Our Vision:
Healthy People in Vibrant Communities

BOARD OF HEALTH MEETING

St. Thomas Location: 1230 Talbot St. St. Thomas, ON
Elgin Rooms; MS Teams Participation
Thursday, September 26, 2024, at 1:00 p.m.

AGENDA			
ITEM	**AGENDA ITEM**	**LEAD**	**EXPECTED OUTCOME**
1.0 CONVENING THE MEETING			
1.1	Call to Order, Recognition of Quorum • Introduction of Guests, Board of Health Members and Staff	Bernia Martin	
1.2	Approval of Agenda	Bernia Martin	Decision
1.3	Reminder to disclose Pecuniary Interest and the General Nature Thereof when Item Arises including any related to a previous meeting that the member was not in attendance for.	Bernia Martin	
1.4	Reminder that meetings are recorded for minute-taking purposes, and open session portions are publicly available for 30 days after being posted on Southwestern Public Health's website.	Bernia Martin	
2.0 APPROVAL OF MINUTES			
2.1	Approval of Minutes • June 27, 2024	Bernia Martin	Decision
3.0 APPROVAL OF CONSENT AGENDA ITEMS			
3.1	Invitation: Association of Local Public Health Agencies (alPHa) *alPHa invites local public health agencies and their Board members to attend their Virtual 2024 Fall Symposium, November 6-8, 2024.*	Cynthia St. John	Receive and File
4.0 CORRESPONDENCE RECEIVED REQUIRING ACTION			
4.1	Letter: Support for Bills S-233 and C-223 "An Act to develop a national framework for a guaranteed livable basic income." July 24, 2024: Middlesex London Health Unit *The Middlesex-London Board of Health recommends supporting Bills S-233 and C-223 to address poverty, income insecurity, and food insecurity.*	Cynthia St. John	Receive and File
5.0 AGENDA ITEMS FOR INFORMATION.DISCUSSION.ACCEPTANCE.DECISION			
5.1	SWPH Strategic Plan Report for September 26, 2024	Cynthia St. John Kerry Bastian Corinne Walsh Andrew Bartley	Receive and File
5.2	Medical Officer of Health's Report for September 26, 2024	Dr. Ninh Tran	Decision
5.3	Governance Standing Committee Report for September 26, 2024	Grant Jones	Decision
5.4	Chief Executive Officer's Report for September 26, 2024	Cynthia St. John	Decision
6.0 NEW BUSINESS/OTHER			

AGENDA			
ITEM	**AGENDA ITEM**	**LEAD**	**EXPECTED OUTCOME**
7.0 CLOSED SESSION			
8.0 RISING AND REPORTING OF THE CLOSED SESSION			
9.0 FUTURE MEETINGS & EVENTS			
9.1	• Board of Health Orientation: Thursday, October 24, 2024 at 12:00 p.m. • Board of Health Meeting: Thursday, October 24, 2024 at 1:00 p.m. ○ Oxford County Administration Building 21 Reeve Street, Woodstock, ON ○ Virtual Participation: MS Teams		
10.0 ADJOURNMENT			

June 27, 2024

Board of Health Meeting

Open Session Minutes

A meeting of the Board of Health for Oxford Elgin St. Thomas Health Unit was held on Thursday, June 27, 2024 commencing at 1:00 p.m.

PRESENT:

Ms. C. Agar	Board Member
Mr. J. Couckuyt	Board Member
Ms. B. Martin	Board Member (Chair)
Mr. S. Molnar	Board Member
Mr. M. Peterson	Board Member
Mr. L. Rowden	Board Member
Mr. M. Ryan	Board Member
Mr. D. Shinedling	Board Member
Mr. D. Warden	Board Member
Ms. C. St. John	Chief Executive Officer (ex officio)
Dr. N. Tran	Medical Officer of Health (ex officio)
Ms. W. Lee	Executive Assistant

GUESTS:

Ms. J. Gordon	Administrative Assistant
Mr. P. Heywood	Program Director
Ms. S. MacIsaac	Program Director
Mr. D. McDonald	Director, Corporate Services and Human Resources
Ms. M. Nusink	Director, Finance
Ms. C. Richards	Manager, Foundational Standards
Ms. N. Rowe*	Manager, Communications
Mr. Y. Santos	Manager, Information Technology
Mr. D. Smith	Program Director

MEDIA:

Mr. R. Perry*	Aylmer Express

**represents virtual participation*

REGRETS:

Mr. J. Herbert	Board Member
Mr. G. Jones	Board Member (Vice-Chair)
Mr. D. Mayberry	Board Member
Mr. J. Preston	Board Member

REMINDER OF DISCLOSURE OF PECUNIARY INTEREST AND THE GENERAL NATURE THEREOF WHEN ITEM ARISES

1.1 CALL TO ORDER, RECOGNITION OF QUORUM

The meeting was called to order at 1:00 p.m.

AGENDA

Resolution # (2024-BOH-0627-1.2)
Moved by M. Ryan
Seconded by M. Peterson

That the agenda for the Southwestern Public Health Board of Health meeting for June 27, 2024 be approved.

Carried.

1.3 Reminder to disclose Pecuniary Interest and the General Nature Thereof when the Item Arises, including any related to a previous meeting that a member may not have been in attendance for.

1.4 Reminder that meetings are recorded for minute-taking purposes.

2.0 APPROVAL OF MINUTES

Resolution # (2024-BOH-0627-2.1)
Moved by M. Peterson
Seconded by D. Warden

That the minutes for the Southwestern Public Health Board of Health meeting for May 23, 2024 be approved.

Carried.

3.0 CONSENT AGENDA

Resolution # (2024-BOH-0627-3.1-3.2)
Moved by L. Rowden
Seconded by D. Warden

That the Board of Health for Southwestern Public Health receive and file consent agenda items 3.1 -3.2.

Carried.

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4.0 CORRESPONDENCE RECEIVED REQUIRING ACTION
C. St. John discussed the City of Woodstock's correspondence addressing Ontario's proposal to phase out free water testing for private wells. She recommended sending a letter supporting Woodstock's position, emphasizing that removing free water testing would likely reduce participation and citing the May 2000 Walkerton tragedy to highlight its importance. M. Ryan noted that while testing would still be available, the costs might shift to healthcare services. C. St. John acknowledged that the letter would emphasize public health's perspective.

Resolution # (2024-BOH-0627-4.1)
Moved by M. Ryan
Seconded by D. Warden

> That the Board of Health for Southwestern Public Health support correspondence 4.1 Phasing Out Free Water Testing for Private Wells Resolution.

Carried.

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AGENDA ITEMS FOR INFORMATION.DISCUSSION.DECISION

5.1 Medical Officer of Health Report for June 27, 2024.
Dr. N. Tran reviewed his report.

S. Molnar inquired if the CTS (Consumption and Treatment Services) needs to be funded by a specific municipality. Dr. N. Tran responded that funding can come from any area, but the application must demonstrate safe and guaranteed funding. S. Molnar asked if this option was feasible, and Dr. N. Tran confirmed that the process is similar to the CTS application and could be pursued concurrently, though a separate funding source is necessary.

L. Rowden inquired if the federal government would support a single site. Dr. N. Tran explained that the provincial model requires community endorsement, while the federal model only requires a secured funding source to demonstrate to Health Canada that the site can operate effectively and safely. L. Rowden noted that private funding would need to cover staff, a building, and physician support, which would require a substantial budget. Dr. N. Tran added that there are various operational UPHNs (Urgent Public Health Needs sites) with costs reflecting their scope, from small to large. M. Ryan encouraged exploring alternatives suggested in Dr. N. Tran's report.

Resolution # (2024-BOH-0627-5.1-3.1)
Moved by M. Ryan
Seconded by M. Peterson

> That the Board of Health for Southwestern Public Health accept the Medical Officer of Health's Report for June 27, 2024.

Carried.

5.2 Governance Standing Committee Report

S. Molnar reviewed the report on behalf of Governance Standing Committee (GSC) Chair G. Jones who expressed his regrets.

S. Molnar noted the positive experience of the committee meeting and appreciated the orderly presentation of the substantial amount of material. M. Peterson expressed that, as a new BOH member, he appreciated reviewing the BOH policies and procedures and found it very informative.

Resolution # (2024-BOH-0627-5.2.1)
Moved by S. Molnar
Seconded by M. Peterson

That the Board of Health for Southwestern Public Health approve the following updated bylaws, polices and procedures as presented:

1. Bylaws No. 1 – No. 3
2. BOH-FIN 010 Reserve Fund Draft
3. BOH-FIN-020 Remuneration & Expenses
4. BOH-FIN-030 Budgets
5. BOH-FIN-040 Banking and Financing
6. BOH-FIN-050 Board Member Allowable Expenses (Conferences, etc.)
7. BOH-Gov-010 Conflict of Interest
8. BOH-Gov-020 Oath of Conduct and Confidentiality
9. BOH-Gov-030 Delegation of Powers and Duties
10. BOH-Gov-040 Recording of BOH Meetings
11. BOH-Gov-050 Accountability and Transparency
12. BOH-Gov-060 Terms for Election of Officers
13. BOH-Gov-070 Board Members Orientation
14. BOH-Gov-080 Order in Council Provincial Representatives
15. BOH-HR-030 CEO and MOH Performance Appraisals
16. BOH-HR-050 In Memoriam Acknowledgement
17. BOH-PM-010 Policy Adherence and Policy Development

Carried.

D. Shinedling and L. Rowden excused themselves from the discussion at 1:35 p.m. due to conflicts related to the following discussion regarding their provincial appointments. It was confirmed that quorum remained for this item.

B. Martin noted that the Board of Health (BOH) has the authority to make the final decision on endorsing or not endorsing the Order in Council (OIC) provincial appointments as recommended by the GSC. It was noted a lack of endorsement could still result in an appointment by the province.

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D. Warden referenced BOH letters sent in July 2023 recommending his and L. Rowden's reappointments and expressed concerns about the BOH's limited role in the appointment process. He highlighted the need for policy review, emphasizing that the BOH cannot remove an OIC appointment and pointing out inconsistencies in the appointment process, particularly regarding the new appointments introduced in September 2023 and January 2024 without following the previous protocol as set by SWPH policy.

C. St. John clarified that current legislation allows the province to appoint up to seven members to SWPH's Board and that during the formation of SWPH, there was only one provincial appointment prior to merging and it was not associated with an ask from the existing Board of Health (at that time Elgin St. Thomas Public Health) She explained that post-merger, the need for additional provincial appointments was identified, and candidates were interviewed by the GSC, including D. Warden. The GSC recommended and the BOH endorsed appointments based on a skills matrix, but the province is not obliged to follow SWPH's process.

M. Ryan noted that despite the province's ability to appoint without BOH input, SWPH should still confidently voice its perspective. S. Molnar added that having the government involved to appoint OICs is positive. J. Couckuyt inquired if the legislation recognizes any role for the BOH in OIC appointments, and it was indicated that there is no such role.

Resolution # (2024-BOH-0627-5.2.3)
Moved by M. Ryan
Seconded by M. Peterson

> That the Board of Health for Southwestern Public Health endorse the re-appointments of L. Rowden and D. Shinedling given their contributions to the Board of Health and to their communities thus far and further, that those endorsements be shared with the Public Appointment Secretariat for their consideration.

Carried.

D. Shinedling and L. Rowden returned to the room after the motion was carried; neither member cast a vote for this resolution.

Resolution # (2024-BOH-0627-5.2)
Moved by S. Molnar
Seconded by D. Warden

> That the Board of Health for Southwestern Public Health accept the Governance Standing Committee Report for June 27, 2024.

Carried.

5.3 Chief Executive Officer's Report

C. St. John reviewed her report.

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J. Couckuyt inquired about the official minority languages and was informed by D. Smith that Health Canada had not yet responded to the inquiry. C. St. John added that the Low-German language would be missed in the census because it is not offered as an option in the languages list.

J. Couckuyt commented on the school survey, expressing disappointment that only half of the administrators considered the school nurse as involved in the school community. C. St. John acknowledged this and noted that SWPH will continue encouraging more engagement in schools. S. Molnar asked about the turnover of school nurses and if it affected their involvement. C. St. John clarified that priority schools have an assigned nurse to build trust and familiarity. She also noted that long gone are the days when every school in a public health region had an assigned public health nurse onsite several days a week.

S. Molnar inquired about public health's stance on roadside stands and S. MacIsaac responded that there was low concern for vendors selling fresh fruits and vegetables.

C. St. John informed the board that work was underway to develop SWPH's strategic plan, which would consider community partners and align with the new Ontario Public Health Standards.

M. Peterson inquired about the Association of Municipalities of Ontario (AMO) conference and offered support for the Planet Youth delegation from the BOH members. C. St. John would determine if further assistance was needed. S. Molnar recommended requesting a longer and more direct meeting with the ministers after the AMO delegation, given the allotted meeting time is only 15 minutes.

B. Martin commended P. Heywood's presentation of SWPH's resolutions at the Association of Local Public Health Agencies (alPHa) annual general meeting and expressed appreciation for his contribution. D. Warden congratulated B. Martin on her appointment to the alPha Executive Board, which was met with applause from the BOH.

Resolution # (2024-BOH-0627-5.3-2.1)
Moved by S. Molnar
Seconded by C. Agar

> That the Board of Health approve the audited financial statements for the Healthy Babies Healthy Children Program and the Pre and Post Natal Nurse Practitioner program for the period ending March 31, 2024 and that the Board of Health approve the signing of the Engagement Letter.

Carried.

Resolution # (2024-BOH-0627-5.3-2.2)
Moved by M. Ryan
Seconded by D. Warden

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That the Board of Health for Southwestern Public Health ratify the Board of Health Chair and CEO's signing of the 2023 program-based grants annual reconciliation report as noted.

Carried.

Resolution # (2024-BOH-0627-5.3)
Moved by J. Couckuyt
Seconded by M. Peterson

That the Board of Health accept the Chief Executive Officer's report for June 27, 2024.

Carried.

6.0 NEW BUSINESS

7.0 TO CLOSED SESSION

Resolution # (2024-BOH-0627-C7)
Moved by D. Warden
Seconded by L. Rowden

That the Board of Health move to closed session in order to consider one or more the following as outlined in the Ontario Municipal Act:

(a) the security of the property of the municipality or local board;
(b) personal matters about an identifiable individual, including municipal or local board employees;
(c) a proposed or pending acquisition or disposition of land by the municipality or local board;
(d) labour relations or employee negotiations;
(e) litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board;
(f) advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
(g) a matter in respect of which a council, board, committee or other body may hold a closed meeting under another Act;
(h) information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them;
(i) a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the municipality or local board, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization;
(j) a trade secret or scientific, technical, commercial or financial information that belongs to the municipality or local board and has monetary value or potential monetary value; or
(k) a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board. 2001, c. 25, s. 239 (2); 2017, c. 10, Sched. 1, s. 26.

Other Criteria:

(a) a request under the *Municipal Freedom of Information and Protection of Privacy Act*, if the council, board, commission or other body is the head of an institution for the purposes of that Act; or
(b) an ongoing investigation respecting the municipality, a local board or a municipally-controlled corporation by the Ombudsman appointed under the *Ombudsman Act*, an Ombudsman referred to in subsection 223.13 (1) of this Act, or the investigator referred to in subsection 239.2 (1). 2014, c. 13, Sched. 9, s. 22.

Carried.

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8.0 RISING AND REPORTING OF CLOSED SESSION

Resolution # (2024-BOH-0627-C8)
Moved by D. Warden
Seconded by C. Agar

That the Board of Health rise with a report.

Carried.

Resolution # (2024-BOH-0627-C3.1)
Moved by M. Ryan
Seconded by M. Peterson

That the Board of Health for Southwestern Public Health accept the Chief Executive Officer's Report for June 27, 2024.

Carried.

9.0 FUTURE MEETING & EVENTS

B. Martin noted that she has seen BOH members and staff out in the community for events such as Pride Week and local and staff events, and thanked the group for their participation, engagement, and support.

10.0 ADJOURNMENT

The meeting adjourned at 2:40 p.m.

Resolution # (2024-BOH-0627-10)
Moved by M. Ryan
Seconded by M. Peterson

That the meeting adjourns to meet again on Thursday, September 26, 2024, at 1:00 p.m. or earlier at the call of the Chair.

Carried.

Confirmed: ______________________________

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Association of Local Public Health Agencies

2024 Fall Symposium, Section Meetings and Workshops

Nov. 6-8, 2024

alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa's Fall Symposium, Section Meetings, and workshops will continue the important conversations on the critical role, value, and benefit of Ontario's local public health system.

On November 8th, participate in online plenary sessions with public health leaders in the morning, followed by BOH Section and COMOH Section meetings in the afternoon.

Attendees will also be invited, at no additional cost, to participate in pre-symposium workshops on November 6th & 7th including an all-day workshop on Artificial Intelligence and Local Public Health Agencies.

Dalla Lana School of Public Health

EOHU Eastern Ontario Health Unit
BSEO Bureau de santé de l'est de l'Ontario

Hosted by alPHa with generous support from the University of Toronto's Dalla Lana School of Public Health and Eastern Ontario Health Unit.

Please note that you must be an alPHa member to participate in the Pre-Symposium Workshops, Symposium or Section meetings.

All events are online.
Registration opens in September (date TBD) and will cost $399+HST.

The Honourable Justin Trudeau
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July 24, 2024

Re: Support for Bills S-233 and C-223 "*An Act to develop a national framework for a guaranteed livable basic income*"

Dear Prime Minster, Deputy Prime Minister and Minister of Finance, Minister of Health, House Leaders, and National Finance Committee:

The Middlesex-London Board of Health supports a guaranteed livable basic income as a policy option for reducing poverty, income insecurity, and food insecurity and for providing opportunities for people with lower incomes. As such, we urge your support of Bills S-233 and C-223 "*An Act to develop a national framework for a guaranteed livable basic income*", currently being considered by the Standing Senate Committee on National Finance and in the process of the second reading in the House of Commons.

