Our Vision:
Healthy People in Vibrant Communities

BOARD OF HEALTH MEETING

Woodstock Location: Oxford County Administration Building
21 Reeve Street, Woodstock, ON N4S 7Y3
Virtual Participation: Microsoft Teams
Thursday, February 22, 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.	Bernia Martin	
2.0 APPROVAL OF MINUTES			
2.1	Approval of Minutes: January 25, 2024	Bernia Martin	Decision
3.0 APPROVAL OF CONSENT AGENDA ***Consent agenda items are routine business items that do not require discussion. Any member of the Board may request an item be moved from the consent agenda to Section 4.0, 5.0, 6.0 or Closed Session (the latter is subject to bylaws governing closed session)***			
4.0 CORRESPONDENCE RECEIVED REQUIRING ACTION			
4.1	**Briefing Note: Enhancing Public Health Functions for Optimal Oral Health in Ontario** February 7, 2024: Ontario Association of Public Health Dentistry (OAPHD) *OAPHD provides advice to the Ministry of Health (MOH) on the important task of aligning provincial programs with the Canadian Dental Care Plan (CDCP) and updating the Ontario Public Health Standards (OPHS) to ensure that every Ontarian can achieve and maintain optimal oral health throughout their lifespan, with a key focus on primary prevention to prevent oral health disease.*	Bernia Martin	Decision
5.0 AGENDA ITEMS FOR INFORMATION.DISCUSSION.ACCEPTANCE.DECISION			
5.1	Building Healthier Communities Together Report for February 22, 2024	Ashlyn Brown	Decision
5.2	Chief Executive Officer's Report for February 22, 2024	Cynthia St. John	Decision
6.0 NEW BUSINESS/OTHER			
7.0 CLOSED SESSION			
8.0 RISING AND REPORTING OF THE CLOSED SESSION			

AGENDA			
ITEM	**AGENDA ITEM**	**LEAD**	**EXPECTED OUTCOME**
9.0 FUTURE MEETINGS & EVENTS			

9.1	• Board of Health Orientation: Thursday, March 28, 2024 at Noon
	• Board of Health Meeting: Thursday, March 28, 2024 at 1:00 pm
	  • Location: 1230 Talbot Street, St. Thomas ON
	  • Remote Participation for the BOH meeting: MS Teams
		Bernia Martin	

10.0 ADJOURNMENT			

January 25, 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, January 25, 2024 commencing at 1:04 p.m.

PRESENT:

Ms. C. Agar	Board Member
Mr. J. Couckuyt	Board Member
Mr. J. Herbert	Board Member
Ms. B. Martin	Board Member (Vice Chair)
Mr. D. Mayberry	Board Member
Mr. S. Molnar*	Board Member
Mr. M. Peterson	Board Member
Mr. J. Preston	Board Member (Chair)
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
Dr. N. Tran*	Medical Officer of Health
Ms. W. Lee	Executive Assistant

GUESTS:

Ms. M. Cornwell*	Manager, Communications
Ms. K. Chambers	Registered Dietitian, Healthy Communities
Ms. J. Gordon	Administrative Assistant
Mr. P. Heywood	Program Director
Ms. R. Gregoire	Public Health Nurse, Healthy Communities
Mr. D. McDonald	Director, Corporate Services and Human Resources
Ms. M. Nusink*	Director, Finance
Mr. I. Santos	Manager, Information Technology
Mr. D. Smith	Program Director
Ms. M. Van Wylie	Program Manager, Healthy Communities
Ms. R. Wallace	Public Health Nurse, Healthy Communities

MEDIA:

Mr. R. Perry*	Aylmer Express

**represents virtual participation*

REGRETS:

Mr. G. Jones	Board Member
Ms. S. MacIsaac	Program Director

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 1:04pm.

C. St. John welcomed Stephen Molnar and Catherine Agar to the Board of Health as Order in Council Provincial Appointees, effective January 18, 2024. Both have received 3-year appointments.

1.2 AGENDA

Resolution # (2024-BOH-0124-1.2)
Moved by M. Ryan
Seconded by D. Warden

> That the agenda for the Southwestern Public Health Board of Health meeting for January 25, 2024 be approved.
>
> Carried.

1.3 Reminder to disclose Pecuniary Interest and the General Nature Thereof when Item Arises.

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

1.5 Election of Officers:

J. Herbert asked for clarity regarding guidelines for electing officers and their expected term of office. He offered his view that a one-year term is insufficient to address larger concerns or issues, suggesting a two- or three-year term for greater continuity.

C. St. John noted the By-Laws and Board policies for the Board of Health regarding the election of officers specifies a one-year term, wherein a second one-year term may be served consecutively, after which a one-year break from the role served is required before being re-elected for another term.

D. Warden noted that the historical approach of the Elgin St. Thomas Board of Health alternated between electing members from Elgin County and the City of St. Thomas to ensure courteous and fair urban and rural representation.

C. St. John indicated she would take these nuances into consideration during her biennial Board policy review and then bring forward a report with her recommendations for consideration.

D. Warden nominated B. Martin for the position of Chair for 2024. B. Martin allowed her name to stand for nomination. J. Preston seconded the nomination.

J. Herbert nominated J. Preston for the position of Chair for 2024. J. Preston respectfully declined the nomination, citing his full commitments as Mayor of St. Thomas, and expressed his wish to remain an active Board member, nevertheless.

Resolution # (2024-BOH-0124-1.5A)
Moved by D. Warden
Seconded by J. Preston

> That Bernia Martin be Chair of the Board of Health for Southwestern Public Health for the year of 2024.
>
> Carried.

D. Warden expressed his thanks to J. Preston for his tremendous contributions and service to the Board of Health and his hope that he remains with the Board, respecting his many commitments.

D. Mayberry nominated G. Jones for the position of Vice Chair for 2024. G. Jones indicated via text message with D. Mayberry his acceptance of this nomination in absentia.

Resolution # (2024-BOH-0124-1.5B)
Moved by D. Mayberry
Seconded by D. Warden

> That Grant Jones be Vice-Chair of the Board of Health for Southwestern Public Health for the year of 2024.
>
> Carried.

Resolution # (2024-BOH-0124-1.5C)
Moved by D. Mayberry
Seconded by M. Ryan

That the Board of Health Chair for Southwestern Public Health delegate the Chief Executive Office as acting “Head” for the purpose of ensuring day-to-day fulfilment of Southwestern Public Health’s compliance obligations under the Municipal Freedom and Information and Protection of Privacy Act (MFIPPA) for the year 2024.

Carried.

2.0 APPROVAL OF MINUTES

Resolution # (2024-BOH-0124-2.1)
Moved by D. Shinedling
Seconded by M. Peterson

That the minutes for the Southwestern Public Health Board of Health meeting for November 22, 2023 be approved.

Carried.

Resolution # (2024-BOH-0124-2.2)
Moved by D. Warden
Seconded by M. Peterson

That the minutes for the Southwestern Public Health Board of Health meeting for December 22, 2023 be approved.

Carried.

3.0 CONSENT AGENDA

No Items.

4.0 CORRESPONDENCE RECEIVED REQUIRING ACTION

C. St. John reviewed the letters of correspondence.

M. Ryan applauded the letter written by the Association of Local Public Health Agencies (alPHa) regarding voluntary mergers and expressed his hope for a report indicating criteria and measures used to assess the suitability of potential merger partners.

C. St. John responded that it was the recommendation of the Board to enlist the support of a consultant to develop measurable indicators of what success would look like if a merger happened, acknowledging the Board's commitment to the importance of improved health outcomes in its communities.

Resolution # (2024-BOH-0124-4.1)
Moved by D. Mayberry
Seconded by J. Preston

That the Board of Health for Southwestern Public Health support correspondence:
4.1 Intimate Partner Violence Public Health Action Letter to the Premier; 4.2 Voluntary Mergers Component of the Strengthening Public Health Initiative; and
4.3 Investing in a Sustainable Federal School Food Policy

Carried.

5.0 AGENDA ITEMS FOR INFORMATION.DISCUSSION.DECISION

5.1 Monitoring Food Affordability in the SWPH-Region and Effective Policy-Based Solutions for January 25, 2024

Kendall Chambers and Randie Gregoire presented the report, acknowledging the contributions of their colleague, Rebecca Wallace (who attended virtually).

J. Herbert asked how those who face food insecurity are able to get by. K. Chambers noted that many residents regularly access food banks, community programs, and shelters.

D. Shinedling asked how organizations become involved in the living wage program. Randie Gregoire cited the Ontario Living Wage Network (OLWN) which certifies organizations through an employer program.

M. Ryan asked if SWPH is a certified living wage employer. C. St. John confirmed that Southwestern Public Health will be applying to become a Living Wage Employer as noted in the recommendations.

M. Peterson asked if there are measures in place in schools for students who may be in need. K. Chambers noted that staff have been hearing of more concerns about food insecurity in the community and that SWPH works to support schools with programs where possible. K. Chambers highlighted that SWPH is trying to work toward more income-based solutions to support people for while there may be many individuals accessing these programs, it typically only represents a fraction of those that are in need.

P. Heywood indicated that the letter the Board just endorsed earlier, Investing in a Sustainable Federal School Food Policy, is a $1 billion dollar investment to provide healthier choices in schools and generate healthier outcomes as well.

M. Ryan praised the report and is strongly in favor of the recommendations. He suggested adding correspondence from SWPH to its funding municipal partners to consider endorsing measures such as advocacy and seeking certification as a living wage employer, supporting the amendment of the motion to the Board.

S. Molnar concurred, praising the report, and asked if there were any additional advocacy measures that can be done regarding the federal government.

P. Heywood noted Bill S-233 (guaranteed livable basic income) is currently with the Senate and they have completed the second reading and will be going to committee. When consultation opens, SWPH will be present to provide insight regarding household food insecurity as well as universal income.

L. Rowden referenced Harvest Hands, a local non-profit that redistributes foods to prevent wastage and connect people with food resources and asked if such operations should be used more. K. Chambers agreed such initiatives are very positive and has been used by community groups. She noted that SWPH has looked at food access as part of a larger food systems discussion that could be framed as a way of supporting community food security.

D. Shinedling asked what the financial impact of becoming a Living Wage Employer would be to SWPH.

C. St. John noted that the cost is negligible since all permanent positions are paid above the living wage threshold. She did note that SWPH will also work with external agencies providing services to SWPH to also consider paying a living wage.

D. Shinedling asked if there is a plan to write a report or go in person to present when consultations open regarding Bill S-233.

P. Heywood explained that when a consultation period opens, respective agencies are notified and given a set timeframe to respond. SWPH generates a response via collaboration with community partners and agencies to inform recommendations based on a review of the legislation via a consultation package.

D. Shinedling asked if there was a more detailed breakdown of where these groups fall within the catchment areas and if there are any regional areas of concern.

K. Chambers noted that SWPH's Foundational Standards team could provide more local data based on Statistics Canada, but also noted that some information was more anecdotal than fact-based. R. Gregoire added that they could look to their local Ontario Works and Ontario Disability Support Program (ODSP) for additional data if possible.

M. Ryan reiterated his support for the income-based solutions in the report as effective preventative measures that could be integrated in community safety well-being plans. D. Mayberry supported the amendment to the motion, asking that the report and handout be circulated to all area municipalities.

B. Martin indicated her full support of the addition to the motion.

Resolution # (2024-BOH-0124-5.1)
Moved by D. Mayberry
Seconded by M. Ryan

> That Board of Health for Southwestern Public Health accept the report entitled "Monitoring Food Affordability in the SWPH-Region and Effective Policy-Based Solutions" for January 25, 2024, including SWPH's application to become a Living Wage Employer, and as amended with the additional recommendation that the report be circulated to member municipalities for consideration and adoption.

Carried.

K. Chambers, R. Gregoire, and M. Van Wylie left the meeting at 2:05pm.

5.2 Medical Officer of Health's Report

Dr. Tran reviewed his report.

Resolution # (2024-BOH-0124-5.2)
Moved by J. Preston
Seconded by M. Peterson

That Board of Health for Southwestern Public Health accept the Medical Officer of Health's report for January 25, 2024.

Carried.

5.3 Chief Executive Officer's Report

C. St. John reviewed her report.

S. Molnar asked for clarity regarding section 1.1 regarding the report's reference to municipalities. C. St. John noted the use refers to all local municipalities, and not just obligated municipalities.

Regarding the Land Acknowledgement (LA), M. Ryan asked if SWPH has had meaningful consultations with the relevant First Nations that are mentioned.

M. Cornwell noted SWPH connected with the Indigenous agency, Atlohsa, and some cultural safety trainers, and there will be additional work regarding consultation processes as the LA will be an iterative practice that develops over time.

M. Ryan noted that the work SWPH has done thus far is excellent, but also noted that, based on his awareness of an array of positive and negative responses to Land Acknowledgements from local First Nations, suggested the organization not move forward in its use of the LA until more meaningful conversations have occurred.

M. Ryan noted that it befits SWPH as an organization to treat the LA as address to the First Nations in our region. M. Peterson identified that some local groups are sensitive to being referenced without consultation. C. Agar agreed with M. Ryan that it would be worthwhile to meet with local groups and to learn if they wish to be referenced. J. Preston concurred, noting there is a duty to consult with regards to the Truth and Reconciliation process.

C. St. John noted the user guide was developed as a starting point to reach out and seek consultation with local First Nations and staff will provide a follow-up report for the Board's consideration later in the year.

J. Herbert asked that the use of the Land Acknowledgement be deferred pending the CEO's follow-up report. B. Martin agreed that an amendment would be noted in the motion. D. Mayberry and M. Ryan supported the amendment.

Resolution # (2024-BOH-0124-5.2)
Moved by M. Ryan
Seconded by M. Peterson

That Board of Health for Southwestern Public Health accept the Chief Executive Officer's report for January 25, 2024 as amended.

Carried.

6.0 NEW BUSINESS

M. Peterson noted the high levels of sodium in the Town of Bright and that many residents indicated a lack of awareness regarding this issue, asking that SWPH provide more active notice to those residents.

P. Heywood noted that annual reminders such as health information advisories are included in their utility bills, as well as general health advisories.

C. St. John & M. Cornwell noted that a general advisory on higher sodium and fluoride levels in the Oxford region went out on SWPH's social media channels but they would review the messaging re: timing and clarity.

Dr. Tran noted that after general messaging is provided, more specific messaging can be more complex, but further strategies to distribute information would be considered by the team.

7.0 TO CLOSED SESSION

Resolution # (2024-BOH-0124-C7)
Moved by D. Shinedling
Seconded by M. Peterson

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.

8.0 RISING AND REPORTING OF CLOSED SESSION

Resolution # (2024-BOH-0124-C8)
Moved by D. Mayberry
Seconded by M. Peterson

That the Board of Health rise with a report.

Carried.

Resolution # (2024-BOH-0124-C3.1)
Moved by J. Herbert
Seconded by M. Peterson

That the Board of Health for Southwestern Public Health accept the Chief Executive Officer's Report for January 25, 2024.

Carried.

Resolution # (2024-BOH-0124-C3.2)
Moved by M. Peterson
Seconded by L. Rowden

That the Board of Health for Southwestern Public Health approve the Special Ad Hoc Strengthening Public Health Report for January 25, 2024.

Carried.

9.0 FUTURE MEETING & EVENTS

10.0 ADJOURNMENT

That the meeting adjourns at 3:46 p.m. to meet again on Thursday, February 22, 2024 at 1:00 p.m.

Resolution # (2024-BOH-0124-10)
Moved by M. Peterson
Seconded by J. Preston

That the meeting adjourns at 3:46 p.m.

Carried.

