising" consists exclusively of effective, evidence-informed warnings that reflect the seriousness of the health effects of vaping;
- Increase the size of the proposed health warnings from 20% to 50% of product surface area and include graphic elements;
- Enact and enforce strict age-verification measures for online sales, including age verification at time of purchase and proof of legal age at delivery;
- Enact tighter prohibitions on the manufacture and sale of e-substance flavours, with an overall reduction/market cap on the number of flavours available for sale in Canada; and
- Cap the nicotine concentration levels in vapour products to a maximum of 20 mg/ml.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

January 19th, 2020

Appendix A to Report No. 011-20

Mathew Cook, Manager
Scientific Regulations Division
Tobacco Products Regulatory Office
Tobacco Control Directorate
Controlled Substances and Cannabis Branch
Health Canada
0301A – 150 Tunney's Pasture Driveway
Ottawa, Ontario
K1A 0K9
Email: hc.pregs.sc@canada.ca

RE: SUBMISSION TO HEALTH CANADA ON THE PROPOSED *VAPING PRODUCTS PROMOTION REGULATIONS* (VPPR)

Dear Mathew Cook;

The Middlesex-London Health Unit shares Health Canada's concerns regarding the increase in vapour product use by young people in Canada and commends Health Canada for its commitment to work with provincial and territorial partners to enhance national collaborative and cooperative efforts to reduce youth vaping.

In Ontario, local Public Health Units play an important role in working with parents, schools, community and social service agencies, and municipalities to prevent youth, young adults, and non-tobacco users from using vaping products, and to promote compliance and ensure enforce the provisions outlined under the *Smoke-Free Ontario Act, 2017*. The enactment of the proposed *Vaping Products Promotion Regulations (VPPR)*, published in the Canada Gazette, Part I on December 21, 2019 would be an important step forward to help reverse the increase in youth initiation of vaping in Canada. The Middlesex-London Health Unit welcomes the opportunity to provide comments on how to strengthen the proposed *Vaping Products Promotion Regulations*. Our submission is attached for your consideration.

While the proposed regulations along with the recommended improvements we have suggested will help to prevent youth, young adults and non-smokers from the initiation of vapour product use, additional regulatory, legislative and policy changes are needed to effectively curb the rapidly growing epidemic of youth vaping. The Middlesex-London Health Unit looks forward to continuing to work in partnership with our federal public health partners to address this emerging public health issue of significant concern. For more information or to discuss further, please do not hesitate to contact me or Linda Stobo, Program Manager for Chronic Disease Prevention and Tobacco Control at (519) 663-5317 ext. 2388.

Sincerely,

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

January 19th, 2020

Comments on the Proposed *Vaping Products Promotion Regulations*

The Middlesex-London Health Unit (MLHU) applauds Health Canada's efforts to prevent the initiation of vaping by youth, young adults, and non-smokers and welcomes the opportunity to provide feedback on the proposed *Vaping Products Promotion Regulations*.

Overall, the regulations, once implemented, will help to reduce youth vaping and will be a significant advancement to the status quo; however, the timeliness of enactment is imperative. Data from the 2018-19 Canadian Student Tobacco Alcohol and Drugs survey (CSTADS) shows that 20% of Canadian students (approximately 418,000) had used an e-cigarette (with or without nicotine) in the past 30 days. Students that reported vaping (with or without nicotine) in the past 30 days are vaping regularly, with approximately 40% reporting daily or almost daily use (Health Canada, 2019). The measures outlined in the proposed regulations will help to reverse the increase in youth initiation of vaping in Canada and should be adopted as soon as possible.

At the same time, there is an opportunity to make improvements to the regulations.

Prohibiting Advertising and Display of Vaping Products to Youth

There has been a sharp increase in youth vaping over the past three years. A recent study, led by Professor David Hammond from the University of Waterloo found that vaping among youth aged 16 to 19 increased by 74% between 2017 and 2018 (Hammond, D., Reid, J.L, Rynard, V.L, et al., 2019). The CSTADS survey indicates that e-cigarette prevalence rates have doubled among students, from 10% in 2016-17 to 20% in 2018-19 (Health Canada, 2019). The volume of advertising and product promotion is likely contributing to the uptick in vaping among Canadian youth. Research has shown that vaping is associated with smoking initiation among youth and young adult populations and that advertising and promotion of tobacco products to young people has led to increasing uptake of smoking (Margolis, K.A, Donaldson E.A., Portnoy, D.B., et al., 2018). Research published in Pediatrics in June 2019 found that the marketing of vapour products at retail stores predicts youth and young adult vapour product initiation, and that exposure to product advertisements on television is also associated with the initiation of vapour product use by young adults (Loukas, A., Paddock, E., Xiaoyin, L., et al., 2019). Youth and young adults are uniquely susceptible to marketing due to hormonal effects during brain development and the blurred lines between entertainment and advertising with digital advertisements (Heart and Stroke Foundation, 2019).

Brands such as JUUL utilize vapour product advertisements that convey fun, trendy and attractive lifestyles which appeal particularly to youth and young adults. A 2019 national Leger poll found that 86% of Canadians believe that the government should apply the same advertising restrictions to vapour products with nicotine as it does to tobacco products to help curb increasing youth consumption of nicotine vaping products (Leger, 2019). Due to the enactment of recent legislation in Ontario, vaping advertisements and promotional materials are no longer permitted at tobacco and vapour product retail outlets where people under the age of 19 years have access; however, youth will continue to be exposed to vapour product advertising in many public spaces, including online and on social media platforms, without the support of the proposed Health Canada regulations.

Vaping products should be brought under the same advertising and promotion control regime as tobacco. Advertising at places such as post-secondary campuses, recreational facilities, special events or places of entertainment, restaurants, public transit facilities, broadcast media, within print publications and online should be prohibited given the potential for youth exposure. In addition, all restrictions on visual advertising, promotional exhibits, signage, and product display at point of sale that exist for tobacco products should also be applied to vaping products.

As proposed, the *VPPR* would allow vapour product promotion on signs and by audio and video media if these advertisements are in age-restricted venues. Other forms of marketing, such as promotional parties or special events, are

London Office
50 King St., London, ON N6A 5L7
tel: (519) 663-5317 • fax: (519) 663-9581

www.healthunit.com
health@mlhu.on.ca

Strathroy Office - Kenwick Mall
51 Front St. E., Strathroy ON N7G 1Y5
tel: (519) 245-3230 • fax: (519) 245-4772

not specifically named as prohibited activities within the regulations. Tobacco industry promotional activities that were permitted historically, including sponsored events and interactive audio-visual exhibits, demonstrate the need for strict regulations that prohibit all forms of advertising and marketing for vaping products, except for signs in adult-only venues and publications sent to named, consenting adults. Young adult non-smokers should be protected from vapour product advertising given the blurred lines between entertainment and advertising, and the industry's history of downplaying the potential health harms associated with vapour product use.

Emerging data suggests that vapour products may be safer than combustible tobacco products; however, this data is not yet conclusive and regardless, they are not harmless. A precautionary approach is required. There is conclusive evidence that non-tobacco users should not start using vapour products due to the increase in exposure to nicotine, particulate matter, heavy metals and other toxic chemicals; this is especially true for young people because of the damage nicotine can have on the developing brain (NASEM, 2018; England, L.J., Bunnell, R.E., Pechacek, T.F, et al., 2015). Strict regulations on advertising are essential to ensure we circumvent the creation of a new generation of young people addicted to nicotine. Since all forms of advertising can make vaping products socially desirable and acceptable, we urge Health Canada to employ strict measures to limit vapour product promotion and advertising.

Health Warnings on Permitted Advertisements and Product Packages

The *List of Health Warnings for Vaping Product Advertising* is currently unavailable for review. Studies on electronic cigarette health warnings have found that the exposure to a health warning increases negative feelings regarding the use of an electronic cigarette. Moreover, these studies have found that exposure to the health warning also reduces positive attitudes about vapour products and intentions to purchase an electronic cigarette (Baig, S. B., Brewer, N. T., Hall, M.G., et al., 2018). The first two warnings proposed for use under the regulation are small, and do not reflect the seriousness of the health effects of vaping as currently documented in scientific evidence.

Youth and young adults are the largest users of vaping products and they continue to lack reliable information and be unaware of the health effects of electronic cigarette use. In 2019, the Ontario Tobacco Research Unit conducted focus groups in Ontario, a couple of which were held in London, ON. Multiple young people stated that they felt that if vaping was unsafe, the government would have stricter regulations. For example, one participant expressed the following opinion, "... I think that's why the government is a bit more lax with [vaping] - because there's no demonstrable proof that it actually does have health implications. If there was, they would do something" (Ontario Tobacco Research Unit, 2019). It is our recommendation that warnings should include clear scientific findings about the effects of nicotine on brain development. This is an indisputable health implication that we feel will add more weight to the proposed warnings. In addition, the MLHU recommends that the *List of Health Warnings for Vaping Product Advertising* consist exclusively of effective warnings with the addition of graphic elements. Canada has been a leader in the implementation of graphic health warnings for tobacco products; therefore, the opportunity exists to apply the evidence from the implementation of graphic health warnings on tobacco product packages to the regulations for vapour product packaging.

In addition, the inclusion of health warnings on advertisements visible to adults is an important step toward enhancing public awareness about the health hazards of vaping. Due to ongoing uncertainty around the harms of specific ingredients and combinations of ingredients, health warnings should also be included on advertisements for all vaping products, and not limited to those for vaping products that contain nicotine or are intended to be used with vaping liquid. The MLHU recommends that the size of the required warning on the permitted advertisement be increased from 20% to 50% of the surface area. Additionally, bilingual health warnings will reduce the size of the font, impacting the visibility and impact of the message. Therefore, MLHU recommends that if an advertisement is in only one official language (as outlined in s.12(2) of the proposed regulations), that the health warning be only in the language of the advertisement.

Lastly, due to the increasing number of confirmed or probable cases of vaping-related severe pulmonary disease in Canada (15 cases reported by Health Canada as of January 7, 2020), and a lack of confirmed evidence regarding the specific cause of these illnesses, there is a need to increase awareness about the potential consequences of vaping. The

MLHU supports the ongoing update of health warnings on advertisements and vapour product packaging to keep the public informed as the body of evidence regarding the health consequences of vaping grows.

Additional Comments

The proposed regulations, along with the recommendations outlined within this submission, will help to prevent the initiation of vapour product use by youth, young adults and non-smokers; however, further regulatory and legislative changes are needed.

- Many youth who vape report that they obtain these products online. Online vendors may be both less able and less inclined to take effective measures to limit sales to minors; some online vendors accept a simple declaration of a client's age. Strict age-verification measures are required for online sales, including age-verification at time of purchase and proof of legal age at delivery. Active enforcement of online sales to assess compliance with age restriction laws is also required. In addition, at the time of delivery of e-cigarettes and e-juice purchased online, confirmation of age by government-issued identification should be required.
- "Flavor is a multisensory perception" that involves taste, aroma, and feelings of cooling and burning within the mouth and throat (Small, D.M. and Green, B.G., 2012). Youth and young adults are particularly influenced by flavours (Mennella, J.A., Pepino, M.Y., and Reed, D.R., 2005). Due to pervasive marketing and promotion tactics, and the addition of attractive candy and fruit flavours to vapour products, sales of e-cigarettes are growing rapidly across Canada and around the world, with over one thousand e-liquid flavours available in the marketplace under the banner of 460 different brands (Euromonitor International, 2015). The MLHU recommends that Health Canada strengthens the current approach to regulating flavoured e-substances to include tighter prohibitions on the manufacturing and sale of e-substance flavours that are attractive to youth and adolescents, with an overall reduction/market cap on the number of flavours available for sale in Canada. Nicotine replacement therapy is only available in a limited number of flavours; therefore, the inventory of vapour product flavours should be limited.
- Nicotine is a highly addictive substance that poses significant risk, especially to young people. The brain continues to develop until an individual reaches the approximate age of 25. Exposure to nicotine during brain development can result in nicotine addiction, mood disorders, permanent lowering of impulse control, and changes in attention and learning (NASEM, 2018). To reduce youth appeal and to protect the developing youth brain, the Health Unit recommends that acceptable nicotine concentration levels for vapour products should be more closely aligned with the approved nicotine concentrations for nicotine replacement therapeutic products (e.g. patches, gum, mist, inhalers, lozenges) already approved and regulated as cessation aids in Canada. The MLHU recommends that the nicotine concentration level for e-substances should not exceed 20 mg/ml. This level is in alignment with the European Union Tobacco Products Directive (20 mg/ml), which states that this concentration allows for delivery of nicotine that is comparable to a standard cigarette (Health Canada, 2019).

The MLHU applauds the finalization of Health Canada's *Vaping Products Labelling and Packaging Regulations* along with continued efforts to prevent youth vaping initiation. The MLHU looks forward to continuing to work in partnership to reduce the negative impact that tobacco and vaping product use is having on our community.

London Office
50 King St., London, ON N6A 5L7
tel: (519) 663-5317 • fax: (519) 663-9581

www.healthunit.com
health@mlhu.on.ca

Strathroy Office - Kenwick Mall
51 Front St. E., Strathroy ON N7G 1Y5
tel: (519) 245-3230 • fax: (519) 245-4772

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MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 012-20

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2020 February 27

MEDICAL OFFICER OF HEALTH / CEO ACTIVITY REPORT FOR FEBRUARY

Recommendation

It is recommended that the Board of Health receive Report No. 012-20 re: "Medical Officer of Health/CEO Activity Report for February" for information.

The following report presents activities of the Medical Officer of Health (MOH)/CEO for the period January 13–February 14, 2020.

January 13 Phone call with Loretta Ryan, Executive Director, Association of Local Public Health Agencies (alPHa), in regard to vaping correspondence

January 14 Interviewed by Reta Ismail, CTV News, about housing and drug use

January 15 Met with Helene Berman, Academic Director, Centre for Research on Health Equity and Social Inclusion, Western University
Monthly meeting preparation phone call with Board of Health Chair
Teleconference with Elizabeth Walker, Director, Accountability and Liaison Branch, Ministry of Health; Susy Faria, Manager, Indigenous and Intergovernmental Relations; and Ministry of Health and Health Unit staff members in regard to Indigenous engagement in Public Health Modernization consultations

January 16 Participated in the Public Health Modernization consultation with Jim Pine, Special Advisor for Public Health Modernization
Attended retirement celebration for Martin Hayward, London City Manager

January 20 Phone call with Brian Lester, Executive Director, Regional HIV/AIDS Connection, to discuss 446 York Street updates
Introductory meeting with Robert Parker, new Board of Health member

January 21 Met with Arielle Kayabaga, Board of Health member

January 22 Attended the Mayor of London's State of the City Address breakfast event
Met with Ian Peer, Board of Health member
Interviewed by Galen Simmons, *Stratford Beacon Herald*, regarding Peterborough Public Health's news release about their consultation document on Public Health Modernization

January 23 Teleconference to discuss the 2019 Novel Coronavirus. (The MOH participated several such meetings throughout the month and continues to be involved, internally and externally, as issues evolve.)
Attended the City of London Budget meeting at City Hall
Attended the Board of Health meeting

January 24 Participated in alPHa teleconference on Public Health Modernization

	Teleconference with organizers of the ImPaKT Summit re: technologies to assist in finding a cure for HIV and other infectious diseases
January 27	Met with Dr. Paul Roumeliotis to discuss COMOH modernization input Interviewed by AM980 Global News and 98.1 Free FM re: Coronavirus
January 28	Interviewed by CTV London, CBC London, and AM980 Global News in regard to Coronavirus, addressing community concerns, and the need for accurate information
January 29	Phone call with Dr. Brian Schwartz, Public Health Ontario, to discuss Coronavirus Phone call with Dr. Miriam Klassen, Medical Officer of Health, Huron Perth Public Health, in regard to Coronavirus Teleconference with alPHa Board members and Ministry representatives on Public Health Modernization Interviewed by XFM Radio in regard to Coronavirus Met with St. Joseph's Hospital staff to discuss who is making inpatient/outpatient decisions in regard to Coronavirus
January 30	Attended the Youth Opportunities Unlimited (YOU) Board meeting Met with John Fyfe-Miller, London entrepreneur, to discuss downtown issues Met with Mike Fisher, Director of Education, Thames Valley District School Board, to discuss supervised consumption
January 31	Co-presented a media announcement, in Toronto, about London's first Coronavirus case Phone call with Kate Young, MPP, London West, to discuss Coronavirus
February 3	Moderated panel discussion at the ImPaKT Summit: Our ImPaKT on Pathogens
February 4	Met with Linda Staudt, Director of Education, London and District Catholic School Board, to discuss supervised consumption
February 6	Attended the Youth Opportunities Unlimited annual breakfast event Attended the Finance & Facilities Committee meeting Shadowed Dr. Alex Summers at the PrEP Clinic, at 50 King Street
February 11	Joint call with Bruce Lauckner, Transitional Regional Lead (West and CEO of Erie St. Clair, South West, Hamilton Niagara Haldimand Brant, and Waterloo Wellington LHINs), Ontario Health, and Dr. Hsiu-Li Wang, Acting Medical Officer of Health, Region of Waterloo, to discuss Coronavirus
February 13	Attended the Finance & Facilities Committee meeting
February 14	Teleconference with COMOH Executive Committee
February 20	Participated in the launch of a ULab connected with the Presencing Institute of the Sloan School of Management at MIT on working toward the UN Sustainable Development Goals in London, Ontario (See Appendix A).

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

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health / CEO

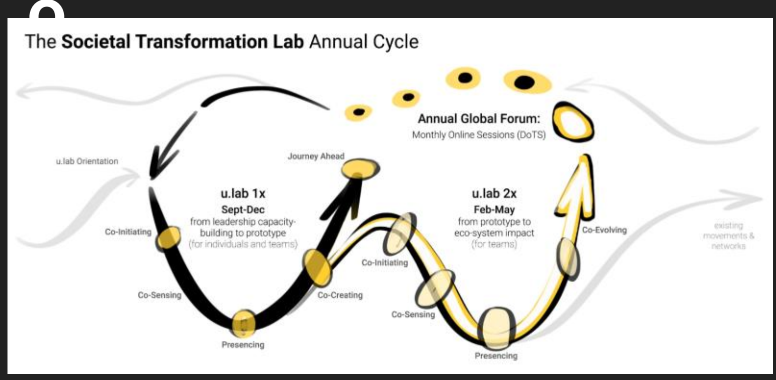
SUSTAINABLE DEVELOPMENT GOALS

Co-initiating

Luis Patricio

luis@povertyresearch.ca

linkedin.com/in/luispatricio



Member of the PI network

Biodiversity

Housing Affordability

Economic Justice

Renewable Energy

Education

Waste Reduction

Active Lifestyle

Inclusive Public Spaces

Social Innovation

Human Rights

Regenerative Agriculture

Mental & Physical Health

SDG Framework

- **Who is already using?**

SDG Framework

- Who is already using?
- **Who is familiar?**

SDG Framework

- Who is already using?
- Who is familiar?
- **Who knows just a little bit?**

1.
Global to Local

A United Nations movement

Global Goals

https://sustainabledevelopment.un.org/post2015/transformingourworld

Integration

Triple Bottom Line

Environmental-Social-Economic
Planet-People-Prosperity
Biosphere-Society-Economy

Interscalar

International
National
Sub-national

No one left behind

Who is not on the table?

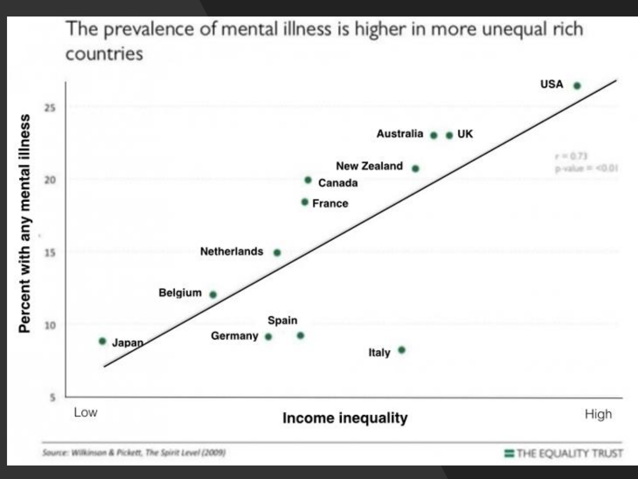
Cross-sector

Government
Private
Non-profit

Cross-sector

Triple bottom line

The Inner Level



https://www.goodreads.com/book/show/40163368-the-inner-level

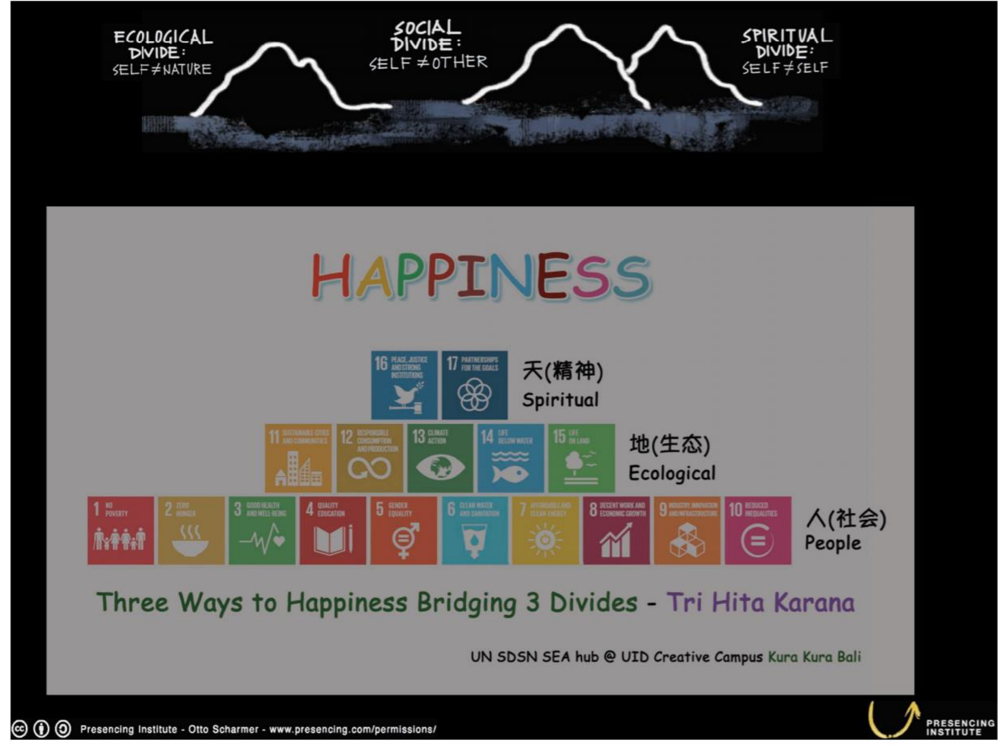
Power of Soil

https://medium.com/presencing-institute-blog/global-climate-action-I-the-power-of-soil-a951a3668b65

Interscalar

- International
  - UN
  - AIESEC
- National
  - Federal Funds
  - StatCan Data Hub
- Subnational
  - Network CFC, Universities

Global Goals



https://www.ottoscharmer.com/sites/default/files/TrigonSalzburg2018h.pdf

2.

Local to Global

SDGs in London, Ontario

69 out of 95
people

41
organizations

13
Local documents and reports

Who Am I?

- *City-wide target for London to achieve net zero GHG emissions...*
- *Prioritize and expedite, active transportation and transit infrastructure and services...*
- *Identify methods for advancing the urban forest strategy...*

“

Climate Emergency Action Plan

- *City-wide target for London to achieve net zero GHG emissions...*
- *Prioritize and expedite, active transportation and transit infrastructure and services...*
- *Identify methods for advancing the urban forest strategy...*

”

Who Am I?

- *A city for entrepreneurs*
- *A supportive business environment*
- *A vibrant urban environment*
- *A top quality workforce*
- *A national Centre of Excellence for medical innovation*

...grow the economy and make our city a better place to live and work.

Community Economic Roadmap

- *A city for entrepreneurs*
- *A supportive business environment*
- *A vibrant urban environment*
- *A top quality workforce*
- *A national Centre of Excellence for medical innovation*

...grow the economy and make our city a better place to live and work.

Who Am I?

Reach its full potential by ending poverty in one generation.

London For All

Reach its full potential by ending poverty in one generation.

Who Am I?

work together to achieve sustainable communities where everyone feels ***safe****, has a sense of* ***belonging****, opportunities to* ***participate****, and where individuals and families are able to meet their needs for education,* ***health care****, food,* ***housing****,* ***income****, and social and cultural expression.*

"*work together to achieve sustainable communities where everyone feels **safe**, has a sense of **belonging**, opportunities to **participate**, and where individuals and families are able to meet their needs for education, **health care**, food, **housing**, **income**, and social and cultural expression.*"

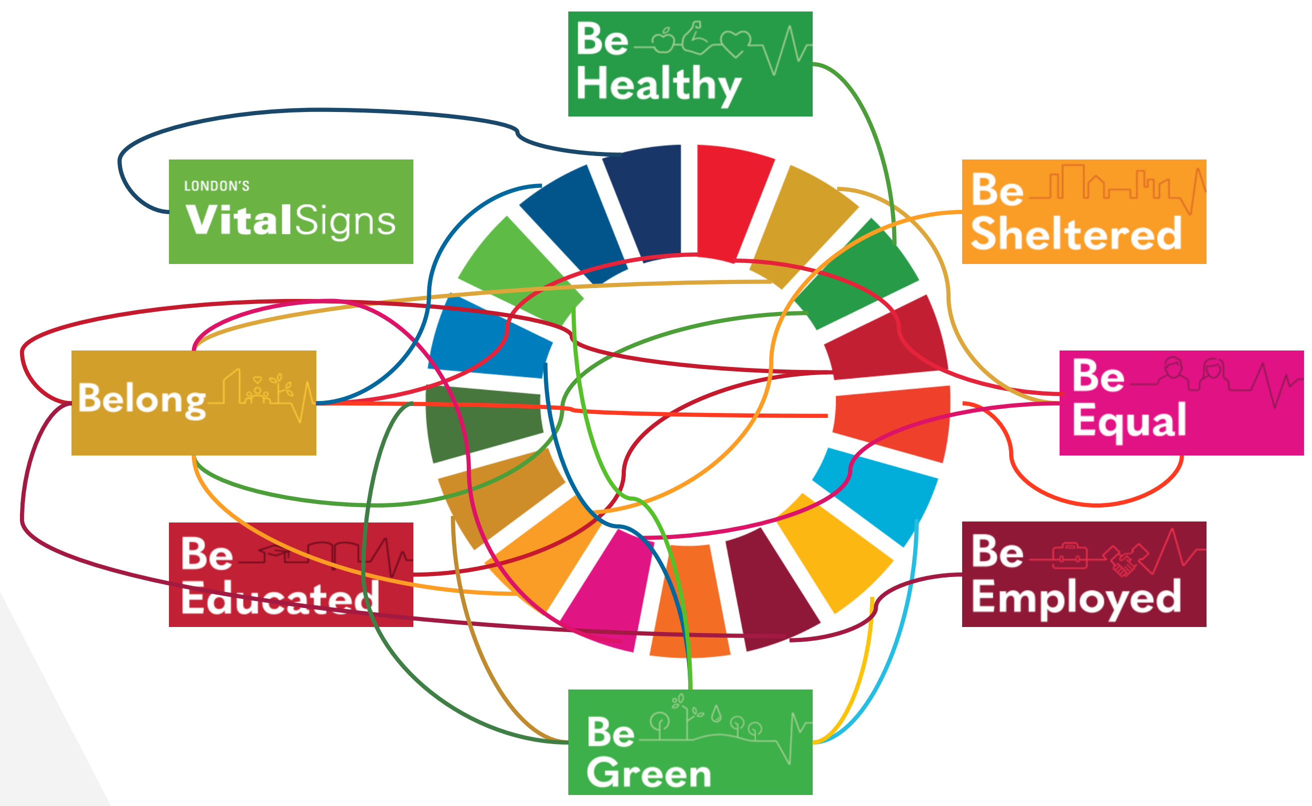
Who Am I?