- Poverty, income insecurity, and household food insecurity have significant impacts on health and well-being.
- Income has a strong impact on health, with better health outcomes associated with higher income levels, and poorer health outcomes associated with lower income levels [1].
- Income increases access to other social determinants of health (e.g., education, food, housing)[1].
- Children living in poverty have an increased risk for cognitive shortfalls and behavioural conditions, and an increased risk of negative health outcomes into adulthood (e.g., cardiovascular disorders, certain cancers, mental health conditions, osteoporosis and fractures, dementia)[2-4].
- Food insecurity is associated with an increased risk of a wide range of physical and mental health challenges, including chronic conditions, non-communicable diseases, infections, depression, anxiety, and stress[5-12].

- Among young children, food insecurity is also associated with poor child health, low birth weight, chronic illness, developmental risk, and poor cognitive outcomes, including vocabulary and math skills[13-15].

A guaranteed livable basic income has the potential to reduce health inequities and positively impact many determinants of health (e.g., income, unemployment and job insecurity, food insecurity, housing, and early childhood development). Evidence suggests that basic income positively impacts health and wellbeing[16,17]. Successful examples of a Canadian basic income include the Old Age Security (OAS) and Guaranteed Income Supplement (GIS). In a cohort of individuals over 65 receiving OAS/GIS, compared to a cohort aged 55-64 years, the probability of food insecurity was reduced by half, even when age, sex, income level, and home ownership were taken into account[18]. In addition, evidence suggests income supplementation reduces food insecurity for low-income Canadians[18] and positively impacts childhood health outcomes (e.g., birth weight, mental health)[19].

In 2022, 10.9% of Ontarians lived in poverty based on the Market Basket Measure, an increase from 7.7% in 2021[20]. In our community in 2021, 16.6% of London households with or without children (89,030 people) were low income based on the Census Family Low Income Measure (CFLIM-AT)[21]. Approximately one in five Middlesex-London residents (18.8%) live in a food insecure household, which represents just over 85,500 residents [22,23].

The Middlesex-London Health Unit conducts the Nutritious Food Basket survey annually to monitor the affordability of food in London and Middlesex County. The 2023 results demonstrate that incomes, particularly when dependent on social assistance, are not adequate for many Middlesex-London residents to afford basic needs[24].

Upstream income-based solutions, such as a guaranteed livable basic income, are needed to address poverty, income insecurity, and household food insecurity and their significant impacts on health and well-being.

Yours truly,

Matt Newton-Reid
Chair, Middlesex-London Board of Health

cc:
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MIDDLESEX-LONDON BOARD OF HEALTH

REPORT NO. 49-24

TO: Chair and Members of the Board of Health

FROM: Dr. Alexander Summers, Medical Officer of Health
Emily Williams, Chief Executive Officer

DATE: 2024 July 18

SUPPORT FOR "AN ACT TO DEVELOP A NATIONAL FRAMEWORK FOR A GUARANTEED LIVABLE BASIC INCOME"

Recommendations

It is recommended that the Board of Health:

1) *Receive Report No. 49-24 re: "Support for 'An Act to Develop a National Framework for a Guaranteed Livable Basic Income'"; and*
2) *Direct the Board Chair to send a letter to the Prime Minister of Canada, Deputy Prime Minister and Minister of Finance, Minister of Health, House Leaders, Standing Senate Committee on National Finance, and local Members of Parliament in support of S-233 and C-223 "An Act to develop a national framework for a guaranteed livable basic income".*

Report Highlights

- In 2022, 10.9% of Ontarians lived in poverty based on the Market Basket Measure, an increase from 7.7% in 2021.
- Upstream income-based solutions, such as a guaranteed livable basic income, are needed to address poverty, income insecurity, and household food insecurity and their significant impacts on health and well-being.
- Opportunities exist to influence healthy public policy through support for "An Act to develop a national framework for a guaranteed livable basic income" which is currently moving through the Senate (S-233) and the House of Commons (C-223).

Background

Upstream income-based solutions are needed to address poverty, income insecurity, and household food insecurity and their significant impacts on health and well-being. The Association of Local Public Health Agencies (alPHa) endorsed the concept of a basic income guarantee as a policy option for reducing poverty and income insecurity and for providing opportunities for people with lower incomes[1]. A guaranteed livable basic income is a cash transfer from the government to citizens, not tied to labour market participation, that ensures everyone has a sufficient income to meet basic needs and live with dignity.

In 2022, 10.9% of Ontarians lived in poverty based on the Market Basket Measure, an increase from 7.7% in 2021[2]. In 2021, 16.6% of London households, with or without children (89,030 people), were low income based on the Census Family Low Income Measure (CFLIM-AT)[3]. Approximately one in five Middlesex-London residents (18.8%) live in a food insecure household, which represents just over 85,500 residents[4,5]. The Middlesex-London Health Unit conducts the Nutritious Food Basket survey annually to monitor the affordability of food in London and Middlesex County. The 2023 results demonstrate that incomes, particularly when dependent on social assistance, are not adequate for many Middlesex-London residents to afford basic needs[6].

Health Impacts

Poverty, income insecurity, and household food insecurity have significant impacts on health and well-being. Income has a strong impact on health, with better health outcomes associated with higher income levels and poorer health outcomes associated with lower income levels[7]. In addition, income increases access to other social determinants of health (e.g., education, food, housing)[7]. Income inequality is a key health policy issue requiring attention from policymakers[7].

Children living in poverty have an increased risk for cognitive shortfalls and behavioural conditions and an increased risk of negative health outcomes into adulthood (e.g., cardiovascular disorders, certain cancers, mental health conditions, osteoporosis and fractures, dementia)[8-10].

Food insecurity is associated with an increased risk of a wide range of physical and mental health challenges, including chronic conditions, non-communicable diseases, infections, depression, anxiety, and stress[11-18]. Among young children, food insecurity is also associated with poor child health, low birth weight, chronic illness, developmental risk, and poor cognitive outcomes, including vocabulary and math skills[19-21].

Guaranteed Livable Basic Income

A guaranteed livable basic income has the potential to reduce health inequities and positively impact many determinants of health (e.g., income, unemployment and job insecurity, food insecurity, housing, and early childhood development). Evidence suggests that basic income positively impacts health and wellbeing[22,23]. Successful examples of a Canadian basic income include the Old Age Security (OAS) and Guaranteed Income Supplement (GIS). In a cohort of individuals over 65 receiving OAS/GIS, compared to a cohort aged 55-64 years, the probability of food insecurity was reduced by half, even when age, sex, income level, and home ownership were taken into account[24]. In addition, evidence suggests income supplementation reduces food insecurity for low-income Canadians[25] and positively impacts childhood health outcomes (e.g., birth weight and mental health)[26].

From 2017-2019, the Ontario government conducted a basic income pilot with 4,000 participants from the Hamilton area, the Thunder Bay area, and in Lindsay, Ontario. There is limited evaluation from the pilot, as the study ended earlier than anticipated. Results from the Hamilton area showed “many recipients reported improvements in their physical and mental health, labour market participation, food security, housing stability, financial status, and social relationships[23(p4)]”. Further assessment of basic income as a policy option could demonstrate positive health outcomes.

"An Act to develop a national framework for a guaranteed livable basic income" is currently moving through the Senate (S-233)[27] and the House of Commons (C-223)[28]. The Bill requires "the Minister of Finance to develop a national framework for the implementation of a guaranteed livable basic income program throughout Canada for any person over the age of 17, including temporary workers, permanent residents and refugee claimants". The framework includes measures to: 1) determine what constitutes a livable basic income for each region in Canada; 2) create national standards for complementary health and social supports; 3) ensure participation in education, training, or the labour market is not required to qualify; and 4) ensure implementation does not result in a decrease in services or benefits related to health or disability.

Senate Bill S-233 is being considered by the Standing Committee on National Finance after passing the second reading (April 2023) and House of Commons Bill C-223 was read a second time and is in the Order of Precedence after an initial debate (May 2024). The Bills require support to continue moving through the Senate and House of Commons.

Public Health Support and Next Steps

The Board of Health has a history of support for income-based solutions to reduce rates of poverty, income insecurity, and household food insecurity including social assistance policy, increased social assistance rates, support for basic income, and support for the Ontario basic income pilot (Report No. 25-23 Minutes[6], Report No. 070-19[29], Report No. 053-18[30], Report No. 007-17[31], Report No. 063-16[32], Report No. 50-15[33]). Recently, Ottawa Public Health (June 2024 – Appendix A), Thunder Bay Public Health Unit (Agenda item 9.1)[34], and Ontario Dietitians in Public Health[35] have submitted reports and letters in support of Bill S-233 and C-223.

It is recommended that the Board of Health send a letter to the Prime Minister of Canada, Deputy Prime Minister and Minister of Finance, Minister of Health, House Leaders, Standing Senate Committee on National Finance, and local Members of Parliament in support of S-233[27] and C-223[28] "*An Act to develop a national framework for a guaranteed livable basic income*" (Appendix B).

References are affixed as Appendix C.

This report was written by the Municipal and Community Health Promotion Team of the Family and Community Health Division.

Alexander Summers, MD, MPH, CCFP, FRCPC	**Emily Williams, BScN, RN, MBA, CHE**
Medical Officer of Health	Chief Executive Officer

This report refers to the following principle(s) set out in Policy G-490, Appendix A:

- The Chronic Disease Prevention and Well-Being and Healthy Growth and Development standards as outlined in the *Ontario Public Health Standards: Requirements for Programs, Services and Accountability*.
- The following goal or direction from the Middlesex-London Health Unit's Strategic Plan:
  - Our public health programs are effective, grounded in evidence and equity

This topic has been reviewed to be in alignment with goals under the Middlesex-London Health Unit's Anti-Black Racism Plan and Taking Action for Reconciliation, specifically recommendations:

Anti-Black Racism Plan
Recommendation #37: Lead and/or actively participate in healthy public policy initiatives focused on mitigating and addressing, at an upstream level, the negative and inequitable impacts of the social determinants of health which are priority for local ACB communities and ensure the policy approaches take an anti-Black racism lens.

Taking Action for Reconciliation
Supportive Environments: Establish and implement policies to sustain a supportive environment, as required, related to the identified recommendations.
Equitable Access and Service Delivery: Clarify all funding sources during the development process for collaborative Indigenous-related programs and/or services. Transparency about funding and operational expenses is important to the relationship-building process.

BOARD REPORT

SWPH Strategic Plan Report

MEETING DATE:	September 26, 2024
SUBMITTED BY:	Cynthia St. John, CEO and Kerry Bastian, Manager of Strategic Initiatives
SUBMITTED TO:	Board of Health
PURPOSE:	☐ Decision ☐ Discussion ☒ Receive and File
AGENDA ITEM #	5.1
RESOLUTION #	2024-BOH-0926-5.1
REPORT TITLE:	Southwestern Public Health Strategic Plan Report

Background

A strategic plan is mandated under the Ontario Public Health Standards (OPHS), which require the Board of Health to establish strategic priorities over a 3 to 5-year period, incorporating input from staff, clients, and community partners. Southwestern Public Health (SWPH) developed its current strategic plan in 2019 as a five-year roadmap to guide operations through 2024. With this timeline nearing its end, and further to previous CEO reports on this matter, SWPH now requires a new strategic plan to shape its future direction.

Project Objectives

The objectives of strategic planning for SWPH including the following:

- Adopt a strategic plan that establishes a long-term vision for SWPH and sets a course of action through focused strategic goals, prioritized initiatives, and measurable objectives.
- Provide the foundation for developing a shorter-term operational plan that includes key performance indicators, such as objectives, outputs, quality measures, and outcomes.
- Develop a strategic planning process that is transparent, inclusive, and aligned with the organization’s capacity and resources.
- Ensure the final strategic plan is integrated into program and service teams, aligning their operational plans with the organization's strategic priorities.

Our Strategic Plan Process

In the spring of this year, we initiated the strategic planning process, which consists of three phases. The first phase, divided into four sub-phases, focuses on developing the new strategic plan, including 3-5 strategic goals, with an anticipated completion by summer 2025. The second phase will involve program and service planning to operationalize the strategy. The third phase, beginning in January 2026, will focus on implementation and progress monitoring, extending through the end of 2029.

Key Milestones Completed

We are currently in Phase 1a: Plan, wherein the following key milestones have been achieved:

- Established process and timelines
- Developed strategic planning project and evaluation plans
- Developed a communication strategy
- Identified a consulting firm to support the Phase 1 work
- Established an internal staff Strategic Planning Steering Committee
- Held the first meeting with the Strategic Planning Steering Committee
- Held a brief strategic planning kick-off meeting with SWPH staff
- Planned evidence gathering and engagement opportunities for Phase 1b: Evidence & Engage

Ongoing Initiatives

- Plan engagement opportunities with internal and external stakeholders (i.e., SWPH staff, the Board of Health members, community partners and agencies, SWPH clients, including members of the public)

Challenges and Opportunities

Strategic planning presents several challenges, including the need to align diverse stakeholder interests and secure buy-in from program and service teams, each of which may have differing priorities. Additionally, limited resources—such as time, budget, and personnel—can constrain the scope of planning efforts. Public health faces unique challenges, such as the unpredictability of emerging health concerns, which can disrupt even the most carefully developed plans. Furthermore, addressing health inequities and ensuring equitable access to care and services places additional strain on already limited budgets and staff. These challenges necessitate a flexible, adaptive approach to strategic planning that can respond to both immediate and long-term health needs.

Strategic planning also presents significant opportunities for SWPH. It allows the organization to proactively address community needs and improve long-term health outcomes. A clear strategic direction helps align teams around shared goals, optimizing resource use and enhancing public well-being. Strategic planning also encourages innovation by fostering the adoption of new health practices, technologies, and partnerships. A well-designed plan will equip SWPH to navigate challenges effectively while strengthening overall community health.

Stakeholder Engagement

Stakeholder engagement will be an essential component of our strategic planning process which is consistent with Board of Health previous discussions. We will engage various stakeholder groups throughout the development process. Internal SWPH stakeholders include the Board of Health members, the Leadership Teams, and frontline staff, and will be engaged through each of the four sub-phases of Phase 1. Engagement opportunities will include a Strategic Planning Kick-Off event, town hall and focus group meetings, a strategic planning event to identify and prioritize strategic goals, etc.

External Stakeholders include community partners and agencies, clients, and members of the public. These stakeholder groups will be engaged in Phase 1b: Evidence and Engage, where we will provide opportunities for these groups to share their thoughts on our future strategic direction. This approach will not only strengthen our plan's relevance and impact, but it also increases the likelihood of successful implementation by aligning SWPH stakeholders around shared goals.

Next Steps

We have made significant progress on completing our Phase 1a deliverables and anticipate finishing this phase by early fall. Following this, we will move into Phase 1b: Evidence and Engage, later in the season. We look forward to the Board's leadership through participation and engagement, which will help design and guide the strategic goals and ensure the plan reflects the long-term needs of the community.

MOTION: 2024-BOH-0926-5.1
That the Board of Health for Southwestern Public Health accept the Strategic Plan Report for September 26, 2024.

Medical Officer of Health

Report to the Board

MEETING DATE:	September 26, 2024
SUBMITTED BY:	Dr. Ninh Tran, Medical Officer of Health (written as of September 13, 2024)
SUBMITTED TO:	Board of Health
PURPOSE:	☐ Decision ☐ Discussion ☒ Receive and File
AGENDA ITEM #	5.2
RESOLUTION #	2024-BOH-0926-5.2

1.0 Fall and Respiratory Season

The end of summer leads to a fall season busy with activity, including return to work and school. This, coupled with colder temperature and more indoor activities, leads to the usual Fall Respiratory Season. Various seasonal respiratory pathogens, such as influenza, respiratory syncytial virus (RSV) along with Covid-19, are expected to circulate putting strains in our health system.

Similar to last Fall, there will be additional vaccine products available, including updated Covid-19 vaccine products and seasonal influenza vaccine. The updated Covid-19 product is expected to be available to higher-risk groups later this month. It will be important to ensure residents are up to date with the recommended Covid-19 vaccine dose and influenza vaccine.

For Covid-19, this is especially important for individuals who have gone 6 months or longer since their last dose or infection and are at an elevated risk of experiencing complications. Those at higher risk for complications due to Covid-19 and/or influenza as well as their providers include:

- Residents and staff living in congregate living settings
- Pregnant individuals
- People >= 65 years of age
- Children 6 months to 4 years (for influenza)
- First Nations, Inuit, and Métis (FNIM)
- Individuals 6 months or older with underlying health conditions as per the National Advisory Committee on Immunization (NACI)
- Members of racialized and other equity deserving communities
- Health care providers

NB: the prior Covid-19 vaccine product targeting the XBB variant has been recalled as of September 1st, 2024 and is no longer available for use in preparation for the updated product.

As well, there has been expansion of the RSV immunization program. In addition to the provincially funded program for those 60 years and older living in long-term care homes, Elder Care Lodges and for some retirement home residents, the Province will be providing an expanded infant RSV prevention program. This will include immunization access to all infants born during and outside of the RSV season and children under 2 years of age with high-risk medical conditions, as well as for pregnant individuals to protect newborns from RSV from birth until they are six months old. The infant product Beyfortus is the recommended approach for protection of infants, with the vaccine in pregnancy being available on a case-by-case basis.

2.0 Ontario Human Rabies Case

Ontario has reported its first locally acquired human case of rabies since 1967, thought to be acquired in Ontario by an exposure to a bat. As of September 6, 2024, this individual was hospitalized at the time.

Rabies is a virus that is spread through the saliva of animals. It affects an animal's brain, which eventually leads to death. Humans exposed to a rabid animal will require treatment to avoid death. Bats are particularly known to carry rabies, and bats in all areas of Ontario are known to carry rabies. Skunks, foxes and raccoons are also common animals to have rabies.

Southwestern Public Health (SWPH) regularly responds to animal bite reports and supports its residents and health care sector to provide treatment to any suspected exposures. In light of this case, we will review our current practice regarding rabies response to determine if any adjustments need to be made and will monitor any changes in provincial guidance or policy as well. In addition, SWPH has partnered with some local veterinarians to provide a low-income animal rabies vaccine clinic on September 28, 2024.