Confirmed: _____

Briefing Note: Enhancing the Roles of Public Health for Optimal Oral Health

Purpose To advise the Ministry of Health (MOH) on enhancing the roles of Public Health so that every Ontarian can achieve and maintain optimal oral health throughout the life span.

Key Highlights

- The Canadian Dental Care Plan (CDCP) will expand access to oral health services for low-income, uninsured Canadians. However, the CDCP is not universal and will not address all oral health inequities.
- The current Ontario Public Health Standards (OPHS) lack standards for preventive oral health programs across the lifespan, with the major focus being on children and seniors.
- It is recommended that the MOH continues to invest in provincial public health prevention interventions to support a multifaceted, cost-effective life course approach to oral health promotion. This will help improve overall population health and support the success of the federal dental program.
- Overarching recommendations:
    - Continue to invest and sustain current oral health practices that are already underway within each of the roles of Public Health.
    - Enhance investments in upstream, population – based roles for health promotion and disease prevention/delay.
    - Expand downstream efforts to reach other marginalized groups facing barriers to accessing care.

Setting the Context

Oral health issues can cause pain, infection, and lead to chronic diseases, with physical, social, and psychological consequences. With a strong knowledge base in working with vulnerable groups experiencing challenges in accessing and receiving care, the Ontario Association for Public Health Dentistry (OAPHD) is committed to promoting universal access to appropriate oral health care for all Ontarians.

The OAPHD considers the CDCP as a major step forward towards universal oral health care access. However, this treatment focused program will not address all oral health inequities experienced by Ontarians. It is imperative for the provincial government to continue investing in Public Health for disease prevention and align public dental programs to ensure that:

- vulnerable populations do not fall through any gaps in accessing oral health care,
- health equity integration is sustained to meet the community's unique needs and
- upstream interventions that use a life course approach are emphasized, with the intention of preventing oral health issues.

Both the roll out of the CDCP and the OPHS review provide opportunity to acknowledge the current public health practices that are working well while addressing their challenges to better promote oral health in the future. Strengthening the multifaceted roles of public health in oral health will result in:

- the long-term prevention of chronic disease,
- improved health and wellbeing, and
- reduced costs and burden placed on the health care system.

The Roles of Public Health in Oral Health

Public Health's role in oral health care integrates a multipronged, health equity focused approach to help those who are most vulnerable both at the population and individual level. This is to help maintain overall health and wellbeing and prevent oral health issues and future chronic diseases. There are seven Public Health roles that, when implemented together, lead to improved health outcomes[1]:

Public Health Roles

1. **Health Promotion:** support disease prevention and healthy behaviours by building healthy public policies, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services.[1]
2. **Primary Prevention**: prevent diseases from developing or significantly delay disease onset (e.g., community water fluoridation [CWF], fluoride varnish [FV], and dental sealants).
3. **Secondary Prevention**: detect diseases, including before noticeable symptoms appear, and aims to decrease the prevalence of disease by shortening its duration (e.g., dental screening and silver diamine fluoride [SDF]).
4. **Tertiary Prevention:** stops disease progression and further adverse health outcomes in marginalized populations (e.g., fillings and extractions).
5. **Navigation Support**: increase awareness of, access to, and utilization of public dental programs.
6. **Data Collection and Surveillance**: collect and analyze population level data, monitor trends, and identify emerging priorities and health inequities that can inform broader health system goals.
7. **Dental Infrastructure Oversight**: support a public model that integrates fixed clinics, dental buses, and portable services in community settings to serve those most at risk.

[1] Health Promotion Ontario. (2023). White Paper on the Value of Local Health Promotion in Ontario. https://www.healthpromotioncanada.ca/wp-content/uploads/2023/10/2HPO-Value-of-Local-Health-Promotion-White-Paper.pdf

The OPHS alludes to all seven roles. However, some areas receive more emphasis than others, and not all roles are considered requirements, leading to minimal implementation. In addition, the CDCP will assist with some of these roles (e.g., primary, and secondary prevention); however, if not aligned well with provincial programs, the CDCP will result in Public Health redirecting significant resources into other roles (e.g., navigation support).

For a substantial shift towards better health outcomes, the OAPHD deems that it is essential for PHUs to offer a **suite of programs and services in all role areas** across the life course and amongst those most at risk. Implementing the bare minimum in each role or offering mainly downstream interventions in each role is not enough to achieve and maintain optimal oral health throughout the life span. Downstream interventions address early detection and treatment of diseases, which are only partially effective at reducing the need for more expensive health care. However, it is the upstream approaches that reduce the burden of disease on the health care system even further since they address the root causes of disease (see Footnote 1).

Proposed Recommendations

The OAPHD reviewed current practices and gaps within Public Health and identified opportunities for enhancement in the future provision of public dental programs, knowing that there will be the added federal program. It is critical to point out that at a minimum, current practices must continue into the future state:

Overarching Recommendations

- Continue to invest and sustain current oral health practices that are already underway within each of the roles of Public Health.
- Enhance investments in upstream, population – based roles for health promotion and disease prevention/delay.
- Expand downstream efforts to reach other marginalized groups facing barriers to accessing care.

This will:

1. supplement the treatment based CDCP.
2. improve equity by increasing Public Health's capacity to expand targeted efforts to more vulnerable populations.
3. enable individuals of all ages to benefit from improved overall health, resulting in more cost savings to the health care system compared to a focus on treatment.

Table 1 proposes more specific recommendations for further enhancing the roles to better meet the needs of vulnerable populations using a life course approach. Some examples of PHUs implementing the enhancements are also included in the table; these show the need and feasibility of the proposed recommendations.

Table 1

Proposed Recommendations for the Roles of Public Health in Oral Health (see Appendix for supporting evidence)

Role of Public Health	Current Practice in PHUs	Challenges/Gaps	Recommendations	Examples of Recommendations[2]
Health Promotion	• Integrate oral health into other Public Health program areas and/or with community stakeholders. • Provide education on oral health behaviours to support positive changes in beliefs and attitudes.	• Some PHUs focus solely on oral health promotion education, resulting in a lack of prioritization, capacity, and qualified skills put towards other health promotion strategies. This also leads to a lack of impact in terms of sustained behaviour change. • The CDCP poses a risk of downstream bias due to an increased focus on treatment versus upstream health promotion. • Provincial campaigns do not always resonate with the local context, requiring additional PHU supports.	• Provide provincial direction that a comprehensive oral health promotion approach with upstream strategies is needed for good oral health outcomes. • Comprehensive oral health promotion programs have proven to be cost-effective. For example, a systematic review indicated that 97% of oral health promotion programs in children were cost saving, with reductions in dental treatment expenses for parents and institutions (see Footnote 1). • Provide provincial direction for targeted approaches to address the underlying determinants of health that lead to health inequities. • Provide standard messaging for integrating into targeted health promotion initiatives. • Encourage pre-existing health services and health sectors (i.e.: nutrition, mental health, tobacco/vaping control etc.) to incorporate cross cutting oral health promotion initiatives.	• Oral Health education at Well Baby Visits [Hastings Prince Edward Public Health (HPEPH)], and for prenatal mothers/new mothers, and adults enrolled in social service programs (Durham). • Train the trainer model to LTC staff (Durham) and PSWs (Hamilton). • Oral health education campaigns and social media messaging (Peel).

[2] This list of examples is not exhaustive.

Role of Public Health	Current Practice in PHUs	Challenges/Gaps	Recommendations	Examples of Recommendations[2]
Primary Prevention	• Provide FV and dental sealants to high needs children. • Monitor and provide support for local CWF.	• Primary prevention programs are lacking across the lifespan as it is not mandated in the OPHS. • Jurisdictional inconsistencies exist with CWF, yet evidence indicates that it is the most effective measure for reducing tooth decay. • The absence of primary prevention increases likelihood of poorer health outcomes (e.g., chronic disease) and higher health care costs (e.g., hospital visits).	• Expand primary prevention programs to include pre-school children, adults, and other vulnerable groups. • Support PHUs to provide sufficient and innovative primary prevention services in a variety of settings (e.g., clinics and community/non-traditional settings such as shelters, long term care). • Provide provincial direction that all communities need to fluoridate water.	• FV provided at daycares, playgroups and during home visits for identified priority populations (HPEPH). • Sealants and FV provided in schools with high dental need via portable and mobile clinics (Peel). • Evidence for CWF is actively monitored for its quality and relevance (Peel).
Secondary Prevention	• Provide oral screening as per OPHS Protocol requirements by intensity level and grade. • Provide case management and follow-up to ensure treatment initiation. • Provide treatment to high-risk Healthy Smiles Ontario (HSO) children.	• Secondary prevention programs are lacking across the life span as they are not mandated in the OPHS. • Children at low and medium screening intensity schools may fall through the gaps without the implementation of screening in higher grades.	• Expand screening, case management and follow-up to pre-school children, additional school grades, and hard to reach groups including residents of congregate settings (e.g., LTC and shelters).	• Free screening and preventive services for 0- to 4-year-olds in the Baby Oral Health Program (Windsor Essex County). • Free screening provided in all LTC homes (Durham). • SDF provided in select high-risk daycares (Durham). • Free screening provided in high schools (Toronto).
Tertiary Prevention	• Provide routine dental care such as fillings and extractions to eligible children and seniors.	• Clients from vulnerable groups such as seniors, recent immigrants and low-income individuals often do not feel comfortable visiting private dental clinics.	• Maintain tertiary prevention investments to ensure that no one falls through the gaps.	• Expand current clinic options based on local needs (Peel).

Role of Public Health	Current Practice in PHUs	Challenges/Gaps	Recommendations	Examples of Recommendations[2]
Navigation Support	• Increase HSO and Ontario Seniors Dental Care Program (OSDCP) client's awareness of oral health services. • Assist with the application process, finding a dental provider, and establishing a dental home.	• If publicly funded dental programs are not aligned, the CDCP will exacerbate pre-existing inconsistencies (e.g., eligibility criteria, application processes, delivery models), reducing capacity for other roles. • Need to be mindful that providing navigation support to complex and marginalized clients is labour intensive in terms of addressing multiple barriers (e.g., transportation, language). • Marginalized communities are not always willing to receive care from those perceived to not represent 'their community'.	• Optimize efficiencies by streamlining and aligning the application and eligibility process for all publicly funded programs. • Invest in community health workers that act as a bridge between the community and Public Health, for clinical care, patient advocacy, cultural supports, and language interpretation. • Allocate funds for community services such as transportation grants for clients that may be hindered by such matters from accessing prevention services. • Provide standard messaging to PHUs that can be tailored to the local context.	• Provision of travel grants to OSDCP clients to access dental services (Public Health Sudbury and Districts). • Utilization of translation services (Remote Interpretation Ontario) to attain informed consent and improve access to care (Windsor Essex County). • Newcomer HSO/Oral Health Navigation Initiative (Hamilton).
Data Collection and Surveillance	• Collect oral screening data for children screened in schools. • Collect HSO and OSDCP program utilization and eligibility data.	• Oral health data collection and surveillance is limited to HSO-enrolled children and OSDCP-enrolled seniors, as per the OPHS. • Challenges exist with extracting and utilizing data from OHISS at the local level. • Existing provincial surveys often do not collect oral health data (e.g., OSDUHS[3], RRFSS[4]).	• Gather and share high quality oral health status data (accurate, complete, reliable, relevant, and timely) on meaningful indictors and that can be disaggregated for the local level with equity considerations.	• Centers for Disease Control and Prevention (CDC) collects oral health data from national and state sources and presents data in useful formats for the broad community interested in promoting oral health.[5]

[3] Ontario Student Drug Use and Health Survey
[4] Rapid Risk Factor Surveillance System
[5] Centers for Disease Control and Prevention. (2022, October 17). Oral Health Data Tools. https://www.cdc.gov/oralhealth/data-tools/index.htm

Role of Public Health	Current Practice in PHUs	Challenges/Gaps	Recommendations	Examples of Recommendations[2]
Dental Infrastructure Oversight	• Oversee provincial funding for constructing and operating public dental clinics.	• Existing infrastructure is not adequate to meet demands for oral health services, which will worsen with increased eligibility from CDCP. • Sufficient resources are lacking to support infrastructure required for harder to reach clients and complex patients.	• Further invest in PHUs to enable a variety of service options within the public model (e.g., mobile dental bus, portable services). • Encourage PHUs to integrate comprehensive wraparound care in health service delivery.	• Dental bus (Peel and Hamilton). • Portable preventive services and restorative treatments offered in LTC homes (Durham). • Portable preventive services in schools and in the community for clients on HSO, OSDCP (Peel and Hamilton), and low- income adults (Hamilton).

Conclusion

Providing oral health care through Public Health Units is an OPHS requirement. However, more can be done for overall health and chronic disease prevention. Provincial investments in enhancing the roles of public health in oral health are needed to sustain and expand public dental programs across the lifespan and ensure that vulnerable populations do not fall through the gaps. Balancing treatment needs with ongoing provincial investments in prevention interventions will support a multifaceted approach to oral health that is rooted in health equity, is cost effective in improving overall population health by reducing chronic disease, and ultimately supports the success of the CDCP. The OAPHD has proposed several recommendations to support this and is available to collaborate further with the Ministry of Health and other provincial oral health stakeholders to outline the roles of public health in the future state of oral health.

Appendix

Appendix A - Supporting Evidence

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Appendix B - Examples of Recommended Enhancements to Public Health Roles

(Please note that this list of examples is not exhaustive)

- **Health Promotion**
    - Build health promoting schools through school health curriculum support resources for educators to facilitate the delivery of oral health education.
        - Grade 1 (Public Health Sudbury and Districts)
        - Grade specific education provided to high-risk elementary schools and high schools upon request (Durham)
    - Incorporate oral health promotion into pre-existing health services such as Well Baby Visits (HPEPH), programs for prenatal mothers/new mothers, and adults enrolled in social service programs (Durham).
    - Involve non-dental professionals in oral health promotion through a train the trainer model to LTC staff (Durham) and Personal Support Workers (PSW) (Hamilton).
- **Primary Prevention**
    - Fluoride Varnish (FV) provided at daycares, playgroups and during home visits for identified priority populations (Hastings Prince Edward Public Health [HPEPH]).
    - Sealants and FV provided in schools with high dental need via portable and mobile clinics (Peel).
    - Evidence for Community Water Fluoridation (CWF) is actively monitored for its quality and relevance (Peel).
- **Secondary Prevention**
    - Free screening and preventive services for 0- to 4-year-olds in the Baby Oral Health Program (Windsor Essex County).
    - Free screening and silver diamine fluoride (SDF) preventive services provided in select high risk daycare centres (Durham).
    - Free screening provided in all long-term care (LTC) homes (Durham).
    - Drop-in dental screening clinics on school PA days for children aged 0-17 (Public Health Sudbury and Districts).
    - Free screening in high schools (Toronto).
    - Newcomers Centre of Peel project provided screening and preventive services for Ukrainian refugee families (Peel).
- **Navigation Support**
    - Provision of travel grants to OSDCP clients to access dental services (Public Health Sudbury and Districts).

- Utilization of translation services (Remote Interpretation Ontario) to attain informed consent and improve access to care (Windsor Essex County).
- Newcomer HSO/Oral Health Navigation Initiative (Hamilton).

- **Data Collection and Surveillance**
  - Centers for Disease Control and Prevention (CDC) collects oral health data from national and state sources and presents data in useful formats for the broad community interested in promoting oral health.

- **Dental Infrastructure Oversight**
  - Dental bus (Peel and Hamilton).
  - Provide preventive and treatment services via mobile vans for LTC clients (Toronto).
  - Portable preventive services and restorative treatments offered in LTC homes (Durham).
  - Portable preventive services in schools and LTC homes (future), brick-and-mortar dental clinics for clients on HSO, OSDCP, and adults experiencing low-income (Hamilton).