*a complex issue with **no single solution** that any one organization or sector can provide. Strengthened coordination, new solutions, and a **long-term focus** is needed to impact meaningful change. As a community, we must also do more to build opportunities for community connectedness and **inclusion for all** citizens...*

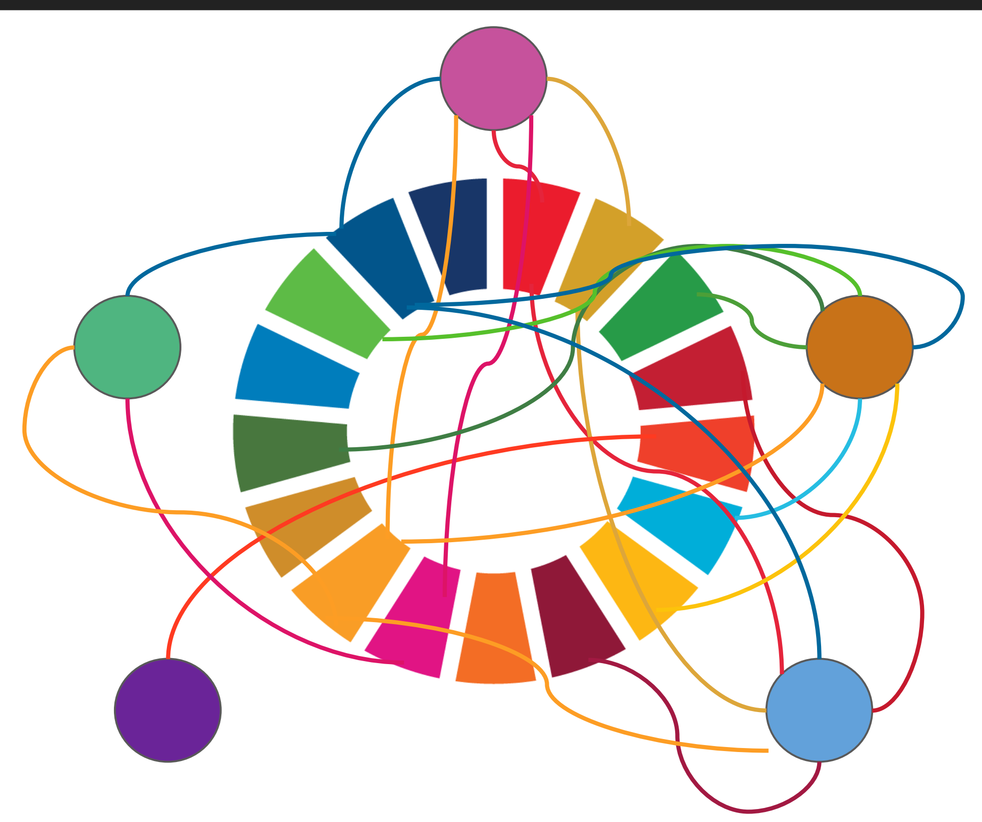
SDGs and London For All

*a complex issue with **no single solution** that any one organization or sector can provide. Strengthened coordination, new solutions, and a **long-term focus** is needed to impact meaningful change. As a community, we must also do more to build opportunities for community connectedness and **inclusion for all** citizens...*

SDGs and London Vital Signs



SDGs and London Strategic Plan 2020-23



Housing Affordability

Proportion of households who are spending more than 30% of income on housing (rent/mortgage, utilities, insurance, property tax) by Renters vs owners, family status, and number of children.

Absolute Energy Use

Total amount of energy used by sector and source.

Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease.

Mode Share

Percentage of urban trips by mode (car driver, car passenger, public transit, biking and walking).

Living Wage

Percentage of individuals who work full time whose annual before tax employment income is over $29,484. calculation based on $16.20 hourly wage working 35 hours/week 52 weeks per year.

Relevant local issues

LGBTQ2+

Gender needs to be addressed beyond binary (male/female).

Urban Agriculture

Agricultural practices within urban areas are present and relevant.

Cycling

Urban cycling has a positive impact in at least eleven of the seventeen goals.

Wealth Inequality

Measure the distribution of wealth and non-monetary transactions including any form of unpaid work or leisure and environmental impact

Finite Resources

Growth needs to tak into account that today, humanity uses the equivalent of 1.75 Earths to provide the resources we use and absorb our waste.

Reconciliation

In Canada, reconciliation is a significant issue in many communities and in all levels of government.

Local Sustainable Development Goals

Localizing the SDG indicators

London Poverty Research Centre

What is your SDG?

TIME TO GO FOR A WALK!

- As a child how did you feel about the issues the SDG’s cover?

- In your life and work now, how do you relate to the issues of the SDG’s today?

HEALTH IN THE SDG ERA
3 GOOD HEALTH AND WELL-BEING
ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES
1 NO POVERTY
PRIORITIZING THE HEALTH NEEDS OF THE POOR
2 ZERO HUNGER
ADDRESSING THE CAUSES AND CONSEQUENCES OF ALL FORMS OF MALNUTRITION
4 QUALITY EDUCATION
SUPPORTING HIGH-QUALITY EDUCATION FOR ALL TO IMPROVE HEALTH AND HEALTH EQUITY
5 GENDER EQUALITY
FIGHTING GENDER INEQUITIES, INCLUDING VIOLENCE AGAINST WOMEN
6 CLEAN WATER AND SANITATION
PREVENTING DISEASE THROUGH SAFE WATER AND SANITATION FOR ALL
7 AFFORDABLE AND CLEAN ENERGY
PROMOTING SUSTAINABLE ENERGY FOR HEALTHY HOMES AND LIVES
8 DECENT WORK AND ECONOMIC GROWTH
PROMOTING HEALTH EMPLOYMENT AS A DRIVER OF INCLUSIVE ECONOMIC GROWTH
9 INDUSTRY, INNOVATION AND INFRASTRUCTURE
PROMOTING NATIONAL R&D CAPACITY AND MANUFACTURING OF AFFORDABLE ESSENTIAL MEDICAL PRODUCTS
10 REDUCED INEQUALITIES
ENSURING EQUITABLE ACCESS TO HEALTH SERVICES THROUGH UNIVERSAL HEALTH COVERAGE BASED ON STRONGER PRIMARY CARE
11 SUSTAINABLE CITIES AND COMMUNITIES
FOSTERING HEALTHIER CITIES THROUGH URBAN PLANNING FOR CLEANER AIR AND SAFER AND MORE ACTIVE LIVING
12 RESPONSIBLE CONSUMPTION AND PRODUCTION
PROMOTING RESPONSIBLE CONSUMPTION OF MEDICINES TO COMBAT ANTIBIOTIC RESISTANCE
13 CLIMATE ACTION
PROTECTING HEALTH FROM CLIMATE RISKS, AND PROMOTING HEALTH THROUGH LOW-CARBON DEVELOPMENT
14 LIFE BELOW WATER
SUPPORTING THE RESTORATION OF FISH STOCKS TO IMPROVE SAFE AND DIVERSIFIED HEALTHY DIETS
15 LIFE ON LAND
PROMOTING HEALTH AND PREVENTING DISEASE THROUGH HEALTHY NATURAL ENVIRONMENTS
16 PEACE AND JUSTICE
EMPOWERING STRONG LOCAL INSTITUTIONS TO DEVELOP, IMPLEMENT, MONITOR AND ACCOUNT FOR AMBITIOUS NATIONAL SDG RESPONSES
17 PARTNERSHIPS FOR THE GOALS
MOBILIZING PARTNERS TO MONITOR AND ATTAIN THE HEALTH-RELATED SDGs
World Health Organization
WWW.WHO.INT/SDGS
SUSTAINABLE DEVELOPMENT GOALS

CORRESPONDENCE – February 2020

a) Date: 2020 January 17
   Topic: "Modernization of Public Health in Ontario, A Position Paper: Recommendations from the Board of Health for Peterborough Public Health"
   From: Peterborough Public Health
   To: All Health Units

   Background:

   On January 17, 2020, the Board of Health for Peterborough Public Health released its position paper, "Modernization of Public Health in Ontario."

   Recommendation: Receive.

b) Date: 2020 January 17
   Topic: Public Health Modernization Consultation
   From: Southwestern Public Health
   To: All Health Units

   Background:

   On January 17, 2020, the Board of Health for Southwestern Public Health released its consultation paper on Public Health Modernization.

   Recommendation: Receive.

c) Date: 2020 January 21
   Topic: alPHa Speaking Points, Standing Committee on Finance and Economic Affairs
   From: Association of Local Public Health Agencies (alPHa)
   To: All Health Units

   Background:

   On January 17, 2020 the Standing Committee on Finance and Economic Affairs for the Association of Local Public Health Agencies (alPHa) met to discuss the 2020 Ontario budget. Highlights from the funding announcements made over the course of the past year are summarized in alPHa's speaking notes from this meeting.

   Recommendation: Receive.

d) Date: 2020 January 20
   Topic: Deputy Premier and Minister Christine Elliott's speech at the 2020 Rural Ontario Municipal Association's annual conference
   From: Association of Local Public Health Agencies (alPHa)
   To: All Health Units

   Background:

On January 20, 2020, the Association of Local Public Health Agencies (alPHa) published a link to Minister Elliott's speech at the 2020 Rural Ontario Municipal Association's (ROMA) annual conference, which includes comments on the current Public Health Modernization process.

Recommendation: Receive.

e) Date: 2020 January 20
Topic: 2020 alPHa annual general meeting and conference, June 7–9
From: Association of Local Public Health Agencies (alPHa)
To: alPHa members

Background:

On January 20, 2020, the Association of Local Public Health Agencies (alPHa) announced that it will hold its annual general meeting and conference this June 7–9 at the Chestnut Conference Centre, in Toronto.

Recommendation: Receive.

f) Date: 2020 January 22
Topic: alPHa Information Break – January 22, 2020
From: Association of Local Public Health Agencies (alPHa)
To: All Health Units

Background:

On January 22, 2020, the Association of Local Public Health Agencies (alPHa) provided updates related to Public Health Modernization and confirmed that alPHa's submission to the provincial discussion paper will be circulated when it becomes available. It was also announced that registration is now open for the Winter 2020 Symposium and Section Meetings to be held February 20–21 at the YMCA in downtown Toronto. The Council of Medical Officers of Health (COMOH) Digital Health Steering Committee announced that it is preparing a response to the Ministry's consultation on Public Health Modernization.

Recommendation: Receive.

g) Date: 2020 January 22 (received January 28)
Topic: E-cigarette and aerosolized product prevention and cessation
From: Peterborough Public Health
To: The Honourable Christine Elliott, All Health Units

Background:

On January 22, 2020, the Board of Health for Peterborough Public Health wrote to Minister Elliott in support of the correspondence received from Public Health Sudbury & Districts regarding e-cigarette and aerosolized product prevention and cessation. Refer to correspondence item d) in the January 23, 2020 Board of Health agenda.

Recommendation: Receive.

h) Date: 2020 January 17 (received January 28)
Topic: Children Count Pilot Study Project
From: Windsor-Essex County Health Unit
To: The Honourable Christine Elliott, All Health Units

Background:

On January 17, 2020, the Board of Health for the Windsor-Essex County Health Unit wrote to Minister Elliott regarding the resolution to endorse the Healthy Living Module of the Children Count Pilot Study Project as a feasible approach to resolve the issue of local, regional, and provincial population health data gaps for children and youth. The Healthy Living Module is a toolkit that was developed to help implement coordinated monitoring and assessment for health service planning using the School Climate Survey for Ontario children and youth. The Healthy Living Module helped to identify areas requiring further work to support student health and well-being. The Board of Health for the Windsor-Essex County Health Unit encourages the Ministry of Health and the Ministry of Education to adopt the Healthy Living Module as part of the Ontario Public Health Standards and the Ontario Climate Survey.

Recommendation: Receive.

i) Date: 2020 January 17 (received January 28)
Topic: Healthy Smiles Ontario funding
From: Windsor-Essex County Health Unit
To: The Honourable Christine Elliott, All Health Units

Background:

On January 17, 2020, the Board of Health for the Windsor-Essex County Health Unit wrote to Minister Elliott regarding the resolution to endorse the recommendation that Healthy Smiles Ontario retain its current (100%) funding and structure, and that it be merged with the Ontario Senior Dental Care Program to create a comprehensive dental care program for vulnerable children and seniors in Ontario.

Recommendation: Receive.

j) Date: 2020 January 28
Topic: Monitoring of food insecurity and food affordability
From: KFL&A Public Health
To: The Honourable Patti Hajdu

Background:

On January 28, 2020, the Board of Health for KFL&A Public Health wrote to Minister Hajdu recommending that the federal government commit to annual local measurement of food insecurity in all provinces and territories by making the Household Food Security Survey Module a core component of the Canadian Community Health Survey. Making this a mandatory module would

facilitate effective and consistent food affordability surveillance and monitoring. Furthermore, it was recommended that foods included in the National Nutritious Food Basket be updated to reflect the 2019 *Canada's Food Guide* recommendations, and that a national protocol be developed to ensure consistency in monitoring food costing across Canada.

Recommendation: Receive.

k) Date: 2020 January 29
Topic: Off-road vehicles and Bills 107 and 132
From: Peterborough Public Health
To: The Honourable Christine Elliott, The Honourable Caroline Mulroney

Background:

On January 29, 2020, the Board of Health for Peterborough Public Health wrote to Ministers Elliott and Mulroney expressing concerns regarding anticipated changes to Ontario Regulation 316/03: Operation of Off-Road Vehicles on Highways. It is recommended that, in the revision of O. Reg 316/03, equipment and operations requirements be made applicable to all off-road vehicles permitted on roads as per Bill 107, Getting Ontario Moving Act (Transportation Statute Law Amendment), 2019.

Recommendation: Receive.

l) Date: 2020 February 4
Topic: Public Health Modernization Discussion Paper
From: Association of Local Public Health Agencies (alPHa)
To: All Health Units

Background:

On February 4, 2020, the Association of Local Public Health Agencies (alPHa) published a response to the Public Health Modernization Discussion Paper. alPHa's response is intended to be complementary to the individual responses of its members. Feedback was synthesized and presented with the framework of themes and questions laid out in the consultation survey. The Statement of Principles for Public Health Modernization released by alPHa in November 2019 formed the foundation of the response to the Discussion Paper.

Recommendation: Receive.

m) Date: 2020 February 4
Topic: Fully funded Universal Healthy School Food Program
From: Public Health Sudbury & Districts
To: The Honourable Patti Hajdu, The Honourable Christine Elliott

Background:

On January 31, 2020, the Board of Health for Public Health Sudbury & Districts wrote to Minister Hadju in support of a fully funded Universal Healthy School Food Program in Canada and calling

upon the federal and provincial governments to ensure it is aligned with Canada's Dietary Guidelines.

Recommendation: Receive.

n) Date: 2020 February 3
Topic: alPHa Information Break
From: Association of Local Public Health Agencies (alPHa)
To: All Health Units

Background:

On February 3, 2020, the Association of Local Public Health Agencies (alPHa) provided updates related to Public Health Modernization, Novel Coronavirus, alPHa's Winter 2020 Symposium and Section Meetings, and the upcoming TOPHC 2020.

Recommendation: Receive.

o) Date: 2020 February 13
Topic: Association of Municipalities of Ontario response to Public Health and Emergency Health Services consultation and notification of ongoing cannabis consultations
From: Association of Local Public Health Agencies (alPHa), Association of Municipalities of Ontario (AMO)
To: All Health Units

Background:

On February 13, 2020, the Association of Local Public Health Agencies (alPHa) notified its members of the release of the Association of Municipalities of Ontario (AMO) response to the Public Health and Emergency Health Services consultation, and provided notification of the cannabis consultations currently underway.

Recommendation: Receive.

p) Date: 2020 January 22
Topic: Nicotine vaping in Canada
From: Public Health Agency of Canada, Council of Chief Medical Officers of Health (CCMOH)
To: All Health Units

Background:

On January 22, 2020, the Public Health Agency of Canada and the Council of Chief Medical Officers of Health (CCMOH) issued a statement regarding nicotine vaping devices, highlighting their concern with the substantial increase in nicotine vaping among youth. The statement outlines key recommendations and policy and regulatory actions for federal, provincial, and municipal jurisdictions. CCMOH also recommends that governments continue to enhance public awareness, establish cessation initiatives, and monitor the health effects of vaping products. To read the full statement, visit the Public Health Agency of Canada website.

Recommendation: Receive.

q) Date: 2020 February 14
Topic: alPHa resolution: sufficient local public health funding
From: Simcoe Muskoka District Health Unit
To: Dr. Chris Mackie, Medical Officer of Health/CEO, MLHU

Background:

On February 14, 2020, the Simcoe Muskoka District Health Unit forwarded a briefing note and advocacy resolution to Dr. Chris Mackie for consideration by the Middlesex-London Board of Health. This advocacy resolution aims to address stable public health funding and will be submitted to the Association of Local Public Health Agencies (alPHa) for discussion at its annual general meeting in June. The resolution calls for 2020 mitigation funding to continue into future years; for the reduction in provincial funding, to 70%, to be reconsidered; and for provincial grants in future years to allow board of health budgets to increase sufficiently to maintain their resource bases, and to address pressures related to population growth and emerging public health issues.

Recommendation: Endorse, and offer via the Chair to second the resolution at the alPHa AGM in June.

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until January 21, 2020

The Modernization of Public Health in Ontario

A Position Paper:
Recommendations from the Board of Health for Peterborough Public Health

Serving the residents of **Curve Lake** and **Hiawatha First Nations**, and the **County** and **City of Peterborough**

January 8, 2020

Executive Summary

Ontario's public health system delivers value for money, and helps to ensure Ontarians are fully able to contribute to a prosperous, sustainable and healthy future. Investments in public health are vital to maximizing prevention efforts in order to protect the Province and reduce demands for downstream health care services. Public health recognizes that it plays an important role in reducing hallway health care.

Peterborough Public Health (PPH) does not support the changes to the Ontario public health system put forward by the Provincial Government as part of its April 2019 budget. Although modifications to the system designed to make it more effective should be considered, the proposals of the Provincial Government were overly broad and did not target key areas for reform. If adopted, their impact would have significantly and irrevocably damaged the governance and delivery of public health services in the province. They were akin to using a sledgehammer to crack open a peanut. Public health in Peterborough is not broken – with the exception of issues related to capacity and funding, our communities benefit from services that are responsive, timely and effective.

PPH has worked hard to inform the Province and other stakeholders about its concerns including:

- Responding to local media in order to inform the public and local stakeholders on the potential negative impacts
- Making written submissions to the Minister and Ministry
- Engaging local government MPPs in discussion with the board and local political leaders
- Developing and presenting an emergency resolution to the Annual General Meeting of the Association of Local Public Health Agencies (alPHa)
- Engaging in discussions with neighbouring boards of health
- Engaging in the Eastern Ontario Wardens Caucus resolution
- Engaging in the formal Provincial consultation
- Completing the Ministry survey on public health modernization
- Engaging decision makers at both the Association of Municipalities of Ontario (AMO) and Rural Ontario Municipal Association (ROMA) conferences

We applaud the Provincial Government for seeking public input before proceeding with any structural changes however PPH continues to express concern that the Government is continuing with its plan to transfer $180 million of public health costs unto the local tax base, although at a slower pace than originally announced.

Principles of Reform

PPH believes that public health in Ontario must be shaped and delivered at the local level and that any proposed changes to public health governance and delivery need to be consistent with the following principles:

1. The enhancement of health promotion and disease prevention must be the primary priority of any changes undertaken;
2. Investments in public health must be recognized as a critical strategy in reducing the need for hallway health care;

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3. Any consolidation of public health units should reflect a community of interests which include distinguishing between rural and urban challenges and facilitates the meaningful participation of First Nations;
4. Adequate provincial funding is necessary to ensure effective health promotion and prevention activities in Ontario. Funding should be predictable and consider factors such as equity, population demographics and density, rural/urban mix and increase to meet new demands;
5. Local funding needs to consider a municipality's ability to pay in the context of the broad range of changes in funding arrangements between the Province and municipalities;
6. As public health is a joint municipal-provincial venture, its governance structure must provide accountability to the local councils that are required to fund local public health agencies;
7. Changes undertaken need to be evidenced based and not ideologically driven; and,
8. Change must be driven from the bottom up, in a process that respects both Provincial and local interests and facilitates genuine collaboration. Change management impact must be acknowledged in this process.

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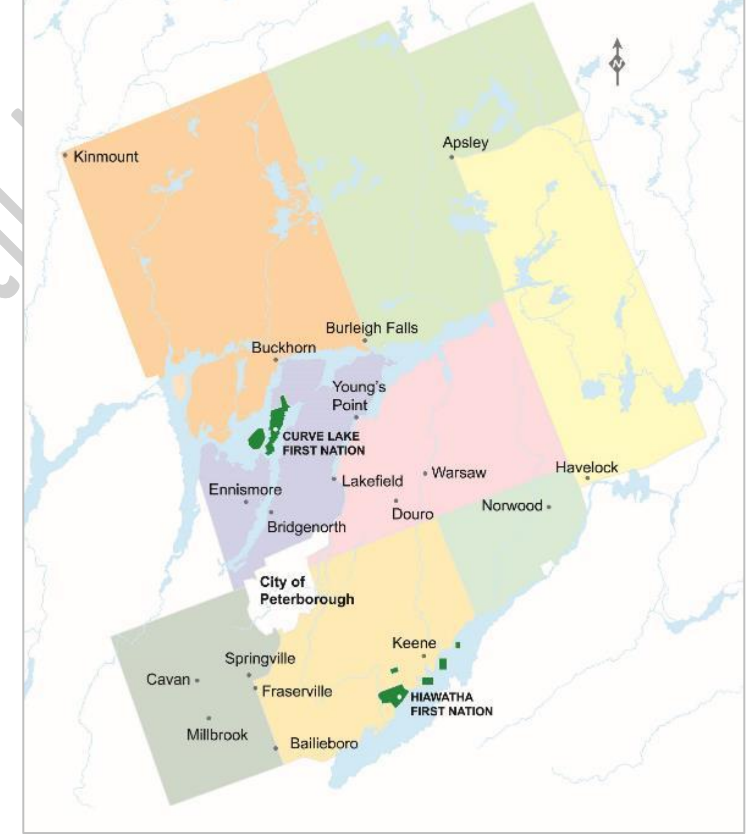
Recommendations

In addressing the reform of public Health in Ontario, PPH has developed a series of recommendations in **three** broad thematic areas consistent with the principles noted above:



1. Structure and Governance

1.1. Negotiate boundaries for a local public health agency (LPHA) with an optimal size of 300,000 to 500,000[1] that reflects a community of interests and recognizes the rights and interests of First Nations.
1.2. Structure negotiations in a manner that respects local concerns and is responsive to local priorities.
1.3. Mandate municipal board representation and accountability that reflects municipal fiscal contributions.
1.4. Consider the establishment of regional structures to assist local boards in the delivery of programming and cost containment (i.e., back office integration, mutual aid agreements, issue-specific expertise).
1.5. Enhance Public Health Ontario's (PHO) coordination role as it relates to knowledge and technical support; central analytics; evidence generation; and, performance measurement.

[1] Mays et al. Institutional and Economic Determinants of Public Health System Performance. Amer J Pub Health2006;96;3;523-531.

2. Program Delivery

2.1. Ensure health promotion and prevention programming is designed to reduce future health care use and costs.
2.2. Ensure stable and predictable provincial funding is provided that reflects demographic, equity and other local conditions, responsive to increased or emerging demands.
2.3. Ensure local financial contributions are reflective of municipalities' abilities to pay.
2.4. The Province should provide LPHAs with training and human resource support to ensure frontline staff have core competencies consistent with provincial standards.
2.5. The local delivery of public health programming should include:
- Community engagement in design and delivery;
- Nurturing of local relationships with delivery partners;
- Supporting local decision makers with healthy public policy;
- Program delivery which encompasses consistent local staffing;
- Promotion of provincial policy development based on local needs and issues;
- Delivery of health promotion campaigns that reflect local conditions and are built on local strategies;
- Ensuring the social determinants of health are a lens through which local policies are developed; and,
- Undertaking local applied research that is disseminated at a provincial level for the benefit of all LPHAs.

3. Implementation

3.1. Provide sufficient time to implement any proposed changes.
3.2. Build on best practices learned from past amalgamations.
3.3. Ensure sufficient provincial financial support is available to meet one-time implementation costs.
3.4. Implement changes using an integrated and comprehensive approach.

Ontario experienced a prolonged drought for public health that was brought to light with the tragedies of both SARS and Walkerton. We hope that important lessons have been learned and that the neglect that occurred in the past will not be repeated. In order to do that, boards of health need to know that the Province is committed to investing in public health in order to protect its citizens and keep our communities open for business.

Peterborough Public Health provides catch up vaccinations for new Canadians, including this boy originally from Syria.

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Introduction

Peterborough's board of health believes public health must be shaped and delivered at the local level. We were encouraged by the current Provincial Government's recognition that this is a strength of our system, and one which we want to build upon. Coupled with a well-designed provincial and regional framework, we can work together to achieve the strategic alignment and efficiencies desired from a public health system.

Any restructuring, including the potential for amalgamations, deserves thoughtful consideration to ensure clear value-added outcomes, limited potential for disruption or paralysis, and minimal risk of unintended consequences.

PPH endorses the following principles and recommends that they be used as a tool to ensure that the best interests of our communities are served well by any changes to our province's local public health system:

1. The enhancement of health promotion and disease prevention must be the primary priority of any changes undertaken;
2. Investments in public health must be recognized as a critical strategy in reducing the need for hallway health care;
3. Any consolidation of public health units should reflect a community of interests which include distinguishing between rural and urban challenges and facilitates the meaningful participation of First Nations;
4. Adequate provincial funding is necessary to ensure effective health promotion and prevention activities in Ontario. Funding should be predictable and consider factors such as equity, population demographics and density, rural/urban mix and increase to meet new demands;
5. Local funding needs to consider a municipality's ability to pay in the context of the broad range of changes in funding arrangements between the Province and municipalities;
6. As public health is a joint municipal-provincial venture, its governance structure must provide accountability to the local councils that are required to fund local public health agencies;
7. Changes undertaken need to be evidenced based and not ideologically driven, and,
8. Change must be driven from the bottom up, in a process that respects both provincial and local interests and facilitates genuine collaboration. Change management impact must be acknowledged in this process.

Many of these principles have been echoed elsewhere in other tables and forums that have emerged in response to the 2019 announcements. It is of utmost importance that the goal of this restructuring be the improvement of population health through enhanced protection and promotion of population health and health equity.

Furthermore, "obligated municipalities", whether municipal or First Nation (Section 50, Health Protection and Promotion Act (HPPA)), must be engaged in a meaningful way in decision-making to ensure public health remains responsive and accountable to the local communities it serves. This means that autonomous boards must continue to contain a majority of municipal representatives. It also means the structure and delivery of services and programs must meet the needs of the communities served. Any new organizational structure should build on the strong collaborative relationships currently existing between the current LPHAs and delivery partners including municipalities. Where there is common interest and benefit at the provincial or regional level, it makes sense to organize and deliver work at these levels. Any new regions established for

this purpose should therefore reflect similar demographics, history and culture, and be flexible enough to enhance planning, priority-setting and delivery in an efficient and effective manner, without adding another layer of bureaucracy.

The funding model/formula for local public health must be sustainable and take into account factors such as equity, population demographics and density, and the rural-urban mix. Any efficiencies identified should be optimized without sacrificing the quality and effectiveness of services provided. And it goes without saying that the best available evidence should be considered as part of policy decision making.

Acknowledging the key challenges raised through the discussion document on Public Health Modernization and this opportunity to improve the impact on the wellbeing of Ontarians through strategic changes to the formal public health system and delivery models, and with consideration of the principles listed above, we respectfully submit the following key recommendations in three key areas.

January 21, 2020

Peterborough Public Health has a proud 130-year history of improving the health of our communities.