3.0 Update on Provincial announcement re: CTS and HART Hubs

On August 20th, 2024, the Province announced major changes to its approach to its Consumption and Treatment Services (CTS) program, including a shift to and increased emphasis and investments on treatment and recovery.

Regarding the supervised consumption services, including the Provincial CTS program:

The province is banning supervised drug consumption sites within 200 metres of schools and child care centres. The ban on consumption sites within 200 metres of a school or child care centre will result in the closure of nine provincially-funded sites and one self-funded site, located in Ottawa, Guelph, Hamilton, Thunder Bay, Kitchener and Toronto, no later than March 31, 2025. These nine provincially-funded sites will be encouraged to submit proposals to transition to Homelessness and Addiction Recovery Treatment (HART) Hubs and will be prioritized by the province during the review process. For the remaining CTS sites that are not impacted with this set-back, they will be subject to new requirements for safety and security

plans, as well as new policies to discourage loitering and promote conflict de-escalation and community engagement.

The provincial government will also introduce legislation this fall that would, if passed, prohibit municipalities or any organization from standing up new consumption sites or participating in federal safer supply initiatives. If passed, the legislation will prohibit municipalities from requesting the decriminalization of illegal drugs by the federal government.

Shift towards Homelessness and Addictions Recovery Treatment (HART) Hubs:

The province is investing $378 million in 19 new HART Hubs. The Province describes this as an investment in a system of care that prioritizes community safety, treatment and recovery. HART Hubs, similar to existing hub models in Ontario that have successfully provided people with care, will reflect regional priorities by connecting people with complex needs to comprehensive treatment and preventative services that could include:

- Primary care
- Mental health services
- Addiction care and support
- Social services and employment support
- Shelter and transition beds
- Supportive housing
- Other supplies and services, including naloxone, onsite showers and food

HART Hubs will add up to 375 highly supportive housing units, in addition to addiction recovery and treatment beds, that the Province anticipates will help thousands of people each year transition to more stable long-term housing. With a focus primarily on treatment and recovery, HART Hubs will not offer safer supply, supervised drug consumption or needle distribution programs. While comprehensive drug strategies generally involve a four pillar approach (prevention, treatment, harm reduction and enforcement/community justice), the Provincial Hart Hub model will primarily be focussing on some of these pillars.

Next Steps:

Given the provincial announcement, including further planned provincial legislation this fall, SWPH will pause its work on CTS and any Urgent Public Health Needs Site/Supervised Consumption Site work while we await further provincial direction and legislation in the fall.

We will review the HART Hub application materials and application process to support any local applications, particularly given the tremendous opportunity to advance local efforts at treatment and recovery.

MOTION: 2024-BOH-0926-5.2
That the Board of Health for Southwestern Public Health accept the Medical Officer of Health's Report for September 26, 2024.

Governance Standing Committee
Report to the Board

MEETING DATE:	September 26, 2024
SUBMITTED BY:	Grant Jones, Governance Standing Committee Chair
SUBMITTED TO:	Board of Health
PURPOSE:	☒ Decision ☐ Discussion ☐ Receive and File
AGENDA ITEM #	5.3
RESOLUTION #	2024-BOH-0926-5.3

The Governance Standing Committee (GSC) met Monday, September 16, 2024 to review the following items.

1.0 Order in Council Representatives (Receive and File):

At the June 2024 Board of Health meeting, the GSC recommended the reappointments of D. Shinedling and L. Rowden for Provincial approval, which the Board endorsed. I am pleased to report that D. Shinedling has been reappointed to Southwestern Public Health's (SWPH) Board for a three-year term, effective August 17, 2024. His reappointment notice arrived just before the expiration of his term, and we appreciate the timely approval. Based on previous experience with the public appointment process, we anticipate receiving notice of L. Rowden's reappointment in late October or early November, ahead of his term ending on November 28, 2024.

2.0 SWPH Board of Health Competency Matrix (Receive and File):

The Board of Health Competency Matrix Survey is an important governance tool that assesses the knowledge, expertise, and experience of Board members, identifying any gaps for future governance work. The 2024 Competency Matrix highlighted strengths in governance, government relations, advocacy, public policy, and financial literacy, with some areas like human resources strategy and quality and safety showing room for growth.

As strategic planning begins, there is an opportunity to integrate learning and development into the process. Brief sessions on topics such as human resources strategy or organizational transformation can be incorporated into the discussions. Additionally, SWPH's orientation

sessions before Board meetings can be used for concise educational updates, such as cyber security, and fiduciary and governance best practices. Such approaches will be further explored by Cynthia and team and Cynthia will report back.

3.0 SWPH Risk Register (Decision):

SWPH conducts annual assessments of both internal and external risks that may impact its operations and its ability to fulfill its mandate. This proactive approach to risk management is essential for providing the Board with the necessary information to govern effectively while ensuring the organization is consistently addressing and mitigating potential risks. Additionally, the Board of Health is required to submit a comprehensive Risk Register to the Ministry of Health each year.

The Governance Standing Committee reviewed the 2024 Risk Register updates and the draft 2025 Risk Register, which were developed by the senior leadership team using the Board of Health-approved risk management framework. This framework enables SWPH to identify, assess, and mitigate risks, formalize responsibilities for risk management, and establish clear reporting timelines. These efforts ensure accountability and support effective governance and operations in public health.

MOTION: 2024-BOH-0926-5.3-3.0
That the Board of Health for Southwestern Public Health approve the 2024 Risk Register with noted Mitigation Strategies Update, and the 2025 Risk Register with Mitigation Strategies, as presented to the Governance Standing Committee for September 26, 2024.

MOTION: 2024-BOH-0926-5.3
That the Board of Health for Southwestern Public Health accept the Governance Standing Committee Chair's report for September 26, 2024.

Chief Executive Officer
Open Session
Report to the Board

MEETING DATE:	September 26, 2024
SUBMITTED BY:	Cynthia St. John, Chief Executive Officer (written as of September 11, 2024)
SUBMITTED TO:	Board of Health
PURPOSE:	☐ Decision ☐ Discussion ☒ Receive and File
AGENDA ITEM #	5.4
RESOLUTION #	**2024-BOH-0926-5.4**

1.0 PROGRAM AND SERVICES UPDATES (RECEIVE AND FILE):

1.1 HEALTHY FOUNDATIONS: COMMUNITY HEALTH STATUS REPORT

Understanding the unique health challenges facing our community, alongside the social, political, and economic factors that influence well-being, is critical for shaping our public health priorities. By identifying these local needs, staff can develop targeted programs and services to address gaps and improve health outcomes. The Community Health Status Report plays a vital role in informing these efforts and I am excited to provide an update on our approach, current progress, and the next steps.

Approach

A community health profile is a compilation of key indicators such as sociodemographic data, health status, quality of life measures, risk factors, and available health resources. These indicators provide a comprehensive view of the community's health and are essential in priority setting and data interpretation. However, the process of developing a full report can take 12 to 18 months, given the breadth of data collection and analysis involved.

Recognizing the need for timely updates, SWPH Foundational Standards team have opted for a chapter-based approach to releasing these reports. This allows internal staff, community partners, and the public to access the most up-to-date information as it becomes available, rather than waiting for the completion of the entire report.

Current Progress

The first in this series, the Community Profile Report, is now accessible on the Southwestern Public Health (SWPH) website (www.swpublichealth.ca/en/reports-and-statistics/community-health-status.aspx.) This report presents the latest demographic and health equity data for our region and

serves as a foundational document for ongoing work. Please have a look at the report using the link above. There are some noteworthy data that can inform programs and services in our community and Page 4 is the summary. In June, the Foundational Standards team completed a series of internal presentations, delivering the most current health status data on a variety of topics to staff.

Next Steps

The Foundational Standards team is now focused on transforming these internal presentations into publicly available reports. These reports will be released throughout the remainder of the year, ensuring that our stakeholders and community members have access to critical health information in real time.

1.2 ORAL HEALTH PRACTICE MANAGEMENT SOFTWARE MIGRATION

SWPH is transitioning from Dentrix, an outdated dental management software, to Curve Dental, a cloud-based solution, to better support its multiple dental clinics. Dentrix, implemented 15 years ago, struggles with multi-site functionality, slow performance, frequent system reboots, and limited features such as inability to perform chart audits. The software's inefficiencies have affected clinic operations and staff productivity (due to software glitches and lag times). Curve Dental was selected due to its streamlined interface, cost-effective pricing (based on sites, not users), and enhanced features like integrated x-ray viewing, chart audits, and secure communication via text and email.

The migration is labour intensive and involves several different staff and a timeline of a data transfer by November. The entire project is within the operating budget and in the end, will be much more effective and efficient for our operations.

1.3 HEALTHY ENVIRONMENTS

1.3.1 Climate Change

The proposal for a HeatAdapt grant was sent to Health Canada on September 5th. Any opportunity to secure other revenue sources to support our programs is worthwhile exploring. The HeatAdapt grant aims to adopt a health equity and human-nature-focused approach to extreme heat adaptation to ensure community and planetary health. This includes providing tailored interventions and engagements with community members to capture their unique strengths and needs while reconnecting people with nature. The project will address policies, practices, resource flows, relationships and connections, power dynamics, and mental models that hold inequitable conditions in place.

Concurrently, work is progressing on actioning the recommendations from the Vulnerability Assessment. The Waterloo Climate Institute is continuing to move forward with these initiatives, ensuring that all necessary steps are being taken to address the identified vulnerabilities.

1.3.2 Vector Borne Diseases

As the West Nile virus and beach season wrap up, it is important to note that, to date, no positive human cases have been reported. However, there were three positive traps and one positive bird reported. Public messaging has been disseminated to inform the community about prevention and protection measures. This proactive communication aims to raise awareness and encourage residents to take necessary precautions to minimize the risk of infection.

1.4 VACCINE PREVENTABLE DISEASES

1.4.1 Investments in Publicly Funded Immunization for our community

Where some programs and services are slower over the summer months to recharge and ready for the Fall season ahead, the Vaccine Preventable Diseases (VPD) team at SWPH was full steam ahead as there have been several changes to improve the coverage available to community members through the publicly funded vaccination program.

1.4.2 Pneumococcal vaccine program changes

Each year, the bacteria *Streptococcus pneumoniae (S. pneumoniae)* is responsible for causing up to 50% of all cases of bacterial meningitis. The case-fatality rate of pneumococcal meningitis is 8% among children and 22% among adults (Ministry of Health, 2024). Permanent neurological damage is common among survivors. *S. pneumoniae* is also responsible for invasive disease when it invades normally sterile sites, such as the blood (bacteremia) with a case-fatality rate of 5-7% and is higher among elderly persons and those with multiple co-morbidities.

Outside of meningitis and bacteremia, *S. pneumoniae* is also a cause of community acquired pneumonia, acute otitis media (ear infection), bronchitis, sinusitis, and others. For the Board's information, in Ontario, there are three pneumococcal vaccine programs:

1. Routine vaccination program for children aged 6 weeks to 4 years
2. Routine vaccination program for individuals aged 65 years and older
3. High risk vaccination program for individuals aged 6 weeks and older with certain medical or non-medical conditions who are at high risk for Invasive Pneumococcal Disease (IPD)

The two very commonly used vaccines in the province of Ontario (Pneu-C-13 and Pneu-P-23) have been recently replaced with improved products (Pneu-C-15 known as Vaxneuvance® and Pneu-C-20 known as Prevnar 20®) as part of the provincial publicly funded vaccination program. These new and enhanced vaccine products protect against more strains of pneumococcal illness and have replaced products that are less immunogenic (referring to their ability to create an immune response).

These newer vaccines - Vaxneuvance® and Prevnar 20® offer longer term protection than previous products and they are offered routinely in our SWPH clinics.

Part of our work is also to physically exchange the older vaccines with the newer ones at all health care provider offices in our region. We added that work to our routine fridge inspection office visits to maximize efficiency and also use the occasion to promote the newer vaccines. This summer, SWPH's VPD team inspected over 70 fridges in health care provider offices, hospitals, walk-in clinics, long term care homes, workplaces, and retirement homes to ensure vaccine in our region is stored safely by providers who are aware of and practice high standards of care related to vaccine storage and handling practices.

1.4.3 RSV Program Enhancements

Further to Dr. Tran's report on the fall respiratory season, and the expanded availability of RSV vaccine, SWPH's staff have ensured our health care providers and hospital setting partner can order

this vaccine through our vaccine ordering process. SWPH is expecting to receive this product for distribution to these health care partners in early to mid-October for immediate administration ahead of the 2024/2025 respiratory illness season.

1.4.4 Expanding Space to Provide Vaccination Support in Aylmer

For many years, the Oral Health team has shared their clinical space (including small office space, a shared waiting room, and single operatory) with the VPD team once monthly to support clients in the Aylmer area. This clinical space at 424 Talbot Street E, Aylmer, has provided a welcoming and familiar environment for families and caregivers as a recognized space for public health services. With the recent departure of another health care provider who was sharing this space, SWPH has taken the opportunity beginning September 1st, 2024 to lease this vacated space and transform it into additional clinical space as a trial for 12 months.

This dedicated two-room, clinical space for the VPD team will allow for a more wraparound experience and more program delivery collaborations. SWPH's VPD team routinely offers multi-antigen clinics (with evening times available) during the 1st Tuesday of every month and appointments can be booked online at www.swpublichealth.ca/booking. Planning is underway to offer increased access to vaccinations in this new clinical space during pressure points of the year such as during elementary and secondary school immunization record review times as well as alongside our oral health program where we can promote vaccination opportunities for families who are attending the space for dental needs. We are excited to grow to meet the vaccination needs of the Aylmer and area communities through this expansion!

1.5 INFECTIOUS DISEASES

The number of institutional outbreaks began to increase in August, with the primary pathogen causing the outbreak being COVID-19. Cases are spreading in some facilities, impacting both residents and staff. Fortunately, only a few cases have required hospitalization. This pattern of COVID-19 activity is similar to what was observed at the end of last summer; however, this year, the residents received their last dose of the COVID-19 vaccine more recently than in 2023.

SWPH is hosting a workshop on Infection Prevention and Control and outbreak preparedness for staff working at Long-Term Care, Retirement homes, and other congregate settings such as group homes on September 12, 2024. The focus of the workshop will be to discuss the impact of the pandemic on workers and how to create an environment to limit the spread of infection and control outbreaks when they occur.

The number of pertussis cases in our region continues to be elevated above the yearly average and greatly increased above the provincial average. The number of cases reported in August decreased from July; however, there may be an increase in cases in the fall with the return of children to class.

1.6 COVID AND INFLUENZA

Further to Dr. Tran's report on the fall respiratory season Influenza Program is getting organized. A variety of vaccine products are available, including quadrivalent vaccines (QIV) for individuals aged 6 months to under 65, quadrivalent high-dose vaccines for adults 65 years and older, and adjuvanted trivalent vaccines (TIV), which enhance immune response. Vaccination can be

administered concurrently with other seasonal vaccines, and the first shipments are expected to arrive in early October.

For the fall COVID-19 vaccination efforts, SWPH plans to host four offsite vaccination events in both Woodstock/Oxford and St. Thomas/Elgin throughout November and early December. These will be walk-in only, providing greater access to individuals facing barriers to traveling to the main clinic locations. Both COVID-19 and influenza vaccines (excluding the high-dose version) will be offered. Oxford EMS/Medavie will continue to offer vaccinations to homebound individuals.

Rapid Antigen Tests (RATs) will remain available free of charge at SWPH offices and local libraries. The current stock has an expiry date at the end of September, and SWPH will continue to order additional tests from the Ministry as long as supplies last.

1.7 EMBRACING DIGITAL INNOVATIONS

The rapid evolution of Generative Artificial Intelligence (AI) tools, such as OpenAI ChatGPT, MS CoPilot, and Google Gemini, have provided new opportunities for public health to embrace and adopt new means to connect with the community and our staff. SWPH is in the initial stages of exploring how Generative AI tools can help us to connect with the communities we serve, build capacity, and leverage these digital innovations to enhance our existing practices and processes.

Over the summer months, SWPH has been learning more about and partner with other health units to design and plan for the implementation of AI tools in how we connect, communicate with the public, and generate ideas for program deliverables. In partnership with Wellington-Dufferin-Guelph Public Health and Simcoe Muskoka District Health Unit, we have applied for the Locally Driven Collaborative Projects (LDCP) program by Public Health Ontario (PHO) which brings together public health units (PHUs) and partners to design and implement research and evaluation projects on public health issues of shared interest. Our submission aims to evaluate the utility and impact of a generative AI-based chatbot that will be available for the public for three Ontario public health units.

In tandem with this proposal, SWPH has also commenced work to update and modernize the existing internet, intranet, and Board of Health portal. The goal being that our sites, tools, and means of communication will reflect current and future practices, accessibility, and demonstrate a commitment to the end-user experience. Our work will continue throughout the fall months, with the completion goal of end of the year, and deployed go-live, January 2025. For each of the external and internal sites, we want to ensure that we provide an easily accessible location where users can find the important documents, policies, procedures, announcements, and any other relevant information to support their queries.

Through a more personalized experience, that encompasses AI technology, SWPH will continue to strive to keep up with digital trends and ensure that we are able to present information and data in a meaningful way that connects users, stakeholders, and members of the public.

1.8 PROGRAM AND ORGANIZATIONAL MONITORING SYSTEM (POMS)

Part of our planning for the 2025 year will include a new method to better understand and represent the progress being made within programs and services across SWPH. Being able to showcase meaningful data, trends, and progress is valuable to the communities we serve and to the Board. This is also a beneficial resource for our staff in their planning and responsiveness to the delivery of their programs.

As part of SWPH's commitment to accountability and transparency, our staff have developed a Program and Organizational Monitoring System (POMS). This system will track and report the progress programs make toward their program plans and objectives on a regular cadence. This new system will aim to demonstrate SWPH's progress in meeting community needs, improving population health, and showcasing organizational performance and responsiveness.