Appendix C – The Group

Name	Title	Organization
Paul Sharma	Director, Chronic Disease and Injury Prevention, Peel Public Health	Ontario Association of Public Health Dentistry
Dr. Faahim Rashid	Dental Consultant, Peel Public Health	Ontario Association of Public Health Dentistry
Dr. Robert Hawkins	Manager, Child and Family Health, York Region Public Health	Ontario Association of Public Health Dentistry
Kelly Palmateer	Oral Health Manager, Clinical Services, Hastings Prince Edward Public Health	Ontario Association of Public Health Dentistry
Brian Convey	Manager, Oral Health Division, Durham Region Health Department	Ontario Association of Public Health Dentistry
Sarah Hill	Manager, Oral Health, Windsor-Essex County Health Unit	Ontario Association of Public Health Dentistry
Kim Casier	Manager, Oral Health, Southwestern Public Health	Ontario Association of Public Health Dentistry
Charlene Plexman	Manager, Clinical Services Division, Public Health Sudbury and Districts	Ontario Association of Public Health Dentistry
Manisha Mehta	Manager, Dental and Oral Health Services, Toronto Public Health	Ontario Association of Public Health Dentistry
Anna Gibson	Supervisor, Community Dental and Vision Screening Services, Hamilton Public Health	Ontario Association of Public Health Dentistry
Jodi Maki	Health Promoter, Health Promotion Division, Public Health Sudbury & Districts	Ontario Association of Public Health Dentistry
Susan Stewart	Director of the Community Health and Well-Being Portfolio, Kingston, Frontenac, and Lennox & Addington Public Health	
Sandra Almeida, RD	Advisor, Chronic Disease and Injury Prevention, Peel Public Health	
Victoria Palmer	Health Promoter, Chronic Disease and Injury Prevention, Peel Public Health	

BOARD REPORT

MEETING DATE:	February 22, 2024
SUBMITTED BY:	Cynthia St. John, Chief Executive Officer Peter Heywood, Program Director, Healthy Communities Division
SUBMITTED TO:	Board of Health
PURPOSE:	☒ Decision ☐ Discussion ☐ Receive and File
AGENDA ITEM #	5.1
RESOLUTION #	2024-BOH-0222-5.1
REPORT TITLE:	Building Healthier Communities Together: Highlighting the Role of Municipal and Public Health Collaboration in Addressing the Social Determinants of Health

Introduction

The social determinants of health (SDOH) are the non-medical factors influencing health (e.g., income, education, food security, employment, etc.). They are the conditions in which we are born, grow, work, and live, as well as the systems that shape the conditions of daily life. Addressing the SDOH is essential for improving health and reducing established health inequities. Public health and municipalities are uniquely positioned to collaborate to address the SDOH through public health and municipal priorities. There is a longstanding history of local public health agencies and municipalities working together to improve their communities. This report highlights how municipalities play a crucial role in improving community health by integrating social determinants' considerations into their policies, plans, and bylaws and fostering healthier, more equitable environments for their residents. The report also outlines further opportunities for collaboration between the area municipalities and Southwestern Public Health (SWPH) in 2024.

Background

The conditions of everyday life largely determine our health and the systems put in place that promote health, prevent disease, and provide support when we are sick.[1] The SDOH are the conditions in which people are born, grow, live, and work that interact to positively or negatively influence health and well-being.[1] The Canadian Public Health Association identifies the following as SDOH:[2]

- Income and income distribution
- Education
- Unemployment and job security
- Employment and working conditions

- Early childhood experiences
- Food insecurity
- Housing
- Physical environments
- Social exclusion
- Access to health services
- Gender
- Culture
- Race and racism
- Disability

The SDOH significantly impacts our health, even stronger than behaviours like what we eat and our level of physical activity.[3] An example of how the SDOH interacts and influences health can be seen with income. People living on low incomes have a higher prevalence of chronic diseases such as diabetes and high blood pressure and have a greater chance of having more than one chronic condition at a time.[4] Income can determine the quality of the SDOH, including food security, housing, education, and early childhood development. Low income can lead to material and social deprivation, meaning individuals and families are less likely to be able to afford necessities such as food, clothing, and housing.[3] Additionally, social deprivation related to income can mean it may be more challenging to be involved in cultural, educational, or recreational activities.[3] The Canadian Public Health Association also illustrates how social isolation can impact health. We often don't think about social isolation affecting health; however, it can impact some individuals more than others. For example, social isolation from the perspective of a single parent can be profound as they often juggle the responsibilities of parenting, work, and their household alone. This lack of support may lead to a lack of access to emergency childcare when they must stay late at their job, which can impact income. This isolation may impact their health, potentially hindering their ability to seek assistance or build connections.

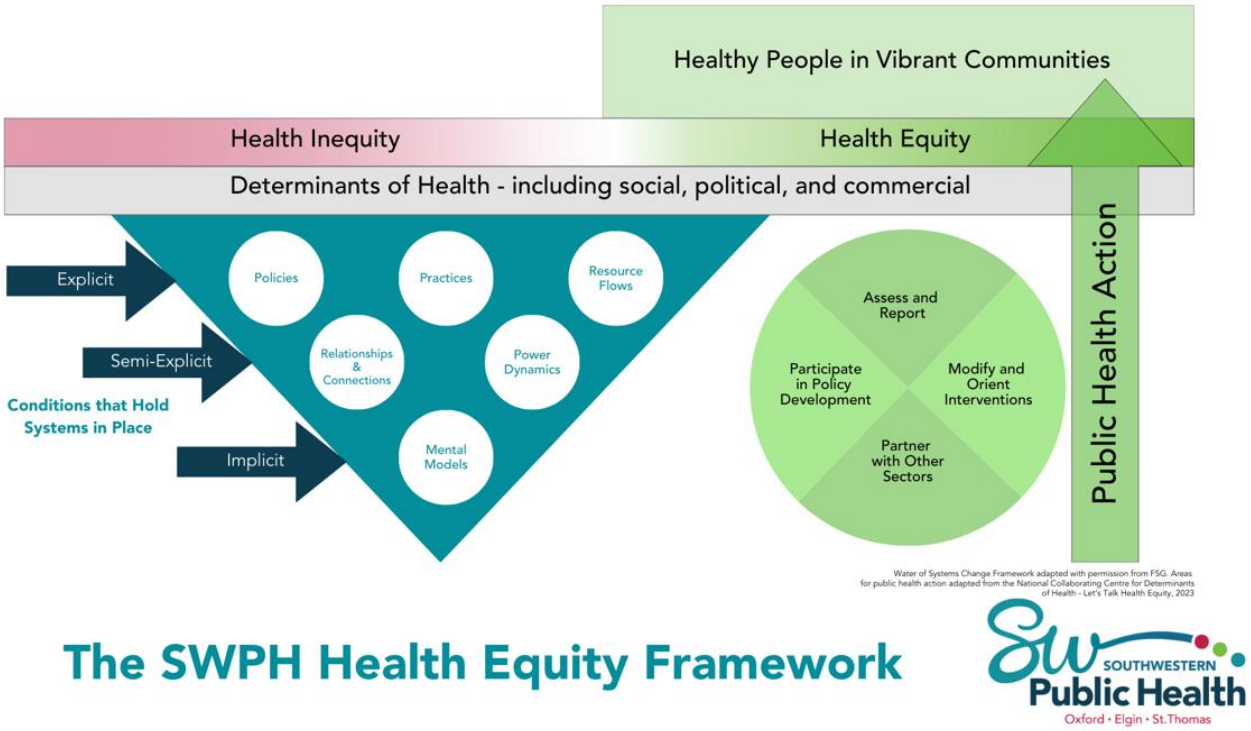
Addressing the SDOH is critical for improving health and reducing longstanding health inequities. As demonstrated above, the SDOH are drivers of health inequities among individuals and groups. The Ontario Public Health Standards identify health inequities as health differences that are:[5]

- Systematic (e.g., patterned as health generally improves as socioeconomic status improves);
- Socially produced, and could be avoided by ensuring that all people have the social and economic conditions that are needed for health and well-being; and
- Unfair and unjust as opportunities for health and well-being are limited.

Health equity is achieved when everyone has a fair opportunity to reach their full health potential. This means everyone, regardless of socioeconomic status, race, ethnicity, age, gender, religion, sexual orientation, gender identity, gender expression, disability, and other diverse backgrounds, can achieve their highest possible level of physical and mental well-being without systemic barriers or inequalities.

In 2023, a health equity framework and associated theory of change was created by SWPH. The framework looks at understanding how to dismantle health inequities and the systems or conditions that hold them in place (Figure 1). Additionally, the health equity framework adopted the water of systems change framework that identifies six conditions that hold systems in place, including policies, practices, resource flows, power dynamics, relationships and connections, and mental models. The conditions that hold systems in place are difficult to see as we are all participants. Applying a systems lens can help illuminate the factors at play and identify areas for action toward equitable health outcomes.

Figure 1: Health Equity Framework



The Role of Municipalities in Addressing the Social Determinants of Health

Social policies implemented, or not implemented, by governments have a direct impact on the SDOH. A World Health Organization report through the Commission on Social Determinants of Health notes that "poor and unequal living conditions are the consequence of poor social policies and programs, unfair economic arrangements, and bad politics."[1] Expansive policies can be applied at the federal or provincial level to address the SDOH. However, municipalities also have an essential role in addressing the health and well-being of their populations at a local level. Policies at the local level can often be implemented in a more direct, focused, and timely manner when compared to other levels of government.[2]

The SDOH can be addressed through a "Health in All Policies" (HIAP) approach. "Health in All Policies" is an umbrella concept defined as "… an approach to public policies across sectors that systematically consider the health implications of decisions, seeks synergies, and avoids harmful health impacts to improve population health and health equity."[3] As demonstrated with the SDOH example of income noted previously, a singular determinant of health can have many impacts relating to population health and wellbeing. The most effective ways to influence a given SDOH (i.e., income) may require actions across multiple sectors of society.[4] To successfully use limited resources and prevent duplication of effort, a well-coordinated response from multiple sectors (such as varying levels of government, civil society, and the private sector) is required to effectively influence a given determinant of health and wellbeing.[4]

Multi-sectoral collaboration is essential to address health challenges and to decrease health inequities experienced in our communities. As many interventions for addressing the SDOH and health equity lie outside the public health sector, stakeholders across multiple sectors must be engaged in executing local strategies.[5] This includes public health, municipalities, community agencies and non-health sector partners such as children and youth services, housing administration, school boards, and grassroots organizations. Key documents in health promotion, including the Ottawa Charter for Health Promotion, emphasize the importance of collective impact or multi-sectoral collaboration in public policy development.[5] The Charter

underlines the placing of health issues on the agenda of policymakers, specifically directing them to be aware of the consequences of their decisions regarding health and to accept their responsibilities for health.[5] Collaboration among governments or agencies is one component of improving health and well-being. However, community engagement is also needed to advance initiatives. Community engagement drives social change, raises awareness, and allows those most impacted by policies to be heard.

Many municipal government responsibilities intersect with public health. According to the Association of Municipalities of Ontario, nearly 90% of municipal operational expenditures contribute to addressing the SDOH, either directly or indirectly.[2] Community safety and well-being plans are an example of the intersectionality of municipal actions, public health actions, and the SDOH. The priority risk themes from the Oxford County plan (mental health, affordable housing, substance misuse and addictions, equity, diversity and inclusion) and Aylmer, Elgin, St. Thomas plan (education and skills development, housing security, mental health and wellbeing, public safety, and substance use and addiction) are either classified as the SDOH or directly impact the SDOH.

Another example of the relationship between public health work and municipal responsibilities can be seen in land use planning. Land use planning significantly impacts people's lives through matters such as affordable housing and access to recreation opportunities and thus demonstrates the impacts of municipal policies on not only health but also social and economic issues. Moreover, municipalities play a crucial role in determining housing in Ontario through zoning, development approval, and servicing land for development.[6] Through the Ontario Public Health Standards, public health is required to promote the development of healthy built environments that support health and mitigate emerging risks.[7] SWPH and local municipalities can support each other in developing healthy communities to meet their respective mandates on this topic by collaborating on local plans/strategies that affect housing.

In addition, from an economic standpoint, many initiatives to address the SDOH yield a return on investment. A recent Health Promotion Ontario white paper noted that local health promotion interventions have a return of investment of four,[i] meaning that every dollar invested yields a four-dollar return, plus the original investment.[8] Health promoting interventions can contribute to healthier populations; healthier populations can contribute to a strong economy and lessened demand for scarce healthcare resources.[9] The impact of an overall healthier population can be shown through the financial effects of improvements in health-related factors; for instance, it has been noted that smoking, alcohol, diet and physical activity-related improvements could offer healthcare cost savings of $89B.[10]

Examples of how municipalities can implement a HIAP approach include:[5]

- Understanding the value and importance of cross-collaboration and fostering collaboration between public health and municipalities
- Utilizing tools such as health impact assessments during policy development to anticipate and address any potential health implications
- Fostering community engagement by involving the community in the decision-making process to ensure policies align with their needs and priorities
- Accessing and using data to inform policy decisions

[i] From the source paper, the 4.1 ROI represents the median ROI all 29 local public health interventions accounted for in the systematic review that was performed. The listed local-level public health interventions included home-based blood pressure monitoring, workplace interventions (such as obesity management, health risk management, and health promotion for various audiences), supervised injection facilities, community-based fall prevention, smoking cessation (including antenatal cessation), multisystemic therapy for juvenile offenders (and their siblings), improvements in walking and cycling infrastructure, medication management, speed cameras in urban areas, water fluoridation, speed limit reduction zones, intensive early education programmes for socioeconomically deprived families, alcoholism therapy, wellness and disease prevention programmes, outpatient pharmacy services for medication adherence, and heart failure disease management.[36]

Several national and subnational governments have adopted a HIAP approach to achieve their policy aims.[11] This includes local and regional governments in Canada who have used intersectional action aligned with the health in all policies approach to achieve their aspirations.[12] One example that took place in Ontario is the Creating Connections project conducted in the City of St. Thomas.[13] This was a collaborative project involving local citizens, the City of St. Thomas, local developers, and SWPH working together to make built environment improvements in the city to support increased walkability and physical activity. Intersectional action is a viable strategy for local government to achieve HIAP.[11-12]

Public health work strives to achieve healthy communities and societies. In this sense, a range of municipal government functions intersect with public health. Many successful collaborative initiatives between public health and municipalities have tremendously influenced our populations' health. The Smoke-Free Ontario Act, introduced in Ontario in 2006, was done so after numerous municipalities across the province, including locally, worked with their local public health staff to protect residents from second-hand smoke. The early adopters (municipalities) influenced provincial legislation on smoke-free spaces.[2] More recently, the COVID-19 pandemic highlighted the important relationship between public health and municipalities. During this emergency, SWPH and local municipalities worked together to house vulnerable populations, protect residents, and ensure access to immunization (e.g., utilizing municipal space for mass immunization clinics). The following section in this report will highlight the importance of municipal and public health collaboration and the use of a HIAP approach.

Municipal Policy Considerations to Address the Social Determinants of Health

This section will explore local policy options and activities to address the SDOH using a HIAP approach. Each highlighted initiative explains the program or activity, the importance of addressing the health issue or SDOH, and examples of how public health and local municipalities can collaborate. Additionally, many of the approaches outlined involve participation from community organizations outside of public health and municipalities. It is important to note that some of these initiatives have been previously reported on and have been discussed in recent Board of Health reports (e.g., living wage, food systems, unregulated and quasi-regulated housing, and alcohol policies).