Section 1: Structure and Governance

As a smaller LPHA, PPH has experienced the challenges and vulnerability of limited capacity. We therefore support expanded boundaries for LPHAs where they are strategic. In consideration of the evidence for effectiveness of LPHAs that serve a population size of 300,000 – 500,000 (Mays et al., 2006), PPH would benefit from a larger area composed of neighbouring municipalities and First Nations, where interested. However, increasing the size of a health unit needs to be carefully balanced with the need to ensure strong local accountability and representation for participating municipalities and First Nations. Amalgamations should be negotiated, and be based on existing collaborative efforts and alignment with other key sectors.

PPH has worked diligently to develop and nurture strong relationships with our partners - both municipal governments and local organizations. Local governments value public health as a key partner and contact. Extreme caution must be applied if any restructuring of local boards is pursued. Such action could seriously handicap the ability of a new board to positively influence the social determinants of health at the local level. These strong credible relationships take years to establish. We are very proud to be a valued partner within the population we serve.

In addition to strategic amalgamations, further coordination can be achieved through a regional and provincial approach that supports and incentivizes collaboration where appropriate. LPHAs could come together to plan at a regional level, establish mutual aid agreements and develop back office integration. These could create opportunities to share expertise across the region. As an example, the LPHAs currently included in the Eastern Ontario Warden's Caucus and Eastern Ontario Mayor's Caucus could work together through established municipal partnerships and public health leadership to strengthen coordination without necessarily adding another layer that requires additional staffing and funding.

But for any modernization effort to work, there is a need to strengthen provincial leadership for public health.

until January 21, 2020

Increasing the size of a health unit needs to be carefully balanced with the need to ensure strong local accountability and representation of municipalities and First Nations.

This will require stronger collaboration between the Ministry of Health, other Ministries, sector partners and provincial associations and PHO. The establishment of leadership tables and themed work groups can ensure relevant voices can contribute to establishing provincial priorities and plans. PHO should continue its role as advisor and support to all three levels of public health planning: provincial, regional and local; and should be given an expanded role in data collection and analysis, training and research. Data systems need to be adequately resourced to produce information that can be applied at the provincial, regional and local level and support setting and monitoring of targets.

When all three levels of program planning and delivery are functioning optimally, there will be added value and improved outcomes. This requires a bottom up and top down approach, bringing together frontline knowledge and central expertise to develop solutions.

We have 5 recommendations to make regarding potential changes to the structure of public health that would address this vision:

1.1. Negotiate boundaries for a local public health agency with an optimal size of 300,000 to 500,000 (Mays et al., 2006) that reflects a community of interests and recognizes the rights and interests of First Nations.
1.2. Structure negotiations in a manner that respects local concerns and is responsive to local priorities.
1.3. Mandate municipal board representation and accountability that reflects municipal fiscal contributions.
1.4. Consider the establishment of regional structures to assist local boards in the delivery of programming and cost containment (i.e., back office integration, mutual aid agreements, issue-specific expertise).
1.5. Enhance Public Health Ontario's (PHO) coordination role as it relates to knowledge and technical support; central analytics; evidence generation; and, performance measurement.

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Improving food systems to address food security is an example of public health work that requires coordination and support from multiple provincial ministries and local partners.

Section 2: Program Delivery

Public health is an investment that prevents future costs and contributes to creating a healthy and productive population. The formal public health system does much more than deliver services. Through strong partnerships at all levels, public health builds community capacity and influences health outcomes through built environment and policy changes. To achieve optimal efficiency and effectiveness, resources need to be invested wisely with actions taken at the appropriate level (provincial – regional – local) and support systems and evidence-based resources must be readily available.

As planning at the provincial, regional and local levels occur, through the system noted above, areas of work such as communications, technology, staff development, continuous quality improvement, knowledge translation and risk management can be optimised through improved alignment with the avoidance of duplication of effort. In addition to the provincial and regional planning tables, ongoing support for existing and potential communities of practice, constituent groups and provincial task groups will create a stronger and more coordinated local system.

Provincially-developed communication campaigns and tools can significantly reduce duplication. These need to be developed with local input and local adaptability with recognition that target audiences and media vehicles vary significantly from community to community. There are, however, significant opportunities with tools such as a common evidence-based website, provincial and regional market research and polling data, and common branding. Common technology platforms provide an opportunity for reduced duplication as well as the improved ability to share and compare data across the system.

To deliver high quality programs, staff at each LPHA must have the appropriate competencies. Organizational leaders (including governors), frontline and back office staff must have core public health competencies and specialized knowledge and skills to meet the provincial standards and requirements. Standards for staffing of

Embargoed Until January 21, 2020

Teaching food skills in PPH's Community Kitchen supports better nutrition for families, preventing hallway health care.

LPHAs should be established with consideration for balancing the benefits of specific disciplines, the core competencies required and adequate flexibility at the local level to their own context.

Ongoing support to maintain and further develop competencies should be supported at the provincial and regional level. Existing provincial agencies (including but not limited to PHO) should be leveraged to respond to priorities and needs. These agencies can also act as resource leads for key areas to support the broader public health system.

Provincial priority setting will enhance alignment and focus at all levels of implementation. This should not, however, supersede the Ontario Public Health Standards and expectations for local flexibility. The Annual Service Plan process should be used to set expectations for provincial priorities and ensure a minimum level of service across all areas of the public health mandate.

Healthy Smiles Ontario provides dental care to low-income children. It used to be 100% funded by the Province, and is now part of the 70-30 provincial-municipal cost-shared budget.

Relationships with Indigenous communities should be retained as a core requirement, with recognition that knowledge keepers within these communities have a great deal to teach us and that relationships are built on trust, self-determination and that each community is unique.

We make 5 recommendations to improve the delivery of services:

2.1 Ensure health promotion and prevention programming is designed to reduce future health care use and costs.
2.2 Ensure stable and predictable provincial funding is provided that reflects demographic, equity and other local conditions, responsive to increased or emerging demands.
2.3 Ensure local financial contributions are reflective of municipalities' abilities to pay.
2.4 The Province should provide LPHAs with training and human resource support to ensure frontline staff have core competencies consistent with provincial standards.
2.5 The local delivery of public health programming should include:
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- Ensuring the social determinants of health are a lens through which local policies are developed; and,
- Undertaking local applied research that is disseminated at a provincial level for the benefit of all LPHAs.

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Section 3: Implementation

The process for implementation of the recommended changes to system and delivery models is equally important to success. Change management principles should be applied with the appropriate support and time to implement. Changes to health unit boundaries and formation of new organizations and regions requires financial support and will benefit from the learnings of past experiences within public health and beyond. Advice and best practices should inform timelines and keys to success.

The resulting system of local public health agencies, regional groupings and strengthened provincial coordination and support systems will require adequate resources to achieve expected outcomes. At the local level, a cost-shared model for public health continues to be accepted as the most appropriate model. There must be recognition, however, of the limited capacity the varied obligated municipalities have to fund beyond existing levels. This varied ability to pay has historically and could continue to create a disparity in service levels across the province. A funding formula needs to be created that will ensure a sustainable delivery of public health service without undue pressure on obligated municipalities.

PPH's 50-year+ partnership with Curve Lake First Nation is an important asset moving forward in modernizing public health.

PPH benefits from a partnership with Curve Lake and Hiawatha First Nations that goes back over 50 years and predates the current HPPA Section 50 language. Modernization of public health presents an opportunity to strengthen First Nation engagement and the process of reconciliation. This requires the active participation and leadership of First Nation communities, as well as that of the federal government.

PPH has 4 recommendations to offer on implementation:

3.1. Provide sufficient time to implement any proposed changes.
3.2. Build on best practices learned from past amalgamations.
3.3. Ensure sufficient provincial financial support is available to meet one-time implementation costs.
3.4. Implement changes using an integrated and comprehensive approach.

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Conclusion

As an autonomous board, Peterborough currently has strong relations with both funders and stakeholders. The board has had representation from Curve Lake First Nation (CLFN) and Hiawatha First Nation (HFN) since 1968. We wish to retain our "autonomous", or independent, board structure with meaningful representation from all three categories of funding partners: municipal, Indigenous and provincial.

We do not believe a one-size-fits-all approach to board governance is necessary, or even recommended, for the maximization of local public health benefits. For example, on the topic of the built environment, which is a powerful determinant of illness and health, some of the most ground-breaking work in Ontario has been done by health departments that are integrated into regional councils. We see the variability in governance models as a strength that can benefit us all. As long as provincial requirements for governance are clearly articulated and diligently met, the sector can be stronger.

The 2017 Auditor General's report called for a provincial strategy to reduce and prevent chronic disease.

By amalgamating smaller public health units like PPH to achieve a minimum target population of between 300,000 and 500,000 (Mays et al., 2006), which is supported by evidence, all local boards of health should have the capacity required to ensure consistent and uninterrupted provision of service. Amalgamating with neighbouring boards to achieve a population of this size would represent a doubling of our current capacity and staff size. We caution that any amalgamated health units not become so large as to compromise access, efficiency, representative governance and the possibility of a shared logical cohesive identity for participating municipalities and First Nations.

Peterborough has benefited from the contributions of PHO and we wish to see these continue and grow, both provincially, as well as in the field. As our technical and scientific arm, having PHO advise and assist all levels of a modernized public health system makes sense.

The Ministry, PHO and other public health leaders in the province have the potential to improve coordination and establish clear provincial priorities through assessment of provincial data and weighing needs against potential impact and appropriateness of action by the public health sector. Provincial planning tables should bring together representatives from the field with key provincial stakeholders on a regular basis to establish strategic directions and to set provincial and regional targets. In addition to a priority setting and coordination table at the provincial level, there will be a need for issue-based planning groups to be established that can facilitate development of more detailed provincial plans and engage the field to facilitate implementation.

The 2017 Auditor General's report identified duplication, inconsistencies and lack of coordination in the

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efforts to reduce and prevent chronic disease. We agree with recommendations for a provincial strategy, provincial goals and targets that would be applicable to all partners across both the health care sector and public health, were applicable.

PPH supports establishing provincial goals and targets for chronic disease and injury prevention.

Since the Auditor General's report was released, public health's mandate, the Ontario Public Health Standards (OPHS), has been modernized. PPH supports the recommendations of the Standing Committee on Public Accounts which calls for greater coordination by the Ministry of Health. We believe this could occur as a result of establishing provincial goals and targets for chronic disease and injury prevention, which could then be reflected and established locally, across health, municipal and public health sectors. As described in the section above, provincially-developed priorities and strategies will be most successful when the field is engaged in the process and the strategies allow for enough variability to accommodate the needs of each local health unit.

The modernized OPHS is currently implemented through provincial approval of the Annual Service Plan (ASP) for each LPHA. The ASP established accountability to ensure that local planning is based on local needs and resources are allocated appropriately to meet minimum requirements and address local needs. This accountability process is still relatively new and evolving, but presents an opportunity for integrating provincial priority setting with local implementation. By adjusting the timing for submissions, and appropriate direction from the Province, these submissions can provide accountability for setting delivery targets for provincial priorities and demonstrating need and appropriate action for local priorities. In doing so, this will preserve the split between "standardized" and "locally-flexible" program areas within the OPHS, but set expectations for areas of flexible programming where there is a clear provincial priority.

Following SARS, 103 recommendations were made and many were implemented, including a shift in provincial/municipal funding to 75/25 provincial/municipal funding formula. In its January 2019 Compendium of Municipal Health Activities and Recommendations, the Association of Municipalities of Ontario (AMO) requested that a forum be established to "guide policy, funding, and planning decisions concerning local public health delivery". Peterborough respectfully requests that the AMO recommendations be considered at this time of modernization. Funding of public health is important because without adequate funding, programs and services will be eroded. PPH is concerned that the new funding formula, which now has local funders paying for 30% of all Ministry of Health-funded public health programs, with the exception of the newly announced Seniors Dental Care Program, is not affordable, sustainable, or fair.

In conclusion, Ontario experienced a prolonged drought for public health that was brought to light with the tragedies of both SARS and Walkerton. We hope that important lessons have been learned and that the neglect that occurred in the past will not be repeated. In order to do that, boards of health need to know that the Province is committed to investing in public health in order to protect its citizens and keep our communities open for business.

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We respectfully acknowledge that Peterborough Public Health is located on the Treaty 20 Michi Saagiig territory and in the traditional territory of the Michi Saagiig and Chippewa Nations, collectively known as the Williams Treaties First Nations, which include: Curve Lake, Hiawatha, Alderville, Scugog Island, Rama, Beausoleil, and Georgina Island First Nations.

Peterborough Public Health respectfully acknowledges that the Williams Treaties First Nations are the stewards and caretakers of these lands and waters in perpetuity, and that they continue to maintain this responsibility to ensure their health and integrity for generations to come.

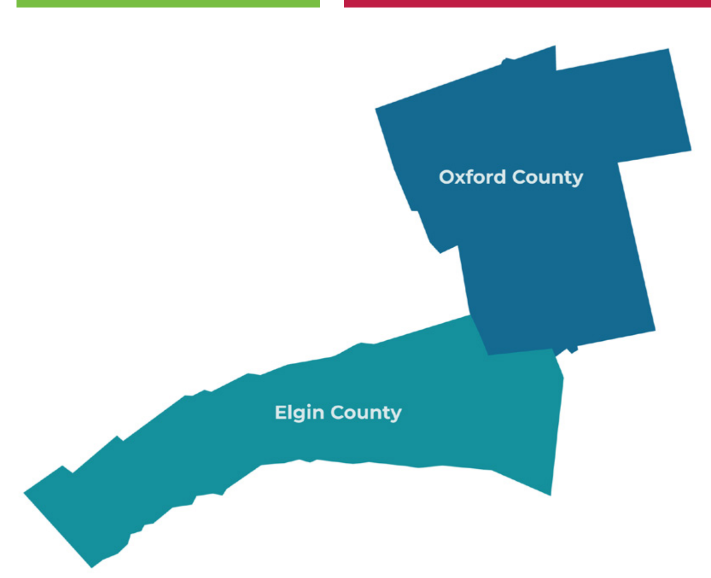
We are all Treaty people.

Aerial view of Rice Lake and the surrounding area.

Public Health Modernization Consultation

Southwestern Public Health (SWPH) is excited about the Ministry of Health's review of the public health sector. We know that the Ministry values the important role that public health plays in helping Ontarians achieve optimal health and well-being.

Southwestern Public Health takes this opportunity to provide the Ministry with some key points for consideration as it modernizes public health. SWPH is in a unique position to participate in this consultation, not only because of its value in the communities that it serves, but also because of its recent amalgamation. We see benefits and challenges with the latter and we are pleased to share these in the spirit of assisting the Ministry in making needed changes in the system.



STRENGTHS OF PUBLIC HEALTH

Maintain the strengths in the existing public health system:

Local presence that supports deep and diverse partnerships with municipalities, schools, community and social agencies; engagement with community leaders; for example, the Community Leaders' Cabinet and Healthy Communities Partnership

Comprehensive models of care delivery ranging from disease prevention (e.g. safe water) to health protection (e.g. vaccination) to health promotion (e.g. walkability)

Legislative authority under the HPPA that supports ability to protect and promote the health of the public

Access to support of Public Health Ontario for clinical decision-making, evidence-informed decision-making, coordination of response to public health outbreaks, laboratory services

Programs and services that meet a range of local client needs be they individuals, families, communities, priority populations, the system. Cradle to grave programs and services that support communities (e.g. the environment) and people to be healthier

Programs and services that focus more resources on areas of greater need and groups of people who face the greatest challenges getting what they need to be healthy

Programs and services that always include interventions that will support the community to be healthier. Even individual health interventions benefit the community e.g. vaccinating individuals contributes to building population immunity which protects everyone

LOCAL VERSUS PROVINCIAL

There are opportunities to strengthen the system by keeping some core functions local and other elements provincially coordinated and/or delivered.

Local (Current Health Unit Region)

- Data-sharing and affiliation agreements
- Planning and implementation of programs and services according to the Ontario Public Health Standards and local needs
- Customization/targeting of provincial responses to align with needs of priority populations
- Daily management of human resources, communications, finance, facilities and information technology services
- Emergency preparedness and response work with municipalities and first responders

Provincial

- Strategy and system design work in the areas of communications, procurement, information technology such as Electronic Medical Record development, databases to support program/service delivery, development of communications platforms, etc.
- Planning and oversight of specific elements of Human Resources, Communications, Finance and IT Support through best practices and resources e.g. workplace violence assessments, software maintenance, support and template creation
- Aspects of Foundational Standards, specifically population health assessments, evaluation, continuous quality improvement planning, performance measurement
- Healthy public policy initiatives
- Mandating a health-in-all policies approach across provincial Ministries
- Health education campaigns such as "Rethink Your Drink"
- Work of provincial associations like Ontario Public Health Association (OPHA) and Association of Local Public Health Agencies (alPHa) that unite public health units around shared issues and support advocacy beyond the public health system
- Expertise provided by Public Health Ontario that assists local planning and program/service delivery, evidence-informed decision making

PUBLIC HEALTH'S CONNECTION WITH THE HEALTH SECTOR AND BEYOND

While public health is not about the care of sick people, it needs to maintain and strengthen its connections with other sectors to achieve optimal health and wellbeing for all.

Public health has had significant success:

- Collecting, analyzing, and sharing local data with local partners
- Connecting with diverse groups of stakeholders. We work beyond the health care system to build a healthier society in partnership with others including government, non-government and citizen organizations
- Working with local Ontario Health Teams to develop these new entities in our communities
- Actively participating in citizen organizations at a local level e.g. Bridges Out of Poverty
- Participating in municipal planning and local initiatives i.e. age friendly strategy, walkability work, access to affordable public transit
- Forming relationships with priority populations and those involved in supporting them e.g. Low German-speaking Mennonites

How to better connect?

- Legislated cooperation with other sectors would assist significantly in our efforts to build a healthier society (e.g. reciprocal data-sharing with school boards that would provide us with better understanding of students' health needs and allow us to design and implement more tailored programs and services)
- Leverage technology to bridge rural and regional boundaries (e.g. video conferencing for internal meetings, community partner meetings)

BOUNDARIES/LEADERSHIP/GOVERNANCE

There are several previous Ministry reports that discuss this area. It is recommended that:

- Any Health Unit mergers be based in part on consideration of shared core attributes that they share (e.g. rural/urban/mixed)
- 100,000 – 500,000 population is ideal to achieve optimal public health performance
- Multimillion-dollar agencies require both a CEO position and a MOH position given they perform different functions and they require different competencies and qualifications
- Autonomous boards of health are optimal for governance allowing the Health Unit's sole focus to be on public health priorities
- "Pay for Say" – Contributing municipalities are represented within the boards of health based on their municipal levy percentage
- If a different model is chosen by the Ministry that doesn't have "pay for say," consider a new funding model that has public health 100% provincially funded

THE BENEFITS AND CHALLENGES OF AMALGAMATIONS

SWPH is in a unique position to offer its thoughts on the benefits and challenges of public health amalgamations given its recent experience.

Benefits

- Voluntary mergers that naturally make sense are much more effective and efficient than involuntary mergers
- Realized cost savings over time
- Increased capacity in program and services area as well as administrative areas
- Innovation and resetting of static ideas and approaches to organizing the work
- Sharing and expansion of best practices as diverse experiences inform program and service design and delivery

Challenges

- Change fatigue of staff and board is real
- Increased money and time required upfront to save money and time down the road
- Mergers are hard work. Greater energy, time and financial investment is needed initially at the administrative level (systems development, strategic direction, policies and procedures, organizational culture development, amalgamation of collective agreements) leaving less of these resources available to support program and service delivery, ongoing organizational culture development
- New local relationship development is time and resource intensive yet necessary for program and service success
- The bulk of the hard work happens after the merger and can take years to yield results (e.g. culture change)

VISION

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1-800-922-0096
info@swpublichealth.ca
1230 Talbot Street
St. Thomas, Ontario, N5P 1G9

www.swpublichealth.ca

Association of Local Public Health Agencies
Speaking Points
Standing Committee on Finance and Economic Affairs
Re: 2020 Ontario Budget
Friday, January 17, 2020

- Good afternoon, Chair and Members of the Standing Committee on Finance and Economic Affairs.

- I am Dr. Eileen de Villa, Vice-President of the Association of Local Public Health Agencies, better known as alPHa, and Toronto's Medical Officer of Health and with me is Loretta Ryan, alPHa's Executive Director.

- alPHa represents all of Ontario's 34 boards of health and medical officers of health (MOHs).

- As you may know, in essence, the work of public health is organized in the Ontario Public Health Standards as follows:

    - Chronic Disease Prevention and Well-Being
    - Emergency Management
    - Food Safety
    - Health Equity
    - Healthy Environments
    - Healthy Growth and Development
    - Immunization
    - Infectious and Communicable Diseases Prevention and Control
    - Population Health Assessment

- Safe Water
    - School Health
    - Substance Use and Injury Prevention

- Last January, in the alPHa Pre-Budget Submission, alPHa noted that:

    - Public Health is on the Front Line of Keeping People Well
    - Public Health Delivers an Excellent Return on Investment
    - Public Health is an Ounce of Prevention that is Worth a Pound of Cure
    - Public Health Contributes to Strong and Healthy Communities
    - Public Health is Money Well Spent

- Furthermore, alPHa recommended that:

    - The integrity of Ontario's public health system be maintained
    - The Province continue its funding commitment to cost-shared programs
    - The Province make other strategic investments, including in the public health system, that address the government's priorities of improving services and ending hallway medicine

- As regards to this last point, Public Health's contribution to ending hallway medicine is summarized in alPHa's Public Health Resource Paper .

- Despite this advice, the 2019 Ontario Budget announced that the Government would be changing the way the public health system was organized and funded.

- On October 10, 2019, Ontario named Jim Pine as its Advisor on Public Health (and Emergency Health Services) consultations.

- Subsequently, on November 18, the Ministry of Health launched renewed Public Health consultations and released a Discussion Paper.

- alPHa was pleased with these recent announcements and has been fully engaged with the consultation.

- For example, on November 15, alPHa released a Statement of Principles respecting Public Health Modernization.

- On a funding note, as was reported by alPHa on September 11, the Ministry of Health confirmed the cost-sharing formula for public health will change to 70% provincial/30% municipal to be applied to almost all mandatory public health programs and services.

- That said, as the Premier announced on August 19 at the AMO Conference, and which alPHa welcomed, municipalities would be receiving one-time transitional funding to limit the increase in costs borne by municipalities in 2020 to no more than 10%.

- Despite this, many boards of health have reported that they have had to draw on their reserves to ease the financial burden that this decision has placed on their obligated municipalities .

- A more positive announcement in the 2019 Ontario budget was the decision to proceed with a new 100% provincially funded, public health unit delivered Ontario Seniors Dental Care Program (OSDCP), which was officially launched on November 20.

- alPHa believes that a modernized, effective and efficient public health system that is adequately resourced is needed more than ever.

- alPHa agrees, for example, with the Standing Committee on Public Accounts Report about the importance of addressing key chronic disease risk factors such as physical inactivity, unhealthy eating, alcohol consumption and

tobacco use of which the attributable burden of illness places huge demands on the health care system.

- Moreover, in its presentation to the Standing Committee on Social Policy, alPHa warned about the unforeseen consequences of the legalization of cannabis and the promotion of vapour products, such as e-cigarettes and other similar products.

- Finally, as the Office of the Chief Medical Officer of Health has recently noted, the Public Health Agency of Canada is tracking a novel coronavirus outbreak in Wuhan, China; as our experience with SARS demonstrated, infectious diseases "know no borders".

- With all the foregoing in mind, alPHa respectfully recommends the following:

    - Led by Ontario's Advisor, the Ministry of Health continue to pursue meaningful consultations with key stakeholders, including alPHa, respecting Public Health Modernization
    - Any changes to the public health system be implemented in accordance with alPHa's Statement of Principles and pending response to the Public Health Modernization discussion paper
    - The public health system receives sufficient and sustainable funding to address population health needs
    - Ontario preferably restore the previous provincial-municipal cost-sharing (75/25) formula for Public Health and, at the very least, make no further changes to the current (70/30) formula
    - Ontario continue to invest in Public Health operations and capital, including 100% funding for priority programs, such as OSDCP

- Thank you for your attention. We would be pleased to answer any questions.

Elizabeth Milne

From: Gordon Fleming <gordon@alphaweb.org>
Sent: Monday, January 20, 2020 3:35 PM
To: All Health Units
Subject: Newsroom : Deputy Premier and Minister Christine Elliott's Speech at the 2020 Rural Ontario Municipal Association's Annual Conference

ATTENTION
CHAIRS, BOARDS OF HEALTH
MEDICAL OFFICERS OF HEALTH
SENIOR MANAGERS, ALL PROGRAMS
****

Please find herein and link to the Minister of Health's remarks from today's ROMA conference. Comments on the current Public Health Modernization process are included.

Deputy Premier and Minister Christine Elliott's Speech at the 2020 Rural Ontario Municipal Association's Annual Conference

https://news.ontario.ca/mohltc/en/2020/01/deputy-premier-and-minister-christine-elliotts-speech-at-the-2020-rural-ontario-municipalities-assoc.html

Gordon WD Fleming, BA, BASc, CPHI(C)
Manager, Public Health Issues
Association of Local Public Health Agencies
480 University Avenue, Suite 300
Toronto ON M5G 1V2
416-595-0006 ext. 223

Elizabeth Milne

From: Susan Lee <susan@alphaweb.org>
Sent: Monday, January 20, 2020 2:22 PM
To: All Health Units
Subject: 2020 alPHa Annual General Meeting & Conference - Notice & Calls

PLEASE ROUTE TO:

All Board of Health Members / Members of Regional Health & Social Services Committee
All Senior Public Health Managers
****

alPHa will be holding its 2020 Annual General Meeting and Conference on June 7, 8 and 9 at the Chestnut Conference Centre, 89 Chestnut Street, Toronto, Ontario.

Click on the link below to download the following conference-related documents:

- Notice of the 2020 alPHa Annual General Meeting
- Call for 2020 alPHa Resolutions (if submitting, click here for a Word template for drafting a resolution)
- Call for 2020 alPHa Distinguished Service Awards
- Call for Board of Health Nominations to the 2020-21 and 2021-22 alPHa Board of Directors.

June 2020 alPHa AGM Notice and Calls

Further details on registration and program will be available in the coming weeks, so please stay tuned!

Regards,

Susan Lee
Manager, Administrative and Association Services
Association of Local Public Health Agencies (alPHa)
480 University Avenue, Suite 300
Toronto ON M5G 1V2
Tel: (416) 595-0006 ext. 225
Email: susan@alphaweb.org
Visit us at www.alphaweb.org

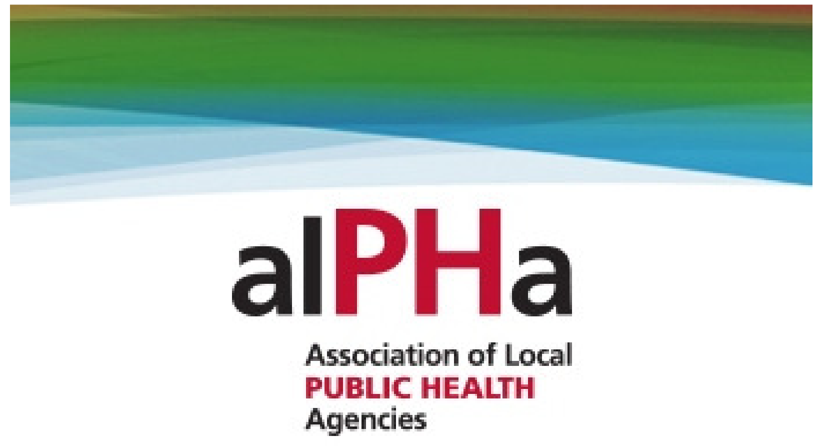
Please note our address and phone extensions have changed

Elizabeth Milne

From: Susan Lee <susan@alphaweb.org>
Sent: Wednesday, January 22, 2020 1:19 PM
To: All Health Units
Subject: alPHa Information Break - January 22, 2020

PLEASE ROUTE TO:

All Board of Health Members / Members of Health & Social Services Committees



January 22, 2020

This update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa activities, correspondence and events.