Our intention and goal for POMS is to build on the existing program planning process and focus on setting performance standards, tracking progress, and making real-time improvements based on information reported and analyzed. Through this work, we will showcase trends, with more comprehensive reporting capabilities of the program planning database. For the end user, this will show up as multiple dashboards on a variety of health topics. The dashboards will highlight indicators in three different areas: program division and team, strategic goals and priorities, and programs that received additional investment in 2023.

We are very excited to deploy this new method of reporting. POMS will provide evidence to demonstrate the value of our communities' continued investment in SWPH and instill confidence in the public health system. We anticipate this will continue to reinforce SWPH as an agency committed to showcasing its performance, and continuing to be a responsive organization that is meeting community needs and improving population health.

2.0 FINANCIAL MATTERS (DECISION):

2.1 SECOND QUARTER FINANCIAL STATEMENTS (DECISION):

At the end of quarter two, June 30, 2024, SWPH is currently underspent by approximately $1,329,030 or 6% of the overall budget, see attached. Key factors influencing this surplus are hires that are at the starting grid compared to incumbents retiring at the top of the grid, vacancies due to leaves of absences (i.e. maternity) where temporary staff are hired to fill in, covid-19 funding that was not anticipated at time of budget, and the corresponding benefits costs associated with those salary fluctuations and expenses charged to 2023 based upon timing that we originally thought would be in 2024..

All program expenses and variances are reviewed monthly. At the end of June, it was anticipated that there will be a surplus at year.

MOTION: 2024-BOH-0926-5.4-2.1
That the Board of Health approve the second quarter financial statements for the period ending June 30, 2024 for Southwestern Public Health.

2.2 2024 FUNDING GRANT AND ACCOUNTABILIT AGREEMENT (RECEIVE AND FILE):

At the end of June, SWPH received its 2024 Ministry of Health grant funding letter and associated amending agreement between the Ministry of Health and SWPH. The operating funding for the Ontario Public Health Standards and Accountability Framework is for the period of January 1, 2024, to December 31, 2024. There was no one-time funding provided in this letter. Please see the attached correspondence along with the funding summary. There were no noteworthy changes to the actual agreement between this version and last year's version of the agreement.

Highlights:

- ✓ Base funding was noted at $12,822,600 which now includes the previous mitigation funding of $1,498,900 (this was used to offset municipal contribution to public health) and a 1% increase over the previous year. Of note, the 1% increase was only applied on the original base and not the mitigation funding as anticipated as part of the SWPH budget; amount received is in line with our expectation.
- ✓ Medical Officer of Health Top Up Compensation Initiative remains at $178,700 and the top up portion of the compensation is funded provincially. Of note, although it states we are eligible for up to $178,700, that amount is determined based on the framework; and due to the minimum salary required of $242,000 it is anticipated we will only receive approximately $80,000.
- ✓ Ontario Seniors Dental Care Program remains at $1,061,100 and continues to be funded 100% provincially. We did request additional funds for 2024 of approximately $500,000 but this request was denied. The additional funding request was based on the assumption that we would be expanding clinical services within a new building, which would include additional dental operatories. However, since the new building has not been constructed, we have not increased our operatory capacity. As a result, there is no immediate need to expand staffing at this time. Our current dental operatories are operating at full capacity within the limits of our existing facilities.
- ✓ Covid-19 General Funding and Vaccine Funding were not included in the funding letter. However, as a reminder, we were approved for one-time funding in the previous funding letter for the first quarter of 2024 in the amount of $257,800.
- ✓ IPAC Hub funding was not noted in the funding letter either. It is anticipated it will be sent in a separate letter at a later date.
- ✓ The Ministry did not allow for submissions of one-time business cases in the 2024 ASP.

MOTION: 2024-BOH-0926-5.4-2.2
That the Board of Health for Southwestern Public Health accept the Amending Agreement between the Ministry of Health and Southwestern Public Health effective January 1, 2024.

3.3 2024/2025 MINISTRY OF CHILDREN AND SOCIAL SERVICES FUNDING GRANT (RECEIVE AND FILE):

On July 4th, 2024 Southwestern Public Health was notified that for the first time in over 10 years, it would be receiving an increase to its base funding for the Healthy Babies Healthy Children program, in the amount of $122,078 which is roughly a 7% increase. This funding will be used to apply towards staff in our mandatory program that are providing services to the HBHC program. . No formal funding letter was received but SWPH did get formal notification through its budget file that was loaded to the MCSS portal early in September in addition to a call from MPP Hardeman.

MOTION: 2024-BOH-0926-5.4
That the Board of Health for Southwestern Public Health accept the Chief Executive Officer's Report for September 26, 2024.

Community Profile

An analysis of demographic and health equity data in the Southwestern Public Health region

Community Health Status Report
Southwestern Public Health
August 2024

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How to cite this document:

Croteau S. Community profile: an analysis of demographic and health equity data in the Southwestern Public Health region. Woodstock, ON: Southwestern Public Health; 2024.

Contents

Summary 4
Demographics 5
Population Size and Growth 5
What is Driving Population Growth? 6
Population Age and Sex 6
Language 7
Immigration 8
Visible Minorities 9
Indigenous Population 9
Health Equity 9
Income and Employment 10
Education 11
Housing and Household Types 11
Food Insecurity 12
Ontario Marginalization Index 13
Conclusion 18
References 19
Data Sources 20
Appendix A 21
Appendix B 22

Summary

- The Southwestern Public Health region had significant population growth between 2016 and 2021, largely driven by intraprovincial migration

- The population is aging; The proportion of the population aged 65 and over is increasing, while the proportion aged 19 and under is decreasing

- Germanic languages are the most common languages spoken at home, besides English, in the region and the individuals who speak these languages are concentrated within a few municipalities

- The most common places of birth of recent immigrants have changed, with many now born in India

- The proportion of the SWPH population that belong to a visible minority group doubled between 2016 and 2021 but remains much lower than the province

- While there was an increase in the proportion of households in higher income categories from 2015 to 2020, temporary COVID-19 related benefits were likely one of the reasons contributing to this shift

- While the overall level of food insecurity in the region was comparable to the province, SWPH had a higher proportion of households that were moderately and severely food insecure

- About 1 in 4 dissemination areas in the region have high material deprivation (a measure closely linked to poverty) and the most deprived areas in the region tend to be in the southeast and in urban centres

Demographics

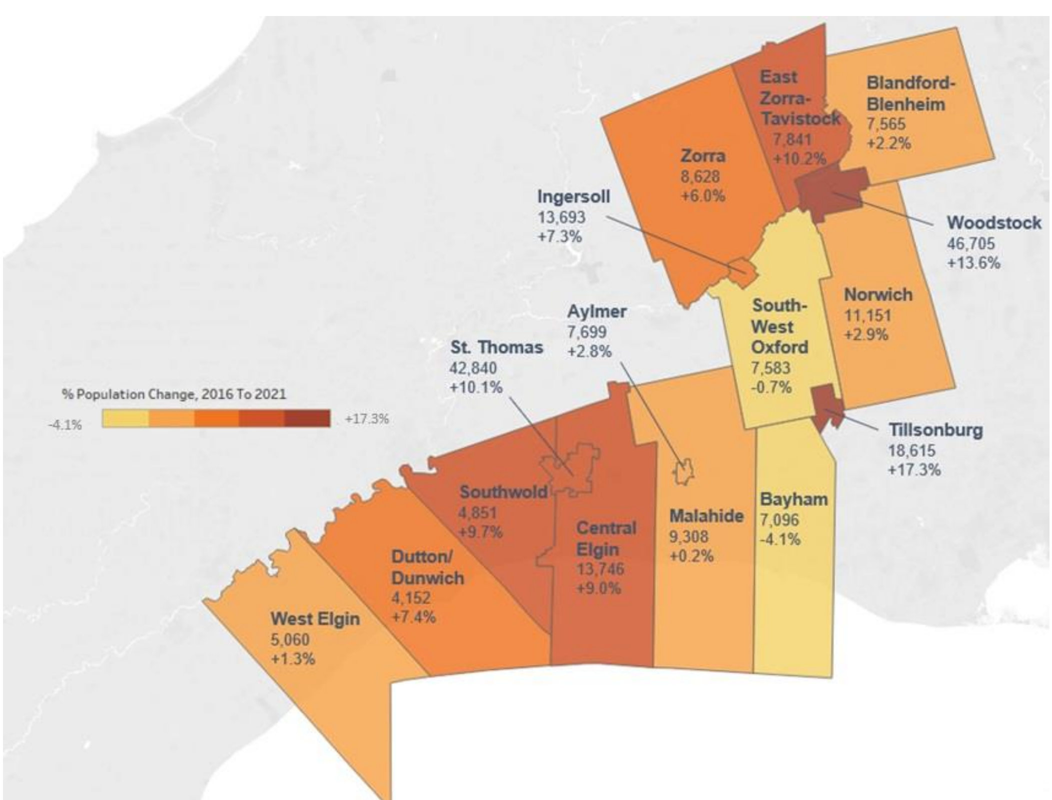
Population Size and Growth

Data Source:
The demographics section of this report uses data from the Census of the Population conducted by Statistics Canada.

According to the most recent census (2021), there were 216,533 people living in the Southwestern Public Health (SWPH) region. The population grew by 8.4% since the previous census was conducted in 2016. This population growth was 2.5x higher than the growth seen between the 2011 and 2016 census. In 2021, the population of Oxford County was 121,781, while the population of Elgin County (including St. Thomas) was 94,752. While both Elgin and Oxford counties saw growth between 2016 and 2021, Oxford County experienced higher population growth (9.9%) compared to Elgin County (6.5%). The population growth across the SWPH region was higher compared to the province at 5.8%.

When examining population growth by municipality between 2016 and 2021 (Figure 1), it is evident that Tillsonburg and Woodstock experienced the highest population growth at 17.3% and 13.6%, respectively. In fact, Statistics Canada named both Tillsonburg and Woodstock as two of the top 10 fastest growing small urban centres across Canada.[1]

Figure 1. 2021 Population Size and Growth by Municipality, SWPH Region

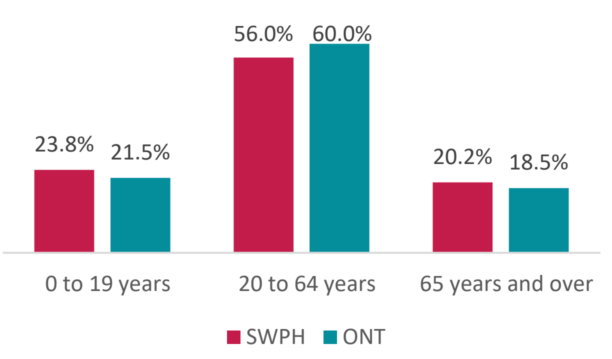


What is Driving Population Growth?

Intraprovincial migration refers to people moving to a different city or town but staying within the same province. This was the number one factor driving population growth between 2016 and 2021 in the SWPH region. It is likely that the COVID-19 pandemic was a major driver of intraprovincial migration, having an impact on how we live and work. In 2021, Statistics Canada estimated that 4 in 10 jobs could be done from home.[2] The ability to work from home creates greater flexibility in where people live in proximity to their workplace. This meant that some people had the opportunity to move away from large urban centres to smaller cities and towns with lower costs of living.

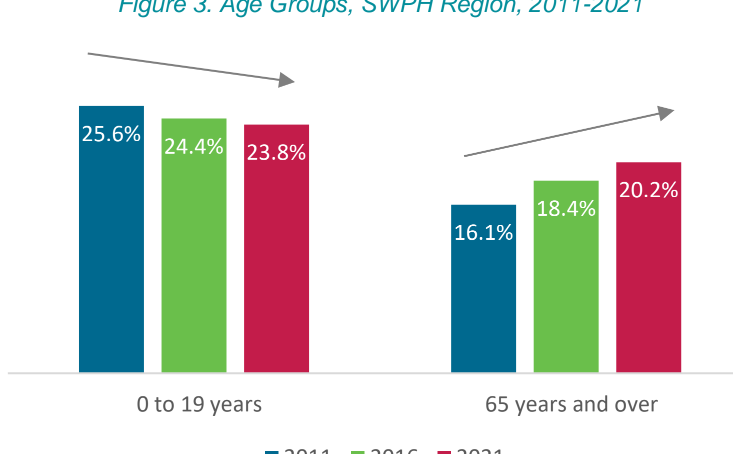
Population Age and Sex

Figure 2. Age Groups, SWPH Region and Ontario, 2021



Proportionately, the SWPH region had slightly more children and youth (0-19 years) and older adults (65+ years) compared to Ontario in 2021 (Figure 2). Examining age groups by municipality, Tillsonburg had the highest proportion of people aged 65 and over (29.3%), while Bayham had the highest proportion of people aged 19 and under (33.9%) (Appendix A).

Figure 3. Age Groups, SWPH Region, 2011-2021

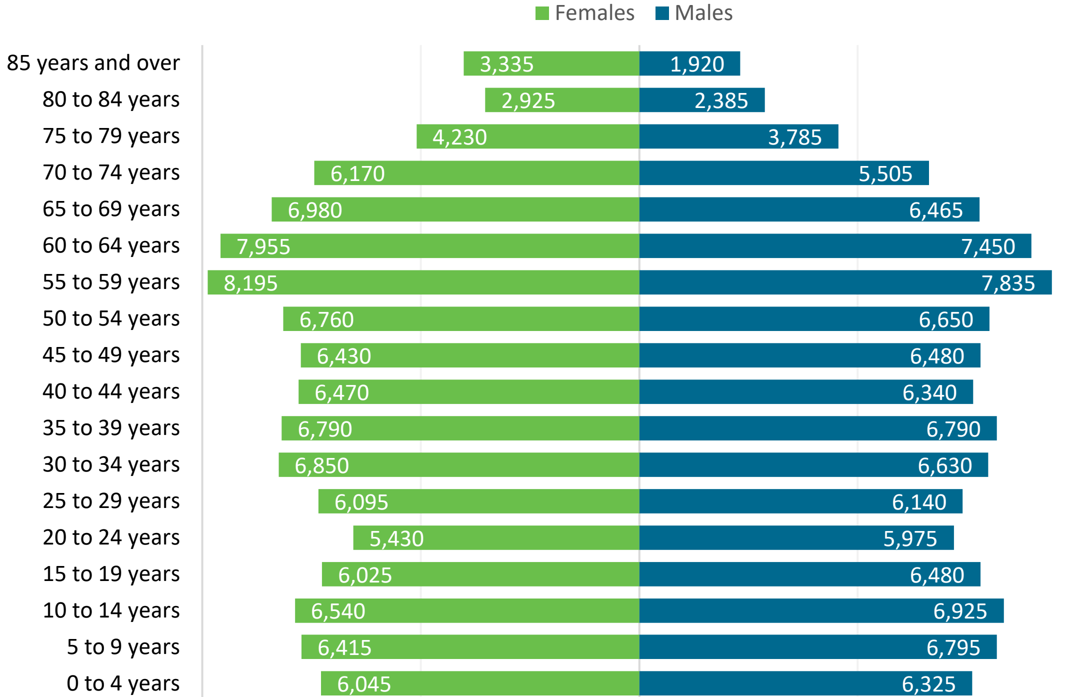


Overall, the population is aging, which mirrors nationwide trends. Between 2011 and 2021, the proportion of the SWPH population aged 65 and over grew from 16.1% to 20.2% while the proportion of children and youth aged 19 years and under decreased from 25.6% to 23.8% (Figure 3).

Though an aging population is not a new concept, the working-age population (15 to 64 years) has never been older (Figure 4). In 2021, the baby boomer generation included people aged 57 to 75 and by 2029 this whole generation will be of retirement age. This shift in age structure is also due to low fertility rates and a gradual increase in life expectancy. According to Statistics

Canada, even a large increase in immigration would not significantly curb the projected decrease in working-age Canadians.[3]

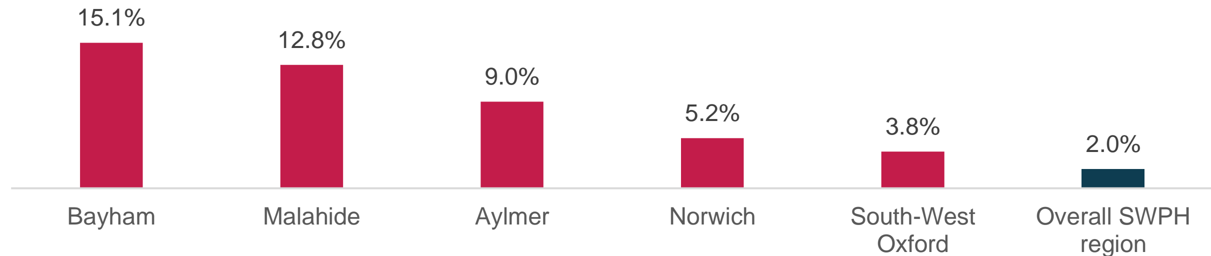
Figure 4. Population Pyramid, SWPH Region, 2021



Language

While the vast majority of the SWPH population can conduct a conversation in English (99.4%), 5.9% of the population report primarily speaking a different language at home. Locally, Germanic languages are the most common languages spoken at home, besides English. While 2.0% of the overall population predominantly speak a Germanic language within their home, these individuals are concentrated within a few communities. Bayham has the highest proportion of the population that primarily speak a Germanic language within their home at 15.1%, followed by Malahide at 12.8% and Aylmer at 9.0% (Figure 5). Many of these individuals are likely part of the Amish or Mennonite communities.