Living Wage and Universal Basic Income

We see the symptoms of poverty daily in our local communities, including the worsening of the housing crisis and homelessness, rising costs of living, and strained frontline services.[14] Poverty is also associated with social exclusion, as a lack of access to resources can lead to reduced participation.[14] Supporting adequate incomes can have direct benefits for our municipalities. A community can impact income by supporting employer efforts to become Living Wage Certified through the Ontario Living Wage Network. This network sets an hourly living wage calculated annually for ten economic regions in Ontario.[15] The living wage is defined as “the hourly wage a worker needs to earn to cover their basic expenses and participate in their community”[16] and considers various costs of living as well as the government transfers and benefits that households would receive.[15] The current living wage for the SWPH region is $18.85 per hour.[15] Much of this information was presented to the Board of Health on January 25, 2024. It is important to be able to ‘walk-the-talk’ when it comes to income interventions and demonstrate the positive impact to fellow community members and business owners.

How Municipalities Can Affect Living Wage and Universal Basic Income:

SWPH and local municipalities can lead by example by becoming certified living wage employers and adopting policies encouraging local businesses to follow suit.

Along with a Living Wage, we must consider broader policy action, including advocating for universal basic income (UBI). We must discuss broader income interventions that support all members of our communities regardless of work status. Municipalities can participate by supporting and advocating for UBI through conversations and connections with provincial and federal governments.

Unregulated and Quasi-Regulated Residential Facilities Servicing Vulnerable Populations

Unregulated residential facilities provide some degree of support for activities of daily living for their residents in addition to providing shelter. However, these facilities operate without provincial standards of care, provincial or municipal funding or licensing for the aspects of care and accommodation that affect a resident's quality of life.

In 2021, a Section 13 Order to Close was issued by SWPH under the *Health Protection and Promotion Act* to the owner/operator of an unregulated residential boarding home in St. Thomas due to unresolved health hazards.[17] In response to this incident and to mitigate future incidents, SWPH undertook a project to understand the prevalence of unregulated and quasi-regulated residential facilities in the region served by SWPH and throughout Ontario and how these facilities operate. The findings from this process were presented to the Board of Health on September 28, 2023 (Resolution #2023-BOH-0928-5.1), and the need for additional regulation, monitoring, and enforcement regarding unregulated residential facilities was identified. In response to the report, the Board of Health requested that an additional recommendation be made to consider the development of local bylaws concerning quasi-regulated and unregulated residential facilities. As such, the next phase of this project is to collaborate with the City of St. Thomas to strengthen regulation, monitoring, and enforcement in unregulated and quasi-regulated residential settings. This is an initial step for this work, and there may be opportunities in the future to collaborate with other municipalities if they show interest.

How Municipalities Can Affect Unregulated and Quasi-Regulated Residential Facilities:

Municipalities can strengthen regulation, monitoring, and enforcement in unregulated and quasi-regulated residential settings through the creation of bylaws.

Sustainable and Equitable Food Systems

Food security is when all people, at all times, have physical, social, and economic access to an adequate amount of safe and nutritious food that meets their food preferences and dietary needs.[18] Food systems are complex and include a range of actors and their interconnected activities involved in the production, processing, distribution and marketing, consumption, and disposal of food.[19]

The built environment and how communities are designed are essential to improve physical food access. Community-supported agriculture, mobile markets, and urban gardens positively impact dietary behaviours and benefit consumers and producers socially and economically.[20] In collaboration with Ontario Dietitians in Public Health (ODPH), SWPH staff are conducting an evidence review on effective municipal land use planning policies that promote sustainable food systems. Municipalities can use data from this review to develop policy recommendations for consideration in local planning documents, such as Official Plans.

Multisectoral collaboration efforts, such as food policy councils, are vital in advancing food policy missions that contribute to more sustainable, resilient, and equitable food systems.[21] These collaborations address local food issues by influencing planning documents and prioritizing policies that enhance access to nutrient-dense foods, particularly for marginalized populations.[22] SWPH has begun investigating effective governance structures for sustainable food systems. Research emphasizes the importance of establishing strong relationships between food collaboratives and local government as a key factor for successful food policy outcomes.[22] Recognizing this evidence, municipalities and community agencies will be key partners in developing a local food systems network.

How Municipalities Can Affect Sustainable and Equitable Food Systems:

Municipalities can develop land use planning policies that promote sustainable food systems and can be key partners in the development of a local food systems network.

Climate Change and Health Vulnerability Assessment

Climate change is a global challenge with significant implications for human health. The impacts of climate change pose substantial risks to physiologic and psychosocial health, particularly for vulnerable populations. Understanding the specific health vulnerabilities of climate change is crucial for effective adaptation and mitigation. SWPH, the University of Waterloo, and the Waterloo Climate Institute have partnered to complete a vulnerability assessment to develop a locally focused and comprehensive assessment examining the interplay between climate factors and health outcomes for residents in Oxford County, Elgin County, and the City of St. Thomas. The assessment has been informed by SWPH staff and external advisors from municipalities and community agencies. The completed assessment will provide recommendations for SWPH, municipalities, and community partners. Working with municipalities in a coordinated and collaborative way will be critical in moving the climate change agenda forward.

How Municipalities Can Affect Climate Change:

Municipalities can work in a coordinated and collaborative way on the climate change agenda.

Municipal Planning Exploration and Engagement

In 2023, SWPH enlisted the support of a consultant to determine the degree of policy support and impact demonstrated through municipal plans for climate change and health equity, with a specific focus on Municipal Official Plans. This was an update to work undertaken in 2018. Throughout the process, official plans were reviewed, and a series of meetings were held between SWPH and each municipality responsible for implementing an Official Plan. Eight of the municipalities participated, and the intent of each meeting was three-fold:

- To provide an overview of the 2018 project findings and updated scope of work for the 2023 assignment.
- To present the Official Plan review findings and suggested policy considerations.
- To solicit input from municipal planning staff on opportunities for future policy development to support climate change and health equity.

Public health practitioners and municipal planners have similar goals in considering the health of our communities. However, there is a varying degree of engagement and coordination between municipal planners and public health practitioners. There are also considerable differences between the tools, tactics, and strategies used by local public health agencies, resulting in different policy approaches and strengths. Both can be attributed to capacity, education, political will, and communication challenges. The report will provide recommendations for SWPH to strengthen collaboration, coordination, and knowledge exchange.

How Municipalities Can Affect Municipal Planning Exploration and Engagement:

Ensure climate resiliency and health equity initiatives are integrated into planning projects within Elgin, Oxford, and The City of St. Thomas.

Establish a working group made up of SWPH staff and municipal representatives to meet bi-annually with the intent of monitoring and facilitating the implementation of the collaboration strategy.

Social Connectivity

A growing body of research has shown that a sense of belonging or social connectedness tremendously impacts physical and mental health. Social connection influences and is influenced by an individual's relationships and interactions with others, their communities, the physical environment, organized systems (public and private), and the policies created in the community.[23] The social environment is present at multiple levels, is people and relationship-centred, has interconnected features, and is influenced by power relations.[23] Social connections and environments play a crucial role in climate change, mental health, physical health, and the built environment. Additionally, they share sustainability and health equity as core actions towards achieving healthy people living in vibrant communities. An environmental scan and evidence review of effective interventions to increase social connectivity in small urban and rural communities or neighbourhoods will be undertaken in 2024. Municipalities must play an important role in addressing social isolation and increasing social connectivity in our communities through housing environments, transportation, and inclusive public spaces.

How Municipalities Can Affect Social Connectivity:

Municipalities must play an important role in addressing social isolation and increasing social connectivity in our communities through issues such as housing environments, transportation, and inclusive public spaces.

Alcohol Policy

Alcohol policy affects the environments that people live, work, and play in, which is a cornerstone of the social determinants of health. In October 2023, the "Actions to Reduce Alcohol-Related Harms Report" was provided to the Board of Health. It provides greater detail on harms due to alcohol and effective policy actions to manage them.

While the provincial and federal governments control the majority of alcohol policy, municipalities can address alcohol-related risk and harm on municipally owned property through Municipal Alcohol Policies (MAPs) and off municipally owned property through by-laws, zoning, and licensing restrictions.[24-26] SWPH and municipal partners can collaborate to influence and support healthy public policy regarding alcohol within municipal control. SWPH plans to monitor and inform municipalities within our region of the harms of alcohol and support municipal staff with concepts and resources for alcohol policies.

How Municipalities Can Affect Alcohol Policy:

Municipalities can address alcohol-related risk and harm on municipally owned property through Municipal Alcohol Policies (MAPs) and off municipally owned property through by-laws, zoning, and licensing restrictions.

Physical Activity Opportunities for Children and Youth

Physical activity is a vital component of health and well-being. The ACT-i-Pass program offers no-cost physical activity opportunities to children during their grade five school year, just prior to a known decline in physical activity levels.[27] The ACT-i-PASS model leverages available or underused spaces in pre-existing youth recreational programs. As part of the program, grade five children receive an ACT-i-Pass card that they can utilize to participate in eligible programs. SWPH has actively invited all recreation service providers to participate by offering no-cost recreation spaces to the ACT-i-Pass program. Municipal recreation departments have provided several no-cost programs (e.g., swimming and skating) that populate the ACT-i-Pass calendar of

activities. Municipal facilities are extensive in scale and offer a setting where supporting ACT-i-Pass is possible by using extra spaces in preexisting activities that were already running without additional cost. SWPH will continue ACT-i-Pass promotion and track targets during this first year of ACT-i-Pass in the SWPH region.

How Municipalities Can Affect Physical Activity Opportunities for Children and Youth:

Municipalities should continue to consider programs that can be offered at no-cost as part of the Act-i-Pass program.

Age-Friendly Communities

Age-friendly communities are communities where policies, services, and structures are implemented or built to support older adults in aging in place, staying involved in their communities, and remaining physically and socially active.[28] Equitable age-friendly planning leads to informed and cost-effective decision-making, stronger community cohesion, and impactful and sustainable changes. The result is the creation of empowering and friendly communities for people of all ages to live healthier lives and experience healthy aging.[29]

SWPH will work with municipalities and community partners through Elgin St Thomas' existing age-friendly committee to update the 2017 strategy and rebuild community mobilization. There is no current age-friendly specific committee in Oxford County, but SWPH is exploring partnership opportunities. In late 2023, SWPH worked with community partners, including the lead organization of United Way Oxford, to submit an application titled *Building our Capacity to Address the Unique Vulnerabilities of Rural Seniors* for a New Horizons Seniors Grant. If this application is successful, it could advance this work in Oxford County. Municipalities and SWPH should continue to work together to support and advance age-friendly initiatives in our communities.

How Municipalities Can Affect Age-Friendly Communities:

Multiple sectors, including public health, municipalities, and community agencies must work collaboratively to advance age-friendly initiatives in our communities.

Planet Youth

Planet Youth is a prevention model proven to decrease substance use rates among youth and positively impact other areas of their lives. It is essential to note that the Planet Youth model is not a program but an approach that identifies and establishes long-term strategies to promote positive changes in the environment where youth live, work, and play. The model, first implemented in Iceland, has led to a decline in substance use in all of Europe. Through the implementation of Planet Youth in other countries, data has shown a 46% reduction in the number of youth drinking to get drunk in the past 30 days and a 60% decline in the use of alcohol, tobacco, and cannabis over ten years.[30] The model is informed by evidence and by gathering data from grade 10 students to provide a complete picture of the risks and strengths that can be enhanced or decreased within a community to protect youth from using substances. The results are then shared with the community to determine priorities and solutions that are feasible, desirable, and viable for the community.

How Municipalities Can Affect Planet Youth:

Municipalities play a key role in supporting the Planet Youth model, including participating in the development of an action plan, and implementing associated actions for implementing Planet Youth.

The Planet Youth model relies on collaboration from multiple sectors to succeed. This includes youth, parents, teachers, schools, communities, policymakers, community agencies, and municipalities. SWPH continues to

work with our various communities to advance the model locally. Municipalities play a crucial role in supporting the Planet Youth model, including developing an action plan and associated actions for implementing Planet Youth in the SWPH region.

Recommendations for Consideration

As stewards of community safety and wellness, embracing a Health in All Policies (HIAP) approach is not just about formulating policies; it is a moral imperative and an ethical obligation for municipalities committed to the well-being of their community. By integrating health considerations into every aspect of policymaking, we can collectively and proactively address the SDOH, promote health equity, and foster thriving and resilient communities. As noted, interconnected well-being is not only determined by healthcare services but is intrinsically linked to income, housing, belonging, and education, among many other SDOHs.[31] Additionally, there are economic benefits to prioritizing a HIAP approach as it leads to a healthier and more productive population, which reduces long-term healthcare costs and boosts economic productivity.[32] A HIAP approach underscores the collective commitment to addressing health inequities and disparities and promoting inclusivity in our communities.[32] It also ensures that municipal policies benefit all community members, regardless of their socioeconomic status or background. Specific recommendations for the Board of Health's consideration are:

1. SWPH strongly encourages our local municipalities to adopt a 'health in all policies' approach using a health lens when developing policies, regardless of the policy area.
2. SWPH and municipalities collaborate to address the SDOH and improve health equity for our population.
3. SWPH shares this report and recommendations with local municipalities.

Conclusion

The transformation of the SDOH for the betterment of the local population will require collaboration from diverse sectors across communities and a systematic, collective, and long-term approach. Rather than working in isolation, activities of public health and municipal partners can be designed to complement and support each other. This collaborative approach will empower both parties to meet the local community's needs.

MOTION: 2024-BOH-0222-5.1
That the Board of Health for Southwestern Public Health approve the report titled "Municipal Collaboration and the Social Determinants of Health" for February 22, 2024.

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CEO REPORT

Open Session

MEETING DATE:	February 22, 2024
SUBMITTED BY:	Cynthia St. John, Chief Executive Officer (written as of February 14, 2024)
SUBMITTED TO:	Board of Health
PURPOSE:	☒ Decision ☐ Discussion ☒ Receive and File
AGENDA ITEM #	5.2
RESOLUTION #	**2024-BOH-0222-5.2**

1.0 PROGRAM UPDATES (RECEIVE AND FILE):

1.1 SOCIAL DETERMINANTS OF HEALTH AND AN OPPORTUNITY TO BUILD ON THE PARTNERSHIP WITH MUNICIPALITIES ACROSS THE REGION

As mentioned in my January CEO report, the Board of Health will be asked to consider a report completed by staff members in the Healthy Communities Division related to the Social Determinants of Health and a collaboration opportunity with our municipal partners. This separate report emphasizes the fundamental close working relationship public health has with all its municipalities and it outlines an even greater way we can expand on our work together. The report contemplates the critical component of considering the Social Determinants of Health when we devise our approaches, our systems, and the fundamental principles with which we govern and act.

The SWPH Board of Health has been steadfast in its commitment to improve health outcomes for all of its communities in the SWPH region. That together with the staff and Board's desire to be innovative and be bold in our work, staff have developed a report that I hope you find worthy of exploration. The staff have developed a report that highlights the opportunities of working more closely with our municipal partners for the betterment of our communities. The team will discuss the report with you and present the opportunities for closer collaboration. I look forward to the discussion!

1.1 CHRONIC DISEASE AND INJURY PREVENTION UPDATE: MENTAL HEALTH & ANTI-STIGMA TRAINING

The stigma surrounding substance use not only has an impact on mental health but also acts as a barrier for individuals to access healthcare, treatment supports and emergency services. Based on a review of the literature and anecdotal evidence from people with living and lived experiences (PWLE) of substance use, Southwestern Public Health (SWPH) has established the need to address stigma in our region. One evidence-based intervention selected in 2023 to tackle this issue was anti-stigma education.

In December, SWPH hosted two anti-stigma training sessions (*Stigma Ends With Me*) facilitated by the Community Addictions Peer Support Association that targeted healthcare providers, social services staff, and first responders. The training was a comprehensive full-day workshop designed to explore the profound and intersectional effects of stigma on individuals, particularly in the context of its impact on the health of people who use substances.