Update on Public Health Modernization

Thank you to the health units that sent in their responses to the provincial discussion paper on public health modernization to alPHa. As previously announced, the Association is collating this information to develop a formal response to the Ministry of Health consultation on public health modernization. alPHa's response will reflect the common themes and top priorities identified by the local public health sector. It is not intended to replace, but will be in addition to the individual submissions by health units, who are encouraged to share their feedback directly with the Ministry.

A copy of the finalized alPHa submission will be circulated when it becomes available within the next two weeks. Please stay tuned.
Visit alPHa's Public Health Modernization web page
Go to the Ministry of Health's public health consultations website

This week, members and alPHa staff attended the annual conference of the Rural Ontario Municipal Association (ROMA) where Ministry officials provided an update on the consultations on public health modernization and emergency health services. Click the link below to learn more.
Download the Ministry of Health update on consultations at ROMA

On January 17, Dr. Eileen de Villa, alPHa Vice President, made a deputation before the Standing Committee on Finance and Economic Affairs in pre-budget hearings.
Read Dr. de Villa's speaking notes and the Committee transcript

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Registration Open for Winter 2020 Symposium & Section Meetings

Registration is now open for alPHa's Winter 2020 Symposium and Section Meetings. These events will be held respectively on February 20 and 21 at the Central YMCA in downtown Toronto. A great program has been planned, including a leadership workshop led by Tim Arnold of Leaders for Leaders and a consultation session with Ministry of Health representatives on public health modernization, among other sessions. Members are advised to book their hotel accommodations now, if they haven't already, at nearby hotels listed on the event page (click link below).
Register here to attend
Visit the Winter 2020 Symposium & Section Meetings page

Members' Corner

Digital Health Update (submitted by Peel Public Health)

The COMOH Digital Health Steering Committee is preparing a response to the Ministry's consultation on Public Health Modernization, which will speak to the following recommendations:

That the province:

- Together with the input of public health units, lead and resource the development and implementation of a province-wide digital public health strategy.
- Strategically invest in the deployment of common digital services and interoperable applications across all pertinent areas of the public health system.
- Prioritize the development of common data standards and terminology and deploy interoperable systems to realize the full benefits and return on investment of digital connectivity, such as integration of public health data with the provincial Electronic Health Record, OLIS and iPHIS,

primary care EMR with the DHIR, workflow efficiencies and improved data quality.
- Ensure legislative and policy changes in digital health includes the priorities and approaches of local public health agencies.

For strength in numbers, we kindly request that alPHa member agencies consider also including these important digital recommendations in your own responses to the consultation. These responses will also be incorporated into alPHa's and COMOH section's overall response to the consultation as well.

Please also stay tuned for information on how to register for a pre-TOPHC workshop on the afternoon of March 24. To be hosted by Public Health Ontario, this event will explore opportunities for improved data governance and developing a province-wide digital strategy for Ontario's public health sector.

Resource on Healthy Built Environments in Ontario - Planning for Health (submitted by Simcoe Muskoka District Health Unit)

Communities designed to improve health are also well designed to mitigate and adapt to climate change. Compact, complete, connected and green communities reduce our collective footprint while making us healthier by increasing walking, cycling and public transit. They can also incorporate features that reduce heat and better withstand adverse weather.

On January 16, Simcoe Muskoka District Health Units released website-based reports on promising practices for the promotion of healthy community design. These were the result of a Locally Driven Collaborative Projection (LDCP) hosted by Public Health Ontario, and overseen by a steering committee with representation from a large number of Ontario health units and other organizations. The study included participation by 32 of Ontario's 35 health units.

Government News Roundup

Council of CMOHs highlights increasing e-cigarette use among Canadian youth - 2020/01/22

Minister of Health speaks at Rural Ontario Municipal Association's conference - 2020/01/20

Council of CMOHs makes statement on sale of new cannabis products entering market - 2020/01/06

Ontario releases Minister's Annual Report on Drinking Water 2019 and 2018-2019 Chief Drinking Water Inspector Annual Report - 2019/12/20

Federal government proposes e-cigarette advertising ban to address rising use among youth - 2019/12/19

Chief Public Health Officer releases 2019 annual report, Addressing Stigma: Towards a More Inclusive Health System - 2019/12/18

Federal health minister makes statement on sale of new cannabis products - 2019/12/17

Ontario launches new public consultation on poverty reduction strategy - 2019/12/16

Prime Minister releases new mandate letters for ministers - 2019/12/13

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alPHa's New Address

In case you missed the announcement, alPHa relocated its office in December to 480 University Avenue, Suite 300, Toronto ON M5G 1V2. E-mails and phone numbers remain the same; however, our extensions are now three digits --a '2' has been added to the beginning of our previous extensions. Please update your records accordingly.

Upcoming Events - Mark your calendars!

Winter 2020 Symposium/Section Meetings - February 20 & 21, 2020, Central YMCA, 20 Grosvenor St., Toronto. Register **here** before the February 13 deadline. View the draft program.

The Ontario Public Health Convention (TOPHC) 2020 - March 25-27, 2020; Beanfield Centre, 105 Princes' Blvd., Toronto. Register here. Early bird registration ends February 12, 2020.

June 2020 Annual General Meeting & Conference - June 7-9, 2020, Chestnut Conference Centre, 89 Chestnut St., Toronto. View the notice and calls.

alPHa is the provincial association for Ontario's public health units. You are receiving this update because you are a member of a board of health or an employee of a health unit.

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January 22, 2020

The Honourable Christine Elliott
Minister of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4
Sent via e-mail: Christine.elliott@pc.ola.org

Dear Minister Elliott:

At its meeting on December 11, 2019, the Board of Health for Peterborough Public Health received correspondence from Public Health Sudbury & Districts (enclosed) regarding e-cigarette and aerosolized product prevention and cessation.

Foremost, we wish to congratulate the Ministry for the recently announced changes to the *Smoke-Free Ontario Act* that, effective January 2020, ban the promotion of e-cigarettes/vapour products in corner stores and gas stations. The Board of Health for Peterborough Public Health also urges **the adoption of an expert-informed comprehensive tobacco and e-cigarette strategy to address flavoured e-juice, online sales to minors, treatment program of youth cessation and public education.**

The previous Smoke-Free Ontario Strategy, released in May 2018, provided an updated framework for tobacco control, guiding direction across the province on tobacco prevention, cessation, protection and enforcement. Considering the increase in use of vapour products and the ongoing prevalence of tobacco use impacting the lives of Ontarians, it is a critical in this time of public health modernization for the Ministry of Health to develop a new comprehensive tobacco and e-cigarette strategy.

A greater proportion of the Peterborough population 12 years and older are currently smoking (2013/2014) compared to both the province and the Peer Group, at 27.0%, 17.3%, and 20.6% respectively.[1] These rates have the potential to increase with 24.1% of Peterborough area students in grades 9 to 12 trying electronic cigarettes.[2] Further to this, Professor David Hammond of the University of Waterloo, found that among Ontario youth 16-19 years old, vaping increased by a stunning 74% from 2017 to 2018, from 8.4% to 14.6%.[3]

The recent rise in youth addiction to vaping products seen in local secondary schools and requests for prevention supports in elementary schools, speak to the current situation and the need for a coordinated and comprehensive tobacco and e-cigarette strategy to improve the health of Ontarians and stay on course for achieving the lowest smoking prevalence rates in Canada.

We look forward to working with the Ministry and local partners to develop and implement a comprehensive tobacco and e-cigarette strategy that will ultimately protect the health of all Ontarians.

Respectfully,

Original signed by

Mayor Andy Mitchell
Chair, Board of Health

/ag
Encl.

cc: Hon. Doug Ford, Premier of Ontario
Dr. David Williams, Ontario, Ontario Chief Medical Officer of Health
Local MPPs
Hon. Doug Downey, Attorney General of Ontario
France Gélinas, MPP, Health Critic
Association of Local Public Health Agencies
Ontario Boards of Health

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[1] Peterborough County-City Health Unit (2016). Tobacco Use in Peterborough: Priorities for Action Peterborough, ON: Beecroft, K., Kurc, AR.

[2] During the 2014/2015 school year, the Peterborough County City Health Unit (PCCHU) collected data on 1,358 students at six (out of nine) different secondary schools across Peterborough with support from the Propel Centre for Population Health Impact at the University of Waterloo. This represents approximately 15% of the population 15 through 19 according to Statistics Canada's 2011 Census. Source: University of Waterloo. Canadian Student Tobacco, Alcohol, and Drugs Survey. Available: https://uwaterloo.ca/canadian-student-tobacco-alcohol-drugs-survey/about

[3] Hammond, D., Reid, J., Rynard, V., Fong, G., Cummings, K.M., McNeill, A., Hitchman, S., Thrasher, J., Goneiwicz, M., Bansal-Travers, M., O'Connor, R., Levy, D., Borland, R., White, C. (2019) Prevalence of vaping and smoking among adolescents in Canada, England, and the United States: repeat national cross sectional surveys. *British Medical Journal* 365:l2219.

December 3, 2019

VIA EMAIL

The Honourable Christine Elliott
Minister of Health
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Elliott:

Re: E-Cigarette and Aerosolized Product Prevention and Cessation

On behalf of the Board of Health for Public Health Sudbury & Districts, I am very pleased to convey our congratulations on your recent decision to protect Ontarians by banning the promotion of vapour products in corner stores and gas stations. This is an important first step in reducing exposure and accessibility to vapour products and working toward improving the health of Ontarians.

By the enclosed resolution, the Board of Health further urges the adoption of an expert-informed comprehensive tobacco and e-cigarette strategy to address flavoured e-juice, online sales to minors, treatment programs for youth cessation, and public education.

Minister, we recognize that your Ministry is committed to establishing a patient centered system for health, and to ensuring system sustainability for Ontarians now and into the future. To this end, we strongly endorse that any vaping strategy is firmly grounded in the connect between vaping and tobacco use.

As you are aware, although vaping is not without risk, tobacco causes nearly 16 000 deaths per year[i] and costs Ontario nearly $7 billion ($2.7 billion direct health care, $4.2 billion indirect costs) annually.[ii] Cigarettes are known to be toxic and cause cancer, lung, and heart disease when used as intended[iii] and nearly one in five Ontarians continue to smoke[iv]. Reducing supply and exposure to products must be part of the system sustainability goal. This holds true for tobacco and anything that may

Sudbury
1300 rue Paris Street
Sudbury ON P3E 3A3
t: 705.522.9200
f: 705.522.5182

Rainbow Centre
10 rue Elm Street
Unit / Unité 130
Sudbury ON P3C 5N3
t: 705.522.9200
f: 705.677.9611

Sudbury East / Sudbury-Est
1 rue King Street
Box / Boîte 58
St.-Charles ON POM 2WO
t: 705.222.9201
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Unit / Unité 100 C
Espanola ON P5E 1J3
t: 705.222.9202
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promote or normalize its use, such as vaping. Below, we are sharing a compelling infographic developed by Public Health Sudbury & Districts to convey this important message to our publics.

Thank you again for your leadership in the protection of youth from the risks of vaping. We urge you to consider in your next steps the linkages between vaping and tobacco and develop a comprehensive tobacco and e-cigarette strategy. Please know that the Board of Health for Public Health Sudbury & Districts is a committed local partner in this important work.

Sincerely,

René Lapierre, Chair
Board of Health, Public Health Sudbury & Districts

Enclosures (2)

cc: The Honourable Doug Ford, Premier, Minister of Intergovernmental Affairs
All Ontario Boards of Health
Dr. David Williams, Chief Medical Officer of Health
The Honourable Jamie West, MPP, Sudbury
The Honourable France Gélinas, MPP, Nickel Belt
The Honourable Michael Mantha, MPP, Algoma-Manitoulin
Council of Ontario Medical Officers of Health
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
Constituent Municipalities within Public Health Sudbury & Districts
The Honourable Doug Downey, Attorney General of Ontario

[i] Ministry of Health and Long-Term Care. (2018, May 3) Minister of Health and Long-Term Care. Letter. Smoke-Free Ontario Strategy.

[ii] CCO and Ontario Agency for Health Protection and Promotion (Public Health Ontario). (2019). The burden of chronic diseases in Ontario: key estimates to support efforts in prevention. Toronto: Queen's Printer for Ontario.

[iii] Health Canada. (2019). Smoking, vaping and tobacco. Retrieved from https://www.canada.ca/en/health-canada/services/smoking-tobacco/vaping.html

[iv] Ministry of Health and Long-Term Care. (2018). Smoke-Free Ontario: The Next Chapter – 2018. Toronto: Queen's Printer for Ontario. Retrieved from http://www.health.gov.on.ca/en/common/ministry/publications/reports/SmokeFreeOntario/SFO_The_Next_Chapter.pdf

The need for a comprehensive tobacco and e-cigarette strategy

The **rapid** proliferation of e-cigarette use is fuelling mass recruitment of new consumers by an established industry, which profits from nicotine addiction.

Many e-cigarette users are **unaware** of the potential harms of regular or occasional use. There is evidence that e-cigarette use **increases youth uptake of tobacco**.

Tobacco continues to kill its users and cause cancer, lung and heart disease, and grips 1.8 million Ontarians daily.

Ingredients of a **comprehensive tobacco and e-cigarette strategy** include cessation, prevention (denormalization, education, taxation), and protection (enforcement, controls, regulations).

In time, e-cigarettes may be proven to help people quit smoking. What's the message to everyone else?

IF YOU DON'T SMOKE, DON'T VAPE.

December 2019

Moved by Hazlett - Thain
Approved by Board of Health for Public Health Sudbury & Districts, November 21, 2019

48-19 E-CIGARETTE AND AEROSOLIZED PRODUCT PREVENTION AND CESSATION

WHEREAS the Board of Health for Public Health Sudbury & Districts has a longstanding history of proactive and effective action to prevent tobacco and emerging product use and to promote tobacco use cessation; and

WHEREAS electronic cigarettes are increasingly popular in Canada, especially among youth and among smokers, including 15% of Canadian youths and 10% of local youths reporting having tried e-cigarettes; and

WHEREAS there is increasing concern about the health hazards of using e-cigarettes including nicotine addiction, transition to tobacco products especially among youth, and emerging risks of severe pulmonary illness; and

WHEREAS the Ontario government recently announced restrictions on the promotion of e-cigarettes and products that will come into effect January 2020;

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts, while congratulating the Minister of Health on the restrictions on e-cigarette promotion, urge the adoption of an expert-informed comprehensive tobacco and e-cigarette strategy to address flavoured e-juice, online sales to minors, treatment programs for youth cessation, and public education; and

FURTHER that the Board urge the Minister to work with provincial, territorial and federal counterparts to adopt other evidence-informed strategies such as taxation, use prohibition, industry denormalization, and cross-Canada public education to address this emerging public health issue.

CARRIED WITH FRIENDLY AMENDMENTS

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Windsor 1005 Ouellette Avenue, Windsor, ON N9A 4J8
Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

January 17, 2020

The Honorable Christine Elliott
Minister of Health and Deputy Premier
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

Dear Minister Elliott:

On January 16, 2020, the Windsor-Essex County Board of Health passed the following Resolution regarding the **Children Count Pilot Project. WECHU's resolution as outlined below recognizes that the Children Count Pilot Study Project, Healthy Living Module, is a feasible approach to fulfil local, regional and provincial population health data gaps for children and youth:**

Windsor-Essex County Board of Health

RECOMMENDATION/RESOLUTION REPORT – Children Count Pilot Project

January 16, 2020

ISSUE

The behaviours initiated in youth create a foundation for health through the life course (Toronto Public Health, 2015). Supporting student achievement and improving overall quality of life for children and youth is a priority shared across multiple sectors, including health and education. Both the Ministry of Health and the Ministry of Education have identified the importance of this stage of development through the Ontario Public Health Standards (OPHS) and the Ontario Curriculum (2019), and the interrelationship between health, well-being and educational outcomes. Collecting, analyzing and reporting data at the local level is essential for the planning, delivery and evaluation of effective and efficient services that meet the unique needs of students and ensure the responsible public stewardship of the resources allocated to these services (Windsor-Essex, 2017). The lack of a coordinated provincial system for the assessment and monitoring of child and youth health that meets local needs has been the focus of many reports, including the 2017 Annual Report of the Ontario Auditor General. The Auditor General's report identified that children are a public health priority population and that epidemiological data on children are not readily available to public health units for planning and measuring effective programming (Office of the Auditor General of Ontario, 2017).

In the initial report, Children Count: Assessing Child and Youth Surveillance Gaps for Ontario Public Health Units (Populations Health Assessment LDCP Team, 2017), public health units and school boards identified a need for local data related to mental health, physical activity and healthy eating for school-aged children and youth. In 2017, the Children Count Locally Driven Collaborative Projects (LDCP) Team convened a Task Force of leaders in education, public health, research, government and non-governmental organizations to explore solutions and make recommendations for improving assessment and monitoring of child and youth health. The Task Force recommendations have been endorsed by many organizations including the Council of Directors of Education (CODE) and Council of Medical Officers of Health (COMOH). In their report, the Children Count Task Force (Children Count Task Force, 2019) recommended building on existing infrastructure by using the Ministry of Education's mandated school climate survey (SCS). The SCS provides population level data for children and youth grades 4 to 12 and represents a significant opportunity to understand local health needs of students.

BACKGROUND

In follow up to this previous work, the Children Count LDCP Team, with a renewal grant from Public Health Ontario (PHO), embarked upon The Children Count Pilot Study Project. The Children Count Pilot Study began in December 2017 with the goal to explore the feasibility of coordinated monitoring and assessment of child and youth health, utilizing the SCS, to address local health data gaps. This provincial project included six school board and public health unit pairings who developed and piloted a Healthy Living Module (HLM) as part of the school board's SCS. The HLM covered the topics previously prioritized of mental health, healthy eating, and physical activity.

The objectives of the Pilot Study were:

1. To work collaboratively to develop a HLM for the SCS;

2. To pilot test and evaluate the applicability and feasibility of the partnership between public health units and school boards in coordinated monitoring and assessment utilizing the SCS; and

3. To develop a toolkit for implementation of coordinated monitoring and assessment for health service planning using the SCS for child and youth health in Ontario.

Using a Participatory Action Research (PAR) model, the steering committee (comprised of school board and public health leadership), worked together to build the HLM. The HLM was successfully integrated into the SCS led by participating school boards. Collaboratively school boards and local public health units analyzed and interpreted the results for knowledge sharing and planning.

The HLM enriched each school boards' SCS and identified areas for further work to support student health and well-being. The process of piloting the HLM with multiple and diverse school boards using different methods demonstrated that the overall process of coordinating a HLM into the SCS is feasible and adaptable to suit local needs while still enabling consistency in data across regions. The Children Count Pilot Project captured the process and lessons learned in their final report (December 2019) as well as developed the *Children Count Pilot Study Project: Healthy Living Module Toolkit* as a guide for school boards and health units across the province.

PROPOSED MOTION

Whereas, boards of health are required under the Ontario Public Health Standards (OPHS) to collect and analyze health data for children and youth to monitor trends over time, and

Whereas, boards of health require local population health data for planning evidence-informed, culturally and locally appropriate health services and programs, and

Whereas, addressing child and youth health and well-being is a priority across multiple sectors, including education and health, and

Whereas, Ontario lacks a single coordinated system for the monitoring and assessment of child and youth health and well-being, and

Whereas, there is insufficient data on child and youth health and well-being at the local, regional and provincial level, and

Whereas, the Children Count Pilot Study Project, Healthy Living Module is a feasible approach to fulfill local, regional and provincial population health data gaps for children and youth, and

Now therefore be it resolved that the Windsor-Essex County Board of Health receives and endorses the Healthy Living Module, and

FURTHER THAT, the Windsor-Essex County Board of Health encourage the Ministry of Health and the Ministry of Education to adopt the Healthy Living Module as part of the Ontario Public Health Standards and the Ontario School Climate Survey.

References

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Toronto Public Health. (2015). Healthy Futures: 2014 Toronto Public Health Student Survey. Toronto: Toronto Public Health

We would be pleased to discuss this resolution with you and thank you for your consideration.

Sincerely,

Gary McNamara
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

c: Hon. Stephen Lecce, Minister of Education
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health & Long Term Care
Pegeen Walsh, Executive Director, Ontario Public Health Association
Association of Local Public Health Agencies – Loretta Ryan
Association of Municipalities of Ontario
Greater Essex County District School Board – Erin Kelly
Windsor Essex Catholic District School Board – Terry Lyons
CSC Providence (French Catholic) – Joseph Picard
Conseil Scolaire Viamonde (French Public) – Martin Bertrand
Ontario Boards of Health
WECHU Board of Health
Corporation of the City of Windsor – Clerk's office
Corporation of the County of Essex – Clerk's office
Local MPP's – Percy Hatfield, Lisa Gretzky, Taras Natyshak, Rick Nicholls
Local MP's – Brian Masse, Irek Kusmeirczyk, Chris Lewis, Dave Epp

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Windsor 1005 Ouellette Avenue, Windsor, ON N9A 4J8
Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

January 17, 2020

The Honorable Christine Elliott
Minister of Health and Deputy Premier
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

Dear Minister Elliott:

On December 18, 2019, the Windsor-Essex County Board of Health passed the following Resolution regarding **Healthy Smiles Ontario Funding. WECHU's resolution as outlined below recognizes the growing need, and increase in dental decay, among vulnerable children in Windsor-Essex and existing barriers to access to care. The WECHU recommends that HSO retain its current funding and structure as 100% funded, merging it with the Ontario Seniors Dental Care Program to be a comprehensive dental care program for vulnerable children and seniors in Ontario:**

Windsor-Essex County Board of Health

RECOMMENDATION/RESOLUTION REPORT – Healthy Smiles Ontario Funding

December 19, 2019

ISSUE

Healthy Smiles Ontario (HSO) is a publically funded dental care program for children and youth 17 years old and under from low-income households. The Ministry of Health introduced HSO in 2010 as a 100% provincially funded mandatory program for local health units, providing $1,529,700 in funding for children in Windsor-Essex (2019). HSO covers regular visits to a licensed dental provider within the community or through public health units.

In April 2019, the provincial government introduced its 2019 Budget Protecting What Matters Most (Minister of Finance, 2019). Following the release of the provincial budget, the Ministry of Health introduced changes to the funding models for health units effective January 2020. The changes in funding for local health units include a change from a 25% municipal share, 75% provincial cost-shared budget for mandatory programs to 30% and 70% respectively. In addition, the Ministry notified health units that formerly 100% provincially funded mandatory programs such as HSO would now share these costs with municipalities at the rate of 30%, a download of approximately $458,910.00 to local municipalities.

BACKGROUND

Oral health is vital to our general health and overall well-being at every stage of life. Most oral health conditions are largely preventable and share common risk factors with other chronic diseases, as well as the social determinants of health, such as income, employment and education, whereby those in the lowest income categories have the poorest oral health outcomes. Approximately 26% of children (0-5 yrs) and 22.6% of children and youth (0-17yrs) in Windsor-

Essex County live in low-income households, compared to 19.8% and 18.4% in Ontario (Windsor-Essex County Health Unit, 2019). Tooth decay is one of the most prevalent and preventable chronic disease, particularly among children. In Windsor-Essex from 2011 to 2016, the number of children screened in school with decay and/or urgent dental needs increased by 51%. Tooth decay is also the leading cause of day surgeries for children ages one to five. The rate of day surgeries in Windsor-Essex in 2016 was 300.6/100K compared to 104.0/100K for Ontario, representing a significant cost and burden to the healthcare system (WECHU Oral Health Report, 2018). For children, untreated oral health issues can lead to trouble eating and sleeping, affect healthy growth and development, speech and contribute to school absenteeism.

In 2016, the MOHLTC integrated six publicly funding dental programs into one 100% funded program, providing a simplified enrolment process and making it easier for eligible children to get the care they need. The HSO program was part of Ontario's Poverty Reduction Strategy commitment to build community capacity to deliver oral health prevention and treatment services to children and youth from low-income families in Ontario. Windsor-Essex Health Unit operates two dental clinics, one in Windsor and one clinic in Leamington. The WECHU provides preventative and restorative services with a team of registered dental hygienists, general dentists and a pediatric dentist. There is about a six-month wait list for services in our current clinics. The number of preventative oral health services provided through the WECHU dental clinics has increased year over year from 1,931 in 2011 to 7,973 in 2017 (WECHU Oral Health Report, 2018).

Community dentists are not required to take patients under the Healthy Smiles Ontario program which can create barriers to accessing services. Changes to the funding model for HSO will not affect the services provided by local dentists and is only applied to local health units. Mixed model funding for public health units and private fee-for-service dental providers, poses a risk to the delivery of the HSO program in Ontario. Based on the data and analysis in the 2018 Oral Health report, the Windsor-Essex County Health Unit proposed recommendations to improve the oral health status in Windsor-Essex including: Improve access to oral health services within Windsor-Essex and advocate for improved funding for oral health services and expansion of public dental programs such as Healthy Smiles Ontario to priority populations. Given the growing urgent need and increase in dental decay among vulnerable children in Windsor-Essex and recognizing the existing barriers to access to care, the WECHU recommends that HSO retain its current funding and structure as 100% funded, merging it with the Ontario Seniors Dental Care Program to be a comprehensive dental care program for vulnerable children and seniors in Ontario.

PROPOSED MOTION

Whereas the WECHU operates a dental clinic in Leamington and Windsor for HSO eligible children with wait times for services exceeding 6 months, and

Whereas one in four children under five years (26.0%), one in five children under 17 years (22.6%), and one in ten seniors (11.4%) in Windsor and Essex County live in poverty, and

Whereas inadequate access and cost remain barriers to dental care for Windsor and Essex County residents, 23.7% report that they lack dental insurance that covered all or part of the cost of seeing a dental professional, and

Whereas indicators show an overall trend of declining oral health status among children in Windsor and Essex County compared to Ontario, and

Whereas the rate of oral health day surgeries for children in Windsor and Essex County (300.6/100K) far exceeds that of Ontario (100.4/100K), and

Whereas there is an increased difficulty in obtaining operating room time for dental procedures in Windsor-Essex with wait times exceeding 1 year for children in need of treatment, and

Whereas there is a chronic underfunding of the Healthy Smiles Ontario program creating barriers to accessing services among local dentists, and

Now therefore be it resolved that the Windsor-Essex County Board of Health recognizes the critical importance of oral health for vulnerable children and youth, and

FURTHER THAT, urges the Ministry of Health to reconsider its decision to download 30% of the funding of the Healthy Smiles Ontario Program to local municipalities, and

FURTHER THAT this resolution be shared with the Ontario Minister of Health, the Chief Medical Officer of Health, the Association of Municipalities of Ontario, local MPP's, the Association of Public Health Agencies, Ontario Boards of Health, the Essex County Dental Society, the Ontario Association of Public Health Dentistry, the Ontario Dental Association and local municipalities and stakeholders .

References:

Windsor-Essex County Health Unit. (2019). Community Needs Assessment 2019 Update. Windsor, Ontario
Windsor-Essex County Health Unit. (2018). Oral Health Report, 2018 Update. Windsor, Ontario

We would be pleased to discuss this resolution with you and thank you for your consideration.