Figure 5. Proportion of the Population that Speaks a Germanic Language Most Often at Home, SWPH Region, 2021

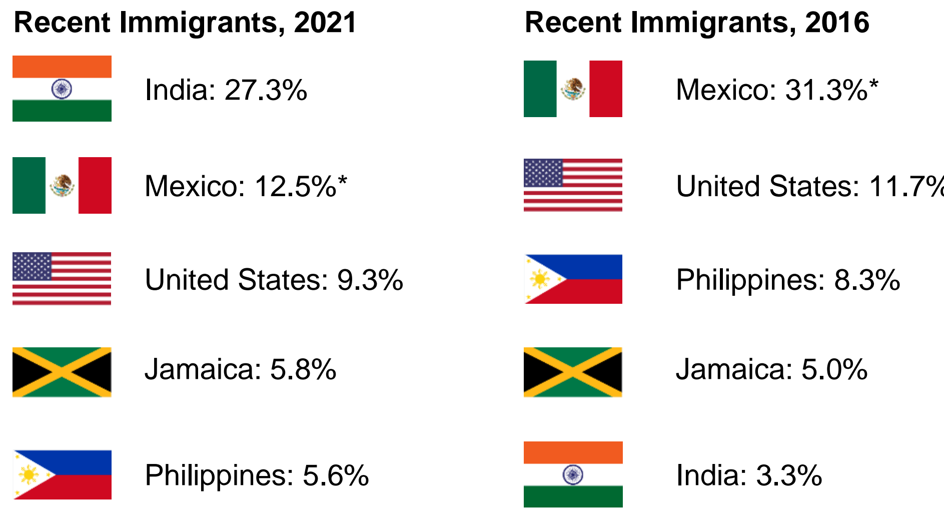


Immigration

Locally, 1 in 10 people in the region are immigrants (11.5%), but only 1.0% are recent immigrants (approximately 2,160 individuals). In the 2021 census, recent immigrants are defined as people who immigrated between 2016 and 2021 (time between census cycles). In 2021, almost half of recent immigrants (44%) lived in Woodstock.

The most common places of birth among the recent immigrant population have changed compared to 2016. In 2016, most recent immigrants in the SWPH region were born in Mexico (31.3%), while in 2021, most were born in India (27.3%) (Table 1). Proportionately, over 8x more recent immigrants were born in India in 2021 compared to 2016.

Table 1. Most Common Places of Birth Among Recent Immigrants, SWPH Region, 2016 and 2021



Recent Immigrants, 2021	Recent Immigrants, 2016
India: 27.3%	Mexico: 31.3%*
Mexico: 12.5%*	United States: 11.7%
United States: 9.3%	Philippines: 8.3%
Jamaica: 5.8%	Jamaica: 5.0%
Philippines: 5.6%	India: 3.3%

*Many of these individuals are likely part of the Mennonite community

Visible Minorities

The proportion of the SWPH population that belongs to a visible minority group doubled between 2016 and 2021 but remains much lower than the province. Visible minorities, which doesn't include Indigenous people, accounted for 6.3% of the SWPH population in 2021, compared to 3.1% in 2016. In 2021, the proportion of visible minorities residing in the SWPH region (6.3%) was much lower than the proportion of visible minorities residing in Ontario (34.3%) (Figure 6).

Figure 6. Proportion of the Population Belonging to a Visible Minority Group, SWPH Region & Ontario, 2021

SWPH Region (1 in 16)

Ontario (1 in 3)

Indigenous Population

The proportion of the SWPH population that identified as Indigenous (off-reserve) on the 2021 census is similar to the province and hasn't changed much over time. About 2.3% of the local population identified as Indigenous in 2021, compared to Ontario at 2.9%. It is important to note that permission was not given by the two nearby reserves (Chippewas of the Thames First Nation and Oneida Nation of the Thames) to conduct the census.

Health Equity

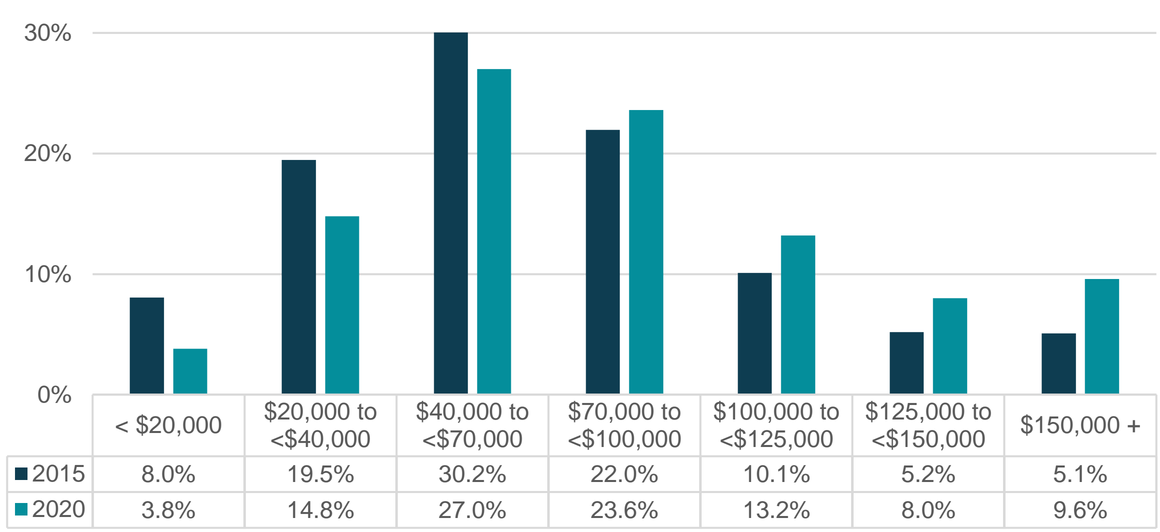
The health of the population is influenced by many factors including lifestyle choices and behaviours, genetics and the environment. The physical, social and economic environment all contribute to the health of individuals and the health of the population overall. The social determinants of health refer to factors beyond individual behaviours and genetics that greatly influence health outcomes. They are the conditions in which people are born, grow, live, work and age and include income, education, employment, housing and food security, among others. Health equity is when everyone has fair access and opportunity to reach their full health potential.[4]

> *"Health equity means that all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance" -Health Equity Guideline, 2018, Ministry of Health and Long-Term Care* [4]

Income and Employment

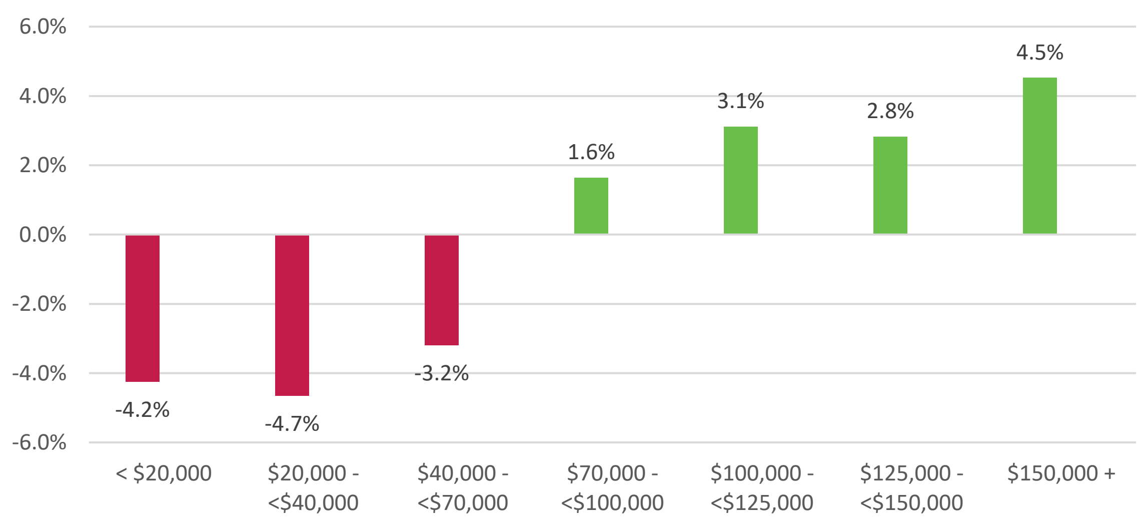
Between 2015 and 2020, there was a decrease in the proportion of local households in lower income categories and an increase in higher income categories, which mirrored a Canada-wide trend (Figure 7 and Figure 8). Across Canada, the median household after-tax income grew by 9.8%, which is over twice the growth experienced between 2010 and 2015 (4.5%).[5] Temporary COVID-19 related benefits, which began in 2020, may have been one of the reasons contributing to this shift. According to Statistics Canada, 2 out of every 3 Canadians benefitted from at least one pandemic relief program in 2020.[6]

Figure 7. Household After-Tax Income, SWPH Region, 2015 and 2020



	< $20,000	$20,000 to <$40,000	$40,000 to <$70,000	$70,000 to <$100,000	$100,000 to <$125,000	$125,000 to <$150,000	$150,000 +
2015	8.0%	19.5%	30.2%	22.0%	10.1%	5.2%	5.1%
2020	3.8%	14.8%	27.0%	23.6%	13.2%	8.0%	9.6%

Figure 8. Difference Between the Proportion of Households in Each After-Tax Income Category, SWPH Region, 2015 and 2020



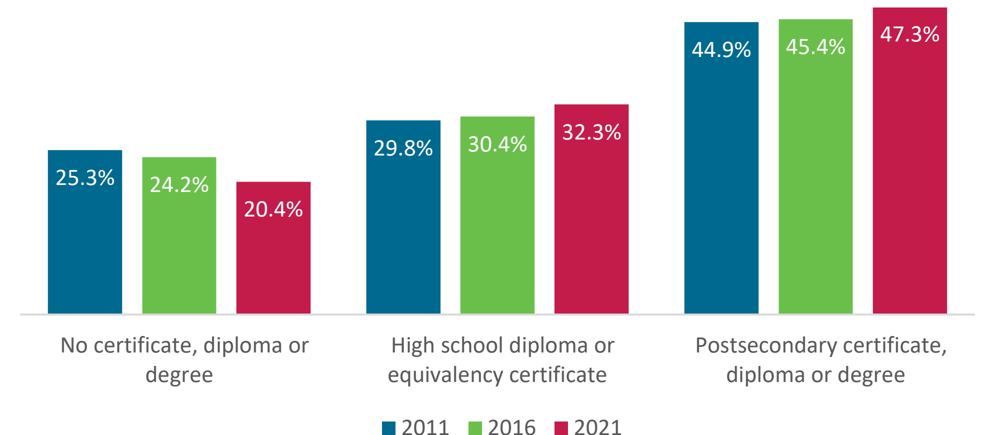
The low-income measure after tax (LIM-AT) is a relative measure of poverty. In 2020, according to the LIM-AT, a 1-person household earning $26,503 or less per year or a 4-person household earning $53,005 or less per year would be considered low-income (Appendix B). The proportion of the SWPH population considered low-income using this measure was 8.8% in 2020, which was lower than the proportion considered low-income in 2015 (12.4%). It's important to note this does not reflect the proportion of the population who are struggling to make ends meet. In 2023, the total basic cost of living for a family of 4 was estimated to be approximately $78,000 annually in the London Elgin Oxford region.[7]

In 2021, about 1 in 5 people (19.3%) living in the SWPH region worked in the manufacturing industry. Other common employment industries included health care and social assistance (12.0%), retail trade (10.1%) and construction (9.2%). The distribution of employment by industry in the region was similar in 2016 compared to 2021.

Education

The proportion of the population with higher levels of education in the SWPH region is increasing. Between 2011 and 2021, the proportion of people with less than a high school education decreased by almost 5%, while the proportion with a secondary or postsecondary education increased (Figure 9).

Figure 9. Highest Level of Education for the Population Aged 15 Years and Over, SWPH region, 2011-2021



Housing and Household Types

In 2021, most households within the region housed one family, without additional people (66.3%), followed by one-person households at 25.3%. Among families with children, 14.6% were one-parent families, which was slightly lower than the province at 17.1%. Locally, most one-parent families were led by women (76.0%).

The census also collects information about the condition of private dwellings. Locally, 5.4% of homes needed major repairs, which includes repairs for defective plumbing or electrical wiring for example, which was similar to the province at 5.7%.

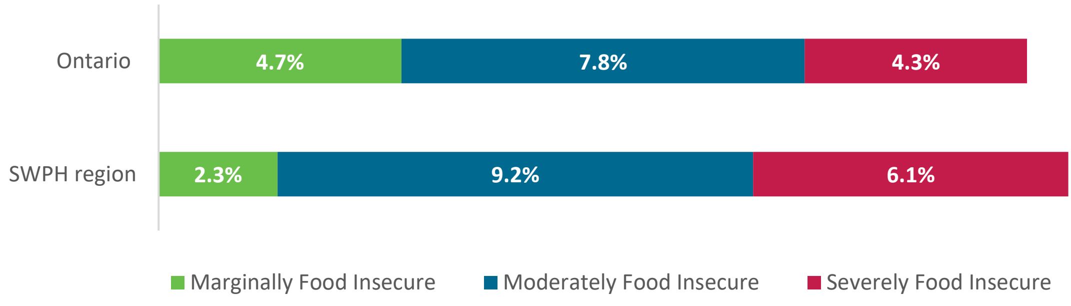
Food Insecurity

Food insecurity refers to inadequate or insecure access to food due to financial constraints. An individual's health and wellbeing are tightly linked to their household food security status. Household food insecurity is associated with worse mental health, higher rates of disease and injuries, greater health care utilization and premature mortality.[8] Almost 1 in 6 households (17.5%) in the SWPH region were food insecure between 2018 and 2020 (Figure 10).

Figure 10. Household Food Insecurity, SWPH Region, 2018-2020

The overall level of food insecurity in the region was comparable to the province (17.5 % locally vs. 16.7% provincially). However, the SWPH region had a higher proportion of households that were moderately and severely food insecure (Figure 11).

Figure 11. Household Food Insecurity, SWPH region and Ontario, 2018-2020



Ontario Marginalization Index

Data Source:
This section of the report uses data from the Ontario Marginalization Index produced by Public Health Ontario and St. Michael's Hospital (Unity Health Toronto)

The Ontario Marginalization Index (ON-Marg) is a tool that combines demographic indicators from the census to show differences in marginalization by geography. Eighteen indicators from the census are grouped into 4 categories (referred to as dimensions), representing different aspects of marginalization.[9,10] These 4 categories, or dimensions, are called:

- Material resources
- Racialized and newcomer populations
- Age and labour force
- Households and dwellings

Dissemination areas (DAs) are small geographic units with a population of 400-700 people. There are 317 DAs in the SWPH region. Within each dimension, the ON-Marg tool ranks all of the DAs in Ontario and sorts them into quintiles (5 equal groups). This means that SWPH ON-Marg maps compare marginalization locally to all of the other regions across the province.

Material Resources

This dimension is closely linked to poverty and refers to the inability to afford or access basic material needs related to housing, food, clothing and education. In the SWPH region, 1 in 4 DAs are in the most deprived quintile in 2021, similar to 2016. The most deprived areas in SWPH tend to be in the Southeast and in urban centres (Figure 12 and Figure 13).

Figure 12. Ontario Marginalization Index Map of Material Resources, SWPH Region, 2021

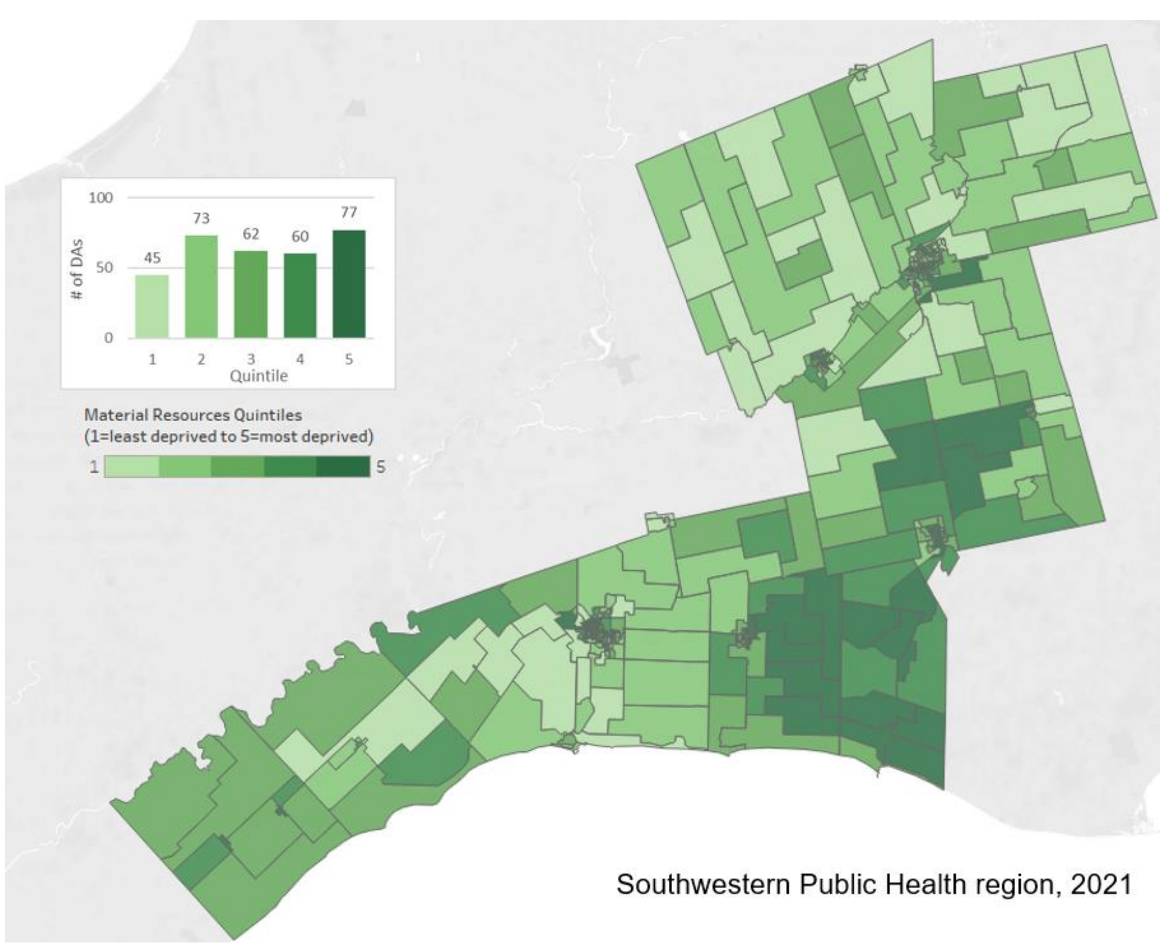
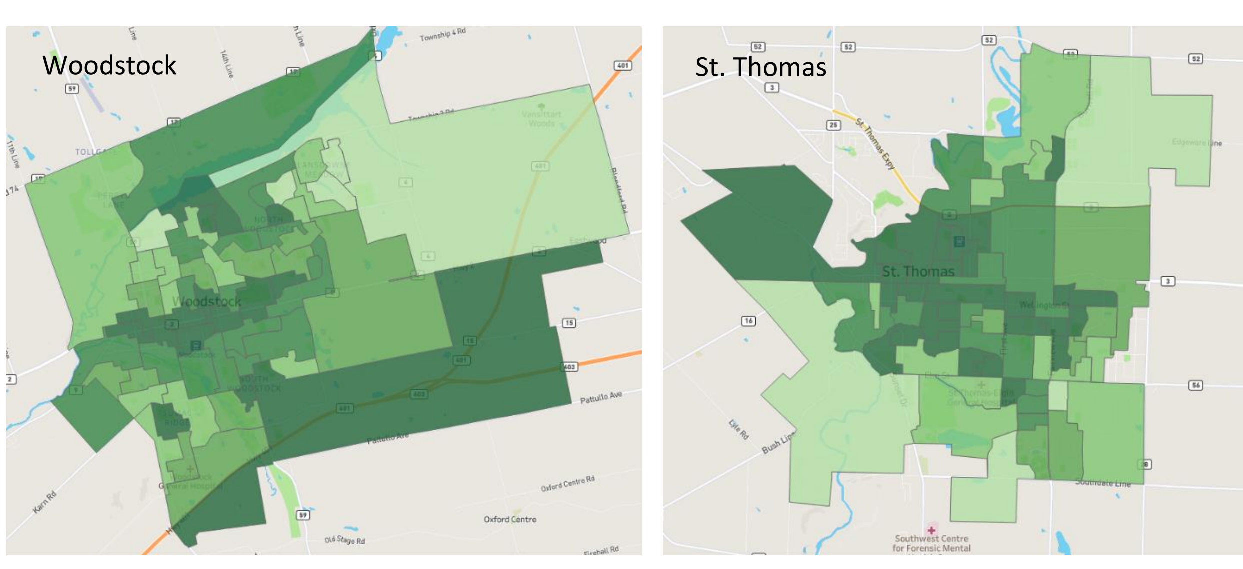