SWPH staff administered pre- and post-training surveys to understand whether there was a change in participant awareness, knowledge and understanding, and confidence and skills relating to stigma after the training session. The survey results found that:

- Before the training, 40% were aware of how stigma relates to their work with people who use substances, their work with those with substance use disorder, and their work with those experiencing intersectional forms of stigma. After the training, 70% indicated that they were aware.
- 68% of respondents had a 1, 2, or 3-tier* positive change in their knowledge and understanding of stigma after the *Stigma Ends With Me* training session.
- 87% of respondents had a 1, 2, or 3-tier* positive change in their confidence and skills to address stigma after the *Stigma Ends With Me* training session.
- The analysis of the pre-session and post-session surveys showed that, on average, 74% reported 1, 2, and 3-tier* improvements in participants' knowledge, understanding, confidence, and skills regarding stigma for each question.

The data from the evaluation showed that participants had increased their awareness, knowledge, understanding, confidence, and skills relating to stigma after the training sessions. Therefore, SWPH is exploring options to deliver more training opportunities in 2024 for individuals in health, social, and emergency response services.

***Note:** To interpret the evaluation findings, it may be helpful to think of the tiered approach as shifts, which can be negative or positive changes, on the Likert scale. For example, a 1-tier positive change would denote a shift in positionality that is one point on the Likert scale in the direction of a positive learning change (e.g., shifting from neutral to agreeing on a survey question).

1.2 SEXUAL HEALTH UPDATE: SYPHILIS EDUCATION SESSION FOR HEALTH CARE PROVIDERS

Due to the rising rates of syphilis, the sexual health team has undertaken a situational assessment to inform our interventions and assess which ones will best address this problem. The situational assessment made it clear that providers' adherence to guidelines for testing, staging and treatment is important. It results in the effective management of syphilis cases and helps to prevent further spread of infection, thereby reducing rates of syphilis. However, syphilis is complex, and requires careful and strategic management with many considerations to appropriately stage and treat.

To support providers with managing this complex disease of public health significance, the sexual health team hosted a virtual syphilis education event for health care providers. This event aimed to:

- Increase awareness of SWPH reporting forms and follow up for syphilis in the SWPH region
- Increase knowledge of appropriate syphilis staging and treatment
- Increase knowledge of follow-up serology and monitoring adequate response to treatment
- Increase knowledge of appropriate treatment and follow up for prenatal screen tests and cases

The event was facilitated by two public health nurses on the sexual health team, with support from Dr. Ninh Tran who presented on local epidemiology. The majority of the event was presented by infectious disease specialists, Dr. Lise Bondy and Dr. Danielle Ouellette. Their presentation offered some case scenarios and an in-depth review of all stages of syphilis, including best practices for syphilis management. We had a good turnout!

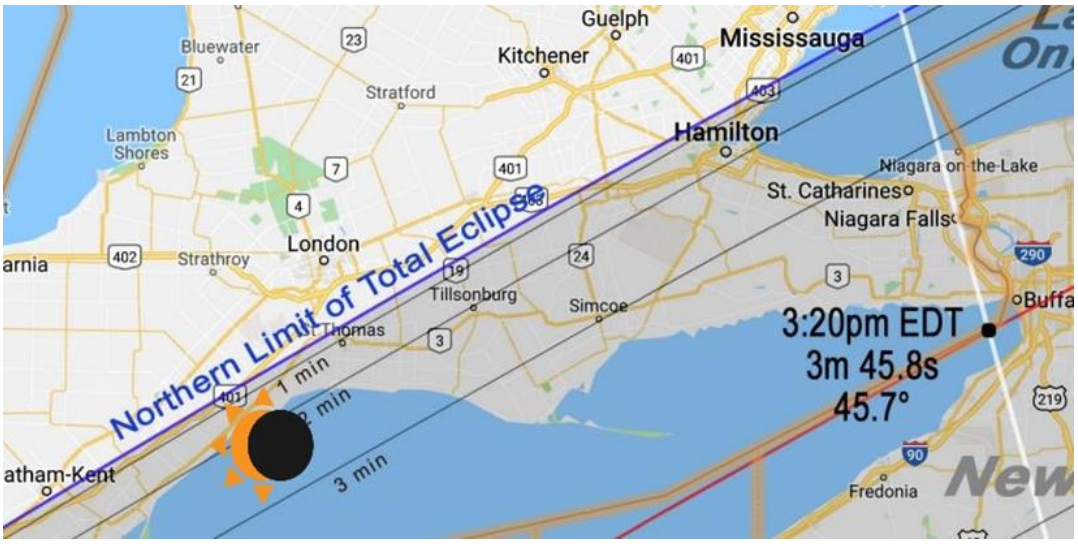
The presentation received an overall positive response from those attending and the sexual health team intends to continue to build on this work to give providers in our area more opportunities to grow their knowledge and confidence in addressing STI/BBIs in our region.

1.3 EMERGENCY MANAGEMENT: SOLAR ECLIPSE PLANNING

Southern Ontario will experience a total solar eclipse on Monday, April 8, 2024. This will be the first total solar eclipse to cross Southern Ontario since 1925. The experience will vary across the province depending on the location. Partial eclipse will begin at approximately 2:04 pm EST. Most of the Counties of Oxford and Elgin will fall under the solar eclipse's "path of totality" starting at 3:17 pm EST on April 8 and lasting approximately 1 - 2+ minutes depending on location. The solar eclipse will end at approximately 4:31 pm EST.

This "once in a lifetime" event is anticipated to bring an influx of visitors to the areas affected by the solar eclipse (for viewing purposes). This will result in increased stress on infrastructure (roads, parking, and sanitation), emergency services and local businesses. Because of this impact, internal preparation has already begun to facilitate information sharing and planning between various SWPH programs and services teams. We are undertaking an event-specific hazard identification and risk assessment, and we are also planning an external public education campaign to ensure residents in the affected areas know how to keep safe during the solar eclipse.

Externally, SWPH has been invited by the County of Elgin to participate in a solar eclipse working group. We have also been engaging with other county and municipal partners to help with pre-eclipse readiness to ensure the safety of residents and visitors during this time.



1.4 HEALTHY ENVIRONMENTS

The Environmental Health (EH) Team is prioritizing the completion of all required inspections, for 2024. This includes food premises, special events, farmers markets, small drinking water systems, recreational water premises, migrant farms, recreational camps, and personal services settings.

This time of year, the EH team also prioritizes program work in preparation for the Spring and Summer seasons which tend to be a high demand time for this team. This year, this includes work on a proactive plan for the vector borne disease response including surveillance and education, and having Student practicum positions in place, well in advance of the summer months.

Our Food Handler Training program is offering no cost courses to High School Students in advance of the summer months to increase job opportunities for them. The EH team is also considering working with area veterinarians and offering a voucher program in 2024 for people needing financial assistance to have their pet vaccinated against the rabies virus.

Work on the Climate Change Vulnerability Assessment is continuing with completion of the technical report expected to be completed by early April.

1.5 COVID-19 & INFECTIOUS DISEASES

COVID Cases and hospitalizations are starting to decrease in the region, although hospitalizations remain at the level of “high risk” with 13+ hospitalizations, with 4 deaths in Jan 2024 in which Covid-19 was the cause or contributing factor.

Covid Immunization Clinics continue to be offered on Wednesdays at each health unit site offering Covid-19 vaccine and flu shots (while product remains) to those under 12 or 65 years and older. Our clinics will continue until end of February and clinic appointments can be booked via SWPH’s website: https://outlook.office365.com/owa/calendar/SouthwesternPublicHealthCovid19Clinic@estph.onmicrosoft.com/bookings/ . Clinics will be offered in March but will focus on children 5-years old and younger or those who have not started or completed primary series.

The team notes that the incidence of invasive group A streptococcus is being closely monitored. There was an increased incidence in 2023 to 13.9 per 100,000 from a yearly average of 6.4 for the last 10 years. A similar increase in incidence rate is being observed across Ontario and Public Health Ontario (PHO) continues to monitor this trend and to explore possible causes. When a report of group A streptococcus is received by SWPH an investigator immediately begins the investigation to determine the severity and if any steps need to be taken to limit the spread of infection.

With respect to institutional outbreaks in general, the number of outbreaks has been decreasing. The primary pathogen continues to be Covid-19; however other pathogens such as influenza and RSV have been identified. On SWPH's YouTube channel, the team has posted the following videos to support outbreak management in LTCH, RH and congregate settings:

- Outbreak Control https://www.youtube.com/watch?v=5O63uo4oztg
- Completing a Test Requisition https://www.youtube.com/watch?v=Kp0_PDxSaew

1.6 ONTARIO PUBLIC HEALTH STANDARDS UPDATES: MENU LABELLING AND EMERGENCY MANAGEMENT

As identified in August 2023 with the initial release of the Strengthening Public Health strategy by the Office of the Chief Medical Officer of Health (OCMOH), a key initiative of 2024 is the Ministry's sector-driven review of the Ontario Public Health Standards (OPHS), with the planned completion and implementation of the fully revised OPHS by January 1, 2025.

At the time of this report, the OCMOH distributed its first updates to the OPHS on February 15, 2024, focusing on Menu Labelling Protocols and Emergency Management Guidelines. SWPH staff are busy reviewing and assessing where opportunities may reside in refining and refocusing program and service support related to these updates.

2.0 GOVERNANCE MATTERS (RECEIVE AND FILE):

2.1 STRATEGIC PLANNING

Further to last year's discussion that recommended holding off on strategic planning, staff continue to recommend pausing this work until the Board decides on whether it will actively pursue a voluntary merger with other partners based on the Strengthening Public Health strategy released by the Office of the Chief Medical Officer of Health in October 2023. Should the Board decide not to pursue a voluntary merger with any other public health unit, there will be still time in 2024 to engage in strategic planning to chart the path for SWPH for 2025 and beyond.

3.0 FINANCIAL MATTERS (DECISION):

3.1 REVISED FUNDING LETTER (RECEIVE AND FILE):

On January 31, 2024, SWPH received an updated funding letter and accountability agreement (see attached documents) highlighting Covid-19 Vaccine Program funding in the amount of $329,400 for

the 2023 fiscal year. The funding provided is based on our third quarter reporting to the Ministry. After completing our year-end reporting it was determined we require $219,547 of the funding. The surplus of provincial funds must be returned to the Ministry of Health.

MOTION: 2024-BOH-0222-5.2-3.1
That the Board of Health receive and file the revised 2023 Public Health Funding and Accountability Agreement.

MOTION: 2024-BOH-0222-5.2
That the Board of Health for Southwestern Public Health accept the Chief Executive Officer's Report for February 22, 2024.

Ministry of Health

Office of Chief Medical Officer of Health, Public Health

Box 12
Toronto, ON M7A 1N3

Fax: 416 325-8412

Ministère de la Santé

Bureau du médecin hygiéniste en chef, santé publique

Boîte à lettres 12
Toronto, ON M7A 1N3

Téléc. :416 325-8412

February 14, 2024

MEMORANDUM

TO: Board Chairs, Medical Officers of Health, Chief Executive Officers

FROM: Dr. Kieran Moore, Chief Medical Officer of Health

RE: Update: Ontario Public Health Standards Review

Dear Colleagues:

In follow-up to my memo dated December 15, 2023, I am writing to share additional details about the Ontario Public Health Standards (OPHS) Review.

First, I would like to share an update on the finalization of Short-Term Opportunities. These are early opportunities to refine, refocus and relevel specific requirements as well as additional areas where releveling or centralizing supports will ease local resources for program and service delivery.

Short-Term Opportunities

Protocol and Guideline Updates

By way of this Memo, the Ministry of Health (the ministry) is officially releasing the following updated protocol and guideline:

- Menu Labelling Protocol
- Emergency Management Guideline

The **Menu Labelling Protocol, 2024** has shifted to complaint-based inspections, which is expected to result in significant inspection and data burden decrease for Local Public Health Agencies (LPHAs) and is consistent with the *Skin Cancer Prevention Act (Tanning Beds), 2013* inspection approach. A Menu Labelling Question and Answer document that addresses all aspects of the *Healthy Menu Choices Act, 2015* and LPHAs' requirements is attached for your reference. A copy of the Question and Answer document is also available on the menu labelling page of the MOH-PHU SharePoint site.

The **Emergency Management Guideline, 2024** includes revisions to better align with national and international approaches and best practices to emergency management, including strengthening continuity of operations planning, encouraging accessible communication, increasing the frequency of exercises, adopting a health equity lens, promoting mental health and well-being, integrating surge capacity strategies, and increasing collaboration with community partners and stakeholders.

The protocol and guideline named above are now in effect and replace the previous versions. The updated documents are posted here.

Releveled or Centralized Supports

In addition, the following releveled or centralized supports will be implemented in the coming weeks:

- Food Handler Training Course and Exam – translations into additional languages. This is expected to improve consistencies in program materials.
- Small Drinking Water Systems – updated program educational materials to support consistent delivery. The educational materials will focus on supporting Public Health Inspectors and operators of SDWS.

Smoke-Free Ontario – Tobacco Signage

Effective January 1, 2024, it is ministry direction that LPHAs no longer utilize their mandatory programs cost-shared budget to produce their own tobacco signage related to the *Smoke-Free Ontario Act, 2017 (SFOA)*.

As noted in my December 15th Memo, LPHAs can re-allocate 2024 budgets associated with SFOA tobacco signage to other program and service needs, as appropriate.

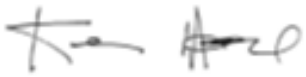
Broader OPHS Review

The attached document provides additional information on the Standards Review Groups and OPHS Review Table.

I would like to thank the sector for their input on the Short-Term Opportunities through the Public Health Leadership Table as well as engagement through program specific groups, Standards Review Groups and the recently established OPHS Review Table.

Should you have any questions about the Short-Term Opportunities or the Broader OPHS Review, please contact the ministry team at OPHS.protocols.moh@ontario.ca.

Sincerely,



Dr. Kieran Michael Moore, MD, CCFP(EM), FCFP, MPH, DTM&H, FRCPC, FCAHS
Chief Medical Officer of Health and Assistant Deputy Minister, Public Health

c:

Peter Kaftarian, Deputy Minister (interim), Ministry of Health
Elizabeth Walker, Executive Lead, Ministry of Health
Senior Leadership Team, Office of Chief Medical Officer of Health, Public Health
Ziyaad Vahed, Director, Ministry of Children, Community and Social Services
Michael Sherar, President and Chief Executive Officer, Public Health Ontario
LPHA Business Administrators
Colin Best, President, Association of Municipalities of Ontario
Brian Rosborough, Executive Director, Association of Municipalities of Ontario
Lindsay Jones, Director of Policy, Association of Municipalities of Ontario
Loretta Ryan, Executive Director, Association of Local Public Health Agencies

Menu Labelling Protocol, 2024

Ministry of Health
Effective: February 2024

ISBN 978-1-4868-7669-3 [PDF]

Citation: Ontario. Ministry of Health. Menu labelling protocol, 2024. Toronto, ON: King's Printer for Ontario; 2024.

Ontario

Preamble

The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (Standards) are published by the Minister of Health under the authority of section 7 of the *Health Protection and Promotion Act* (HPPA) to specify the mandatory health programs and services provided by boards of health.[1,2] The Standards identify the minimum expectations for public health programs and services. Boards of health are accountable for implementing the Standards including the protocols and guidelines that are referenced in the Standards. Protocols are program and topic-specific documents incorporated into the Standards which provide direction on how boards of health shall operationalize specific requirement(s) identified in the Standards.