Sincerely,

Gary McNamara
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

c: Hon. Doug Ford, Premier of Ontario
Hon. Patty Hadju, Minister of Health
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health & Long Term Care
Pegeen Walsh, Executive Director, Ontario Public Health Association
Association of Local Public Health Agencies – Loretta Ryan
Association of Municipalities of Ontario
Essex County Dental Society
Ontario Association of Public Health Dentistry
Ontario Dental Association
Ontario Boards of Health
WECHU Board of Health
Corporation of the City of Windsor – Clerk's office
Corporation of the County of Essex – Clerk's office
Local MPP's – Percy Hatfield, Lisa Gretzky, Taras Natyshak, Rick Nicholls
Local MP's – Brian Masse, Irek Kusmeirczyk, Chris Lewis, Dave Epp

January 28, 2020

VIA: Electronic Mail (Patty.Hajdu@parl.gc.ca)

Honourable Patty Hajdu
Minister of Health, Canada
House of Commons
Ottawa, ON K1A 0A6

Dear Minister Hajdu:

RE: Monitoring of food insecurity and food affordability

The Kingston, Frontenac and Lennox & Addington (KFL&A) Board of Health passed the following motion at its January 22, 2020 meeting:

THAT the KFL&A Board of Health recommend that the Federal Government

- **commit to annual local measurement of food insecurity in all the provinces and territories by making the Household Food Security Survey Module a core module in the Canadian Community Health Survey, and**
- **update the foods included in the National Nutritious Food Basket to reflect recommendations in the 2019 Canada's Food Guide and develop a national food costing protocol.**

FURTHER THAT a copy of this letter be forwarded to:

1) **Honourable Christine Elliott, Minister of Health, Ontario**
2) **Honourable Navdeep Bains, Minister of Innovation, Science and Industry**
3) **Mark Gerretsen, MP Kingston and the Islands**
4) **Scott Reid, MP Lanark-Frontenac Kingston**
5) **Derek Sloan, MP Hastings-Lennox and Addington**
6) **Ian Arthur, MPP Kingston and the Islands**
7) **Randy Hillier, MPP Lanark-Frontenac-Kingston**
8) **Daryl Kramp, MPP Hastings-Lennox and Addington**
9) **Loretta Ryan, Association of Local Public Health Agencies**
10) **Ontario Boards of Health**
11) **Mary Ellen Prange, The Ontario Dietitians in Public Health**
12) **Kim Loupos, The Ontario Dietitians in Public Health**

Monitoring food insecurity and food affordability supports KFL&A Public Health in assessing trends over time, identifying community needs and priority populations, supporting and promoting access to safe and healthy food, and informing healthy public policy. Requiring the Household Food Security Survey Module as mandatory rather than optional for provinces and territories would facilitate effective and consistent food affordability surveillance and monitoring.

KFL&A Public Health completes the Ontario Nutritious Food Basket survey tool annually to monitor the cost of healthy food in KFL&A. The National Nutritious Food Basket which serves as the basis for the Ontario Nutritious Food Basket survey tool was last updated using the 2007 Canada's Food Guide. KFL&A Public Health recommends that the Federal Government take leadership in developing a national protocol that would accompany the National Nutritious Food Basket to ensure consistency in monitoring food costing across Canada.

The consistent, systematic and relevant measurement of food insecurity is foundational for measuring and surveilling food insecurity in Canada.

Yours truly,

Denis Doyle, Chair
KFL&A Board of Health

Copy to: Hon. C. Elliott, Minister of Health, Ontario
Hon. N. Bains, Minister of Innovation, Science and Industry
M. Gerretsen, MP Kingston and the Islands
S. Reid, MP Lanark-Frontenac Kingston
D. Sloan, MP Hastings-Lennox and Addington
I. Arthur, MPP Kingston and the Islands
R. Hillier, MPP Lanark-Frontenac-Kingston
D. Kramp, MPP Hastings-Lennox and Addington
L. Ryan, Association of Local Public Health Agencies
Ontario Boards of Health
M. E. Prange, The Ontario Dietitians in Public Health
Kim Loupos, The Ontario Dietitians in Public Health

Kingston, Frontenac and Lennox & Addington Public Health www.kflaph.ca

Main Office: 221 Portsmouth Avenue, Kingston, Ontario K7M 1V5, 613-549-1232 | 1-800-267-7875, Fax: 613-549-7896

Branch Offices:
Cloyne 613-336-8989 Fax: 613-336-0522
Napanee 613-354-3357 Fax: 613-354-6267
Sharbot Lake 613-279-2151 Fax: 613-279-3997

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
P: **705-743-1000** or 1-877-743-0101
F: 705-743-2897
peterboroughpublichealth.ca

January 29, 2020

The Honourable Caroline Mulroney
Minister of Transportation
Sent via e-mail: minister.mto@ontario.ca

The Honourable Christine Elliott
Minister of Health
Sent via e-mail: christine.elliott@ontario.ca

Dear Honourable Ministers,

Re: Off Road Vehicles (ORV) and Bills 107 and 132

Peterborough Public Health (PPH) is mandated by the Ontario Public Health Standards and the Health Promotion and Protection Act to deliver public health programs and services that promote and protect the health of Peterborough City and County residents.[1] One of our stated goals is to reduce the burden of preventable injuries, where road safety is an important factor. Given the Provincial Government's recent passing of Bills 107 and 132, we anticipate changes to Ontario Regulation 316/03 are being drafted and wish to express several concerns and propose recommendations to consider. For the purpose of this letter, the term ORV is inclusive of all-terrain vehicles (ATVs), side-by-side ATVs, utility-terrain vehicles, and off-road motorcycles (i.e., dirt bikes), and does not include snowmobiles.

The popularity of ORVs has greatly increased over the last 30 years and with increased use, ORV-related injuries and deaths have also risen.[2,3] In Canada in 2010 there were 435 ORV users seriously injured and 103 ORV-related fatalities. This compares to 149 seriously injured users in 1995 and 45 fatalities in 1990.[2] These statistics are based on police reported data and medical examiner files. Hospital records are another source of data where Emergency Department (ED) visits, hospitalizations, and deaths may be identified to be caused by an ORV injury. In Ontario in 2015 to 2016, there were over 11,000 ORV-related ED visits and over 1,000 ORV-related hospitalizations.[4] There have been between 29 and 52 fatalities each year relating to ORV or snowmobile use from 2005 to 2012.[4] The most affected demographic group has been males aged 16-25.[2,4] Rollovers, falling off the vehicle, and ejection are the most commonly cited mechanisms for ORV injury.[4] The most common cause of death is due to head and neck injuries.[4]

ORV-related incidents are classified according to whether they occur on roadways ("traffic") or off-roadways ("non-traffic"). Research indicates that there are higher rates of fatalities and serious injuries for ORV riders on roadways compared to off-roadways.[5,6,7] Riding on roadways increases the risk of collisions with other motor vehicles.[5,8,9] Also, design characteristics of certain classes of ORVs make them unsafe on roadways.[5,10,11] Indeed, across the border in 2007 it was found that 65% of ATV rider deaths occurred on roads. There was also a greater increase in on-road than off-road deaths between 1998 and 2007, which coincided with more states increasing legal ATV access to roads in some way.[11]

Some of the associated risk factors related to ORVs used in Ontario include alcohol and drug use, riding at night, lack of helmet use, and excessive speed.[4,12] It has been found that the majority of ORV-related ED visits occur on the weekend (Friday to Sunday), and almost all are related to recreational use of ORVs.[4]

With these factors in mind, in revision of O. Reg 316/03, we recommend the following in PART III:

- Equipment requirements:
    - Maintain current* contents of section, ensuring content is up-to-date and is applicable to all classes of ORVs that will be permitted on roads.
- Operation requirements:
    - Maintain current* contents of section and requirements. Specifically:
        - Requiring the driver to hold a valid driver's licence, with restrictions on number of passengers at night for novice young drivers;
        - Requiring all riders to wear an approved helmet; and
        - Setting maximum speed limits of 20 kilometres per hour, if the roads speed limit is not greater than 50 kilometres per hour, and 50 kilometres per hour, if the roads speed limit is greater than 50 kilometres per hour.
    - Under "Driver's licence conditions", include the condition that the blood alcohol concentration level of young or novice drivers be zero, as per the Highway Traffic Act (2019).

Finally, we encourage the Ministry of Transportation and the Ministry of Health to establish an effective communication strategy to educate all road users about forthcoming changes to ORV road-use laws, as well as to communicate the risks of riding ORVs on roads.

In summary, ORV-related accidents continue to be a significant cause of injury, with on roadway accidents resulting in higher proportions of severe injury (hospitalization) and fatalities than off roadway accidents. We appreciate your consideration of the safety implications of on-road ORV use as you revise O. Reg. 316/03.

If you have any questions or would like additional information about our comments, please contact Deanna Leahy, Health Promoter, at 705-743-1000 ext. 354, dleahy@peterboroughpublichealth.ca.

Sincerely,

Original signed by

Mayor Andy Mitchell
Chair, Board of Health

cc: The Hon. Doug Ford, Premier of Ontario
Dr. David Williams, Chief Medical Officer of Health
Local MPPs
Opposition Health Critics
The Association of Local Public Health Agencies
Ontario Boards of Health

**"current" refers to O. Reg. 316/03: Operation of off-road vehicles on highways, dated January 1, 2018*

References

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9. Ontario Medical Association. (2009). OMA Position Paper: All-Terrain Vehicles (ATVs) and children's safety. Ontario Medical Review, p. 17–21.
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11. Consumer Federation of America. (2014). ATVs on roadways: A safety crisis. Retrieved from https://consumerfed.org/pdfs/ATVs-on-roadways-03-2014.pdf.
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Public Health Modernization Discussion Paper Response Submitted to the Public Health Modernization Team

The Association of Local Public Health Agencies (alPHa) is pleased to present the following response to the Public Health Modernization Discussion Paper. We invited our members to provide answers to the questions that are posed in the paper to help us identify themes common to the local public health sector throughout the province. This feedback has been synthesized and presented within the framework of themes and questions laid out in the consultation survey.

alPHa's response is intended to be complementary to the individual responses of its members, not a summary or a substitute. alPHa urges the Public Health Modernization team to take the unique local circumstances and perspectives presented in its members' and partners' direct feedback to the survey and in-person consultations into careful consideration as it formulates its advice to the Minister.

PREAMBLE and PRINCIPLES

alPHa agrees with the Ministry's vision of a "coordinated public health sector that is nimble, resilient, efficient and responsive to the province's evolving health priorities". alPHa also agrees with improving consistency where it makes sense to do so and improving clarity and alignment of the related roles and responsibilities of the province, Public Health Ontario (PHO), and local public health. alPHa certainly agrees that enhanced investment in health promotion and prevention will be critical to the success of Ontario's plan to end hallway health care.

In November of 2019, alPHa transmitted its Statement of Principles for Public Health Modernization to the Minister and the Public Health Modernization Team and these remain the foundation of alPHa's present response. These principles are incorporated into the responses to the survey questions as appropriate and the full document is attached.

The foundational principle is that any and all changes must serve the goal of strengthening the Ontario public health system's capacity to improve population health in all of Ontario's communities through the effective and efficient local delivery of evidence-based public health programs and services. Public health unit (PHU) realignments, identification of efficiencies, clarification of roles and strengthening of institutional relationships must all have that central aim as their starting point.

It must be recognized that Ontario already has an enviable public health system, based on a network of 34 PHUs with expert staff, strong partnerships and a clear and authoritative mandate to protect and promote health within their local communities. These are supported by the central research and evidence functions of PHO and the oversight of the Chief Medical Officer of Health (CMOH) within the Ministry. Building on the Ontario system's existing strengths must be the strategic foundation for any proposed changes.

Theme: Insufficient Capacity

What is currently working well in the public health sector?

- Actions taken in response to the Walkerton and SARS crises in the early 2000s (e.g., increased provincial responsibility for funding, strengthened role of the Chief Medical Officer of Health (CMOH), creation of PHO) have led to measurable improvements to the Ontario public health sector's capacity to detect and respond to emerging threats. The swift collective and thorough response to the developing Novel Coronavirus (2019-nCoV) epidemic is a clear application by Ontario's public health sector of the lessons learned from the 2003 SARS outbreak.

- Ontario's public health sector is already an effective network of 34 local public health units (PHUs)with a strong and detailed mandate to identify and meet the health protection and promotion needs of their communities. That mandate is clearly spelled out in the Health Protection and Promotion Act (HPPA) and the Ontario Public Health Standards (OPHS), with explicit flexibility built in to ensure that programs and services can be adapted according to local circumstances.

- Within each of the existing PHUs' boundaries, strong partnerships have been forged with local municipalities, social services, school boards and health care providers among others to support this work.

- The sector benefits from the collaborative work of province-wide professional (e.g., alPHa, COMOH, ASPHIO, ODPH, OPHNL, APHEO) and topic-specific (e.g. TCAN, LDCP) groups. These groups provide ongoing opportunities for collaboration and information exchange across PHU boundaries throughout Ontario.

- There is clear public and political recognition of the critical importance of investments in health protection and promotion to improving population health and ensuring the sustainability of the health care system.

- There is an invaluable range of professional, political and technical expertise resident in the public health sector (public health physicians, elected officials, epidemiologists, nurses, public health inspectors, health promoters, policy analysts, dentists, dietitians, business administrators, lawyers and highly skilled support staff).

- Local representation on boards of health (in a variety of models that includes elected municipal officials in all cases, with provincial appointees and citizen representatives serving in many) reflects community characteristics and values within the PHU boundary and provides direct accountability.

- Collaboration among PHUs including the development of consistency of practice (e.g., HIV case management, immunization enforcement in schools and child care centres, infection prevention and control inspections in the health care sector, electronic medical record use, records retention policies), mutual aid agreements, cross-coverage, outbreak management, and voluntary mergers (Southwestern and Huron-Perth).

- PHO is a unique and invaluable resource within the sector that has strong roles in research, professional development, ethics review, knowledge translation and response to emerging threats.

- The cost-sharing model provides the framework to ensure a stable and predictable source of adequate funding for public health programs and services while ensuring accountability at both the provincial and municipal levels.

- PHUs with large populations have budgets that allow them to deliver services efficiently and cost-effectively while also ensuring surge capacity.

- PHUs that are integrated with Regions (e.g., Halton, Durham) and cities (e.g., Toronto, Ottawa) benefit from support services (e.g. administrative, IT) embedded within those structures. This integration also facilitates coordination among public health, social services, emergency health services and public works.

What are some changes that could be considered to address the variability in capacity in the current public health sector?

- Formal mechanisms and commitment at both the provincial and municipal levels to ensure that the total annual public health funding envelope is stable, predictable, protected and sufficient to cover all costs for the full delivery of all public health programs and services in all PHUs whether they are mandated by the province or developed to serve unique local needs as authorized by Section 9 of the HPPA.

- Provincial support for voluntary mergers of PHUs with complementary characteristics where it can be demonstrated that functional capacity will be improved. Any realignments of present PHU boundaries must be considered only to ensure critical mass to efficiently and equitably deliver public health programs and services. As a general rule, existing PHUs should be left intact, particularly with regard to municipal boundaries, and complementary geographic, demographic and organizational characteristics should be key factors in deciding which mergers should be considered. Evidence about the relationship between critical population mass and the effective allocation of public health resources should also be examined.

- Enhance centralized provincial supports, to increase efficiency and the capacity of all public PHUs to deliver the full scope of the OPHS. PHO already has important research and evidence roles but is also well-positioned to coordinate the strengths of different PHUs. Provincial-level strategic and topic-specific advisory tables that include PHO, the CMOH and local public health leadership have also proven very useful in the past.

- In partnership with local public health, educational institutions and other relevant organizations, develop a provincial public health human resources strategy to build on the successful recruitment and retention of a skilled and competent public health workforce. Maintaining the visibility of the public health sector, demonstrating its stability and importance, presenting the wide range of opportunities within it, providing incentives to work in remote areas and keeping salaries competitive will be vital components.

- Increase decision-making flexibility at the local level to develop their own models for the provision of mandated services according to local circumstances and resources, as well as to develop more formal arrangements to share resources if surge capacity is needed (e.g. epidemiology, analysis, evaluation).

What changes to the structure and organization of public health should be considered to address these challenges?

- alPHa does not believe that systemic structural and organizational changes are necessary to address capacity challenges. As we have demonstrated in our answers to the other discussion questions, any capacity issues can be appropriately addressed within the existing framework by building on its strengths.

- Capacity for most PHUs has been steadily eroding over the years largely due to the Ministry putting caps (often 0%) on annual budget increases that are necessary to cover the costs of delivery of new programs, annual Consumer Price Index (CPI) increases and honouring collective agreements. This erosion will be significantly magnified by the Province's decision to shift 5% of the cost-shared and 30% of previously 100% provincially funded public health programs to municipalities. More details on this were presented by alPHa to the Standing Committee on Finance and Economic Affairs on January 17, 2020 as part of its pre-budget consultation. Speaking notes and the transcript of this presentation are linked above and attached below.

- The autonomy of each local board of health (BOH) must be maintained and stronger mechanisms should be considered to reinforce their sole focus on and local decision-making authority over public health matters as well as to protect them from intrusive policies (e.g., municipal hiring freezes, vacancies on local boards and Associate Medical Officer of Health (AMOH) positions due to inappropriate delays in the provincial appointment and approval processes).

- Several organizational considerations are outlined in the attached alPHa Statement of Principles.

Theme: Misalignment of Health, Social, and Other Services

What has been successful in the current system to foster collaboration among public health, the health sector and social services?

- alPHa respectfully observes that the use of the term "misalignment" in the wording of this theme is misleading, as it creates the false impression that misalignments are a significant systemic problem. On the contrary, PHUs are very well aligned with municipalities, social services, school boards and other community-based services and partners. Previous proposals to align PHU boundaries with those of the health sector (i.e., LHINs) has threatened these existing local relationships without demonstrating the necessity for doing so. If misalignments in certain areas are identified, they must be measured against and prioritized in context of existing alignments in others.

- The reciprocal mandate between the local MOH and LHIN CEO became an important enabler for public health's relationship with the health care sector and this is being expanded upon with most PHUs having direct involvement in the new Ontario Health Teams (OHTs).

- Our members provided us with many specific examples of successful local collaborations with the health care sector related to such topics as injury prevention, substance use, perinatal health, infectious disease prevention and health equity in program design. These will surely be presented in more detail in their individual submissions to the present survey.

- Our members provided us with many specific examples to demonstrate the strength of local collaboration with social services, boards of education and community agencies. The existing geographical alignments of these different groups was cited as critically important. Where public health is integrated within a municipal or regional government, links to their social services

departments are particularly strong. In other cases, formal service agreements and partnerships are highly dependent on shared community boundaries and characteristics.

- The OPHS are explicit in their requirement of all boards of health to carry out their mandated obligations in partnership with local stakeholders. Public health is in turn seen as a credible broker within the local community that can support multi-stakeholder engagement and community mobilization for healthy public policy.

How could a modernized public health system become more connected to the health care system or social services?

- Strengthen the health and social services sectors' focus on prevention and the social determinants of health. Explore the implementation of a "health in all policies" approach with parallel mandates, clear role expectations and accountability for protecting population health across related provincial government ministries and government-funded agencies.

- The Ministry of Health (Ministry) could provide a reciprocal and clearly defined mandate for PHUs and OHTs to utilize public health's surveillance and analysis expertise to conduct population-based needs assessments to inform the effective local allocation of primary health care resources and build capacity among health service providers to offer evidence-based health promotion and prevention interventions.

- Improvements to information technology to support interoperability and data standards to accelerate the appropriate inclusion of public health information into electronic health records and facilitate public health's receipt of vital information from primary care and the broader health care system. This collaboration would support disease prevention and health promotion at the individual to population-level to end hallway health care. More details on digital modernization will be provided in a separate submission by the COMOH Digital Health Committee.

What are some examples of effective collaborations among public health, health services and social services?

- Our members provided us with many specific examples of successful local collaborations among public health, health services and social services. These will surely be presented in more detail in their individual submissions to the present survey.

- The mandated reciprocal relationship between the local Medical Officer of Health (MOH) and Local Health Integration Network (LHIN) CEO was cited as instrumental in promoting a better understanding of public health's mandate, focus and functions to the health care conversation. Direct involvement of public health in local OHTs is expected to increase the momentum.

- The partnership between the Council of Ontario Directors of Education and COMOH (CODE-COMOH) is expected to contribute to the well-being of Ontario's children and students through enhancing PHU and school board partnerships in order to achieve optimal delivery of services and ongoing supports for children and students.

Theme: Duplication of Effort

As with the previous theme, alPHa would argue that the use of the term "Duplication of Effort" suggests that it is a systemic problem that underlies widespread inefficiencies. While we agree that

there are public health functions that could in fact be carried out jointly, regionally or centrally, the local nature of public health requires certain programs and services with similar aims to be developed and implemented in different ways to meet unique local needs.

Care must therefore be taken in defining the term and in identifying and eliminating duplication that is in fact redundant. Care must also be taken when examining alleged duplication of effort between sectors. Public health has a unique set of roles and responsibilities and it would be a mistake to assume that they are transferrable. For example, health promotion in public health differs fundamentally from health promotion in primary care. Only public health focuses on upstream population-level approaches to prevent injuries and illnesses before they occur, and success often depends on strong existing relationships with community partners.

What functions of public health units should be local and why?

- The health protection functions of public health are local by definition. Health hazard investigation and response, infection prevention and control, communicable disease outbreak management, water quality and food safety are examples of areas where local public health has clearly prescribed and detailed roles and responsibilities under the HPPA and OPHS. Carrying these out relies heavily on interaction with individuals, institutions, businesses and service providers throughout the local community. Timeliness and efficiency are supported by preexisting positive relationships.

- Health promotion work is also informed in large part by understanding the local population's characteristics, identifying local priorities and strategically developing approaches for policy development and program and service delivery that will be most responsive to local population health needs. Ongoing population health assessment and surveillance ensures that local data are at the root of program planning as well as healthy public policy development through public health's relationship with municipalities.

- Some public health services (e.g. harm reduction, screening programs, prenatal education, Healthy Babies Healthy Children, neighbourhood groups) focus on individuals and families with high needs. Public health's knowledge of the community and partnerships are a valuable resource for connecting clients with necessary services, which are also primarily local.

What population health assessments, data and analytics are helpful to drive local improvements?

- The epidemiological capacity to collect and access data to conduct detailed local population health assessments within local contexts must be enhanced. Public health programs and services benefit from solid data at the sub-health unit level (e.g., priority neighbourhoods, planning zones, ER admissions). Local epidemiologists have a keen understanding of the local context and are well positioned to collaborate with stakeholders to gather data, conduct analysis and inform recommendations for action and priority setting.

- The CMOH's 2017 Annual Report recommended a provincial population health survey to collect data at the local community and neighbourhood levels to contribute to a better understanding of community wellness. The survey would need to be flexible and nimble, with the ability to customize questions to local needs.

- The Rapid Risk Factor Surveillance System is an ongoing local health telephone survey conducted collaboratively since 2001 by numerous PHUs and the Institute for Social Research at York

University. Information is gathered using questionnaires on a wide variety of health topics to inform service planning for the broad range of public health programs that are required by the OPHS, to advocate for healthy public policy development and to improve community awareness of health risks.

- Strategies to identify and address gaps in data and information must be considered. The Children Count Locally Driven Collaborative Project is an important current example of a strategy to improve available data and interventions to improve child and youth health in Ontario.

What changes should the government consider to strengthen research capacity, knowledge exchange and shared priority setting for public health in the province?

- alPHa believes that the most important development in this regard was the establishment of the Ontario Agency for Health Protection and Promotion, a.k.a. PHO. PHO has been instrumental in supporting our health protection activities with excellent standards of practice developed in communicable disease control, vaccination, and infection prevention and control. We believe that there is an important opportunity to reinforce PHO's capacity to strengthen similar work in the areas of environmental health and non-communicable diseases (which account for over 70% of ill health in Ontario) by focusing on evidence, translating it into recommended practice, and setting common implementation standards. PHO is the key agency for scientific expertise, research and knowledge exchange and is one of the Ontario public health sector's strongest assets. This is one of the strengths that needs to be built upon as the Ministry seeks to achieve the outcomes outlined in this discussion paper.

What are public health functions, programs or services that could be strengthened if coordinated or provided at the provincial level? Or by Public Health Ontario?

- As noted above, the existing roles and responsibilities of PHO should be reinforced and expanded.

- Increased centralized supports, provided by PHO or the Ministry, have the potential to reduce duplication of effort, and contribute to increased consistency and improved delivery of public health programs and services. Examples include a provincial immunization registry, provincial electronic medical records, centralized digital supports including facilitation of data sharing, provincial health communication campaigns, continuing professional education opportunities, centralized reviews of evidence, bulk purchasing, access to data repositories, provincial advisory committees etc. Centralized supports must be designed to sustain the local capacity to develop and implement innovative and locally relevant campaigns.

- Developing provincial leadership on surveillance and population health assessment, technical direction (especially on emerging public health issues), emergency management, healthy policy development and chronic disease prevention coordination. Setting provincial population health goals with targets and cross-sectoral strategies would be a useful foundation upon which to carry out these functions.

- The Ministry, likely via the independent authority of the CMOH, needs to be more active in providing local public health with guidance and / or direction when asked to ensure consistent approaches where there is agreement that they are required. There have been instances (ISPA enforcement, IPAC investigations and HIV Case management for recent examples) where local public health asked for direction to address disparate and sometimes conflicting local practices. With none provided, local MOHs were compelled to work together to develop their

own recommendations for a collective approach.

Beyond what currently exists, are there other technology solutions that can help to improve public health programs and services and strengthen the public health system?

- The COMOH Digital Health Committee will be making a detailed submission to the Public Health Modernization consultation. It will call on the Province to develop a digital strategy for public health; provide sufficient resources to support aligned and necessary information systems and common applications; work with public health partners to facilitate the incorporation of public health information into a provincial electronic health record; centralized coordination and technical support for digital solution integration and Provincial leadership on data standards and interoperability.

- Other suggestions put forth by our members included bulk purchasing of information technology hardware and software, a centralized website with important public health information, a seamless provincial immunization registry, a centralized online inspection disclosure system, enhanced technology to reduce travel requirements (e.g., video calls for client interactions and videoconferencing for health unit staff in rural areas). Inequities in access to technology solutions and tech-mediated opportunities for collaboration were also raised. We expect that many other suggestions will be made in other submissions to the survey question.

Theme: Inconsistent Priority Setting

As with previous themes, alPHa would argue that the use of the term "Inconsistent Priority Setting" suggests a systemic problem that underlies widespread inefficiencies. The existence of different public health priorities in different parts of the province is a feature of the system, not a bug, and is one of its strengths. Local authority over priority setting must be preserved to ensure that the unique health needs of each community can be served. This should include the authority to adapt programs and services to address province-wide public health priorities according to the local context.

What processes and structures are currently in place that promote shared priority setting across public PHUs?

- PHUs are required, through the HPPA, to meet the requirements of the OPHS. These standards provide a framework to support consistent priority setting across Ontario and the related Accountability Agreements ensure provincial approval and awareness of each BOH's plan for the delivery of mandated programs and services each year.

- Ontario's 34 PHUs are connected to a wide range of networks that provide opportunities for sharing of information, priority setting and collective action. alPHa, including COMOH, BOHs and Affiliate Sections, is the most important of these at the systemic level as it brings the governance, medical and programmatic aspects of the entire system together at a single table, which in turn provides an ideal point of contact for government and other stakeholders.

- Profession-specific associations such as ASPHIO, OPHNL, APHEO, AOPHBA, OAPHD, ODPH and HPO provide similar opportunities for the collective identification of priorities within their purview. Each of these groups is represented at the alPHa table.

- Topic-specific collaboratives, spanning regions or the province, provide opportunities to share information and resources, and to collectively address common goals. For example, regional

TCANs allow for shared priority setting and planning related to reducing smoking behavior in regions spanning multiple PHUs. Similar collaborative groups have addressed cannabis, alcohol and opioids.

- Regional PHU groupings (South West, Central West, Central East, North East, North West, East) are networks that provide similar opportunities for neighbouring PHUs that share geographic and demographic characteristics.

- 100% provincially funded public health programs (e.g. Universal Influenza Immunization Program, Ontario Seniors Dental Care Program (OSDCP)) are a clear demonstration of priorities that are shared province wide.

What should the role of Public Health Ontario be in informing and coordinating provincial priorities?

- PHO's mandate is to provide a foundation of sound information, knowledge and evidence to support policy, action and decisions of government, public health practitioners, front-line health workers and researchers. Centralized and timely evidence reviews, provision of provincial and local data, guidance documents and best practices, research ethics, and coordination of tables to address significant province-wide needs (e.g., Healthy Human Development table, Provincial Infectious Disease Advisory Committee) are key functions that underlie evidence-based setting of priorities throughout the public health sector. Reinforcing PHO's capacity to perform these functions in the areas of health promotion and non-communicable disease prevention should be considered.

- PHO's "hub and spoke" model, which was the basis for the former Regional Infection Control Networks, could be used to establish collaborative regional tables in the various public health areas of focus to inform common priorities and joint projects. Such an approach would be valuable in setting province-wide priorities as common themes emerge.

- PHO would be instrumental in providing the evidentiary basis for the establishment of provincial population health goals as proposed above.