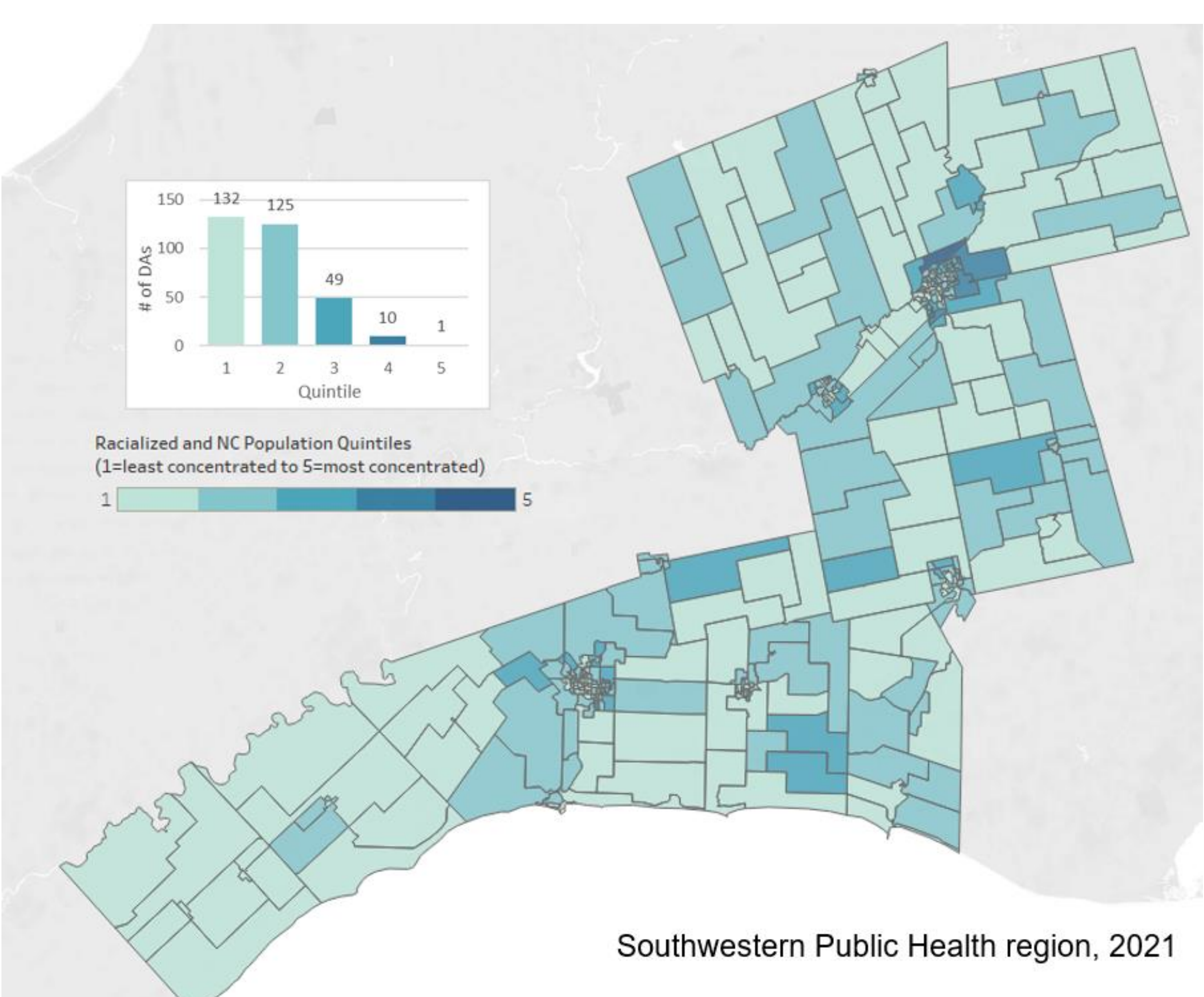
Figure 13. Ontario Marginalization Index Map of Material Resources, Woodstock and St. Thomas, 2021



Racialized and Newcomer Populations

This dimension measures the proportion of recent immigrants and/or visible minorities. These communities may experience high levels of racialization and prejudice. Compared to other parts of Ontario, the SWPH region has a very low concentration of racialized and newcomer populations, with only 1 DA in Woodstock in the most concentrated quintile (Figure 14).

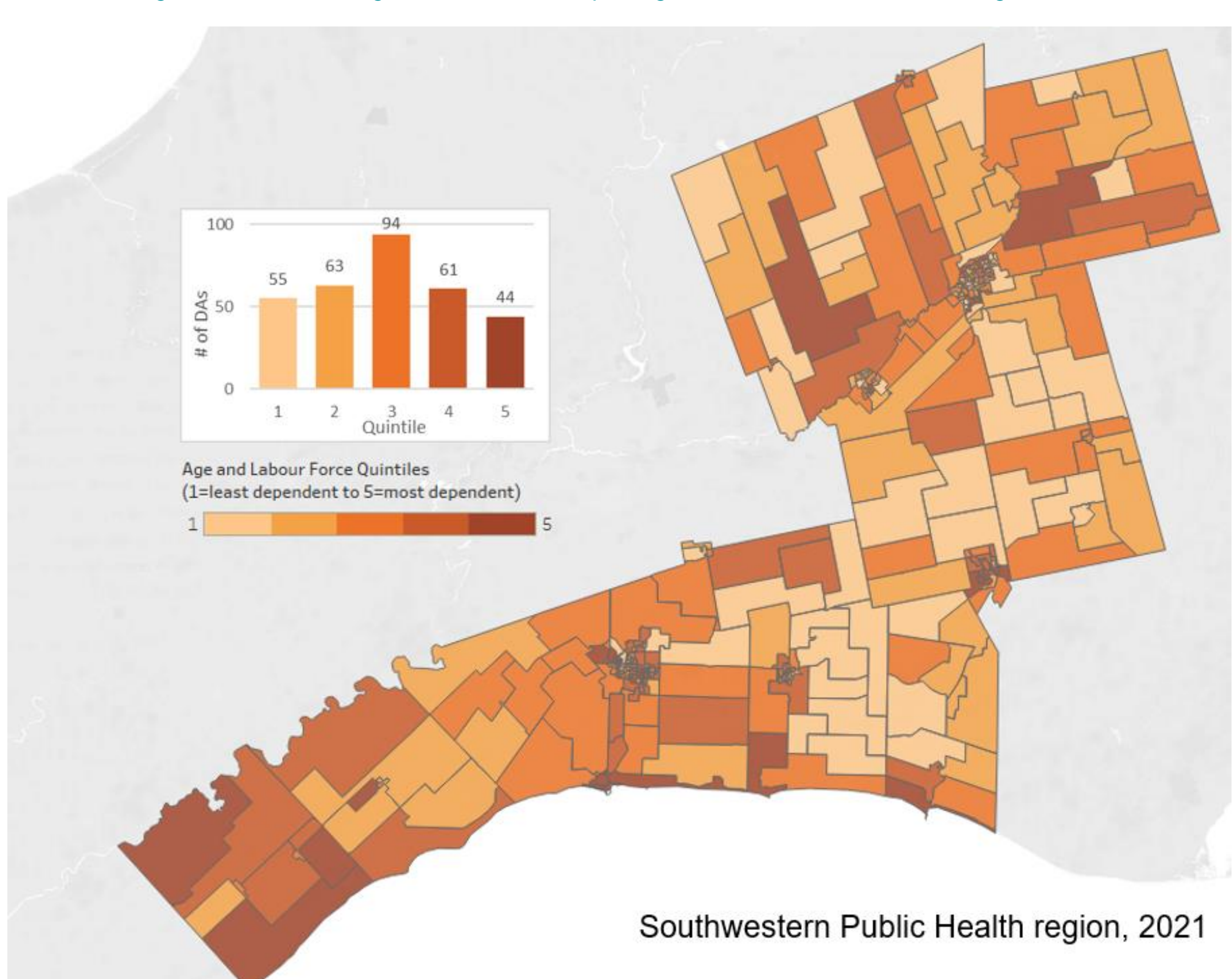
Figure 14. Ontario Marginalization Index Map of Racialized and Newcomer Populations, SWPH Region, 2021



Age and Labour Force

This dimension measures the proportion of people who may require more financial and service support because they do not have income from employment. This includes older adults, children, and those unable to work due to disability. There are pockets of dependency throughout the SWPH region (Figure 15).

Figure 15. Ontario Marginalization Index Map of Age and Labour Force, SWPH Region, 2021



Households and Dwellings

This dimension relates to family and neighbourhood stability and is based on measures of housing, age and marital status to identify areas with more people who do not own houses, who move frequently and who live alone. High residential instability is concentrated in urban areas in the SWPH region (Figure 16 and Figure 17).

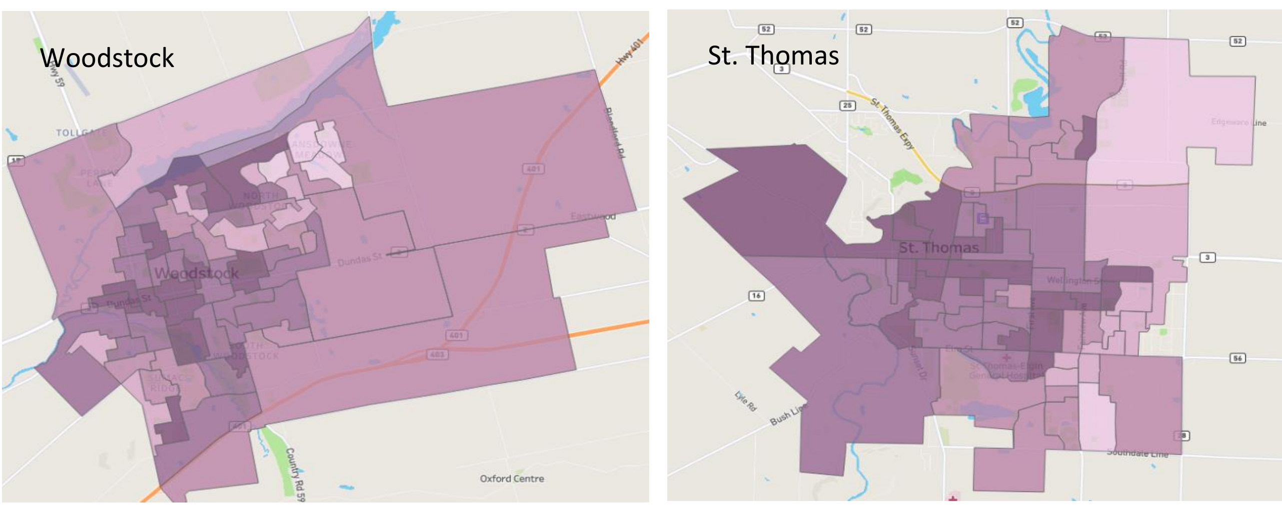
Figure 16. Ontario Marginalization Index Map of Households and Dwellings, SWPH Region, 2021

100
50
0
# of DAs
56 76 73 66 46
1 2 3 4 5
Quintiles

Households and Dwellings Quintiles
(1=least unstable to 5=most unstable)
1 5

Southwestern Public Health region, 2021

Figure 17. Ontario Marginalization Index Map of Households and Dwellings, Woodstock and St. Thomas, 2021



Conclusion

The population in the Southwestern Public Health region is changing. Not only is it important for organizations that serve the public to understand *how* the population is changing but it is also critical that these changes inform the development and delivery of programs and services. Understanding the characteristics of the population of Oxford County, Elgin County and the City of St. Thomas will help work towards the goal of improving population health and ensuring equitable access to programs and services.

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Appendix A

Age Groups by Municipality in the Southwestern Public Health Region, 2021

Municipality	Pop'n Count 0 - 19 years	Pop'n Count 20 - 64 years	Pop'n Count 65 years +	% 0 - 19 years	% 20 - 64 years	% 65 years +
Aylmer	2,020	4,130	1,550	26.2%	53.6%	20.1%
Bayham	2,410	3,640	1,060	33.9%	51.2%	14.9%
Blandford-Blenheim	1,775	4,465	1,315	23.5%	59.1%	17.4%
Central Elgin	2,735	7,850	3,155	19.9%	57.1%	23.0%
Dutton/Dunwich	935	2,390	825	22.5%	57.6%	19.9%
East Zorra-Tavistock	1,800	4,440	1,600	23.0%	56.6%	20.4%
Ingersoll	3,275	8,080	2,340	23.9%	59.0%	17.1%
Malahide	2,850	5,015	1,450	30.6%	53.8%	15.6%
Norwich	3,445	5,990	1,720	30.9%	53.7%	15.4%
South-West Oxford	2,135	4,180	1,260	28.2%	55.2%	16.6%
Southwold	1,185	2,710	950	24.5%	55.9%	19.6%
St. Thomas	9,530	24,200	9,115	22.2%	56.5%	21.3%
Tillsonburg	3,595	9,575	5,450	19.3%	51.4%	29.3%
West Elgin	990	2,840	1,225	19.6%	56.2%	24.2%
Woodstock	10,720	26,840	9,150	23.0%	57.5%	19.6%
Zorra	2,160	4,905	1,560	25.0%	56.9%	18.1%

Appendix B

Low-Income Measure After Tax (LIM-AT) Thresholds [11,12]

Household Size	Household After-tax Income, 2020	Household After-tax Income, 2015
1 person	$26,503	$22,133
2 persons	$37,480	$31,301
3 persons	$45,904	$38,335
4 persons	$53,005	$44,266
5 persons	$59,261	$49,491
6 persons	$64,918	$54,215
7 persons	$70,119	$58,558