Purpose

The purpose of this protocol is to provide direction to boards of health to support the enforcement of the *Healthy Menu Choices Act, 2015* and its Regulation 50/16 (HMCA) including requirements with respect to:

1) The display of calorie information for standard food items that are sold or offered for sale (as those standard food items are defined in the HMCA) on menus and tags/labels at the regulated food service premises and on menus that are distributed outside the premises; and

2) The display of:
   a) The contextual statement regarding average daily caloric requirements on signs and menus;
   b) Calorie information on signs where food and drink items are self-serve; and
   c) Calorie information for alcoholic beverages on signs and menus.[3,4]

Regulations which are relevant to this protocol include Ontario Regulation 50/16 (General) made under the HMCA.[4]

Reference to the Standards

This section identifies the standard and requirement to which this protocol relates.

Chronic Disease Prevention and Well-Being

Requirement 4. The board of health shall enforce the *Healthy Menu Choices Act, 2015*, in accordance with the *Menu Labelling Protocol, 2018* (or as current).

Operational Roles and Responsibilities

Inspection

All regulated food service premises to which the HMCA applies, including, but not limited to: grocery stores, movie theatres, restaurants, cafeterias, quick service restaurants, and convenience stores with 20 or more locations in Ontario may be subject to inspection(s).[3]

1) The board of health shall:
   a) Have inspectors respond within 10 business days to all complaints in relation to the HMCA and carry out inspections of regulated food services premises on a complaint basis.
   b) Have inspectors take appropriate action in any instance[·] where non-compliance with the Act is identified, which may include providing additional education or taking enforcement action as deemed necessary using a progressive enforcement approach, including considering charges under the *Provincial Offences Act* if it is not possible to achieve compliance.[5]
   c) If requirements of the HMCA change and should the Ministry of Health ("ministry") instruct boards of health to do so, have inspectors conduct inspections as required to ensure compliance with the requirements of the HMCA that have changed.
2) The board of health shall, with respect to online menus, menu applications, and menus distributed outside the regulated food service premises:
   a) Have inspectors respond within 10 business days to all complaints in relation to the HMCA.

[·] For example, in addition to non-compliance identified during complaint-based inspections, this would also include if during a food safety risk categorization process, an inspector notices that calories and/or contextual statements are missing from a menu.

b) Have inspectors take appropriate action in any instance[‡] where non-compliance with the Act is identified, which may include providing additional education or taking enforcement action as deemed necessary using a progressive enforcement approach, including considering charges under the *Provincial Offences Act* if it is not possible to achieve compliance.[5]

Information to be Displayed

3) As part of each inspection, the board of health shall:
   a) Inspect for compliance with the requirements to display calorie information and the contextual statement on menus and, in respect of calorie information, on labels or tags; and
   b) Inspect for compliance with the requirements to post calorie information on signs.

The requirements with respect to information to be displayed on menus, labels, or tags are set out in section 2 of the Act, and further specified in s. 6 and 7 of the regulation in respect of calorie information and section 9 in respect of the contextual statement.[3,4]

The requirements in respect of information to be displayed on signs are set out in subsection 2(6) of the Act and further specified in s. 8 of the regulation in respect of calorie information.[3,4]

Inspection and Enforcement Activity

For the purposes of inspection of the HMCA, the board of health shall adhere to the following enforcement requirements:

4) The board of health shall employ an effective compliance strategy which includes a balance of education, inspection, and progressive enforcement. "Progressive enforcement" means the use of more stringent enforcement options to reflect the frequency and severity of the level of non-compliance.

Compliance monitoring and enforcement activities include education visits, inspections, inquiries into complaints, issuing warnings, and laying charges under the HMCA.

[‡] For example, in addition to non-compliance identified through a complaint, this would also include if an academic paper or news article notes non-compliance for a specific chain.

5) The board of health shall inform the ministry of any considerations that would impact the determination of whether a chain is captured under the HMCA. The decision to remove a chain from the ministry's annual "List of Chains of Food Service Premises to Which the HMCA May Apply" is solely that of the ministry. The ministry will provide support[‡], where possible, including coordinating and facilitating dialogue across boards of health and notifying chains when they are added to the List of Chains of Food Service Premises to Which the HMCA May Apply and seeking confirmation of understanding and intent to comply with the requirements under the Act.

6) In responding to inquiries from regulated food service premises regarding implementation of the HMCA, the board of health shall consider engaging in other boards of health prior to responding to the inquiry in order to increase consistency in implementation across jurisdictions.

7) When an owner or operator of a regulated food service premises has provided calorie information, but an inspector has indicated that additional changes are required to a menu in order to comply with the HMCA, the board of health shall provide the owner or operator with a timeframe to apply changes by the premises' next menu print run, ideally not to exceed a 6 month timeframe, but recognizing that there may be instances where a longer timeframe, may, be reasonable.

8) When conducting inspections of regulated food service premises that are grocery stores, the board of health shall limit inspections to the food service section(s) of the store (for example, clerk served hot food counter, clerk served café, self-serve salad bar). The sections that meet the definition of traditional section(s) of the grocery store (for example, produce section, prepackaged food aisles) shall not be inspected, and are not in scope for the purposes of inspections under the HMCA.

   "traditional section(s)" is generally understood to mean a section of the grocery store outside the food service section(s) where the food and drink items that are

[‡] The Ministry is unable to provide implementation guidance related to specific menus/signage and/or whether a vendor is in compliance with the regulation, as minister-appointed inspectors have the authority to interpret the HMCA.

sold or offered for sale are primarily unprepared items, and can include, but may not be limited to, sections selling primarily:

a) Unprepared fresh produce;
b) Household products;
c) Frozen foods;
d) Unprepared fish or meat items;
e) Bulk nuts or bulk spices;
f) Unprepared deli meats or cheeses;
g) Baked goods usually sold in bulk or in multi-packs; and
h) Prepackaged items that already have a Nutrition Facts table as per the definition of the *Food and Drug Regulations* made under the *Food and Drugs Act* (Canada).

9) The board of health shall limit inspections within hotels to the following types of premises:
   a) Food service premises that operate inside the hotel and are part of a chain of 20 or more food service premises in Ontario operating under the same or substantially the same name; and
   b) Cafeteria-style food service premises that sell food to the general public and that are owned or operated by a person that owns or operates 20 or more cafeteria-style food service premises in Ontario.

Room service run by the hotel or under the hotel name shall not be inspected and is not in scope for the purposes of inspection. Similarly, items that are provided for free (e.g. free breakfast with the room booking or free coffee) are not considered to be standard food items.

Data Collection and Reporting

10) The board of health shall maintain an up-to-date inventory of all food service premises, which includes:
   a) Name of the food service premises;
   b) Name of owner/operator;
   c) Premises address; and
   d) Premises type.

11) The board of health shall provide to the ministry annually the inventory of all food service premises in an Excel format. The ministry will collate the data and

share the List of Chains of Food Service Premises to Which the HMCA May Apply with boards of health for each calendar year.

12) The board of health shall collect and maintain up-to-date inspection and enforcement data, which should be recorded after each visit and provided to the ministry upon request. Inspection and enforcement data means a record of every enforcement activity conducted for the purpose of determining compliance with HMCA, including:
    a) Education visits;
    b) Inspections;
    c) Warnings issued; and
    d) Charges laid.[3]

Authority of an Inspector

The Minister of Health appoints inspectors for the purposes of HMCA (s.3 (1) of the Act).[3] Medical officers of health have discretion to select and nominate staff to be designated as inspectors under the HMCA (e.g., public health inspectors, public health nurses, dietitians, etc.) .[§ 3] Nominated inspectors must be trained according to the requirements established in the *Menu Labelling Protocol, 2018* (or as current) by the time of their appointments.

An inspector may, during regular business hours, enter a regulated food service premises or business premises of a company that owns, operates, franchises or licenses one or more regulated food service premises to determine whether the owner or operator is in compliance with the HMCA, and for this purpose, may conduct an inspection in accordance with section 3(7) of the HMCA.[3]

Any person who contravenes any provision of the HMCA or its regulations, including those who hinder, obstruct or otherwise interfere with an inspector in the conduct of his/her duties is guilty of an offence. Warnings or tickets can be issued where an inspector finds a violation of the HMCA or its regulations.[3]

For a comprehensive list of inspector authority and powers refer to Section 3 of the HMCA.[3]

[§] Note that the ministry does not consider students for designation as inspectors under the HMCA. However, the value of this learning experience is recognized. Students are encouraged to accompany designated inspectors during enforcement of the HMCA, if they wish to do so.

Education and Training

13) The board of health shall ensure that the inspectors designated under the HMCA are trained in accordance with ministry-sanctioned training and have reviewed up-to-date implementation materials prior to conducting inspection and/or enforcement activities. Ministry-developed implementation materials include:
    a) "A Guide to Menu Labelling Requirements in Regulated Food Service Premises in Ontario" (2019, or as current);[6]
    b) All sector-specific fact sheets;[7]
    c) All Questions and Answers documents; and
    d) Any other ministry-developed training and/or implementation materials that the ministry may specify from time to time in writing.

Glossary

Chain of Food Service Premises: means 20 or more food service premises in Ontario that operate under the same or substantially the same name, regardless of ownership, and that offer the same or substantially the same standard food items.

Inspection: means an inspection conducted by a person appointed as an inspector pursuant to section 3 of the HMCA.

Inspector: means a person appointed as an inspector by the Minister of Health pursuant to section 3 of the HMCA.

Progressive Enforcement: means the use of more stringent enforcement options to reflect the frequency and severity of the level of non-compliance.

Regulated Food Service Premises: means

1) A food service premises that is part of a chain of food service premises, and
2) Any other food service premises that may be provided for in the HMCA regulations.

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Ontario

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Ontario

Preamble

The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (Standards) are published by the Minister of Health under the authority of section 7 of the *Health Protection and Promotion Act* (HPPA) to specify the mandatory health programs and services provided by boards of health.[1,2] The Standards identify the minimum expectations for public health programs and services. Boards of health are accountable for implementing the Standards including the protocols and guidelines that are referenced in the Standards. Guidelines are program and topic-specific documents which provide direction on how boards of health shall approach specific requirement(s) identified within the Standards.

Purpose

A robust public health emergency management program must be capable of addressing disruptions*, planned events, and/or emergencies that may affect Ontario's public health system. To achieve provincial and local readiness, boards of health must develop their own public health emergency management programs which complement the emergency management programs of municipal, provincial, and health sector partners. This Guideline is intended to assist boards of health in developing, implementing, and evaluating their public health emergency management programs according to the requirements of the Standards, while aligning with national and international evidence-informed approaches to emergency management. These minimum expectations are based on criteria established in the former Public Health Emergency Preparedness Protocol. For the purpose of this Guideline, a public health emergency management program

*A board of health's ability to maintain and restore their functions/services amidst a disruption to normal activities at pre-defined recovery time objectives (RTO) (i.e., non-stop, within 24 hrs etc.) and acceptable service levels (i.e., full, partial) is part of its business continuity plan/planning. Each board of health shall pre-define their own RTOs and service levels based on their comfort against the maximum tolerable length of time and service capacity that their functions/services can be down after a disruption and/or emergency event.

considers the activities that support foundational components of emergency management in: prevention, mitigation, preparedness, response, and recovery.

In reviewing this Guideline, the References to the Standards section cite the specific references to emergency management in the Standards. The Context section provides an overview of key legislation and approaches to inform program planning, implementation, and evaluation. The Roles and Responsibilities section identifies the core functions that boards of health shall consider in addressing their responsibilities for emergency management under the Foundational Standards. The remainder of this Guideline provides operational advice and guidance, including resources, on specific elements of a public health emergency management program. To support this Guideline, see the Glossary.

Reference to the Standards

This section identifies the standard and requirement to which this guideline relates:

Emergency Management

Requirement 1: The board of health shall effectively prepare for emergencies to ensure 24/7 timely, integrated, safe, and effective response to, and recovery from emergencies with public health impacts, in accordance with ministry policy and guidelines.

Context

The legal authority for emergency management in Ontario is established in the *Emergency Management and Civil Protection Act* (EMCPA) and Order in Council 1739/2022. The EMCPA and its Regulation (O. Reg 380/04) require ministries and municipalities to develop and implement an emergency management program consisting of emergency plans, training programs and exercises, and public education. This includes identifying and regularly monitoring and assessing the various hazards and risks to public health that could give rise to emergencies, and identifying the necessary goods, services, and resources to respond to the hazards and risks identified.[4]

The legal authority for the delivery of public health programs and services in Ontario is established in the *Health Protection and Promotion Act* (HPPA). The HPPA provides for the powers and responsibilities of local boards of health, medical officers of

health, the Minister of Health, and the Chief Medical Officer of Health.[2] Its purpose is to "provide for the organization and delivery of public health programs and services, the prevention of the spread of disease, and the promotion and protection of the health of the people of Ontario".[2] Health promotion and protection are cornerstones of the HPPA and of public health activities in Ontario.[2] Boards of health are responsible for identifying, preventing, reducing, or eliminating health hazards and addressing communicable diseases in their public health units. The HPPA provides legal authority for the boards of health to respond to a public health emergency that has been determined to be a health hazard or as the result of a communicable disease under the HPPA.[2]

As emergencies vary in scope, scale, duration and time of onset, public health emergency management programs must be broadened to adopt an all-hazards approach to risks. Since public health impacts can emerge from hazards of different origins including natural (e.g., communicable diseases, major storms), human-induced (e.g., civil disorder, terrorism), or technological (e.g., cyber-attacks, infrastructure failures), focusing on common roles and responsibilities, and processes and procedures can ensure more effective and scalable responses and plans. Understanding and prioritizing hazards also enables boards of health to plan and prepare for mixed types of emergencies to inform strategies and priorities in prevention, mitigation, preparedness, response, and recovery activities. This can better ensure appropriate focus is placed on high-priority risks, priority populations, and system resilience. As each board of health may be exposed to its own unique risks and have its own population characteristics and resource limitations, hazard identification and risk assessments should assess the potential level of risk in terms of likelihood and consequences in each board of health's community to inform strategies and set priorities. Risk assessments must regularly integrate changing risks, adapting to evolving probabilities and consequences of events, especially in light of dynamic factors like climate change.

Public health emergency management programs should adopt a disaster risk reduction and whole-of-society approach to emergency management which are seen as essential for managing risks and impacts, and supporting the resilience of communities. Disaster risk reduction supports resilience by aiming to prevent new and reduce existing disaster risk through systematic efforts to analyze and mitigate the causal factors of disasters. For example, assessing the evolving nature of climate change and its impacts on human health from extreme weather. A whole-

of-society approach leverages the capacities and opportunities across sectors and community partners to reduce risk, vulnerabilities, and impacts of emergencies.[6,7,15] For example, a global pandemic response that leverages both public and private sector stakeholders in health and non-heath sector, including individuals, families, religious institutions, academia, the media etc., to work together to develop and/or apply integrated policies and programs towards the achievement of their interdependent goals.

Public health emergency management programs shall adopt, or incorporate concepts and/or principles consistent with the Incident Management System (IMS) as a standardized approach to emergency management response encompassing personnel, facilities, equipment, procedures, and communications operating within a common organizational structure.

Roles and Responsibilities

Emergency management is one of the Foundational Standards of the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (Standards). As such:

1) The board of health shall consider emergency management in all public health program development, implementation, and evaluation.

Population health assessment, health equity, and effective public health practice are also Foundational Standards. As such:

2) The board of health shall consider the above in the development, implementation, and evaluation of the board of health's emergency management program.