What models of leadership and governance can promote consistent priority setting?

- A model of leadership and governance to promote consistent priority setting is already in place. The HPPA provides a clear, detailed and specific framework for the organization and delivery of public health programs and services, including the composition, authority and duties of boards of health. The HPPA is in turn the enabling legislation for the OPHS, which set out clear, detailed and specific requirements for the delivery of public health programs and services in each of the province's 34 PHUs.

- The Office of the CMOH is responsible for ensuring that the OPHS continue to be relevant and based on evidence, and for supporting local public PHUs in meeting the requirements of the standards. Each BOH is required to submit annual business plans to the Ministry through this office as part of the budget and accountability processes.

- Leadership and governance principles are outlined in the attached alPHa Statement, including preserving the autonomy and authority of the local MOH and reinforcing local boards' autonomy, skill sets, effective governance and public health focus.

Theme: Indigenous and First Nation Communities

What has been successful in the current system to foster collaboration among public health and Indigenous communities and organizations?

- PHUs with significant indigenous populations long ago identified the importance of improving their access to public health programs and services, especially in First Nations communities. Many have independently entered into formal agreements with local bands under Section 50 of the HPPA for the provision of programs and services.

- The 2018 OPHS added a requirement for boards of health to engage with First Nations and Indigenous communities and organizations under the Health Equity Standard. The *Relationship with Indigenous Communities Guideline, 2018* was developed to support this work and a *Relationship with Indigenous Communities Toolkit* is said to be under development by the Ministry.

- The widespread acceptance of and commitment to the Truth and Reconciliation Calls to Action throughout the public health sector. Staff training in cultural awareness / competency /safety, the local involvement of Indigenous leaders in decision making, program planning and relationship development, and local partnerships and initiatives have sprung forth from that commitment in all of Ontario's PHUs.

Are there opportunities to strengthen Indigenous representation and decision- making within the public health sector?

- In its Statement of Principles, alPHa notes the necessity of special consideration being given to the effects of any proposed organizational change on Ontario's many Indigenous communities, especially those with a close relationship with the boards of health for the PHUs within which they are located. It is further notes that opportunities to formalize and improve these relationships must be explored as part of the modernization process. alPHa recommends that this exploration, including consideration of the above question, be conducted in full consultation with Indigenous communities and organizations as well as boards of health that have already demonstrated commitment to and experience with Indigenous engagement and service delivery to these populations.

- In its Statement of Principles, alPHa recommends that local BOHs be reflective of the communities that they serve. In areas with large indigenous populations and / or First Nations communities, consideration should be given to appointing one or more members of those communities to the BOH itself. This has already been done, for example, in Peterborough. This could be reinforced with the formation of local Indigenous health advisory committees with more widespread stakeholder involvement. These committees would be especially important for identifying and addressing the health needs of Indigenous people living off-reserve in a culturally sensitive way.

- Provincially, the Office of the CMOH should ensure that central resource and policy supports are in place to facilitate local engagement with Indigenous communities and reinforce pathways to increasing representation and decision-making. The Health Equity requirements of the OPHS that are specific to improving the health of First Nations, Métis, and Inuit people living in Ontario should be the foundation of these supports. The CMOH will also have an important role to play as a liaison with the Government of Canada (through the Public Health Agency of Canada) to ensure that it abides by its complementary obligation to contribute to the improvement of health care and health outcomes for these communities.

Theme: Francophone Communities

What has been successful in the current system in considering the needs of Francophone populations in planning, delivery and evaluation of public health programs and services?

- alPHa's members have extensive experience in providing programs and services aimed at different cultural and linguistic groups within their communities, including Ontario's significant Francophone population. PHUs with significant Francophone populations are best equipped to share what has been successful, identify the gaps and provide advice on how to address them. This is in fact a good example of the importance of ensuring that local boards of health retain decision-making authority over program planning and service delivery to best serve local needs.

What improvements could be made to public health service delivery in French to Francophone communities?

- The provision of a 100% provincially funded centralized translation service that is accessible to all boards of health was cited repeatedly in our members' feedback to this question, as was support for French-language training programs for health unit staff.

Theme: Learning from Past Reports

What improvements to the structure and organization of public health should be considered to address these challenges?

- Most past reports have recommended PHU mergers, and alPHa is not opposed to this in principle, as long as such mergers are of entities with complementary community characteristics and values, will lead to a demonstrable positive impact on capacity, are worth the extraordinary cost and disruption, and are favoured by all concerned parties. The Simcoe-Muskoka, North Bay-Parry Sound, Southwestern and Huron-Perth PHUs are the results of mergers that have taken place since 2005, and valuable insights on the process, including the identification of driving forces, key success factors and challenges, are readily available.

- As noted above, alPHa does not believe that structural and organizational changes are necessary to address capacity challenges. While we agree that health unit mergers as a means to finding efficiencies and reducing duplication of efforts are worth considering, we have not been presented with a clear and convincing argument that a wholesale restructuring of the Ontario's public health system – with its concomitant major costs and disruptions - is a prerequisite for making it nimble, resilient, efficient and responsive.

What about the current public health system should be retained as the sector is modernized?

From alPHa's Statement of Principles:

- Ontario's public health system must remain financially and administratively separate and distinct from the health care system.

- The strong, independent local authority for planning and delivery of public health programs and services must be preserved, including the authority to customize centralized public health programming or messaging according to local circumstances.

- Parts I-V and Parts VI.1 – IX of the HPPA should be retained as the statutory framework for the purpose of the Act, which is to "provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario".

- The OPHS should be retained as the foundational basis for local planning and budgeting for the delivery of public health programs and services.

- The leadership role of the local MOH as currently defined in the HPPA must be preserved with no degradation of independence, leadership or authority.

What else should be considered as the public health sector is modernized?

- Any and all changes must serve the goal of strengthening the Ontario public health system's capacity to improve population health in all of Ontario's communities through the effective and efficient local delivery of evidence-based public health programs and services.

- Achieving efficiencies must be defined in terms of improvements to service delivery and not cost savings. Each of the completed health unit mergers for example has had the former as their central aim but the merger process itself has always been costly.

- Provincial supports (financial, legal, administrative) must be provided to assist existing local PHUs in their transition to any new state without interruption to front-line services. Any costs associated with Public Health Modernization should be fully covered by the Ministry, including additional funding to address technology changes associated with any structure or governance changes.

- alPHa is very pleased with the format and process of the current consultation. That said, in the period between the initial 2019 budget announcement and the formal launch of this consultation (a period of over seven months), there was an unacceptable scarcity of information available to Ontario's considerable public health workforce. This has had a measurable and possibly irreversible negative impact on culture and morale within Ontario's public health workplaces. It has also put a considerable hindrance on the working relationship between local public health leadership and its partners within the Ministry. We hope that the transparency, comprehensiveness and reciprocity of this consultation will continue throughout the analysis and implementation phases to restore trust and demonstrate that the Government of Ontario values the public health professionals that are the foundational strength of the system.

ABBREVIATIONS

alPHa	Association of Local Public Health Agencies
AOPHBA	Association of Ontario Public Health Business Administrators
APHEO	Association of Public Health Epidemiologists in Ontario
ASPHIO	Association of Supervisors of Public Health Inspectors of Ontario
BOH	Board of Health
CMOH	Chief Medical Officer of Health
COMOH	Council of Ontario Medical Officers of Health
HPO	Health Promotion Ontario
HPPA	*Health Protection and Promotion Act*
HIV	Human Immunodeficiency Virus
IPAC	Infection Prevention and Control
ISPA	*Immunization of School Pupils Act*
LDCP	Locally Driven Collaborative Project
OAPHD	Ontario Association of Public Health Dentistry
OPHNL	Ontario Association of Public Health Nursing Leaders
ODPH	Ontario Dietitians in Public Health
OPHS	Ontario Public Health Standards
PHO	Public Health Ontario
PHU	Public Health Unit
TCAN	Tobacco Control Area Network

Enclosures:

alPHa Statement of Principles (November 2019), also attached.
alPHa Deputation, Standing Committee on Finance and Economic Affairs (January 17, 2020), also attached

BACKGROUND

On April 11, 2019 the Minister of Finance announced the 2019 Ontario Budget, which included a pledge to modernize “the way public health units are organized, allowing for a focus on Ontario’s residents, broader municipal engagement, more efficient service delivery, better alignment with the health care system and more effective staff recruitment and retention to improve public health promotion and prevention”.

Plans announced for this initiative included regionalization and governance changes to achieve economies of scale, streamlined back-office functions and better-coordinated action by public health units, adjustments to the provincial-municipal cost-sharing of public health funding and an emphasis on digitizing and streamlining processes.

On November 6, 2019, further details were presented as part of the government’s Fall Economic Statement, which reiterates the Province’s consideration of “how to best deliver public health in a way that is coordinated, resilient, efficient and nimble, and meets the evolving health needs and priorities of communities”. To this end, the government is renewing consultations with municipal governments and the public health sector under the leadership of Special Advisor Jim Pine, who is also the Chief Administrative Officer of the County of Hastings. The aim of the consultation is to ensure:

- Better consistency and equity of service delivery across the province;
- Improved clarity and alignment of roles and responsibilities between the Province, Public Health Ontario and local public health;
- Better and deeper relationships with primary care and the broader health care system to support the goal of ending hallway health care through improved health promotion and prevention;
- Unlocking and promoting leading innovative practices and key strengths from across the province; and
- Improved public health delivery and the sustainability of the system.

In preparation for these consultations and with the intent of actively supporting positive systemic change, the alPHa Board of Directors has agreed on the following principles as a foundation for its separate and formal submissions to the consultation process.

PRINCIPLES

Foundational Principle

1) Any and all changes must serve the goal of strengthening the Ontario public health system's capacity to improve population health in all of Ontario's communities through the effective and efficient local delivery of evidence-based public health programs and services.

Organizational Principles

2) Ontario's public health system must remain financially and administratively separate and distinct from the health care system.

3) The strong, independent local authority for planning and delivery of public health programs and services must be preserved, including the authority to customize centralized public health programming or messaging according to local circumstances.

4) Parts I-V and Parts VI.1 – IX of the Health Protection and Promotion Act should be retained as the statutory framework for the purpose of the Act, which is to "provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario".

5) The *Ontario Public Health Standards: Requirements for Programs, Services, and Accountability* should be retained as the foundational basis for local planning and budgeting for the delivery of public health programs and services.

6) Special consideration will need to be given to the effects of any proposed organizational change on Ontario's many Indigenous communities, especially those with a close relationship with the boards of health for the health units within which they are located. Opportunities to formalize and improve these relationships must be explored as part of the modernization process.

Capacity Principles

7) Regardless of the sources of funding for public health in Ontario, mechanisms must be included to ensure that the total funding envelope is stable, predictable, protected and sufficient for the full delivery of all public health programs and services whether they are mandated by the province or developed to serve unique local needs as authorized by Section 9 of the Health Protection and Promotion Act.

8) Any amalgamation of existing public health units must be predicated on evidence-based conclusions that it will demonstrably improve the capacity to deliver public health programs and services to the residents of that area. Any changes to boundaries must respect and preserve existing municipal and community stakeholder relationships.

9) Provincial supports (financial, legal, administrative) must be provided to assist existing local public health agencies in their transition to any new state without interruption to front-line services.

Governance Principles

10) The local public health governance body must be autonomous, have a specialized and devoted focus on public health, with sole oversight of dedicated and non-transferable public health resources.

11) The local public health governance body must reflect the communities that it serves through local representation, including municipal, citizen and / or provincial appointments from within the area. Appointments should be made with full consideration of skill sets, reflection of the area's socio-demographic characteristics and understanding of the purpose of public health.

12) The leadership role of the local Medical Officer of Health as currently defined in the Health Protection and Promotion act must be preserved with no degradation of independence, leadership or authority.

DESIRED OUTCOMES

- Population health in Ontario will benefit from a highly skilled, trusted and properly resourced public health sector at both the provincial and local levels.
- Increased public and political recognition of the critical importance of investments in health protection and promotion and disease prevention to population health and the sustainability of the health care system.
- Local public health will have the capacity to efficiently and equitably deliver both universal public health programs and services and those targeted at at-risk / vulnerable / priority populations.
- The geographical and organizational characteristics of any new local public health agencies will ensure critical mass to efficiently and equitably deliver public health programs and services in all parts of the province.
- The geographical and organizational characteristics of any new local public health agencies will preserve and improve relationships with municipal governments, boards of education, social services organizations, First Nations communities, Ontario Health Teams and other local stakeholders.
- The geographical and organizational characteristics of any new local public health agencies will reflect the geographical, demographic and social makeup of the communities they serve in order to ensure that local public health needs are assessed and equitably and efficiently addressed.
- Local public health will benefit from strong provincial supports, including a robust Ontario Agency for Health Protection and Promotion (Public Health Ontario) and a robust and independent Office of the Chief Medical Officer of Health.
- The expertise and skills of Ontario's public health sector will be recognized and utilized by decision makers across sectors to ensure that health and health equity are assessed and addressed in all public policy.

Association of Local Public Health Agencies
Speaking Points
Standing Committee on Finance and Economic Affairs
Re: 2020 Ontario Budget
Friday, January 17, 2020

- Good afternoon, Chair and Members of the Standing Committee on Finance and Economic Affairs.

- I am Dr. Eileen de Villa, Vice-President of the Association of Local Public Health Agencies, better known as alPHa, and Toronto's Medical Officer of Health and with me is Loretta Ryan, alPHa's Executive Director.

- alPHa represents all of Ontario's 34 boards of health and medical officers of health (MOHs).

- As you may know, in essence, the work of public health is organized in the Ontario Public Health Standards as follows:

    - Chronic Disease Prevention and Well-Being
    - Emergency Management
    - Food Safety
    - Health Equity
    - Healthy Environments
    - Healthy Growth and Development
    - Immunization
    - Infectious and Communicable Diseases Prevention and Control
    - Population Health Assessment

- Safe Water
- School Health
- Substance Use and Injury Prevention

- Last January, in the alPHa Pre-Budget Submission, alPHa noted that:

  - Public Health is on the Front Line of Keeping People Well
  - Public Health Delivers an Excellent Return on Investment
  - Public Health is an Ounce of Prevention that is Worth a Pound of Cure
  - Public Health Contributes to Strong and Healthy Communities
  - Public Health is Money Well Spent

- Furthermore, alPHa recommended that:

  - The integrity of Ontario's public health system be maintained
  - The Province continue its funding commitment to cost-shared programs
  - The Province make other strategic investments, including in the public health system, that address the government's priorities of improving services and ending hallway medicine

- As regards to this last point, Public Health's contribution to ending hallway medicine is summarized in alPHa's Public Health Resource Paper .

- Despite this advice, the 2019 Ontario Budget announced that the Government would be changing the way the public health system was organized and funded.

- On October 10, 2019, Ontario named Jim Pine as its Advisor on Public Health (and Emergency Health Services) consultations.

- Subsequently, on November 18, the Ministry of Health launched renewed Public Health consultations and released a Discussion Paper.

- alPHa was pleased with these recent announcements and has been fully engaged with the consultation.

- For example, on November 15, alPHa released a Statement of Principles respecting Public Health Modernization.

- On a funding note, as was reported by alPHa on September 11, the Ministry of Health confirmed the cost-sharing formula for public health will change to 70% provincial/30% municipal to be applied to almost all mandatory public health programs and services.

- That said, as the Premier announced on August 19 at the AMO Conference, and which alPHa welcomed, municipalities would be receiving one-time transitional funding to limit the increase in costs borne by municipalities in 2020 to no more than 10%.

- Despite this, many boards of health have reported that they have had to draw on their reserves to ease the financial burden that this decision has placed on their obligated municipalities .

- A more positive announcement in the 2019 Ontario budget was the decision to proceed with a new 100% provincially funded, public health unit delivered Ontario Seniors Dental Care Program (OSDCP), which was officially launched on November 20.

- alPHa believes that a modernized, effective and efficient public health system that is adequately resourced is needed more than ever.

- alPHa agrees, for example, with the Standing Committee on Public Accounts Report about the importance of addressing key chronic disease risk factors such as physical inactivity, unhealthy eating, alcohol consumption and

tobacco use of which the attributable burden of illness places huge demands on the health care system.

- Moreover, in its presentation to the Standing Committee on Social Policy, alPHa warned about the unforeseen consequences of the legalization of cannabis and the promotion of vapour products, such as e-cigarettes and other similar products.

- Finally, as the Office of the Chief Medical Officer of Health has recently noted, the Public Health Agency of Canada is tracking a novel coronavirus outbreak in Wuhan, China; as our experience with SARS demonstrated, infectious diseases "know no borders".

- With all the foregoing in mind, alPHa respectfully recommends the following:

    - Led by Ontario's Advisor, the Ministry of Health continue to pursue meaningful consultations with key stakeholders, including alPHa, respecting Public Health Modernization
    - Any changes to the public health system be implemented in accordance with alPHa's Statement of Principles and pending response to the Public Health Modernization discussion paper
    - The public health system receives sufficient and sustainable funding to address population health needs
    - Ontario preferably restore the previous provincial-municipal cost-sharing (75/25) formula for Public Health and, at the very least, make no further changes to the current (70/30) formula
    - Ontario continue to invest in Public Health operations and capital, including 100% funding for priority programs, such as OSDCP

- Thank you for your attention. We would be pleased to answer any questions.

STANDING COMMITTEE ON FINANCE AND ECONOMIC AFFAIRS
FRIDAY 17 JANUARY 2020
PRE-BUDGET CONSULTATIONS

Full Transcript (all presentations)

Association of Local Public Health Agencies

The Chair (Mr. Amarjot Sandhu): Next, I would like to call upon the Association of Local Public Health Agencies. Please state your name for the record. You have seven minutes for your presentation.

Dr. Eileen de Villa: Thank you very much. Good afternoon, Chair and members of the Standing Committee on Finance and Economic Affairs. I'm Dr. Eileen de Villa, vice-president of the Association of Local Public Health Agencies, better known as ALPHA, and I'm also Toronto's medical officer of health. I'm joined today by my colleague Loretta Ryan, ALPHA's executive director.

ALPHA represents all of Ontario's 34 boards of health and medical officers of health. As you may know, in essence, the work of public health is organized in the Ontario Public Health Standards as follows: chronic disease prevention and well-being, emergency management, food safety, health equity, healthy environments, healthy growth and development, immunization, infectious and communicable diseases prevention and control, population health assessment, safe water, school health, substance use, and injury prevention.

Last January, in the ALPHA pre-budget submission, ALPHA noted that public health is on the front line of keeping people well. Public health delivers an excellent return on investment. Public health is an ounce of prevention that is worth a pound of cure. Public

health contributes to strong and healthy communities, and public health is money well spent.

Furthermore, ALPHA recommended that the integrity of Ontario's public health system be maintained, that the province continue its funding commitment to cost-shared programs and that the province make other strategic investments, including in the public health system, that address the government's priorities of improving services and ending hallway health care. In regard to this last point, public health's contribution to ending hallway health care is summarized in ALPHA's public health resource paper.

Despite this advice, the 2019 Ontario budget announced that the government would be changing the way the public health system was organized and funded.

On October 10, 2019, Ontario named Jim Pine as its adviser on public health and on emergency health services for the consultations. Subsequently, on November 18, the Ministry of Health launched renewed public health consultations and released a discussion paper. ALPHA was pleased with these recent announcements and has been fully engaged with the consultation. For example, on November 15, ALPHA released a statement of principles respecting public health modernization.

On a funding note, on September 11, the Ministry of Health confirmed that the cost-sharing formula for public health will change to 70% provincial and 30% municipal, to be applied to almost all mandatory public health programs and services. This said, as the Premier announced on August 19 at the AMO conference—and which ALPHA welcomed—municipalities would be receiving one-time transitional funding to limit the increase in costs borne by municipalities in 2020 to no more than 10%. Despite this, many boards of health have reported that they have had to draw on their reserves to ease the financial burden that this decision has placed on their obligated municipalities.

A more positive announcement in the 2019 Ontario budget was the decision to proceed with a new, 100% provincially funded, public-health-unit-delivered Ontario Seniors Dental Care Program, or OSDCP, which was officially launched on November 20.

ALPHA believes that a modernized, effective and efficient public health system that is adequately resourced is needed more than ever. ALPHA agrees, for example, with the Standing Committee on Public Accounts report about the importance of addressing key chronic disease risk factors, such as physical inactivity, unhealthy eating, alcohol consumption and tobacco use, of which the attributable burden of illness places huge demands on the health care system. Moreover, in its presentation to the Standing Committee on Social Policy, ALPHA warned about the unforeseen consequences of the legalization of cannabis and the promotion of vapour products, such as e-cigarettes and other similar products.

Finally, as the Office of the Chief Medical Officer of Health has recently noted, the Public Health Agency of Canada is tracking a novel coronavirus outbreak in Wuhan, China. As our experience with SARS demonstrated, infectious diseases know no borders.

With all the foregoing in mind, ALPHA respectfully recommends the following:

—led by Ontario's adviser, the Ministry of Health continue to pursue meaningful consultations with key stakeholders, including ALPHA, respecting public health modernization;

—any changes to the public health system be implemented in accordance with ALPHA's statement of principles and pending response to the public health modernization discussion paper;

—that the public health system receive sufficient and sustainable funding to address population health needs—

The Chair (Mr. Amarjot Sandhu): One minute.

Dr. Eileen de Villa:—that Ontario preferably restore the previous provincial-municipal cost sharing 75-25 formula for public health and, at the very least, make no further changes to the current 70-30 formula; and

—that Ontario continue to invest in public health operations and capital, including 100% funding for priority programs such as the Ontario Seniors Dental Care Program.

I'll thank you for your attention, and we would be very pleased to address any questions you might have.

The Chair (Mr. Amarjot Sandhu): Thank you. We'll go to the opposition side this time. MPP Shaw.

Ms. Sandy Shaw: Thank you very much for your presentation. I commend you for your work. I would say that people didn't understand what public health did previous to these abrupt changes; we understand it now.

I would also like to say, we remember when SARS happened, and Dr. Sheela Basrur—the heroic efforts that we took to prevent that from being a full-blown crisis. It was 15 or 16 years ago; how quickly we forget, right? So I think we need to keep reminding ourselves that when we need public health to be able to mobilize, we really, really need it.

So I want to commend you. I understand the work that you do. I always did. I want to say that we're fully supportive of what you do. There's no misunderstanding on the part of the New Democrats of what you do.

My question is very specific because we've got a short time. About the changes to the public health unit, the geographic deployment—so 35 units that are going to now, perhaps, be shrunk down to 10. This is a question about my riding in Hamilton, where our medical officer of health, Dr. Richardson, has expressed some of her concerns, particularly now that we are an Ontario health team and we do not know how the Ontario health team is trying to get on with their work without any direction—really clear direction, I would say—from the government and without the understanding that this public health unit will now maybe be beyond the geographic area of the Ontario health team.

So there's a lot of confusion out there in terms of what's happening. I'm wondering if you have any understanding of that or any advice around what the impact will be when these health units shrink.

1620

Dr. Eileen de Villa: Thank you for the question. At this stage of the game and as alluded to in my remarks, there are ongoing consultations right now in respect of public health modernization as proposed by the current provincial government. My understanding at this stage is that there is still open discussion with respect to what will be the configuration of local public health units. You're right: Right now, there are currently 34. There were some original proposals made last year. We're understanding at this stage of the game that there is some revisiting, a "reset," I believe, is the word that has been used. So we don't know yet where the discussions will land.

However, I would say that there are some important questions to ask here and some important considerations for the committee. First public health as a system is separate from the health care system. There are important areas of interaction that we need to have between public health and health care, but they are in fact distinct and separate. The Ontario health teams fall more within the context of health care, and that's a very important role that needs to be played. I think there are certainly some questions as to how that will manifest itself in the future. However, it is in fact separate from public health.

The Chair (Mr. Amarjot Sandhu): One minute.

Dr. Eileen de Villa: That's not to take away from its importance.

Ms. Sandy Shaw: Thank you.

The Chair (Mr. Amarjot Sandhu): MPP Arthur.

Mr. Ian Arthur: Thank you so much for your presentation. I echo the sentiments of my colleague.

Just very quickly: The upstream causes of health care costs were talked about for a long time. It seems to have receded a bit in terms of the discussion. With skyrocketing health care costs, do you see any avenue other than dealing with those upstream causes for bringing those expenditures under control?

Dr. Eileen de Villa: Thank you for the question. As a public health practitioner, we are all about the upstream. That is our focus. That is where we live, and that's where we provide the most value to the system. There will always be some need for health care, which is downstream. However, we know that what constitutes and what maintains

health are the social determinants of health, the conditions within which people live and the environments within which they live—

The Chair (Mr. Amarjot Sandhu): Thank you. I apologize to cut you off. We'll have to move to the government side now. MPP Skelly.

Ms. Donna Skelly: Thank you for your presentation. This year our government committed over $700 million—close to $800 million—in funding for public health units right across Ontario. Yes, we believe that there is an opportunity and several challenges moving forward in the restructuring and modernization of delivery of those services, and we are consulting, I believe under the leadership and direction of Jim Pine. He is the emergency health services adviser. He is leading the dialogue, meeting with representatives from municipalities, meeting with health service sector representatives from right across the province, in order to understand what the challenges are, in order to identify perhaps some of the duplication of services. We have seen examples that have been brought forward to our government.

I'm just wondering if maybe you could, while we have this opportunity at this committee hearing, share with this committee some of the areas that you have identified as duplication in the delivery of health care services under these current boards.

Dr. Eileen de Villa: Thank you for the question. I'm going to talk about duplication in respect of public health as opposed to health care.

Ms. Donna Skelly: I should say "public health." Thank you.

Dr. Eileen de Villa: Yes, because they are quite distinct, as I indicated earlier. You're quite right around the consultations; I think that there is an opportunity to engage in conversation around what's best for public health. The public health system, however, does require the co-operation and collaboration of several partners. There's certainly a

role for provincial entities. There's a role for local entities, some of which are governmental and some of which are community-based.

Where are there areas that we could improve? There are always areas for improvement, whether we're talking about public health or health care. When it comes to public health, I think what we have seen through the various reports—some of which emanated from local public health; some of which have come through Auditor General-type reports—would include areas like research.

I think there is an opportunity, as well, to confer across the province around what are some of the directions and priorities that we should be seeking together, because we know that where we have had success in public health in the past, most of the successes have come through the collaborative efforts of a variety of local or regional public health entities, as well as the province.

I think those are just a few examples of some areas where we could collaborate better and perhaps reduce duplication.

Ms. Donna Skelly: One of the programs that you raised involves dental care for seniors, which is, of course, something I think most of us really believe is long overdue.

The Chair (Mr. Amarjot Sandhu): One minute.

Ms. Donna Skelly: Can you speak to some of the limitations, some of your observations, since we've started introducing that program?

Dr. Eileen de Villa: It's a relatively new program, launched in November and currently being delivered through public health units. I would say that for many of my colleagues around the province, one of the challenges is that they did not have pre-existing seniors'

dental care programs, or facilities through which to deliver such clinical services. Certainly, establishing those facilities is one of the challenges that exist right now.

But as mentioned in our remarks, we at ALPHA are extremely pleased. This was certainly one of the positives in respect of recent funding announcements when it came to public health and public health delivery programs.

Ms. Donna Skelly: Thank you.

The Chair (Mr. Amarjot Sandhu): Thank you so much for your presentation.