SOUTHWESTERN PUBLIC HEALTH

For the Six Months Ending Sunday, June 30, 2024

STANDARD/ PROGRAM	YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR	FULL YEAR BUDGET	VAR	% VAR
Direct Program Costs						
Foundational Standards						
Emergency Management	$61,957	$63,203	$1,247	$126,407	$64,450	49.%
Effective Public Health Practise	152,551	161,493	8,942	322,986	170,435	47.%
Health Equity Program	148,302	150,633	2,331	301,266	152,963	49.%
Population Health Assessment	158,319	187,012	28,692	374,023	215,704	42.%
Foundational Standards Total	**521,129**	**562,341**	**41,212**	**1,124,682**	**603,552**	**46.%**
Chronic Disease Prevention & Well-Being						
Built Environment	112,131	135,004	22,873	270,008	157,877	42.%
Healthy Eating Behaviours	53,635	54,888	1,253	109,777	56,142	49.%
Physical Activity and Sedentary Behaviour	60,345	61,363	1,018	122,727	62,382	49.%
Suicide Risk & Mental Health Promotion	109,899	133,107	23,208	266,213	156,314	41.%
Chronic Disease Prevention & Well-Being Total	**336,010**	**384,362**	**48,352**	**768,725**	**432,714**	**44.%**
Food Safety						
Food Safety (Education, Promotion & Inspection)	261,149	253,728	-7,420	507,457	246,308	51.%
Food Safety Total	**261,149**	**253,728**	**-7,420**	**507,457**	**246,308**	**51.%**
Healthy Environments						
Climate Change	128,214	172,636	44,423	345,273	217,059	37.%
Health Hazard Investigation and Response	224,675	270,060	45,385	540,121	315,446	42.%
Healthy Environments Total	**352,889**	**442,696**	**89,808**	**885,394**	**532,504**	**40.%**
Healthy Growth & Development						
Breastfeeding	165,124	198,041	32,916	396,082	230,957	42.%
Parenting	111,593	194,934	83,341	389,868	278,275	29.%
Reproductive Health/Healthy Pregnancies	219,113	313,455	94,342	626,910	407,797	35.%
Healthy Growth & Development Total	**495,830**	**706,430**	**210,599**	**1,412,860**	**917,029**	**35.%**
Immunization						
Vaccine Administration	75,845	78,772	2,927	157,544	81,698	48.%
Vaccine Management	49,123	66,691	17,568	133,382	84,259	37.%
Community Based Immunization Outreach	0	0	0	0	0	0.%
Immunization Monitoring and Surveillance	56,520	60,287	3,767	120,574	64,055	47.%
Immunization Total	**181,488**	**205,750**	**24,262**	**411,500**	**230,012**	**44.%**
Infectious & Communicable Diseases						
Infection Prevention & Control	834,438	1,040,056	205,618	2,080,112	1,245,674	40.%
Needle Exchange	4,919	25,600	20,681	51,200	46,281	10.%
Rabies Prevention and Control and Zoonotics	81,173	88,143	6,969	176,285	95,112	46.%
Sexual Health	509,843	558,944	49,100	1,117,887	608,044	46.%
Tuberculosis Prevention and Control	39,526	45,249	5,723	90,497	50,971	44.%
Vector-Borne Diseases	67,935	112,681	44,746	225,362	157,427	30.%
COVID-19 Mass Immunization	272,247	434,435	162,188	868,869	596,622	31.%
Infectious & Communicable Diseases Total	**1,810,081**	**2,305,108**	**495,024**	**4,610,212**	**2,800,131**	**39.%**
Safe Water						
Water	100,745	81,895	-18,850	163,789	63,044	62.%
Safe Water Total	**100,745**	**81,895**	**-18,850**	**163,789**	**63,044**	**62.%**
School Health - Oral Health						
Healthy Smiles Ontario	428,794	429,979	1,185	859,958	431,164	50.%
School Screening and Surveillance	183,093	182,173	-919	364,347	181,254	50.%
School Health - Oral Health Total	**611,887**	**612,152**	**266**	**1,224,305**	**612,418**	**50.%**
School Health - Immunization						
School Immunization	570,103	637,438	67,335	1,274,875	704,772	45.%
School Health - Other						
Comprehensive School Health	775,757	819,766	44,010	1,639,533	863,776	47.%
Substance Use & Injury Prevention						
Harm Reduction Enhancement	84,715	90,760	6,045	181,520	96,805	47.%
Injury Prevention	101,493	102,702	1,209	205,404	103,911	49.%

Smoke Free Ontario Strategy: Prosecution	109,672	123,176	13,504	246,352	136,680	45.%
Substance Misuse Prevention	201,351	214,903	13,552	429,807	228,455	47.%
Substance Use & Injury Prevention Total	**497,231**	**531,541**	**34,310**	**1,063,083**	**565,851**	**47.%**
TOTAL DIRECT PROGRAM COSTS	6,514,299	7,543,207	1,028,907	15,086,415	8,572,114	43.%
INDIRECT COSTS						
Indirect Administration	1,673,048	1,680,637	7,589	3,361,274	1,688,226	50.%
Corporate	14,957	116,402	101,445	232,805	217,848	6.%
Board	27,368	17,473	-9,895	34,945	7,577	78.%
HR - Administration	352,202	465,410	113,208	930,820	578,618	38.%
Communications	23,554	26,750	3,196	53,500	29,946	44.%
Premises	774,996	859,577	84,581	1,719,154	944,158	45.%
TOTAL INDIRECT COSTS	2,866,125	3,166,249	300,123	6,332,498	3,466,372	45.%
TOTAL GENERAL SURPLUS/DEFICIT	9,380,424	10,709,456	1,329,030	21,418,913	12,038,486	44.%
100% MINISTRY FUNDED PROGRAMS						
MOH Funding	31,316	39,907	8,591	79,814	48,498	39.%
Senior Oral Care	529,174	788,603	259,429	1,577,205	1,048,032	34.%
TOTAL 100% MINISTRY FUNDED	560,490	828,510	268,020	1,657,019	1,096,530	34.%
One-Time Funding - April 1, 2024 to March 31, 2025						
OTF NEP	3,363	0	-3,363	0	-3,363	0.%
OTF Public Health Inspector Practicum	8,447	5,000	-3,447	20,000	11,553	42.%
OTF IPAC HUB	93,407	98,563	5,156	394,250	300,843	24.%
Total OTF	105,217	103,563	-1,655	414,250	309,033	25.%
Programs Funded by Other Ministries, Agencies						
Healthy Babies Healthy Children	431,715	413,385	-18,330	1,653,539	1,221,824	26.%
Pre and Post Natal Nurse Practitioner	34,470	34,750	280	139,000	104,530	25.%
PHAC Smoking Cessation	57,962	67,760	9,798	271,040	213,078	21.%
Low German Speaking Partnership Study	2,625	0	-2,625	0	-2,625	0.%
Total Programs Funded by Other Ministries, Agencies	545,773	515,895	-29,878	2,063,579	1,517,806	26.%

New Schedules to the Public Health Funding and Accountability Agreement

BETWEEN THE PROVINCE AND THE BOARD OF HEALTH

(BOARD OF HEALTH FOR THE OXFORD ELGIN ST. THOMAS HEALTH UNIT)

EFFECTIVE AS OF THE 1ST DAY OF JANUARY 2024

Schedule A
Grants and Budget

Board of Health for the Oxford Elgin St. Thomas Health Unit

DETAILED BUDGET - MAXIMUM BASE FUNDS (GRANTS TO BE PAID SEMI-MONTHLY, FOR THE PERIODS OF JANUARY 1ST TO DECEMBER 31ST)		
Programs / Sources of Funding	**Grant Details**	**2024 Grant ($)**
Mandatory Programs (Cost-Shared)	Per the March 28, 2024 Funding Letter, the 2024 Grant includes an annualized increase of $1,625,900.	12,822,600
MOH / AMOH Compensation Initiative (100%)	Cash flow will be adjusted to reflect the actual status of Medical Officer of Health (MOH) and Associate MOH positions, based on an annual application process.	178,700
Ontario Seniors Dental Care Program (100%)	Funding to support comprehensive dental care to eligible low-income seniors.	1,061,100
Total Maximum Base Funds		**14,062,400**

NOTES:

(1) Cash flow will be adjusted when the Province provides a new Schedule "A".

SCHEDULE B
RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base Funding***

Provincial base funding is provided to the Board of Health for the purposes of delivering public health programs and services in accordance with the Health Protection and Promotion Act (HPPA), Regulations under the HPPA, Ontario Public Health Standards, and the Agreement. Provincial base funding is also provided to the Board of Health for the purposes of delivering related public health programs and initiatives in accordance with Schedule B.

Mandatory Programs: Harm Reduction Program Enhancement

The scope of work for the Harm Reduction Program Enhancement is divided into three components:

1. Local Opioid Response;
2. Naloxone Distribution and Training; and,
3. Opioid Overdose Early Warning and Surveillance.

<u>Local Opioid Response</u>
Base funding must be used to build a sustainable community outreach and response capacity to address drug and opioid-related challenges in their communities. This includes working with a broad base of partners to ensure any local opioid response is coordinated, integrated, and that systems and structures are in place to adapt/enhance service models to meet evolving needs.

Local response plans, which can include harm reduction and education/prevention, initiatives, should contribute to increased access to programs and services, and improved health outcomes (i.e., decrease overdose and overdose deaths, emergency room visits, hospitalizations). With these goals in mind, the Board of Health is expected to:

- Conduct a population health/situational assessment, including the identification of opioid-related community challenges and issues, which are informed by local data, community engagement, early warning systems, etc.
- Lead/support the development, implementation, and evaluation of a local overdose response plan (or drug strategy). Any plan or initiative should be based on the needs identified (and/or gaps) in your local assessment. This may include building community outreach and response capacity, enhanced harm reduction services and/or education/prevention programs and services.
- Engage stakeholders – identify and leverage community partners to support the population health/situational assessment and implementation of local overdose response plans or initiatives. Community stakeholders, including First Nations, Métis and Inuit communities and persons with lived experience, should be meaningfully engaged in the planning and implementation of all initiatives, where appropriate.

SCHEDULE B
RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base Funding***

- Adopt and ensure timely data entry into the Ontario Harm Reduction Database, including the Transition to the Ontario Harm Reduction Database and ensure timely collection and entry of minimum data set as per direction from the Province.

Naloxone Kit Distribution and Training
The Board of Health (or their Designate) must be established as a naloxone distribution lead/hub for eligible community organizations, as specified by the Province, which will increase dissemination of kits to those most at risk of opioid overdose.

To achieve this, the Board of Health is expected to:

- Order naloxone kits as outlined by the Province; this includes naloxone required by eligible community organizations distributing naloxone.
- Coordinate and supervise naloxone inventory, including managing supply, storage, maintaining inventory records, and distribution of naloxone to eligible community organizations, and ensuring community organizations distribute naloxone in accordance with eligibility criteria established by the Province.
- With the exception of entities (organizations, individuals, etc.) as specified by the Province:
  - Train community organization staff on naloxone administration, including how to administer naloxone in cases of opioid overdose, recognizing the signs of overdose and ways to reduce the risk of overdose. Board of Health staff would also instruct agency staff on how to provide training to end-users (people who use drugs, their friends and family).
  - Train community organization staff on naloxone eligibility criteria, including providing advice to agency staff on who is eligible to receive naloxone and the recommended quantity to dispense.
  - Support policy development at community organizations, including providing consultation on naloxone-related policy and procedures that are being developed or amended within the eligible community organizations.
  - Promote naloxone availability and engage in community organization outreach, including encouraging eligible community organizations to acquire naloxone kits for distribution to their clients.

Use of naloxone (NARCAN® Nasal Spray and injectable naloxone formulations)

The Board of Health will be required to submit orders for naloxone to the Province in order to implement the Harm Reduction Program Enhancement. By receiving naloxone, the Board of Health acknowledges and agrees that:

- Its use of naloxone is entirely at its own risk. There is no representation, warranty, condition or other promise of any kind, express, implied, statutory or otherwise, given by her Majesty the Queen in Right of Ontario as represented by the Ministry of Health, including Ontario Government Pharmaceutical and Medical Supply Service in connection with naloxone.
- The Province takes no responsibility for any unauthorized use of naloxone by the Board of Health or by its clients.
- The Board of Health also agrees to:
    - Not assign or subcontract the distribution, supply or obligation to comply with any of these terms and conditions to any other person or organization without the prior written consent of the Province.
    - Comply with the terms and conditions as it relates to the use and administration of naloxone as specified in all applicable federal and provincial laws.
    - Provide training to persons who will be administering naloxone. The training shall consist of the following: opioid overdose prevention; signs and symptoms of an opioid overdose; and, the necessary steps to respond to an opioid overdose, including the proper and effective administration of naloxone.
    - Follow all provincial written instructions relating to the proper use, administration, training and/or distribution of naloxone.
    - Immediately return any naloxone in its custody or control at the written request of the Province at the Board of Health's own cost or expense, and that the Province does not guarantee supply of naloxone, nor that naloxone will be provided to the Board of Health in a timely manner.

Opioid Overdose Early Warning and Surveillance
Base funding must be used to support the Board of Health in taking a leadership role in establishing systems to identify and track the risks posed by illicit opioids in their jurisdictions, including the sudden availability of illicit synthetic opioids and resulting opioid overdoses. Risk based information about illicit synthetic opioids should be shared in an ongoing manner with community partners to inform their situational awareness and service planning. This includes:

- Surveillance systems should include a set of "real-time" qualitative and quantitative indicators and complementary information on local illicit synthetic opioid risk. Partners should include, but are not limited to: emergency departments, first responders (police, fire and ambulance) and harm reduction services.
- Early warning systems should include the communication mechanisms and structures required to share information in a timely manner among health system and community

partners, including people who use drugs, about changes in the acute, local risk level, to inform action.

Mandatory Programs: Healthy Smiles Ontario Program

The Healthy Smiles Ontario (HSO) Program provides preventive, routine, and emergency and essential dental treatment for children and youth, from low-income families, who are 17 years of age or under.

In addition to the program requirements under the Ontario Public Health Standards, the Board of Health must ensure that the following requirements are met:

- The Board of Health is responsible for ensuring promotional/marketing activities have a direct and positive impact on meeting the objectives of the HSO Program.
- The Board of Health is reminded that HSO promotional/marketing materials approved by the Province and developed provincially are available for use by the Board of Health in promoting the HSO Program.
- The overarching HSO brand and provincial marketing materials were developed by the Province to promote consistency of messaging, and “look and feel” across the province. When promoting the HSO Program locally, the Board of Health is requested to align local promotional products with the provincial HSO brand. When the Board of Health uses the HSO brand, it is required to liaise with the Ministry of Health’s Communications Division to ensure use of the brand aligns with provincial standards.
- The Board of Health is required to bill back relevant programs for services provided to non-HSO clients. All revenues collected under the HSO Program, including revenues collected for the provision of services to non-HSO clients such as Ontario Works adults, Ontario Disability Support Program adults, municipal clients, etc., must be reported as income in financial reports as per Schedule C of the Agreement.
- For the purposes of reporting and monitoring for the HSO Program, the Board of Health must use the following provincial approved systems or mechanisms, or other as specified by the Province.
    - Aggregate screening, enrolment, and utilization data for any given month must be submitted by the 15th of the following month to the ministry in the ministry-issued template titled Dental Clinic Services Monthly Reporting Template.
    - Client-specific clinical data must be recorded in either dental management software (e.g., ClearDent, AbelDent, etc.) or in the template titled HSO Clinic Treatment Workbook that has been issued by the ministry for the purposes of recording such data.
- The Board of Health must enter into Service Level Agreements with any partner organization (e.g., Community Health Centre, Aboriginal Health Access Centre, etc.)

delivering services as part of the HSO Program. The Service Level Agreement must set out clear performance expectations, clearly state funding and reporting requirements between the Board of Health and local partner, and ensure accountability for public funds.

- Any significant change to previously approved HSO business models, including changes to plans, partnerships, or processes, must be approved by the Province before being implemented. Any contract or subcontract entered into by the Board of Health for the purposes of implementing the HSO Program must be conducted according to relevant municipal procurement guidelines.

Mandatory Programs: Nursing Positions

Base funding may be utilized to support Chief Nursing Officer, Infection Prevention and Control, and Social Determinants of Health Nursing positions, as well as other nursing positions at the Board of Health.

The Board of Health shall only employ a Chief Nursing Officer with the following qualifications:

- Registered Nurse in good standing with the College of Nurses of Ontario;
- Baccalaureate degree in nursing;
- Graduate degree in nursing, community health, public health, health promotion, health administration or other relevant equivalent OR be committed to obtaining such qualification within three years of designation;
- Minimum of 10 years nursing experience with progressive leadership responsibilities, including a significant level of experience in public health; and,
- Member of appropriate professional organizations (e.g., Registered Nurses' Association of Ontario, Association of Nursing Directors and Supervisors in Official Health Agencies in Ontario-Public Health Nursing Management, etc.).

The Chief Nursing Officer role must be implemented at a management level within the Board of Health, reporting directly to the Medical Officer of Health or Chief Executive Officer and, in that context, will contribute to organizational effectiveness.

The Board of Health shall only employ an Infection Prevention and Control Nurse with the following qualifications:

- The position is required to have a nursing designation (Registered Nurse, Registered Practical Nurse, or Registered Nurse in the Extended Class); and,
- Certification in Infection Control (CIC), or a commitment to obtaining CIC within three years of beginning of employment.

SCHEDULE B
RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base Funding***

The Board of Health shall only employ a Social Determinants of Health Nurse with the following qualifications:

- The position is required to be to be a Registered Nurse; and,
- The position is required to have or be committed to obtaining the qualifications of a public health nurse as specified in section 71(3) of the HPPA and section 6 of Ontario Regulation 566 under the HPPA.

Mandatory Programs: Smoke-Free Ontario

Smoke-Free Ontario is a comprehensive approach that combines programs, policies, social marketing, and legislation to reduce the use of tobacco and vapour products and lower health risks by protecting Ontarians from second-hand smoke and vapour, and to keep harmful products out of the hands of children and youth.

In addition to the program requirements under the Ontario Public Health Standards, the Board of Health must ensure that it complies with any written directions provided by the Province on the interpretation and enforcement of the Smoke-Free Ontario Act, 2017.

Medical Officer of Health / Associate Medical Officer of Health Compensation Initiative (100%)

The Province provides the Board of Health with 100% of the additional base funding required to fund eligible Medical Officer of Health (MOH) and Associate Medical Officer of Health (AMOH) positions within salary ranges initially established as part of the 2008 Physician Services Agreement and continued under subsequent agreements.

Base funding must be used for costs associated with top-up for salaries and benefits, and for applicable stipends, to eligible MOH and AMOH positions at the Board of Health and cannot be used to support other physicians or staffing costs. Base funding for this initiative continues to be separate from cost-shared base salaries and benefits.

The maximum base funding allocation in Schedule A of the Agreement does not necessarily reflect the cash flow that the Board of Health will receive. Cash flow will continue to be adjusted regularly by the Province based on up-to-date application data and information provided by the Board of Health during a funding year. The Board of Health is required to notify the Province if there is any change in the eligible MOH and/or AMOH(s) base salary, benefits, FTE and/or position status as this may impact the eligibility amount for top-up.

The Board of Health must comply and adhere to the eligibility criteria for the MOH/AMOH Compensation Initiative as per the Policy Framework on Medical Officer of Health

Appointments, Reporting, and Compensation, including requirements related to minimum salaries to be eligible for funding under this Initiative.

Ontario Seniors Dental Care Program (100%)

The Ontario Seniors Dental Care Program (OSDCP) provides free, routine dental services for low-income seniors who are 65 years of age or older. It provides comprehensive dental care to eligible low-income seniors to help reduce unnecessary trips to the hospital, prevent chronic disease and increase quality of life for seniors.