3) In addition, the board of health shall consider Program Standards in the development, implementation, and evaluation of the board of health's emergency management program, including:
    a) Substance Use and Injury Prevention Requirements 1 and 2
    b) Food Safety: Requirement 5
    c) Healthy Environments: Requirements 1, 2, 5, 6, 7, 8, 9, and 10
    d) Immunization: Requirement 6
    e) Infectious and Communicable Diseases Prevention and Control: Requirements 1, 5, 6, 20, and 21

f) Safe Water: Requirements 1 and 8

General

4) The board of health shall:
   a) Develop and maintain networks of health sector and community partners for coordination and collaboration in the board's emergency management program activities as described in this section.
      i. Encourage cultures of collaboration by engaging with communities, local partners, and government organizations across sectors to identify and minimize health inequities as per the Health Equity Guideline, and promote enduring relationships as per the Relationship with Indigenous Communities Guidelines.
      ii. Focus on continuous improvement and building resiliency in the board's emergency management program activities as described in this section.
      iii. Encourage cultures of continuous improvement by adopting a complexity theory lens to account for the dynamic and interdependent nature of emergencies, environments, and systems through the use of public health emergency preparedness tools (found on page 11 in the Public Health Emergency Preparedness Framework and Indicators).

Health Hazards Identification and Risk Assessment (HIRA), Awareness and Surveillance

5) The board of health shall, in collaboration with health sector and community partners as applicable, conduct processes that maintain ongoing awareness of:
   a) Public health hazards and risks particular to the health unit area that may give rise to an emergency.
   b) Hazards and risks particular to the health unit area (e.g., extreme weather, respiratory season, climate change, other community risks, etc.) that may give rise to emergencies, planned events or disruptions with public health impacts.

6) The board of health shall use the results of their risk assessment to consider priority populations in the community and the potential for them to experience

disproportionate health impacts from emergencies, planned events, or disruptions.

a. Population health assessment strategies to identify priority populations and monitor their health are outlined in the Population Health Assessment and Surveillance Protocol, and the Health Equity Guideline.

7) The board of health shall use the results of their risk assessment to inform relevant preparedness plans/protocols for emergency management and business continuity and risk reduction.

8) The board of health shall publicly post results of their risk assessment or link to their municipality's publicly posted HIRA.

9) The board of health shall, in collaboration with health sector and community partners as applicable, ensure public education and awareness of public health hazards and risks.

Emergency Planning

10) The board of health shall, in coordination and collaboration with health sector and community partners as applicable, conduct planning for the public health sector, including:
    a) Continuity of operations plans. Planning shall:
        i. identify the time-critical public health functions/services for which the board of health is responsible;
        ii. assess the dependencies and interdependencies (i.e., systems, infrastructure, assets, technology, and resources) upon which the time-critical public health functions/services rely;
        iii. identify recovery time objectives (e.g., non-stop, within 24hrs, within 5 business days, etc.) and the acceptable service levels (e.g., full, half) for each time-critical public health function/service, accounting for disruptions of varying lengths, scope, and scale;
        iv. identify recovery strategies and assign resources required for the maintenance/resumption of time-critical public health functions/services;
        v. include a human resource strategy;
            i. encourage cross-functionality and adaptive skills in key public health functions (e.g., immunization, outbreak management etc.).

   ii. consider rapid recruitment and training models, including potential contributions from partner organizations to support surge capacity for disruptions of varying lengths, and redeployments for training.
vi. contain a mental health and wellness strategy, including considerations for healthy work environments and access to resources, to support staff and well-being (e.g., psychosocial supports);
vii. identify the applicability of workplace health and safety rights and responsibilities, such as the Occupational Health and Safety Act and its Regulations;
viii. adopt an all-hazards approach;
ix. include a communications strategy for internal and external stakeholders;
x. be reviewed and updated annually, as needed;
xi. engage the senior management team and be approved by the Medical Officer of Health; and
xii. be shared with relevant health sector and community partners, as applicable (e.g., other public health units, Community Emergency Management Coordinators).

b) Emergency response plans. Planning shall:
   i. include a clear governance and organizational structure that is, at a minimum, consistent with roles and responsibilities established in the HPPA;[2] and IMS structures.
   ii. identify and align with the corresponding response plans of other relevant organizational and government bodies, including but not limited to relevant local health sector, municipal, provincial and federal government response plans;
   iii. assign responsibilities to staff to implement the emergency response plan as directed by the local Medical Officer of Health, Community Emergency Management Coordinator (CEMC), or appropriate individuals, as outlined in IMS structures and/or local public health unit plans;
   iv. leverage network of health sector and community partners to enable integrated planning and response;

i. consider contributions (e.g., staff and other resources) by partner organizations that can support local public health with their emergency response roles;

v. include a human resource strategy;
   i. encourage cross-functionality and adaptive skills in key public health functions (e.g., immunization, outbreak management etc.).
   ii. consider rapid recruitment and training models, including identifying potential contributions from partner organizations to support surge capacity for emergencies of varying lengths, and redeployments for training.

vi. contain a mental health and wellness strategy, including considerations for healthy work environments and access to resources, to support staff and community mental health and well-being (e.g., psychosocial supports);

vii. identify the applicability of workplace health and safety rights and responsibilities, such as the Occupational Health and Safety Act and its Regulations;

viii. adopt an all-hazards approach;

ix. considers recovery capabilities as part of pre-disaster recovery planning to effectively enable recovery efforts;

x. contain a communications strategy for internal and external stakeholders;

xi. be reviewed annually and updated as needed;

xii. engage the senior management team and be approved by the Medical Officer of Health; and

xiii. be shared with relevant health sector and community partners, as applicable (e.g., other public health units, Community Emergency Management Coordinators)

11) The board of health shall incorporate concepts consistent with IMS in emergency plans and planning.

12) The board of health shall ensure their plans are tested and/or exercised annually.

Communications and Notifications

13) The board of health shall ensure access to the Medical Officer of Health or designate during and after business hours.

14) The board of health shall develop, implement, and maintain 24/7 notification protocols for communications with board of health staff, community partners, and governmental bodies, including the ministry. Protocols for communication shall outline processes for receiving, notifying, and responding to reports of an emergency, planned events or disruption, a potential health hazard, or a reportable or communicable disease including institutional and hospital outbreaks.

15) The board of health shall ensure that 24/7 notification protocols across all programs and services are coordinated to ensure alignment and consistency in coverage and response.

16) The board of health shall identify and maintain a range of communication modalities (e.g., voice, text, video) and platforms (e.g., traditional and social media) to ensure the dissemination of timely and accurate information.

17) The board of health shall develop clear and transparent evidence-based communication to increase health literacy and build trust.

18) The board of health shall develop communication strategies for multiple audiences (e.g., communications in relevant languages, accessible content) including leveraging joint messaging efforts, in coordination and collaboration with health sector and community partners as applicable, to target and reach priority and diverse populations (e.g., requests to community leaders to disseminate information with identified audience).

19) The board of health shall maintain and/or have access to personnel that maintain competencies in crisis and risk communication, including identifying and using communication platforms (e.g., social media, town halls) and approaches (e.g., two-way communication) that supports building transparency, credibility, and trust to address false or misleading information.

20) The board of health shall ensure communication and notification protocols are embedded in their emergency plans.

Learning and Practice, Training and Exercises

21) The board of health shall ensure, in coordination and collaboration with health sector and community partners as applicable[†], learning and training for board of health staff (including senior leadership) at intervals that supports a culture of excellence in professional practice and promotes a skilled and resilient workforce, which includes:
    a) a workplace orientation for new board of health staff members;
    b) knowledge of foundational emergency management and public health legislations and frameworks, including key concepts governing health equity (e.g., social determinants of health), mental health promotion (e.g., community-based interventions), healthy environments (e.g., climate change impacts), and population health (e.g., priority populations).
    c) 24/7 notification protocols, or crisis/risk communications for staff and board of health leadership with a role in emergency planning and response;
    d) cross training of staff in key emergency response roles to facilitate staff rotation, staff respite, and staff redeployment for surge response; and
    e) concepts consistent with IMS.

22) The board of health shall ensure any training and/or certification for board of health staff is documented for internal awareness purposes.

23) The board of health shall ensure a timely debrief/after-action-review is conducted following a disruption, planned event or emergency. The board of health may choose to engage in an intra- or in-action review during emergency responses as well.

24) If no lived experience from disruptions, planned events or emergencies occurred in the past 12 months, the board of health shall conduct an exercise once every year. Exercises may include discussions-based exercises (e.g., tabletops), functional or full-scale exercises. Exercises should:

[†] Per the EMPCA sec. 2.1, municipalities shall provide training and exercises to include employees of the municipality and other persons with respect to the provision of necessary services and the procedures to be followed in emergency response and recovery activities. Boards of health should communicate with municipalities to identify streamlined options for applicable emergency management training.

a) simulate a disruption against time-critical public health functions/ services, or an emergency selected from a range of hazards;
b) provide the opportunity to test assumptions, relationships, and plans, and identify and address key problems or gaps;
c) include board of health staff members and board of health leadership with a role in emergency planning, emergency response, 24/7 notification protocols, and crisis communications;
d) include engagement with health sector and community partners, and other stakeholders as appropriate to the scenario;
e) graduate in difficulty over time or adjusted to the skillset and expertise of the attending players so it provides for continuous learning and quality improvement; and
f) include a debrief session/after-action review to identify learnings and provide recommendations to future responses and plans, to be further documented in an improvement plan (IP) that promotes ongoing program improvement.

25) The board of health shall, in coordination and collaboration with health sector and community partners as applicable, ensure a culture of continuous organizational self-improvement and adaptive learning.

Glossary

After-Action Report (AAR): A report that documents the performance of tasks related to an emergency, exercise, or planned event and, where necessary, makes recommendations for improvements.[11]

After-Action Review: qualitative review conducted after the end of an emergency response to identify best practices, gaps, and lessons learned. AAR This allows stakeholders to reflect on shared experiences and perceptions of a response, and work together to identify what worked well, what did not work, why, and areas for improvement.[23]

All-Hazards Approach: an emergency management approach to risk assessments that helps identify, analyze, and prioritize the full range of potential threats when planning for response capacities and mitigation efforts.[15]

Community Emergency Management Coordinator (CEMC): an employee of a municipality or a member of the municipal council responsible for the development and implementation of the municipality's emergency management program.[5]

Complexity Theory: A lens to understand the complex adaptive system operating in public health emergencies. Characteristics of complex systems include dynamic, rapidly evolving context; interconnectedness of the system; feedback from within and outside the system and features of change such as self-organization and adaptability.[10]

Continuity of Operations Plan (COOP): A plan developed and maintained to direct an organization's internal response to an emergency.[11]

Critical Infrastructure (CI): Interdependent, interactive, interconnected networks of institutions, services, systems, and processes that meet vital human needs, sustain the economy, protect public safety and security, and maintain continuity of and confidence in government.[11]

Disaster Risk Reduction (DRR): a systematic, whole-of-society approach to identifying, assessing and analyzing the causal effects of disasters and reducing the risks and impacts of disaster based on risk assessment.[15]

Disruption: Disruptive events or disruptions are time-limited events that impact, or are likely to impact, the ability of the health system to maintain regular health services and where required, to support individuals negatively impacted as a consequence of the disruption.[11]

Emergency: A situation or an impending situation that constitutes a danger of major proportions that could result in serious harm to persons or substantial damage to property and that is caused by the forces of nature, a disease or other health risk, an accident or an act whether intentional or otherwise.[11]

Emergency Management: Organized activities undertaken to prevent, mitigate, prepare for, respond to, and recover from actual or potential emergencies.[11]

Emergency Management Program: A risk-based program consisting of prescribed elements that considers components of emergency management such as prevention, mitigations, preparedness, response and recovery.[11]

Exercise: A simulated emergency in which players carry out actions, functions, and responsibilities that would be expected of them in a real emergency. Exercises can be used to validate plans and procedures, and to practice prevention, mitigation,

preparedness, response, and recovery capabilities. Exercises can be discussion-based (e.g., seminars, workshops, table-top exercises) or operations-based (e.g., drills, functional exercises, full-scale exercises).[12]

Hazard: A phenomenon, substance, human activity, or condition that may cause loss of life, injury or other health impacts, property damage, loss of livelihoods and services, social and economic disruption, or environmental damage. These include natural, technological, or human-caused incidents or some combination of these.[11]

Hazard Identification and Risk Assessment (HIRA): A structured process for identifying the nature and extent of risk of those hazards which exist within a selected area and defining their causes and characteristics.[11]

Health Hazard: Chemical, physical, or biological factors in our environment that can have negative impacts on our short- or long-term health. Exposure can occur through touch, inhalation, and ingestion.[14]

Health Sector and Community Partners: A range of health care and community-based or focused organizations and/or individuals. This may include Ontario Health, Public Health Ontario, hospitals, long-term care homes, paramedic services, Indigenous health services providers, Community Emergency Management Coordinator(s) (CEMCs), local authorities (e.g., community police, emergency social services) and any other relevant community partners, in addition to board of health staff and governmental bodies.[8,9]

Improvement Plan (IP): For each task, the Improvement Plan (IP) lists the corrective actions that will be taken, the responsible party or agency, and the expected completion date. The IP is included at the end of the After-Action Report.[22]

Incident Management System (IMS): A standardized approach to emergency management encompassing personnel, facilities, equipment, procedures, and communications operating within a common organizational structure. The IMS is predicated on the understanding that in any and every incident there are certain management functions that must be carried out regardless of the number of persons who are available or involved in the emergency response.[11]

Intra- or In-Action Review (IAR): qualitative review conducted during an emergency response to identify opportunities for ongoing learning and allow for implementation of actionable items to improve the response. The IAR and AAR

process is similar except the IAR is smaller in scope, follows a shorter timeframe, and can inform a longer-term response.[20]

Mitigation: Actions taken to reduce the adverse impacts of an emergency or disaster. Such actions may include diversion or containment measures to lessen the impacts of a flood or a spill.[11]

Priority Populations: those that are experiencing and/or at increased risk of poor health outcomes due to the burden of disease; factors for disease; determinants of health, including social determinants of health; and/or the intersection between them. They are identified using local, provincial and/or federal data sources, emerging trends, local context, community assessments, surveillance, and epidemiological and other research studies.[9]

Preparedness: Actions taken prior to an emergency or disaster to ensure an effective response. These actions include the formulation of emergency response plans, business continuity/continuity of operations plans, training, exercises, and public awareness and education.[11]

Prevention: Actions taken to stop an emergency or disaster from occurring. Such actions may include legislative controls, zoning restrictions, improved operating standards/procedures or critical infrastructure management.[11]

Recovery: The process of restoring a stricken community to a pre-disaster level of functioning or higher level of functioning. This may include the provision of financial assistance, repairing building, and/or restoration of the environment.[11] The recovery, rehabilitation and reconstruction phase is a critical opportunity to build back better.[21]

Recovery Time Objective (RTO): The period of time within which systems, applications, or functions must be recovered after an outage. RTOs are often used as the basis for the development of recovery strategies, and as a determinant as to whether or not to implement the recovery strategies during a disaster situation.[11]

Resilience: The ability to resist, absorb, accommodate and recover from the effects of a hazard in a timely and efficient manner.[11]

Response: The provision of emergency services and public assistance or intervention during or immediately after an incident in order to protect people, property, the environment, the economy and/or services. This may include the provision of resources such as personnel, services and/or equipment.[11]

Risk: The product of the probability of the occurrence of the hazard and its consequences.[11]

Risk Communication: an evidence-based approach to communicating effectively with the public in times of controversy.[16]

Shall: This term is used to specify mandatory requirements.

Should: This term is used to specify recommended practices.