January 31, 2020

VIA ELECTRONIC MAIL

The Honourable Patti Hajdu
Minister of Health
Government of Canada
Tunney's Pasture
Ottawa, ON K1A0K9

The Honourable Christine Elliott
Minister of Health
Government of Ontario
Toronto, ON M7A 2J3

Dear Ministers:

Re: Fully Funded Universal Healthy School Food Program

At its meeting on January 16, 2020, the Board of Health for Public Health Sudbury & Districts carried the following resolution #02-20:

> *WHEREAS a universal publicly funded healthy school food program in Canada enables all students to have the opportunity to eat healthy meals at school every day, and no child is left out due to their family's ability to pay, fundraise, or volunteer with the program; and*
>
> *WHEREAS only 19% of Sudbury & District youth (ages 12-19) reported meeting the recommended intake of fruit and vegetables, an indicator of nutrition status and a risk factor for the development of nutrition-related chronic diseases;*
>
> *THEREFORE BE IT RESOLVED THAT That the Board of Health for Public Health Sudbury & Districts support resolutions by Federation of Canadian Municipalities, and Boards of Health for Grey Bruce Health Unit, Toronto Public Health, Peterborough Public Health and Windsor-Essex County Health Unit for a universal publicly funded healthy school food program.*

Sudbury
1300 rue Paris Street
Sudbury ON P3E 3A3
t: 705.522.9200
f: 705.522.5182

Rainbow Centre
10 rue Elm Street
Unit / Unité 130
Sudbury ON P3C 5N3
t: 705.522.9200
f: 705.677.9611

Sudbury East / Sudbury-Est
1 rue King Street
Box / Boîte 58
St.-Charles ON P0M 2W0
t: 705.222.9201
f: 705.867.0474

Espanola
800 rue Centre Street
Unit / Unité 100 C
Espanola ON P5E 1J3
t: 705.222.9202
f: 705.869.5583

Île Manitoulin Island
6163 Highway / Route 542
Box / Boîte 87
Mindemoya ON P0P 1S0
t: 705.370.9200
f: 705.377.5580

Chapleau
101 rue Pine Street E
Box / Boîte 485
Chapleau ON P0M 1K0
t: 705.860.9200
f: 705.864.0820

Toll-free / Sans frais
1.866.522.9200

phsd.ca

FURTHER THAT the Board calls on federal and provincial Ministers of Health to work in consultation with all provinces, territories, Indigenous leadership, and other interest groups to collaboratively develop a universal publicly funded school food program that is aligned with Canada's Dietary Guidelines.

In Ontario, the school or student nutrition program aims to support students' learning and healthy development through additional nourishment. The current model of the school nutrition programming includes contributions from the province, community groups, organizations, grants, food donations, and fundraising efforts. The patchwork funding model threatens the quantity and quality of food served to children. The lack of sustainable funding also impacts the availability of infrastructure and human resources to effectively run the program.

A publicly fully-funded universal school food program model can positively impact students' nourishment, health and well-being, behaviours and attitudes, school connectedness, and academic success. This proposed universal program model with leadership by Canada and Ontario's Ministers of Health would enable all students to have the equal opportunity to eat healthy meals at school every day, and that no child is left out due to their family's ability to pay, fundraise, or volunteer with the program.

Further, this motion is in support of Senator Art Eggleton's motion (#358, 2015) that urges an adequately funded national cost-shared universal nutrition program. Given the impact of nutrition related chronic diseases, we trust you will advance this work quickly and so that no child is left out.

Sincerely,

Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health and Chief Executive Officer

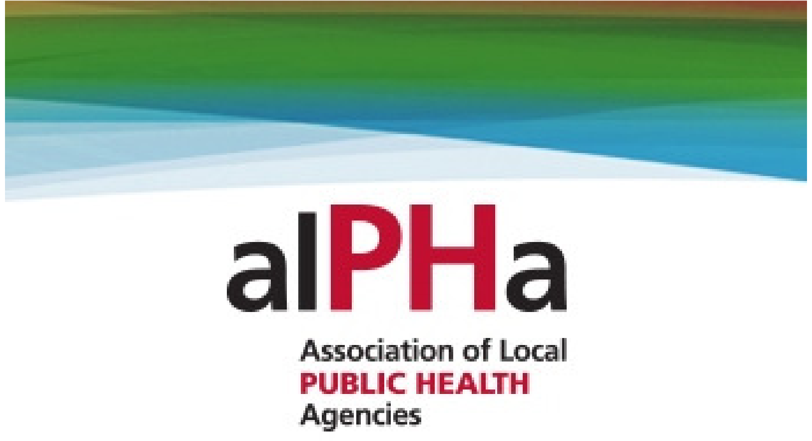
cc: Paul Lefebvre, Member of Parliament for Sudbury
Marc Serré, Member of Parliament for Nickel Belt
Carol Hughes, Member of Parliament for Algoma-Manitoulin-Kapuskasing
Hon. Todd Smith, Ontario Minister of Children, Communities, and Social Services
Association of Local Public Health Agencies
Federation of Canadian Municipalities
Ontario Boards of Health

Elizabeth Milne

From: Susan Lee <susan@alphaweb.org>
Sent: Monday, February 3, 2020 12:16 PM
To: All Health Units
Subject: alPHa Information Break - February 3, 2020

PLEASE ROUTE TO:

All Board of Health Members / Members of Health & Social Services Committees



February 3, 2020

This update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa activities, correspondence and events.

Update on Public Health Modernization

On January 30, alPHa submitted its response to the Ministry of Health's discussion paper on public health modernization and shared a copy with all health units afterward. The submission followed a teleconference held the previous day between the alPHa Board of Directors and Ministry of Health representatives that included Jim Pine, Special Advisor. Mr. Pine updated the board on feedback received to date from stakeholders since the release of the discussion paper. He also noted that while several in-person consultations with stakeholders have been completed to date, others will be taking place in different regions over the next month or so. He further indicated that the February 10 cutoff to respond to the consultation paper is no longer a fixed deadline.

Download alPHa's response on public health modernization
Go to the Ministry of Health's public health consultations website

alPHa invites health units and their boards to share their submissions to the provincial discussion paper with us by emailing them to Gordon Fleming at gordon@alphaweb.org. These will be uploaded to alPHa's dedicated resource page on public health modernization (link below), which contains announcements, responses and updates on related matters.
Visit alPHa's Public Health Modernization resource web page

Novel Coronavirus

As part of the collective effort to communicate timely information about novel coronavirus (2019-nCoV), alPHa is attending daily ministry-led briefings and sending daily situation reports from the Ministry of Health to update health units on this emerging issue. COMOH members are monitoring the situation closely and, through the COMOH Chair, are in frequent contact with provincial officials, including Chief Medical Officer of Health Dr. David Williams, to ensure the health and well-being of the public. For convenience, alPHa has provided links to the Ministry's dedicated website and others on its home page and below.
Go to the Ministry of Health's novel coronavirus website
Visit the Ministry's page for health professionals here
Go to Public Health Ontario's novel coronavirus website
Visit the Government of Canada's website on novel coronavirus

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Winter 2020 Symposium & Section Meetings

alPHa looks forward to members' participation at the upcoming Winter 2020 Symposium and Section Meetings on February 20 and 21 at the Central YMCA in downtown Toronto. The not-to-miss program includes a leadership workshop led by Tim Arnold of Leaders for Leaders, a consultation session with Ministry of Health representatives on public health modernization, and an update from the Association of Municipalities of Ontario (AMO). For more information about this event, please click the link below.
Register here to attend
Visit the Winter 2020 Symposium & Section Meetings page

TOPHC 2020

Members are advised to register for TOPHC 2020 early and and book their preferred workshop as space is limited. The annual event will take place March 25-27 at the Beanfield Centre in Toronto. Highlights include keynotes on the impact of racism on communities' health, and how persuasive technologies (apps, games) can improve health and wellness behaviours. This year's HOT TOPHC focuses on the causes and characteristics of syndemics

and their effect on health. Early bird promotional pricing ends February 12, so register soon.
Learn more about TOPHC 2020 here
Register for TOPHC 2020

Public Health News Roundup

Minister Elliott lauds public health's response to coronavirus - 2020/01/31

Ontario confirms third case of novel coronavirus - 2020/01/31

World Health Organization declares novel coronavirus a global public health emergency - 2020/01/30

British Columbia reports first presumed confirmed case of novel coronavirus - 2020/01/28

Ontario briefs leaders from colleges and universities on novel coronavirus and directs public to trusted information resources - 2020/01/28

Ontario confirms second presumptive case of novel coronavirus - 2020/01/27

Ontario briefs school boards' directors of education on novel coronavirus - 2020/01/26

Toronto reports first presumptive confirmed case of novel coronavirus - 2020/01/25

Ontario confirms first case of new coronavirus - 2020/01/25

Canada announces screening measures for novel coronavirus at major airports - 2020/01/24

US Surgeon General releases first report on smoking cessation in 30 years - 2020/01/23

Ontario Minister of Health designates novel coronavirus as a reportable disease - 2020/01/22

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alPHa's New Address

In case you missed the announcement, alPHa relocated its office in December to 480 University Avenue, Suite 300, Toronto ON M5G 1V2. E-mails and phone numbers remain the same; however, our extensions are now three digits --a '2' has been added to the beginning of our previous extensions. Please update your records accordingly.

Upcoming Events - Mark your calendars!

Winter 2020 Symposium/Section Meetings - February 20 & 21, 2020, Central YMCA, 20 Grosvenor St., Toronto. Register **here** before the February 13 deadline. View the draft program.

The Ontario Public Health Convention (TOPHC) 2020 - March 25-27, 2020; Beanfield Centre, 105 Princes' Blvd., Toronto. Register here. Early bird registration ends February 12, 2020.

June 2020 Annual General Meeting & Conference - June 7-9, 2020, Chestnut Conference Centre, 89 Chestnut St., Toronto. View the notice and calls.

alPHa is the provincial association for Ontario's public health units. You are receiving this update because you are a member of a board of health or an employee of a health unit.

This email was sent to susan@alphaweb.org from the Association of Local Public Health Agencies (info@alphaweb.org).
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Please note that if you unsubscribe, you will no longer receive notices, important announcements, and correspondence from alPHa.

Elizabeth Milne

From: Loretta Ryan <loretta@alphaweb.org>
Sent: Thursday, February 13, 2020 10:05 AM
To: All Health Units
Subject: AMO Response to Public Health and Emergency Health Services Consultation and Cannabis Consultations Underway

Hello,

Please see below information regarding AMO's response to the Public Health and Emergency Health Services consultation and notification about cannabis consultations that are underway.

AMO's Response is also posted on alPHa's webpage dedicated to PH Modernization: https://www.alphaweb.org/page/PHR_Responses. On this page you can also link to alPHa's recent response to the government along with those of our members and partners.

Take Care,

Loretta

Loretta Ryan, CAE, RPP
Executive Director
Association of Local Public Health Agencies (alPHa)
480 University Avenue, Suite 300
Toronto, ON M5G 1V2
Tel: 416-595-0006 ext. 222
Cell: 647-325-9594
loretta@alphaweb.org
www.alphaweb.org

AMO Update not displaying correctly? View the online version
Add Communicate@amo.on.ca to your safe list

February 11, 2020

AMO Response to Public Health and Emergency Health Services Consultation and Cannabis Consultations Underway

Public Health and Emergency Health Services Modernization Consultation

AMO provided comprehensive, written submissions to the Minister of Health this week in response to the Public Health and Emergency Health Services Modernization consultations. Our members heard assurances in Minister Elliott's remarks at the 2019 AMO conference that nothing is "set in stone". Underlying both submissions is the notion that municipal governments and the Province can work together to collectively preserve what is working well and fix what needs fixing.

The outcome of public health modernization should achieve better population health outcomes through effective, cost efficient, and locally responsive services. Investments in public health make sense to keep people healthy through a focus on the social determinants of health. It contributes to ending hallway health care and saves provincial health costs in the long term. AMO feels that a separate discussion on 2020 and 2021 funding is needed urgently prior to any consideration of restructuring. Municipal governments cannot be expected to make up for reductions in provincial funding. Nor can they bear the costs of provincial restructuring.

When it comes to structure, one size will not fit all. Consistency in service delivery and reducing inefficiencies do not depend on a single governance or leadership type. There are many ways to continuously improve the existing system by building capacity and better system coordination. With provincial help, new ways to serve our Francophone population and Indigenous People are possible.

On emergency health services, AMO has provided advice with an aim to strengthening municipal EMS services in a way that contributes to helping end hallway health care and meets the local needs of communities. Addressing longstanding municipal priorities should be the focus of current efforts before any potential consideration of restructuring. This includes improvements to dispatch as a first priority. Others include addressing non-urgent transfers, fixing the funding model, expanding fully 100% provincially funded community paramedicine and developing strategies to reduce offload delays. Increasing hospital capacity and having alternative health facilities, especially mental health and addictions programs, for patients who do not need hospital care available in communities will help. The new models of care for low acuity 9-1-1 patients can help improve access and reduce hallway health care, but they need to have alternative 24/7 health facilities that are available in all communities.

The Ministry of Health has committed to further conversations with AMO's Health Task Force. AMO also expects further discussions at the MOU table before decisions are made.

In recognition of the work underway to prepare for, and respond to, the 2019 novel coronavirus the Ministry of Health has extended the deadline for submitting written feedback to March 31, 2020. The technical discussion papers and information on how to respond is found on the Ministry website.

AMO Contact:
Michael Jacek, Senior Advisor, mjacek@amo.on.ca, 416-971-9856 ext. 329.

Ontario Consulting on Cannabis Consumption Venues and Special Occasion Permits

The Ministry of the Attorney General has announced consultations on cannabis consumption venues and special occasion permits for cannabis in Ontario. The Ministry is seeking feedback on whether to allow these and the rules and parameters guiding their establishment and operation.

The Ministry is specifically consulting on the role of the Alcohol and Gaming Commission of Ontario (AGCO), the agency responsible for regulating, licensing and inspecting cannabis stores; and the potential role of municipal governments in regulating the proposed cannabis consumption lounges.

AMO's Board has previously supported cannabis consumption venues as a potential tool for local economic development. The Board viewed cannabis consumption venues positively in conjunction with municipal government discretion to allow these establishments in their communities, local zoning and licensing powers to ensure appropriate locations and community responsiveness.

Special Occasion Permits for cannabis could also be desirable for some events. The AGCO regulates Special Occasions Permits for alcohol and it is possible that a single regulator for these permits may be the most efficient and desirable system subject to municipal government and community input.

Municipal governments are encouraged to review the consultation materials and respond as appropriate by the deadline of March 10, 2020.

AMO Contact:
Craig Reid, Senior Advisor, creid@amo.on.ca, 416-971-9856 ext. 334.

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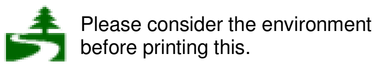
*Disclaimer: The Association of Municipalities of Ontario (AMO) is unable to provide any warranty regarding the accuracy or completeness of third-party submissions. Distribution of these items does not imply an endorsement of the views, information or services mentioned.



Association of Municipalities of Ontario
200 University Ave. Suite 801,Toronto ON Canada M5H 3C6
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Government of Canada Gouvernement du Canada

Statement from the Council of Chief Medical Officers of Health on Nicotine Vaping in Canada

From: Public Health Agency of Canada

Statement

January 22, 2020

During National Non-Smoking Week, the Council of Chief Medical Officers of Health (CCMOH) wants to highlight that smoking continues to pose a significant risk to the health of Canadians with over 45,000 people dying from smoking-related causes each year. We recommend that Canadians needing support with nicotine addiction speak to a health care provider and seek out proven cessation therapies, such as medication or approved nicotine replacement therapies.

At this time, we also remain significantly concerned by the substantial rise of nicotine vaping among Canadian youth. In follow up to our previous position statements on this issue in July 2014, April 2019 and October 2019, we provide the following set of regulatory and policy recommendations that we believe are necessary to be taken by federal, provincial/territorial and municipal governments to address this rapidly emerging public health threat. We acknowledge that governments have already taken steps to implement some of these recommendations.

This statement pertains to nicotine vaping devices. The CCMOH released a related statement on cannabis vaping on January 6, 2020.

The overarching objectives of these recommendations are to protect young people from inducements to use vaping devices by regulating such devices as equivalent to tobacco products, and to encourage smokers who use vaping devices to use them solely to end or reduce their use of all nicotine-containing products.

These recommendations are made in the context of the emerging evidence of the short and long-term harms associated with the use of vaping products. We recognize that evidence is still emerging on the effectiveness of nicotine vaping products to help smokers decrease or stop their use of all nicotine-containing products. It is important that the regulatory and policy approaches for vaping products be reviewed as the evidence of health risks and benefits evolve. For example, if it becomes clear that vaping products are effective in helping people stop or reduce their use of all nicotine-containing products, then it may then be appropriate to approve, license and regulate vaping products in the same way as other tobacco cessation products.

Opportunities for both federal and provincial/territorial jurisdictions

Federal action would be preferred to create national consistency, but individual provinces/territories can consider individual action.

- Ban all flavoured vaping products and then provide regulatory exemptions or market authorizations for a minimum set of flavours to support smokers who choose to use vaping to end or reduce their use of nicotine-containing products

- Limit the nicotine content in vaping products, including pods, to a maximum of 20mg/ml (levels lower than this may further decrease the addictive potential for youth) and adopt other appropriate standards regarding nicotine delivery
  (e.g. temperature, use of nicotine salts) as evidence on vaping products evolves
- Regulate all constituents of e-liquids based on potential to cause harm when inhaled rather than oral ingestion
- Tax vaping products in a manner consistent with maximizing youth protection while providing some degree of preferential pricing as compared to tobacco products
- Consider making the age of 21 the minimum sales age for both tobacco and vaping products, knowing that establishing the legal minimum sales age requires balancing policy objectives to minimize an illegal market while delaying the onset of youth use through limiting access through social sources
- Create requirements for age-verification of internet purchases of vaping products that are the same as those required for cannabis
- Enhance surveillance and reporting of vaping product use and population health impacts

Opportunities for Federal Jurisdiction

- Restrict the advertising/marketing/promotion/sponsorship of vaping devices in a manner consistent with maximizing youth protection, including online advertising/promotion and social influencers, while allowing adult-oriented marketing of vaping devices as a product that supports adult smokers solely to end or reduce their use of all nicotine-containing products

- Require product manufacturers to disclose all ingredients of vaping devices to Health Canada as a condition of being marketed, including establishing consistency in reporting nicotine levels in both open and closed vaping systems
- Require plain and standardized packaging along with health risk warnings for all vaping products
- Include vaping as part of smoke-free restrictions for locations under federal jurisdiction
- Enhance compliance, enforcement and public reporting of the provisions of the *Tobacco and Vaping Products Act*

Opportunities for Provincial/Territorial Jurisdictions

- Ban all point of sale advertising of vaping devices and products with an exception for specialized vaping product stores accessible only to those of minimum age
- Require a vendor's licence for those selling vaping devices and products
- Include vaping as part of provincial/territorial smoke-free restrictions
- Routinely use youth test purchaser programs for all tobacco and vaping product retail locations

Opportunities for Municipal Jurisdictions:

- Include vaping as part of municipal smoke-free restrictions
- Restrict the density of tobacco and vaping products retail sites and ban the sale of vaping products and devices within at least 250 metres of a school

Along with these policy and regulatory actions, we recommend that federal, provincial and territorial governments continue to work collaboratively to:

- Enhance public awareness and educational initiatives on the risks of vaping products targeted at youth, parents, educators and health care professionals
- Establish comprehensive cessation initiatives for people with nicotine addiction, especially for youth
- Monitor and research the short and long-term health effects of vaping products
- Research the effectiveness of vaping products in supporting smokers to end or reduce their use of all nicotine-containing products
- Research the effectiveness of policy approaches to address youth vaping

A number of other products for the delivery of nicotine have or are being developed (e.g. heated tobacco devices, oral nicotine products). We encourage federal and provincial/territorial governments to work together to develop a broad regulatory approach to all alternative methods of nicotine delivery (i.e. other than tobacco products) that offers strong youth protection while allowing appropriate access for adult smokers to products if they are proven effective in decreasing or stopping the use of all nicotine-containing products. A key component of any such regulatory approach should be the requirement for the manufacturer to provide enough evidence to satisfy the regulator that allowing any new product on the market is in the public interest before that product can be legally sold.

Dr. Theresa Tam
Chief Public Health Officer of Canada

Dr. Bonnie Henry
Provincial Health Officer, British Columbia
Chair, Council of Chief Medical Officers of Health

Dr. Brendan E. Hanley
Chief Medical Officer of Health, Yukon
Vice-Chair, Council of Chief Medical Officers of Health

Dr. Janice Fitzgerald
I/Chief Medical Officer of Health, Newfoundland and Labrador

Dr. Heather Morrison
Chief Public Health Officer, Prince Edward Island

Dr. Robert Strang
Chief Medical Officer of Health, Nova Scotia

Dr. Jennifer Russell
Chief Medical Officer of Health, New Brunswick

Dr. Horacio Arruda
Director of Public Health and Assistant Deputy Minister
Ministry of Health and Social Services, Québec

Dr. David Williams
Chief Medical Officer of Health, Ontario

Dr. Brent Roussin
Chief Provincial Public Health Officer, Manitoba

Dr. Saqib Shahab
Chief Medical Health Officer, Saskatchewan

Dr. Deena Hinshaw
Chief Medical Officer of Health, Alberta

Dr. Michael Patterson
Chief Medical Officer of Health, Nunavut

Dr. Kami Kandola
Chief Public Health Officer, Northwest Territories

Dr. Evan Adams
Chief Medical Officer, First Nations Health Authority, British Columbia

Dr. Tom Wong
Chief Medical Officer, Public Health, Indigenous Services Canada

Important Links

- About Vaping
- Quit Smoking Supports

Contacts

Media Relations
Public Health Agency of Canada
613-957-2983
hc.media.sc@canada.ca

Public Inquiries
Call toll-free: 1-866-225-0709
Email: info@hc-sc.gc.ca

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Date modified:

2020-01-22

BRIEFING NOTE

Item #8.1

Advocacy for Stable Public Health Funding

Update: #1 **Date: February 19, 2020**

Issue:

Stable, reliable and sufficient funding is required over time to ensure the capacity of local boards of health to fulfill their mandate to protect and promote health, and to prevent disease for the entire population. In recent years, public health funding from the province has not kept pace with population growth or the Consumer Price Index. In addition, with the Public Health Modernization changes in the 2019 provincial budget, the shift in financial responsibility for public health to the obligated municipalities also creates a challenge to the resource base of local boards of health.

This briefing note provides an advocacy resolution to address these issues for the Board of Health's consideration to be submitted to the Association of Local Public Health Agencies (alPHa) for its annual general meeting in June.

Recommendation:

THAT the Board of Health receive this briefing note as information;

AND FURTHERMORE THAT the Board of Health support the submission of the resolution in Appendix A for the alPHa annual general meeting, with this briefing note provided as its background document.

Current Facts:

Base funding from the province for most health units, including Simcoe Muskoka District Health Unit (SMDHU), has been frozen for all but one of the past five years, resulting in a loss in local public health capacity. Furthermore, an ongoing freeze going into future years in the base funding from the province would erode the capacity of local public health substantially over time.

In 2020 the shift in funding responsibility to the municipalities, combined with the 10% cap in levy increases and a mitigation fund (as we have been verbally informed by provincial staff, will be based on actual expenditures in 2018) that does not sufficiently cover the resulting shortfall, results in a significant reduction beyond the impact of the base freeze. The continued shift in funding, with 30% of funding coming from the obligated municipalities and the probable loss of the mitigation funding in 2021, will place substantial pressure on our obligated municipalities. This may result in a levy increase insufficient to cover costs for many, if not most boards of health. In addition, the conversion of all former 100% funded programs to 70/30 has been particularly challenging. The loss of 100% provincial funding for the Smoke Free Ontario Program, Healthy Smiles Ontario, Harm Reduction supplies, and a number of staffing positions (on infection control and the determinants of health) has a substantial financial impact. Thus, a reconsideration of the downloading of the 70:30 ratio is also included in the resolution.

Background:

To date the Board has advocated for the following regarding funding:

- A letter from the SMDHU Board chair to the Ontario Minister of Health, June 27, 2019 recommended 'the continued comprehensive mandate of public health as defined in the Ontario Public Health Standards (2018) and for gradual adjustments to the provincial-municipal cost-sharing of public health funding formula be phased in over five (5) years commencing in fiscal year 2021-22."

The resolutions of alPHa in recent years regarding finance are provided in Appendix B.

Contact:

Dr. Charles Gardner, Medical Officer of Health, and CEO Ext. 7219
Karen Ellis-Scharfenberg, VP Program Foundations and Finance, and CFO Ext. 7820

Appendix A:

Sufficient Local Public Health Funding

Whereas the effectiveness of boards of health depends in part on the sufficiency of their resource base and funding; and

Whereas the majority of the funding of boards of health in Ontario is provided by the provincial government; and

Whereas since 2015 most boards of health in Ontario have only had one year (2018) in which base funding from the province increased from the previous year; and

Whereas a continued freeze in the base funding from the province for boards of health will over time greatly erode their resources; and

Whereas the further reduction in provincial funding to 70% for most public health programs offset with additional mitigation funding in 2020, but with a 10% limit imposed by the province on levy increases in 2020 will still result in a significant shortfall in funding to boards of health; and

Whereas the continued reduction in provincial funding to 70% in 2021 without a continuation of the mitigation funding would result in the need for a substantial levy increase (well beyond the 10% limit imposed by the province on levy increases in 2020), and

Whereas it is anticipated that in 2021 most boards of health will be very challenged to increase the levies to their obligated municipalities sufficiently to avoid a further substantial shortfall in resources; and

Whereas population increases and the need for population health programs to address emerging public health issues apply additional pressures on the resources of boards of health; and

Whereas the erosion of the resources of boards of health would substantially reduce the capacity of health units to provide their programs and services; and

Whereas a reduction in local public health programs and services would endanger the health of the population of Ontario;

Therefore be it resolved that the Association of Local Public Health Agencies (alPHa) write to the Minister of Health urging that the 2020 mitigation funding continue into future years, that the reduction in provincial funding to 70% be reconsidered, and that provincial grants in future years allow for the overall budgets of boards of health to increase sufficiently to maintain their resource base, and to address pressures related to population growth and emerging public health issues.

Appendix B:

The Associations of Local Public Health Agencies (alPHa) Resolutions on Finance

The following are alPHa resolutions on funding in recent years:

A19-12 - Public Health Modernization: Getting it Right

THAT the Ontario public health mandate as currently outlined in the Ontario Public Health Standards not be altered or diminished in an effort to achieve budget reduction targets and that the Province continues to financially support public health units to adequately implement the Standards;

AND FURTHER that the Association of Local Public Health Agencies (alPHa) calls upon the Ontario government to delay the implementation of any organizational and financial changes to local public health until April 1, 2021 with a commitment to engage in meaningful consultation over the next eighteen (18) months;

AND FURTHER that any changes in the cost-shared formula be phased in over five (5) years commencing in fiscal 2021-22;

AND FURTHER that in ongoing consultations with the province, that alPHa propose the establishment of a joint task force made up of both political representatives and professional staff from existing public health agencies, alPHa, the Association of Municipalities of Ontario (AMO) and the City of Toronto to undertake the following activities:

- Establish a set of principles to guide the reorganization of public health in Ontario that include:
    - Assurance that the enhancement of health promotion and disease prevention is the primary priority of any changes undertaken
    - Undertaking the consolidation of health units around a community of interests which include distinguishing between rural and urban challenges, and the meaningful participation of First Nations
    - Taking into account the ability of municipalities to pay, considerations for the broad range of proposed changes in funding arrangements between the province and municipalities
    - Developing a governance structure that provides accountability to local councils required to fund local public health agencies; and
- Conduct public outreach to municipal, public health and other stakeholders to validate both the principles and the resulting plans for future re-organization; and
- Ensure that the municipal and public health perspectives on any proposed changes, including the outcomes of consultation, are incorporated.

A18-1 - Sustainable Funding for Local Public Health in Ontario

THAT the Association of Local Public Health Agencies' (alPHa) board and staff will make the long-term sustainable provincial funding for local boards of health a priority for advocacy and strategy development for its members, specifically that the following elements be addressed:

THAT alPHa urge the Ministry of Health and Long Term Care to commit to maintaining a minimum cost of living annual growth rate for grants provided to all boards of health to fund public health programs;

AND FURTHER THAT alPHa urge the Ministry of Health and Long-Term Care to make an evidence-informed decision to adjust upwards the overall percentage of the Ministry's total budget that is allocated to fund public health programs delivered through boards of health;

AND FURTHER THAT alPHa urge the Ministry of Health and Long-Term Care to engage in a process to implement a comprehensive monitoring strategy in close consultation with Ontario's boards of health to evaluate the impacts of the new funding model, both in terms of health outcomes and total public health expenditures at the local level.