The government announced the launch and staged implementation of the OSDCP on November 20, 2019. During the first stage of implementation, dental services were available for eligible seniors through Boards of Health, participating Community Health Centres and Aboriginal Health Access Centres. Through Stage 1, dental care was initiated and provided to eligible low-income seniors through Boards of Health, participating Community Health Centres, and Aboriginal Health Access Centres based on increasing Board of Health operational funding and leveraging existing infrastructure. The second stage of the program, which began in winter 2020, expanded the program by investing in new dental clinics to provide care to more seniors in need. This included new dental services in underserviced areas, including through mobile dental buses and an increased number of dental suites in Boards of Health, participating Community Health Centres, and Aboriginal Health Access Centres.

Program Enrolment

Program enrolment is managed centrally and is not a requirement of the Board of Health. The Board of Health is responsible for local oversight of dental service delivery to eligible clients under the program within the Public Health Unit area.

In cases where eligible seniors present with acute pain and urgent need, and are not already enrolled in the program, OSDCP providers, at the clinical discretion of the attending dental care provider, may support timely access to emergency dental treatment by providing immediate services following the seniors' signing of an emergency need and eligibility attestation. This attestation and enrollment process is to be administered at the local level. Following the delivery of emergency treatment, all seniors will need to submit an OSDCP application, be determined eligible, and be enrolled to receive any further non-emergency dental care through the OSDCP.

Program Delivery

The OSDCP is delivered through Boards of Health, participating Community Health Centres, and Aboriginal Health Access Centres across the province. These service delivery partners are well positioned to understand the needs of priority populations and provide high quality dental care to low-income seniors in their communities.

SCHEDULE B
RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base Funding***

With respect to Board of Health service delivery under the OSDCP, the Board of Health may enter into partnership contracts with other entities/organizations or providers/specialists as needed (e.g., to address potential access issues) to provide services to enrolled clients in accordance with the OSDCP Schedules of Services for Dentist and Non-Dentist Providers on behalf of the Public Health Unit.

Where OSDCP client service access issues exist, as evidenced by waiting lists, for example, the Board of Health must take prompt action as feasible to establish OSDCP partnership agreements to address these access issues, including engaging in outreach and consultation with local dental providers and in compliance with the Board of Health or municipal procurement processes.

Base funding for the OSDCP must be used in accordance with the OSDCP-related requirements of the Oral Health Protocol, 2018 (or as current), including specified requirements for service delivery, oral health navigation, and data collection and analysis. The Board of Health may allocate base funding for this Program across the program expense categories, with every effort made to maximize clinical service delivery and minimize administrative costs.

Planning for delivery of the OSDCP began when the program was announced in April 2019 with clinical service delivery beginning with the program launch in November 2019.

As part of implementation, eligible expense categories under this Program also include:

- *Clinical service delivery costs*, which are comprised of:
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff of the Board of Health or local service delivery partner which provide clinical dental services for the Program.
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff of the Board of Health or local service delivery partner which undertake ancillary/support activities for the Program, including: management of the clinic(s); financial and programmatic data collection and reporting for the clinic(s); and, general administration (e.g., reception services) at the clinic(s).
  - Overhead costs associated with the Program's clinical service delivery such as: clinical materials and supplies; building occupancy costs; maintenance of clinic infrastructure; staff travel associated with clinical service delivery (e.g., portable clinics, mobile clinics, long-term care homes, if applicable); staff training and professional development associated with clinical staff and ancillary/support staff, if applicable; office equipment, communication, and information and information technology.

Type of Funding	***Base Funding***

- *Oral health navigation costs*, which are comprised of:
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff engaged in: client enrolment assistance for the Program's clients (i.e., assisting clients with enrolment forms); program outreach (i.e., local-level efforts for identifying potential clients); and, oral health education and promotion to the Program's clients.
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff that undertake the following ancillary/support activities related to oral health navigation: management, financial and programmatic reporting, and general administration (if applicable).
  - Overhead costs associated with oral health navigation such as: materials and supplies; building occupancy costs incurred for components of oral health navigation; staff travel associated with oral health navigation, where applicable; staff training and professional development associated with oral health navigation and ancillary/support staff, if applicable; office equipment, communication, and information and information technology costs associated with oral health navigation.
  - Client transportation costs in order to address accessibility issues and support effective program delivery based on local need, such as where the enrolled OSDCP client would otherwise not be able to access dental services. Boards of Health will be asked to provide information on client transportation expenditures through in-year reporting and should track these expenditures and the number of clients accessing these services accordingly.

Operational expenses that are not eligible under this Program include:

- Staff recruitment incentives;
- Billing incentives; and,
- Costs associated with any activities required under the Ontario Public Health Standards, including the Oral Health Protocol, 2018 (or as current), which are not related to the OSDCP.

<u>Other Requirements</u>

Marketing

- When promoting the OSDCP locally, the Board of Health is required to align local promotional products with the provincial Program brand and messaging. The Board of Health is required to liaise with the Province to ensure use of the brand aligns with provincial standards.

SCHEDULE B
RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base Funding***

Revenue

- While priority must be given to clients eligible under this Program, the Board of Health may provide services to non-OSDCP clients using resources under this Program. If this occurs, the Board of Health is required to bill-back relevant programs for services provided to non-OSDCP clients using resources under this Program. All revenues collected under the OSDCP, including revenues collected for the provision of services to non-Program clients such as Ontario Works adults, Ontario Disability Support Program adults, Non-Insured Benefits clients, municipal clients, HSO clients, etc., with resources under this Program must be reported as an offset revenue to the Province. Priority must always be given to clients eligible under this Program. The Board of Health is required to closely monitor and track revenue from bill-back for reporting purposes to the Province.
- A client co-payment is required on new denture services. Co-payment amounts are specified by the Province in Appendix A of the OSDCP Denture Services Factsheet for Providers (Factsheet), which applies to both dentists and denturists. It is the Board of Health's responsibility to collect the client co-payment for the codes outlined in Appendix A of the Factsheet. The Board of Health may determine the best mechanism for collecting co-payments, using existing payment and administration processes at the local level, in collaboration with OSDCP service delivery partners (e.g., Community Health Centre, Aboriginal Health Access Centre), as needed. The remaining cost of the service, after co-payment, is to be absorbed by the Board of Health through its operating base funding for the OSDCP. The revenue received from client co-payments for OSDCP service(s) is to be used to offset OSDCP program expenditures. Co-payment revenues are to be reported as part of the financial reporting requirements to the Province.

Community Partners

- The Board of Health must enter into discussions with all Community Health Centres and Aboriginal Health Access Centres in their catchment area to ascertain the feasibility of a partnership for the purpose of delivering this Program.
- The Board of Health must enter into Service Level Agreements with any partner organization (e.g., Community Health Centres, Aboriginal Health Access Centres) delivering services under this Program. The Service Level Agreement must set out clear performance expectations, clearly state funding and reporting requirements between the Board of Health and the local partner, and ensure accountability for public funds.
- The Board of Health must ensure that base funding is used to meet the objectives of the Program, with a priority to deliver clinical dental services to clients, while staying within the base funding allocation.

Type of Funding	***Other***

Infectious Diseases Programs Reimbursement

Funding for Infectious Diseases Programs will be provided on a case-by-case basis through direct reimbursement. These funds are provided to offset the costs of treatment medications not made available through the Ontario Government Pharmaceutical and Medical Supply Service (OGPMSS).

To be reimbursed, original receipts and client identification information needs to be submitted to the Infectious Diseases Section of the Health Protection and Surveillance Policy and Programs Branch (Office of Chief Medical Officer of Health, Public Health). Clients will not be directly reimbursed.

Questions about the reimbursement process and expense eligibility can be submitted to the following email: IDPP@ontario.ca.

Leprosy

The Board of Health may submit claims on a case-by-case basis for medication costs related to the treatment of Leprosy. As per Chapter A: Leprosy, of the Infectious Diseases Protocol, 2018 (or as current), treatment should be under the direction of an infectious disease specialist and should refer to World Health Organization (WHO) treatment recommendations.

Tuberculosis

The Board of Health may submit claims on a case-by-case basis for second-line and select adjunct medications related to the treatment of active tuberculosis and latent tuberculosis infection. For more information on the reimbursement process, see section 9 of the Tuberculosis Program Guideline, 2018 (or as current).

Vaccine Programs Reimbursement

Funding on a per dose basis will be provided to the Board of Health for the administration of influenza, meningococcal, and human papillomavirus (HPV) vaccines.

In order to claim the vaccine administration fees, the Board of Health is required to submit, as part of the Standards Activity Reports or other reports as requested by the Province, the number of doses administered. Reimbursement by the Province will be made on a quarterly basis based on the information.

The Board of Health is required to ensure that the vaccine information submitted in the Standards Activity Reports, or other reports requested by the Province, accurately reflects the vaccines administered.

SCHEDULE B
RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Other***

Influenza
- The Province will continue to pay $5.00/dose for the administration of the influenza vaccine.
- All doses administered by the Board of Health to individuals aged 6 months or older who live, work or attend school in Ontario.

Meningococcal
- The Province will continue to pay $8.50/dose for the administration of the meningococcal vaccine.
- Routine immunization program: Doses administered as part of the grade 7 school-based or catch-up program for eligible students up to grade 12.
- Men-C-C doses if given in substitution of Men-C-ACYW135 for routine doses.

Note: Doses administered through the high-risk program are not eligible for reimbursement.

Human Papillomavirus (HPV)
- The Province will continue to pay $8.50/dose for the administration of the HPV vaccine.
- Routine immunization program: Doses administered as part of the grade 7 school-based or catch-up program for eligible students up to grade 12.
- High-risk program: MSM <26 years of age.

SCHEDULE C
REPORTING REQUIREMENTS

The reports mentioned in this Schedule are provided for every Board of Health Funding Year unless specified otherwise by the Province.

The Board of Health is required to provide the following reports/information in accordance with direction provided in writing by the Province (and according to templates provided by the Province):

Name of Report	Reporting Period	Due Date
1. Annual Service Plan and Budget Submission	For the entire Board of Health Funding Year	March 1 of the current Board of Health Funding Year
2. Quarterly Standards Activity Reports		
Q2 Standards Activity Report	For Q1 and Q2	July 31 of the current Board of Health Funding Year
Q3 Standards Activity Report	For Q3	October 31 of the current Board of Health Funding Year
Q4 Standards Activity Report	For Q4	January 31 of the following Board of Health Funding Year
3. Annual Report and Attestation	For the entire Board of Health Funding Year	April 30 of the following Board of Health Funding Year
4. Annual Reconciliation Report	For the entire Board of Health Funding Year	April 30 of the following Board of Health Funding Year
5. MOH / AMOH Compensation Initiative Application	For the entire Board of Health Funding Year	As directed by the Province
6. Other Reports and Submissions	As directed by the Province	As directed by the Province

Definitions

For the purposes of this Schedule, the following words shall have the following meanings:

“Q1” means the period commencing on January 1st and ending on the following March 31st
“Q2” means the period commencing on April 1st and ending on the following June 30th
“Q3” means the period commencing on July 1st and ending on the following September 30th
“Q4” means the period commencing on October 1st and ending on the following December 31st

Report Details

Annual Service Plan and Budget Submission

- The Annual Service Plan and Budget Submission Template sets the context for reporting required of the Board of Health to demonstrate its accountability to the Province.
- When completed by the Board of Health, it will: describe the complete picture of programs and services the Boards of Health will be delivering within the context of the Ontario Public Health Standards; demonstrate that Board of Health programs and services align with the priorities of its communities, as identified in its population health assessment; demonstrate

accountability for planning – ensure the Board of Health is planning to meet all program requirements in accordance with the Ontario Public Health Standards, and ensure there is a link between demonstrated needs and local priorities for program delivery; demonstrate the use of funding per program and service.

Quarterly Standards Activity Reports

- The Quarterly Standards Activity Reports will provide financial forecasts and interim information on program achievements for all programs governed under the Agreement.
- Through these Standards Activity Reports, the Board of Health will have the opportunity to identify risks, emerging issues, changes in local context, and programmatic and financial adjustments in program plans.
- The Quarterly Standards Activity Reports shall be signed on behalf of the Board of Health by an authorized signing officer.

Annual Report and Attestation

- The Annual Report and Attestation will provide a year-end summary report on achievements on all programs governed under the Agreement, in all accountability domains under the Organizational Requirements, and identification of any major changes in planned activities due to local events.
- The Annual Report will include a narrative report on the delivery of programs and services, fiduciary requirements, good governance and management, public health practice, and other issues, year-end report on indicators, and a board of health attestation on required items.
- The Annual Report and Attestation shall be signed on behalf of the Board of Health by an authorized signing officer.

Annual Reconciliation Report

- The Board of Health shall provide to the Province an Annual Reconciliation Report for funding provided for public health programs governed under the Accountability Agreement.
- The Annual Reconciliation Report must contain: Audited Financial Statements; and, Auditor's Attestation Report in the Province's prescribed format.
- The Annual Reconciliation Report shall be signed on behalf of the Board of Health by an authorized signing officer.

MOH / AMOH Compensation Initiative Application

- The Board of Health shall complete and submit an annual application to participate in this Initiative and be considered for funding.
- Supporting documentation such as employment contracts must be provided by the Board of Health, as requested by the Province.
- Application form templates and eligibility criteria/guidelines shall be provided by the Province.

SCHEDULE D

BOARD OF HEALTH FINANCIAL CONTROLS

Financial controls support the integrity of the Board of Health's financial statements, support the safeguarding of assets, and assist with the prevention and/or detection of significant errors including fraud. Effective financial controls provide reasonable assurance that financial transactions will include the following attributes:

- **Completeness** – all financial records are captured and included in the Board of Health's financial reports;
- **Accuracy** – the correct amounts are posted in the correct accounts;
- **Authorization** – the correct levels of authority (i.e., delegation of authority) are in place to approve payments and corrections including data entry and computer access;
- **Validity** – invoices received and paid are for work performed or products received and the transactions properly recorded;
- **Existence** – assets and liabilities and adequate documentation exists to support the item;
- **Error Handling** – errors are identified and corrected by appropriate individuals;
- **Segregation of Duties** – certain functions are kept separate to support the integrity of transactions and the financial statements; and,
- **Presentation and Disclosure** – timely preparation of financial reports in line with the approved accounting method (e.g., Generally Accepted Accounting Principles (GAAP)).

The Board of Health is required to adhere to the principles of financial controls, as detailed above. The Board of Health is required to have financial controls in place to meet the following objectives:

1. Controls are in place to ensure that financial information is accurately and completely collected, recorded, and reported.

Examples of potential controls to support this objective include, but are not limited to:

- Documented policies and procedures to provide a sense of the organization's direction and address its objectives.
- Define approval limits to authorize appropriate individuals to perform appropriate activities.
- Segregation of duties (e.g., ensure the same person is not responsible for ordering, recording, and paying for purchases).
- An authorized chart of accounts.
- All accounts reconciled on a regular and timely basis.
- Access to accounts is appropriately restricted.
- Regular comparison of budgeted versus actual dollar spending and variance analysis.
- Exception reports and the timeliness to clear transactions.
- Electronic system controls, such as access authorization, valid date range test, dollar value limits, and batch totals, are in place to ensure data integrity.
- Use of a capital asset ledger.
- Delegate appropriate staff with authority to approve journal entries and credits.
- Trial balances including all asset accounts that are prepared and reviewed by supervisors on a monthly basis.

2. Controls are in place to ensure that revenue receipts are collected and recorded on a timely basis.

Examples of potential controls to support this objective include, but are not limited to:

- Independent review of an aging accounts receivable report to ensure timely clearance of accounts receivable balances.
- Separate accounts receivable function from the cash receipts function.
- Accounts receivable sub-ledger is reconciled to the general ledger control account on a regular and timely basis.
- Original source documents are maintained and secured to support all receipts and expenditures.

3. Controls are in place to ensure that goods and services procurement, payroll and employee expenses are processed correctly and in accordance with applicable policies and directives.

Examples of potential controls to support this objective include, but are not limited to:

- Policies are implemented to govern procurement of goods and services and expense reimbursement for employees and board members.
- Use appropriate procurement method to acquire goods and services in accordance with applicable policies and directives.
- Segregation of duties is used to apply the three (3) way matching process (i.e., matching 1) purchase orders, with 2) packing slips, and with 3) invoices).
- Separate roles for setting up a vendor, approving payment, and receiving goods.
- Separate roles for approving purchases and approving payment for purchases.
- Processes in place to take advantage of offered discounts.
- Monitoring of breaking down large dollar purchases into smaller invoices in an attempt to bypass approval limits.
- Accounts payable sub-ledger is reconciled to the general ledger control account on a regular and timely basis.
- Employee and Board member expenses are approved by appropriate individuals for reimbursement and are supported by itemized receipts.
- Original source documents are maintained and secured to support all receipts and expenditures.
- Regular monitoring to ensure compliance with applicable directives.
- Establish controls to prevent and detect duplicate payments.
- Policies are in place to govern the issue and use of credit cards, such as corporate, purchasing or travel cards, to employees and board members.
- All credit card expenses are supported by original receipts, reviewed and approved by appropriate individuals in a timely manner.
- Separate payroll preparation, disbursement and distribution functions.

SCHEDULE D

BOARD OF HEALTH FINANCIAL CONTROLS

4. Controls are in place in the fund disbursement process to prevent and detect errors, omissions or fraud.

Examples of potential controls include, but are not limited to:

- Policy in place to define dollar limit for paying cash versus cheque.
- Cheques are sequentially numbered and access is restricted to those with authorization to issue payments.
- All cancelled or void cheques are accounted for along with explanation for cancellation.
- Process is in place for accruing liabilities.
- Stale-dated cheques are followed up on and cleared on a timely basis.
- Bank statements and cancelled cheques are reviewed on a regular and timely basis by a person other than the person processing the cheques / payments.
- Bank reconciliations occur monthly for all accounts and are independently reviewed by someone other than the person authorized to sign cheques.