In-Year alPHa Board Resolution (2015) - Public Health Funding Formula

THAT alPHa urge the Ministry of Health and Long Term Care to commit to maintaining a minimum cost of living annual growth rate for grants provided to all boards of health to fund public health programs;

AND FURTHER THAT alPHa urge the Ministry of Health and Long-Term Care to make an evidence-informed decision to adjust upwards the overall percentage of the Ministry's total budget that is allocated to fund public health programs delivered through boards of health;

AND FURTHER THAT alPHa urge the Ministry of Health and Long-Term Care to engage in a process to implement a comprehensive monitoring strategy in close consultation with Ontario's boards of health to evaluate the impacts of the new funding model, both in terms of health outcomes and total public health expenditures at the local level.

PRIVACY AND FREEDOM OF INFORMATION

PURPOSE

To facilitate the Board of Health's (Board) compliance with governance accountabilities and legislative requirements with respect to privacy and freedom of information.

To outline the confidentiality obligations of Board members.

POLICY

The Board recognizes its legal and ethical obligation to protect the privacy of individuals with respect to their personal information (PI) and personal health information (PHI), and is committed to ensuring the confidentiality and security of the PI and PHI under the custody and control of the Middlesex-London Health Unit (MLHU), as set out in the Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) and the Personal Health Information Protection Act (PHIPA).

The Board further recognizes its obligation to provide a right of access to information under its control, as set out in MFIPPA, and is committed to openness, transparency and accountability.

Board members are further accountable for maintaining the confidentiality and security of PI, PHI and other confidential information that they gain access to for the purpose of discharging their duties and responsibilities as a member of the Board.

The Board shall be informed of all significant privacy risks and significant privacy breaches.

PROCEDURE

1. Board of Health Accountabilities Under MFIPPA

1.1. The Board designates from among its members the Board Chair to serve as the "head" of the institution for the purposes of meeting the requirements outlined in this Act (s. 3).

1.2. The Board Chair delegates the duties and responsibilities of the head to the Medical Officer of Health/Chief Executive Officer (MOH/CEO). Appendix A describes duties and powers of the head with respect to freedom of information and protection of individual privacy. The day-to-day administration and management of MLHU's privacy program will be operationalized by MLHU's Privacy Officer, who reports to the Director, Healthy Organization.

2. Board of Health Accountabilities Under PHIPA

2.1. The medical officer of health of a board of health within the meaning of the Health Protection and Promotion Act serves as the health information custodian (HIC) for the purposes of PHIPA (s. 3 (1)).

2.2. In accordance with the requirements set out in the Ontario Public Health Standards, the board of health shall ensure that the medical officer of health, as the designated HIC, maintains information systems and implements policies/procedures for privacy and security, data collection and records management. Appendix B describes required practices to protect PHI.

3. Board of Health Member Confidentiality Attestation

3.1. Board members shall confirm understanding of their confidentiality obligations under applicable privacy legislation and governance policies, and their agreement to honour these obligations, by signing an Annual Confidentiality Attestation (Appendix C).

New Board members shall provide initial attestation upon orientation to the Board and according to the annual schedule thereafter.

DEFINITIONS

"**Agents**", in relation to a health information custodian, means a person that, with the authorization of the custodian, acts for or on behalf of the custodian in respect of personal health information for the purposes of the custodian, and not the agent's own purposes, whether or not the agent has the authority to bind the custodian, whether or not the agent is employed by the custodian and whether or not the agent is being remunerated (PHIPA s. 2).

"**Collection**" means to gather, acquire, receive or obtain the information by any means from any source.

"**Confidentiality**" means the nondisclosure of PI or PHI except to another authorized person or where disclosure is permitted by law. Confidentiality also refers to the ethical and fiduciary duty and obligation of individual Board members to safeguard confidential information.

"**Confidential Information**" means personal information, personal health information and/or information regarding the organization which is not publicly disclosed by the organization, this information may include, but is not limited to:

- Matters including personal information and personal health information;
- Personnel matters relating to an employee of the health unit;
- The security of the property of the Board of Health;
- Proposed or pending acquisition of land, assets, or services for Board of Health purposes;
- Labour relations or employee negotiations;
- Litigation or potential litigation, including matters before administrative tribunals, affecting the Board;
- Advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
- Matters related to other Acts that may be closed for discussion by the Board of Health;
- Matters that relate to requests under the Personal Health Information Protection Act or the Municipal Freedom of Information and Protection of Privacy Act.

“**Disclosure**” means to make the information available or to release it to another health information custodian or to another person, but does not include to use the information.

“**Head**” means the individual designated, in writing, by the Board from among themselves, to act as head of the institution for the purposes of MFIPPA.

“**Health Information Custodian**” means a person or organization as defined and described in PHIPA who has custody or control of personal health information as a result of or in connection with performing the person’s or organization’s powers or duties.

“**Identifying Information**” means information that identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual (PHIPA s. 4 (2)).

“**Institution**” means a board of health (MFIPPA, s. 2 (1)).

“**Personal Health Information**” means identifying information about an individual in oral or recorded form, if the information:

(a) Relates to the physical or mental health of the individual, including information that consists of the health history of the individual’s family;
(b) Relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual;
(c) Is a plan of service within the meaning of the Home Care and Community Services Act, 1994 for the individual;
(d) Relates to payments or eligibility for health care, or eligibility for coverage for health care, in respect of the individual;
(e) Relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any such body part or bodily substance;
(f) Is the individual’s health number; and/or
(g) Identifies an individual’s substitute decision-maker. (PHIPA, s. 4 (1))

“**Personal Information**” means recorded information about an identifiable individual, including:

(a) Information relating to the race, national or ethnic origin, colour, religion, age, sex, sexual orientation or marital or family status of the individual;
(b) Information relating to the education or the medical, psychiatric, psychological, criminal or employment history of the individual or information relating to financial transactions in which the individual has been involved;
(c) Any identifying number, symbol or other particular assigned to the individual;
(d) The address, telephone number, fingerprints or blood type of the individual;
(e) The personal opinions or views of the individual except if they relate to another individual;
(f) Correspondence sent to an institution by the individual that is implicitly or explicitly of a private or confidential nature, and replies to that correspondence that would reveal the contents of the original correspondence;
(g) The views or opinions of another individual about the individual; and/or
(h) The individual’s name if it appears with other personal information relating to the individual or where the disclosure of the name would reveal other personal information about the individual. (MFIPPA, s. 2(1))

“**Privacy**” means the qualified right of individuals to exercise control over the collection, use and disclosure of their personal information and personal health information, unless the collection, use and/or disclosure of the information is permitted or required by law.

“**Privacy Breach**” means the theft, loss unauthorized use or disclosure of personal information, personal health information or other confidential information.

“**Privacy Officer**” means the individual designated by the Medical Officer of Health/Chief Executive Officer to administer and manage MLHU’s privacy program.

“**Records**” means any record of information in any form or in any medium, whether in oral, written, printed, photographic or electronic form or otherwise, but does not include a computer program or other mechanism that can produce a record (MFIPPA s. 2 and PHIPA, s. 2).

“**Security**” means a system of safeguards and precautions established to preserve confidentiality. These means may be legislative, administrative/procedural and/or technical.

“**Use**” means to view, handle or otherwise deal with the information.

APPENDICES

Appendix A – MFIPPA: Duties and Powers of the Head Related to Freedom of Information and Protection of Individual Privacy
Appendix B – PHIPA: Practices to Protect Personal Health Information
Appendix C – Annual Confidentiality Attestation

APPLICABLE LEGISLATION AND STANDARDS

Municipal Freedom of Information and Protection of Privacy Act
Personal Health Information Protection Act
Regulated Health Professions Act
Ontario Public Health Standards: Requirements for Programs, Services, and Accountability, 2018

APPENDIX A
To Policy G-100

Municipal Freedom of Information and Protection of Privacy Act (MFIPPA) Duties and Powers of the Head Related to Freedom of Information and Protection of Individual Privacy

<table>
<tr><th>MFIPPA Section</th><th>Summary of Duties and Powers</th></tr>
<tr><td colspan="2">Part I – Freedom of Information</td></tr>
<tr><td>Right of access
4 (1)</td><td>4 (1) Every person has a right of access to a record or a part of a record in the custody or under the control of an institution unless,
a) the record or the part of the record falls within one of the exemptions under sections 6 to 15; or
b) the head is of the opinion on reasonable grounds that the request for access is frivolous or vexatious.</td></tr>
<tr><td>Severability of the record
4 (2)</td><td>4 (2) If an institution receives a request for access to a record that contains information that falls within one of the exemptions under sections 6 to 15 and the head of the institution is not of the opinion that the request is frivolous or vexatious, the head shall disclose as much of the record as can reasonably be severed without disclosing the information that falls under one of the exemptions. 1996, c. 1, Sched. K, s. 13.</td></tr>
<tr><td>Measures to ensure preservation of records
4.1</td><td>4.1 Every head of an institution shall ensure that reasonable measures respecting the records in the custody or under the control of the institution are developed, documented and put into place to preserve the records in accordance with any recordkeeping or records retention requirements, rules or policies, whether established under an Act or otherwise, that apply to the institution. 2014, c. 13, Sched. 6, s. 3.</td></tr>
<tr><td>Obligation to disclose
5 (1)</td><td>5 (1) Despite any other provision of this Act, a head shall, as soon as practicable, disclose any record to the public or persons affected if the head has reasonable and probable grounds to believe that it is in the public interest to do so and that the record reveals a grave environmental, health or safety hazard to the public.</td></tr>
<tr><td>Notice
5 (2)</td><td>5 (2) Before disclosing a record under subsection (1), the head shall cause notice to be given to any person to whom the information in the record relates, if it is practicable to do so.</td></tr>
<tr><td colspan="2">Part II – Protection of Individual Privacy</td></tr>
<tr><td>Notice [of collection] to individual
29 (2) and (3)</td><td>29 (2) If personal information is collected on behalf of an institution, the head shall inform the individual to whom the information relates of,
(a) the legal authority for the collection;
(b) the principal purpose or purposes for which the personal information is intended to be used; and
(c) the title, business address and business telephone number</td></tr>
</table>

MFIPPA Section	Summary of Duties and Powers
	of an officer or employee of the institution who can answer the individual's questions about the collection. R.S.O. 1990, c. M.56, s. 29 (2). Exception (3) Subsection (2) does not apply if, a) the head may refuse to disclose the personal information under subsection 8 (1) or (2) (law enforcement), section 8.1 (Civil Remedies Act, 2001) or section 8.2 (Prohibiting Profiting from Recounting Crimes Act, 2002); b) the Minister waives the notice; or c) the regulations provide that the notice is not required. R.S.O. 1990, c. M.56, s. 29 (3); 2001, c. 28, s. 23 (3); 2002, c. 2, ss. 16 (3), 19 (10); 2007, c. 13, s. 45 (3).
Right of access to personal information 36 (1) and 38	36 (1) Every individual has a right of access to, (a) any personal information about the individual contained in a personal information bank in the custody or under the control of an institution; and (b) any other personal information about the individual in the custody or under the control of an institution with respect to which the individual is able to provide sufficiently specific information to render it reasonably retrievable by the institution. 38 A head may refuse to disclose to the individual to whom the information relates personal information, if the record or the part of the record falls within one of the exemptions under section 38.

Personal Health Information Protection Act (PHIPA)
Health Information Custodian Practices to Protect Personal Health Information

PHIPA Section	Requirement
Information practices 10 (1), (2) and (3)	10 (1) A health information custodian that has custody or control of personal health information shall have in place information practices that comply with the requirements of this Act and its regulations. 2004, c. 3, Sched. A, s. 10 (1). (2) A health information custodian shall comply with its information practices. 2004, c. 3, Sched. A, s. 10 (2). (3) A health information custodian that uses electronic means to collect, use, modify, disclose, retain or dispose of personal health information shall comply with the prescribed requirements, if any. 2004, c. 3, Sched. A, s. 10 (3).
Collection 11.1	11.1 A health information custodian shall take steps that are reasonable in the circumstances to ensure that personal health information is not collected without authority. 2016, c. 6, Sched. 1, s. 1 (3).
Security 12 (1)	12 (1) A health information custodian shall take steps that are reasonable in the circumstances to ensure that personal health information in the custodian's custody or control is protected against theft, loss and unauthorized use or disclosure and to ensure that the records containing the information are protected against unauthorized copying, modification or disposal. 2004, c. 3, Sched. A, s. 12 (1).
Notice of theft, loss, etc. 12 (2) and (3)	Notice to individual 12 (2) Subject to subsection (4) and to the exceptions and additional requirements, if any, that are prescribed, if personal health information about an individual that is in the custody or control of a health information custodian is stolen or lost or if it is used or disclosed without authority, the health information custodian shall, (a) notify the individual at the first reasonable opportunity of the theft or loss or of the unauthorized use or disclosure; and (b) include in the notice a statement that the individual is entitled to make a complaint to the Commissioner under Part VI. 2016, c. 6, Sched. 1, s. 1 (4). Notice to Commissioner (3) If the circumstances surrounding a theft, loss or unauthorized use or disclosure referred to in subsection (2) meet the prescribed requirements, the health information custodian shall notify the Commissioner of the theft or loss or of the unauthorized use or disclosure. 2016, c. 6, Sched. 1, s. 1 (4).

Handling of records 13 (1)	13 (1) A health information custodian shall ensure that the records of personal health information that it has in its custody or under its control are retained, transferred and disposed of in a secure manner and in accordance with the prescribed requirements, if any. 2004, c. 3, Sched. A, s. 13 (1).
Contact person 15 (1) and (3)	15 (1) A health information custodian that is a natural person may designate a contact person described in subsection (3). 2004, c. 3, Sched. A, s. 15 (1). (3) A contact person is an agent of the health information custodian and is authorized on behalf of the custodian to, (a) facilitate the custodian's compliance with this Act; (b) ensure that all agents of the custodian are appropriately informed of their duties under this Act; (c) respond to inquiries from the public about the custodian's information practices; (d) respond to requests of an individual for access to or correction of a record of personal health information about the individual that is in the custody or under the control of the custodian; and (e) receive complaints from the public about the custodian's alleged contravention of this Act or its regulations. 2004, c. 3, Sched. A, s. 15 (3).
Written public statement 16 (1) and (2)	16 (1) A health information custodian shall, in a manner that is practical in the circumstances, make available to the public a written statement that, (a) provides a general description of the custodian's information practices; (b) describes how to contact, i. the contact person described in subsection 15 (3), if the custodian has one, or ii. the custodian, if the custodian does not have that contact person; (c) describes how an individual may obtain access to or request correction of a record of personal health information about the individual that is in the custody or control of the custodian; and (d) describes how to make a complaint to the custodian and to the Commissioner under this Act. 2004, c. 3, Sched. A, s. 16 (1). (2) If a health information custodian uses or discloses personal health information about an individual, without the individual's consent, in a manner that is outside the scope of the custodian's description of its information practices under clause (1) (a), the custodian shall, (a) inform the individual of the uses and disclosures at the first reasonable opportunity unless, under section 52, the individual does not have a right of access to a record of the information;

	(b) make a note of the uses and disclosures; and (c) keep the note as part of the records of personal health information about the individual that it has in its custody or under its control or in a form that is linked to those records. 2004, c. 3, Sched. A, s. 16 (2).
Agents and information 17 (1) and (3)	17 (1) A health information custodian is responsible for personal health information in the custody or control of the health information custodian and may permit the custodian's agents to collect, use, disclose, retain or dispose of personal health information on the custodian's behalf only if, (a) the custodian is permitted or required to collect, use, disclose, retain or dispose of the information, as the case may be; (b) the collection, use, disclosure, retention or disposal of the information, as the case may be, is necessary in the course of the agent's duties and is not contrary to this Act or another law; and (c) the prescribed requirements, if any, are met. 2004, c. 3, Sched. A, s. 17 (1); 2016, c. 6, Sched. 1, s. 1 (5). (3) A health information custodian shall, (a) take steps that are reasonable in the circumstances to ensure that no agent of the custodian collects, uses, discloses, retains or disposes of personal health information unless it is in accordance with subsection (2); and (b) remain responsible for any personal health information that is collected, used, disclosed, retained or disposed of by the custodian's agents, regardless of whether or not the collection, use, disclosure, retention or disposal was carried out in accordance with subsection (2). 2016, c. 6, Sched. 1, s. 1 (7).
Notice to governing College 17.1 (2)	17.1 (2) Subject to any exceptions and additional requirements, if any, that are prescribed, if a health information custodian employs a health care practitioner who is a member of a College, the health information custodian shall give written notice of any of the following events to the College within 30 days of the event occurring: 1. The employee is terminated, suspended or subject to disciplinary action as a result of the unauthorized collection, use, disclosure, retention or disposal of personal health information by the employee. 2. The employee resigns and the health information custodian has reasonable grounds to believe that the resignation is related to an investigation or other action by the custodian with respect to an alleged unauthorized collection, use, disclosure, retention or disposal of personal health information by the employee. 2016, c. 6, Sched. 1, s. 1 (8)

ANNUAL CONFIDENTIALITY ATTESTATION BOARD OF HEALTH MEMBERS

I, ____,
Printed Name of Board Member

understand that as a member of the Board of Health for the Middlesex-London Health Unit (MLHU), I may have access to:

- Confidential information (as defined within Policy G-100)
- Personal information (PI) (as defined by MFIPPA)
- Personal health information (PHI) (as defined by PHIPA)

This information could be related to MLHU clients and their families; MLHU employees, students and volunteers; members of my own family, friends or associates; and/or MLHU business, financial and management matters.

I understand that I will only be provided access to such information for the purpose of discharging my duties and responsibilities as a member of the Board of Health. Therefore, due to the highly sensitive nature of this information, I will:

1. Safeguard all confidential information including, but not limited to, PI and PHI, from unauthorized access, use or disclosure in accordance with Policy G-100.
2. Not collect, use or disclose any confidential information including, but not limited to, PI and PHI, without authorization; nor will I discuss, divulge, or disclose such information to others, unless it is necessary to fulfill my duties and responsibilities. Specifically, I will not:
    a) Reveal to anyone the name or identity of a client, employee, student or volunteer that is disclosed through information provided to me in the course of my duties.
    b) Repeat to anyone any statements or communications made by or about confidential MLHU business, financial or management matters, or about an MLHU client, client's family or associates.
    c) Reveal to anyone any information that I learn about an MLHU client, client's family or associates as a result of discussions with others providing care to the client, client's family or associates.
    d) Write, publish, or contribute to any articles, papers, stories or other written materials, or speak with members of the media with respect to information disclosed to me in the course of my duties as a member of the Board of Health, which has been deemed confidential by the Board of Health or Medical Officer of Health/Chief Executive Officer, or would be reasonable to consider confidential or sensitive given the type of information disclosed and the context in which such disclosure is made to the Board of Health, including without limitation, the names or identities of any client, client's family or associates who can be discerned, unless such disclosure is authorized by the Board of Health.
3. Obtain authorization from the Board Chair and/or the Secretary-Treasurer prior to disclosing any confidential information including, but not limited to, PI and PHI.

I have read this statement and understand my obligation to maintain confidentiality. I agree to honour that obligation during my term as a member of the Board of Health and thereafter. I understand that any contravention of the Board of Health/MLHU privacy and confidentiality policies could result in financial penalties, legal liability and other consequences and assessments as deemed appropriate or relevant which could be initiated by the MLHU, another governing body or otherwise.

Signature	Signature of Witness
Name (Please PRINT)	Name of Witness (Please PRINT)
Date	Date

DEFINITIONS

Confidential Information" means personal information, personal health information and/or information regarding the organization which is not publicly disclosed by the organization, this information may include, but is not limited to:

- Matters including personal information and personal health information;
- Personnel matters relating to an employee of the health unit;
- The security of the property of the Board of Health
- Proposed or pending acquisition of land, assets, or services for Board of Health purposes;
- Labour relations or employee negotiations;
- Litigation or potential litigation, including matters before administrative tribunals, affecting the Board;
- Advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
- Matters related to other Acts that may be closed for discussion by the Board of Health
- Matters that relate to requests under the Personal Health Information Protection Act or the Municipal Freedom of Information and Protection of Privacy Act.

"**Personal Health Information**" means identifying information about an individual in oral or recorded form, if the information:

(a) Relates to the physical or mental health of the individual, including information that consists of the health history of the individual's family;
(b) Relates to the providing of health care to the individual, including the identification of a person as a provider of health care to the individual;
(c) Is a plan of service within the meaning of the Home Care and Community Services Act, 1994 for the individual;
(d) Relates to payments or eligibility for health care, or eligibility for coverage for health care, in respect of the individual;
(e) Relates to the donation by the individual of any body part or bodily substance of the individual or is derived from the testing or examination of any such body part or bodily substance;
(f) Is the individual's health number; and/or
(g) Identifies an individual's substitute decision-maker. (PHIPA, s. 4 (1))

"**Personal Information**" means recorded information about an identifiable individual, including:

(a) Information relating to the race, national or ethnic origin, colour, religion, age, sex, sexual orientation or marital or family status of the individual;
(b) Information relating to the education or the medical, psychiatric, psychological, criminal or employment history of the individual or information relating to financial transactions in which the individual has been involved;
(c) Any identifying number, symbol or other particular assigned to the individual;
(d) The address, telephone number, fingerprints or blood type of the individual;
(e) The personal opinions or views of the individual except if they relate to another individual;
(f) Correspondence sent to an institution by the individual that is implicitly or explicitly of a private or confidential nature, and replies to that correspondence that would reveal the contents of the original correspondence;
(g) The views or opinions of another individual about the individual; and/or
(h) The individual's name if it appears with other personal information relating to the individual or where the disclosure of the name would reveal other personal information about the individual. (MFIPPA, s. 2(1))

CONFLICTS OF INTEREST AND DECLARATION

PURPOSE

This policy is intended to ensure the highest business and ethical standards and the protection of the integrity of the Board of Health. The policies contained herein are subject to the requirements of the Health Protection and Promotion Act and the Municipal Conflict of Interest Act. The Municipal Conflict of Interest Act S. 5(1) and S. 5(2) imposes Disclosure requirements on all Board of Health members.

This policy guides Board of Health members, with a real, potential or perceived conflict of interest, on how to declare their conflict and the process for dealing with conflict situations.

POLICY

Board members owe a fiduciary duty to the Board of Health. Included in that duty is the requirement to avoid conflicts of interest. The term “conflict of interest” refers to situations where financial, professional or other personal considerations may compromise, or have the appearance of compromising, a Board member’s judgment in carrying out his/her fiduciary duties as a Board of Health member.

Board members have the responsibility to determine whether a conflict of interest exists. Board members are expected to consult Ontario’s Municipal conflict of Interest Act – A Handbook 2017 and consult independent legal counsel if necessary.

All Board members must understand their duties (see Policy G-270 Roles and Responsibilities of Individual Board Members) when a conflict of interest arises. The principles set out in this policy are to be regarded as illustrative. Board members are required to meet both the letter and spirit of this policy.

Examples of Conflict of Interest

Situations where a conflict of interest might arise cannot be set out exhaustively. Conflicts of interest generally arise in the following circumstances:

1. When a Board member is directly or indirectly interested in a contract or proposed contract with the Board of Health. For example: Board members are bidding on or doing contract work for the Board of Health.

2. When a Board member acts in self-interest or for a collateral purpose. When a Board member diverts to his/her own personal benefit an opportunity in which the Board of Health has an interest.

3. When a Board member has a conflict of “duty and duty”. This might arise when:
    - the Board member serves as a board member or officer of another corporation that is related to; has a contractual relationship with; has the ability to influence the Board of Health policy; or has any dealings whatsoever with the Board of Health; or
    - the Board member is also a Board member or officer of another corporation related or otherwise, and possesses confidential information received in one boardroom that is of importance to a decision being made in the other boardroom. The Board member cannot discharge the duty to maintain such information in confidence as a Board member of one corporation while at the same time discharging the duty to make disclosure as a Board member of the other.

4. When a Board member uses for personal gain information (for example related to human resources, financial aspects of the Board of Health, or related to services provided) received in confidence only for the Board of Health’s purposes.

5. When a Board member or a member of the Board member’s immediate family accepts gifts, payments, services or anything else of more than token or nominal value from a party that hopes to transact business with the Board of Health (including a supplier of goods and services) for the purposes or perceived purpose of influencing an act or decision of the Board.

6. When a Board member and his/her family will gain or be affected by the decision of the Board. For example, a Board member or member of the Board member’s family may benefit from a specific health care service or program that the Board of Health is considering.

Special Considerations for the Board of Health

The Board of Health’s unique governance structure creates automatic potential conflicts. These structural conflicts need not be a bar to participation in most aspects of the Board’s deliberations. In these circumstances, the Board members are aware of the potential for conflict of interest and as a practical matter it should not be necessary to make note of the potential conflict in regular Board proceedings. Where the potential for conflict might not be obvious, the potential conflict of interest should be declared and recorded in the minutes so that all Board members are aware of the situation. This places an extra burden on Board members to be acutely aware of when their actions and/or other responsibilities might create a conflict and follow the procedures in this policy to protect themselves and the best interests of the Board of Health.

PROCEDURE

Conflict of Interest Process

Each Board member of the Board of Health is made aware of how to access the most recent version of the *Municipal Conflict of Interest Act*. This conflict of interest policy also applies to Committees of the Board of Health.

At the beginning of each Board of Health meeting or Committee meeting, the Chairperson asks Board members if they have any conflicts of interest to declare.

Board members must declare any conflict of interest as soon as it has been identified. The declaration should be made to the Board Chair. The declaration shall disclose the nature and extent of the Board member's interest. Disclosure shall be made at the earliest possible time and prior to any discussion, vote or decision-making on the matter (unless such discussion, vote or decision making has occurred before the conflict was discovered). The Board member shall not attempt in any way to influence and such vote or decision.

Public Meeting

Once a conflict of interest has been identified, the Board member(s) with the conflict of interest cannot participate in the discussion or vote. The Board member(s) is not to attempt, in any way, to influence the voting on the issue under consideration.

In Camera Meeting

Where the meeting is not open to the public, the Board member shall forthwith leave the meeting or the part of the meeting during which the matter is under consideration.

Disclosure to Be Recorded in Minutes

Where the meeting is open to the public, the declaration of interest and the general nature is to be recorded in the minutes of the meeting.

Where the meeting is not open to the public, every declaration, but not the general nature of that interest, is to be recorded in the minutes of the next meeting that is open to the public.

When Absent from Meeting at Which Matter Considered

Where the interest of a Board member has not been disclosed by reason of the Board member's absence from the meeting, the member shall disclose the interest at the first meeting of the Board/Committee, as the case may be, attended by the Board member after the meeting where the matter was considered.

Financial Endorsements

Board members of the Board of Health/Committees shall not accept any financial or other endorsements for fulfilling their duties and obligations as members of the Board of Health other than provided for by Legislation and Board of Health policy.

Annual Responsibilities

In addition to complying with the ongoing responsibilities set forth above, the Board members are required to complete an Annual Declaration Form (Appendix A).

APPLICABLE LEGISLATION AND STANDARDS

Municipal Conflict of Interest Act, R.S.O. 1990, c. M.50

RELATED POLICIES

G-270 Roles and Responsibilities of Individual Board Members

APPENDIX A
To Policy G-380

ANNUAL CONFLICTS OF INTEREST DECLARATION
BOARD OF HEALTH MEMBERS

Introduction:

Members of the Board of Health are required to complete, sign and deliver this annual declaration form to the Chair of the Board. Any questions concerning this form or the Conflicts of Interest Policy (G-380) should be directed to the Board Chair or the Medical Officer of Health/Chief Executive Officer.

Declaration:

I declare that:

a) I have read Policy G-380 Conflicts of Interest.

b) I acknowledge that I am bound by Policy G-380 Conflicts of Interest, including the disclosure requirements that apply to me.

c) I understand and acknowledge that my failure to comply with Policy G-380 Conflicts of Interest will be considered a breach of my obligations to the Health Unit and may result in my removal from the Board.

Name	Signature	Date (YYYY/MM/DD)