Time Critical Service (TCS): These are services that cannot be interrupted for more than a predetermined period of time without significantly impacting the organization.[11]

Vulnerability: The susceptibility of a community, system or asset to the damaging effects of a hazard.[11]

Whole of Society: a means by which residents, emergency management practitioners, organizational and community leaders, and government officials can collectively understand and assess the needs of their respective communities and determine the best ways to organize and strengthen their assets, capacities, and interests.[19]

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Ontario

Ministry of Health

Office of the Deputy Premier
and Minister of Health

777 Bay Street, 5th Floor
Toronto ON M7A 1N3
Telephone: 416 327-4300
www.ontario.ca/health

Ministère de la Santé

Bureau du vice-premier ministre
et ministre de la Santé

777, rue Bay, 5e étage
Toronto ON M7A 1N3
Téléphone: 416 327-4300
www.ontario.ca/sante

Ontario

January 30, 2024

e-Approve-72-2023-612

Mayor Joe Preston
Chair, Board of Health
Oxford Elgin St. Thomas Health Unit
1230 Talbot Street
St. Thomas ON N5P 1G9

Dear Mayor Preston:

I am pleased to advise you that the Ministry of Health will provide the Board of Health for the Oxford Elgin St. Thomas Health Unit up to $329,400 in one-time funding for the 2023-24 funding year to support extraordinary costs incurred associated with COVID-19 response activities, including delivering the COVID-19 Vaccine Program at the local level.

Elizabeth Walker, Executive Lead, will write to the Oxford Elgin St. Thomas Health Unit shortly concerning the terms and conditions governing the funding.

Thank you for the important service that your public health unit provides to Ontarians, and your ongoing dedication and commitment to addressing the public health needs of Ontarians.

Sincerely,

Sylvia Jones
Deputy Premier and Minister of Health

c: Dr. Ninh Tran, Medical Officer of Health, Oxford Elgin St. Thomas Health Unit
Cynthia St. John, Chief Executive Officer, Oxford Elgin St. Thomas Health Unit
Dr. Kieran Moore, Chief Medical Officer of Health and Assistant Deputy Minister
Elizabeth Walker, Executive Lead, Office of Chief Medical Officer of Health, Public Health

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 2023

Issued 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 AND APRIL 1ST TO MARCH 31ST)			
Programs / Sources of Funding	**Grant Details**	**2023 Grant ($)**	**2023-24 Grant ($)**
Mandatory Programs (Cost-Shared)	• The 2023 Grant includes a pro-rated increase of $83,175 for the period of April 1, 2023 to December 31, 2023 • Per the Funding Letter, the 2023-34 Grant includes an annualized increase of $110,900 for the period of April 1, 2023 to March 31, 2024	11,168,975	11,196,700
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	178,700
Ontario Seniors Dental Care Program (100%)		1,061,100	1,061,100
Total Maximum Base Funds		**12,408,775**	**12,436,500**

DETAILED BUDGET - MAXIMUM ONE-TIME FUNDS (GRANTS TO BE PAID SEMI-MONTHLY, FOR THE PERIOD OF APRIL 1, 2023 TO MARCH 31, 2024, UNLESS OTHERWISE NOTED)			
Projects / Initiatives			**2023-24 Grant ($)**
Cost-Sharing Mitigation (100%) (For the period of January 1, 2023 to December 31, 2023)			1,498,900
Mandatory Programs: Needle Syringe Program (100%)			55,000
Mandatory Programs: New Purpose-Built Vaccine Refrigerators (100%)			32,600
Mandatory Programs: Public Health Inspector Practicum Program (100%)			20,000
COVID-19: Vaccine Program (100%) (For the period of January 1, 2023 to December 31, 2023)			329,400
Infection Prevention and Control Hubs (100%)			582,500
School-Focused Nurses Initiative (100%) (For the period of April 1, 2023 to June 30, 2023)	# of FTEs	9	225,000
Total Maximum One-Time Funds			**2,743,400**

Total Maximum Base and One-Time Funds[1]	**15,179,900**

2022-23 CARRY OVER ONE-TIME FUNDS[2] (CARRY OVER FOR THE PERIOD OF APRIL 1, 2023 to MARCH 31, 2024)		
Projects / Initiatives	**2022-23 Grant ($)**	**2023-24 Approved Carry Over ($)**
Ontario Seniors Dental Care Program Capital: New Fixed Site - Oxford County Dental Suite (100%)	1,540,000	1,540,000
Total Maximum Carry Over One-Time Funds	**1,540,000**	**1,540,000**

NOTES:

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

(2) Carry over of one-time funds is approved according to the criteria outlined in the provincial correspondence dated March 17, 2023.

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.

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:

Type of Funding ***Base Funding***

- 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.

<u>Opioid Overdose Early Warning and Surveillance</u>

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

Type of Funding	***Base Funding***

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 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 program is being implemented through a phased approach.

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. The second stage of the program will continue throughout 2023-24, with consideration being given to the implementation challenges following the COVID-19 response.

<u>Program Enrolment</u>

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.

SCHEDULE B

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base Funding***

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.

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).

Type of Funding	***Base Funding***

- 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.

- *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.

Type of Funding	***Base Funding***

Other Requirements

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.

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.

SCHEDULE B

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base Funding***

- 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	***One-Time Funding***

Cost-Sharing Mitigation (100%)

One-time cost-sharing mitigation funding must be used to offset the increased costs of municipalities as a result of the cost-sharing change for mandatory programs.

Mandatory Programs: Needle Syringe Program (100%)

One-time funding must be used for extraordinary costs associated with delivering the Needle Syringe Program. Eligible costs include purchase of needles/syringes, associated disposal costs, and other operating costs.

Mandatory Programs: New Purpose-Built Vaccine Refrigerators (100%)

One-time funding must be used for the purchase of 2 new purpose-built vaccine refrigerator(s) used to store publicly funded vaccines. The purpose-built refrigerator(s) must meet the following specifications:

a. Interior
   - Fully adjustable, full extension stainless steel roll-out drawers;
   - Optional fixed stainless-steel shelving;
   - Resistant to cleaning solutions;
   - Ongoing positive forced fan air circulation to ensure temperature uniformity at all shelf levels;
   - Fan is either encased or removed from the chamber. Fan auto shut-off when door is opened; and,
   - Walls are smooth, scratch and corrosion resistant painted interior and exterior surfaces.

b. Refrigeration System
   - Heavy duty, hermetically sealed compressors;
   - Refrigerant material should be approved for use in Canada;
   - Advanced defrost sensor(s) to manage the defrost cycle and minimize trace amounts of frost build-up; and,
   - Evaporator operates at +2°C, preventing vaccine from freezing.

c. Doors
   - Full view non-condensing, glass door(s), at least double pane construction;
   - Option spring-loaded closures include ≥90º stay open feature and <90º self-closing feature;
   - Door locking provision;
   - Option of left-hand or right-hand opening; and,
   - Interior cabinet lights with door activated on/off switch, as well as, an independent external on/off.

d. Tamper Resistant Thermostat
   - The thermostat should be set at the factory to +5ºC with a control range between +2ºC to +8ºC but this could be done at the time of delivery/installation at no additional cost.

e. Thermometer
   - An automatic temperature recording and monitoring device with battery backup;
   - An external built-in visual digital display thermometer independent of the temperature recording and monitoring device which has a digital temperature display in Celsius and temperature increment readings of 0.1ºC;
   - The external built-in digital thermometer must also be able to record and display the maximum, minimum and current temperatures and allow the user to easily check and reset these recordings as required; and,
   - The automatic temperature recording and monitoring device and digital display thermometer must be calibrated/accurate within +/- 0.5ºC or better.

f. Alarm Condition Indicator
   - Audible and visual warnings for over-temperature, under-temperature and power failure;
   - Remote alarm contacts;
   - Door ajar enunciator; and,
   - Alarm testing system.

g. Top or Bottom Mounted Compressors/Condensers
   - Compressor mounted at top or bottom but not in rear.

h. Noise Levels
   - The noise produced by the operation of the refrigerator shall not exceed 85 decibels at one metre. Specifications of the refrigerator must include the noise level measured in decibels of sound at one metre from the refrigerator.

i. Locking Plug
   - Power supply must have a locking plug.

j. Castors
   - Heavy duty locking castors either installed at the factory or upon delivery.

k. Voltage Safeguard
   - Voltage safeguard device capable of protecting against power surges related to the resumption of power to the refrigerator.

l. Warranty
   - The warranty should include, from date of acceptance, a five-year comprehensive parts and labour warranty with the stipulation that a qualified service representative shall be on-site no later than 12 hours after the service call

was made. Software upgrades provided free of charge during the warranty period.

m. Electrical Equipment

- All electrically operated equipment must be UL, CSA and/or Electrical Safety Authority approved and bear a corresponding label. The equipment should specify the electrical plug type, voltage and wattage rating, and the recommended breaker size for the circuit connection.

Mandatory Programs: Public Health Inspector Practicum Program (100%)

One-time funding must be used to hire at least one (1) or more Public Health Inspector Practicum position(s). Eligible costs include student salaries, wages and benefits, transportation expenses associated with the practicum position, equipment, and educational expenses.

The Board of Health must comply with the requirements of the Canadian Institute of Public Health Inspectors Board of Certification for field training for a 12-week period; and, ensure the availability of a qualified supervisor/mentor to oversee the practicum student's term.

COVID-19: Vaccine Program (100%)

One-time funding must be used to offset extraordinary costs associated with organizing and overseeing the COVID-19 immunization campaign within local communities, including the development of local COVID-19 vaccination campaign plans. Extraordinary costs refer to the costs incurred over and above the Board of Health's existing funding/approved budget for mandatory programs in organized and unorganized areas (where applicable).

Eligible costs include, but are not limited to:

- Staffing – salaries and benefits, inclusive of overtime, for existing staff or redeployed Board of Health staff (including management staff directly engaged in COVID-19 activities); staff redeployed from associated regional governments; new temporary or casual staff; and, salaries and benefits associated with overtime worked by indirect staff (e.g., finance, human resources, legal, communications, etc.) and management staff (where local Board of Health policies permit such arrangements) that have not been redeployed directly to COVID-19, but have incurred overtime due to working on COVID-19 related activities. Activities include providing assistance with meeting provincial and local requirements for COVID-19 surveillance and monitoring (including vaccine safety surveillance, adverse events and number of people vaccinated), administering the COVID-19 vaccine, managing COVID-19 Vaccine Program reporting requirements, and planning and deployment of immunization/ vaccine clinics.

Type of Funding	***One-Time Funding***

- Travel and Accommodation – for staff delivering COVID-19 Vaccine Program services away from their home office location, including transporting vaccines, and transportation/accommodation for staff of mobile vaccine units.
- Supplies and Equipment – supplies and equipment associated with the storage and handling of the COVID-19 vaccines (including vaccine refrigerators, freezers, coolers, etc.), small equipment and consumable supplies (including personal protective equipment) not already provided by the Province, supplies necessary to administer the COVID-19 vaccine (including needles/syringes and disposal, sterile gauze, alcohol, bandages, etc.) not already provided by the Province, information and information technology upgrades related to tracking COVID-19 immunization not already approved by the Province.
- Purchased Services – service level agreements for services/staffing with community providers and/or municipal organizations, professional services, security services, cleaning services, hazardous waste disposal, transportation services (e.g., courier services, transporting clients to vaccination clinics), data entry or information technology services for reporting COVID-19 data related to the Vaccine Program to the Province from centres in the community that are not operated by the Board of Health or increased services required to meet pandemic reporting demands, outside legal services, and additional premises leased or rented by the Board of Health.
- Communications – language interpretation/translation services, media announcements, public and provider awareness, signage, and education materials regarding COVID-19 immunization outreach.
- Other Operating – recruitment activities, staff training.

Other requirements of this one-time funding include:

- The Board of Health must ensure that any goods and services acquired with this one-time funding are procured through an open and competitive process that aligns with municipal and provincial procurement directives to the greatest extent possible.
- The Board of Health must enter into a Memorandum of Understanding / Service Level Agreement (or other similar arrangement) with any partner organization delivering services under this program (this includes services provided by a municipality of which a Public Health Unit is a part of). The Memorandum of Understanding / 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 the funds (value for money). Funding included as part of a Memorandum of Understanding / Service Level Agreement must NOT exceed those that would have been paid if the transaction was at “arm’s length” (and is subject to

provincial audit or assessment). Copies of these agreements must be provided to the Province upon request.

The following are examples of non-admissible expenditures:

- Costs associated with delivering other public health programs and services.
- Lost revenues for public health programs and services not considered a direct COVID-19 cost, including lost revenue claimed by another organization and/or third party.
- Any COVID-19 costs directly incurred by other organizations and/or third parties (i.e., long-term care homes, hospitals, municipalities). However, if a Board of Health is entering into an agreement with another organization and/or third party, then those costs would be admissible if a Memorandum of Understanding / Service Level Agreement is in place that sets out clear performance expectations and ensures accountability for the funds, as noted above.
- Sick time and vacation accruals, or banked overtime (funding of these items will be considered only when these amounts are paid).
- Costs that are reimbursable from other sources.

The Board of Health is required to track COVID-19 spending separately and retain records of COVID-19 spending.

Infection Prevention and Control Hubs (100%)

One-time funding must be used by the Board of Health for the Infection Prevention and Control (IPAC) Hubs, to enhance IPAC practices in congregate living settings in the Board of Health's catchment area. Congregate living settings (CLSs) include, but are not limited to:

- Long-Term Care Homes;
- Retirement Homes;
- residential settings funded by the Ministry of Health (the ministry);
- Residential settings for adults and children funded by Ministry of Children, Community and Social Services (MCCSS);
- Shelters; and
- Supportive Housing.

Out-of-scope settings* include:

- Childcare settings;
- Day camps;
- Farms;
- Non-Ministry funded congregate living settings;
- Personal Service Settings (PSS);

Type of Funding	***One-Time Funding***

- Hospitals;
- Primary care offices;
- Correctional facilities;
- Offices and workplaces;
- Schools; and,
- Hospices

*This is not an exhaustive list of out-of-scope settings. Please seek clarification/guidance from the ministry.

The IPAC Hubs may receive requests to support an out-of-scope setting due to pressures faced in the community / setting. The supports being offered, and the degree of Hub involvement should be discussed with the ministry for guidance / situational awareness and to minimize any potential duplication of services/support.

If the IPAC Hub is unable, or is not supporting, one of the in-scope CLSs listed above, discussion should take place with the ministry for guidance / situational awareness.

The IPAC Hub will be required to provide IPAC supports and services to CLSs in its catchment. The type, amount, and scheduling of services provided by the IPAC Hub to CLSs will be based on the need, as identified by any of the following: the congregate living settings, the IPAC Hub, and IPAC Hub networks. IPAC Hubs that were previously operating as satellite or sub-hubs are expected to continue working within their core Hub networks. The IPAC Hub will conduct an assessment to determine the allocation and priority of services.

These services include provision of the following IPAC services supports either directly or through partnership with Hub Partners (other local service providers with expertise in IPAC):

- Deliver education and training;
- Host community/ies of practice to support information sharing, learning and networking to congregate living settings;
- Support the development of IPAC programs, policy and procedures within sites/organizations;
- Support assessments and audits of IPAC programs and practices;
- Provide recommendations to strengthen IPAC programs and practices;
- Mentor those with responsibilities for IPAC within congregate living settings;
- Support the development and implementation of outbreak management plans (in conjunction with public health partners and congregate living settings); and,
- Support congregate living settings to implement IPAC recommendations.

SCHEDULE B
RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***One-Time Funding***

Recognizing that IPAC Hub staff often have dual roles, **out of scope functions / services for IPAC Hubs include, but are not limited to:**

Clinical support and other services

- Offering testing or swabbing supports for COVID-19 or other respiratory viruses
- Offering vaccines / vaccine clinics
- Providing medical assessments
- Prescribing antivirals
- Inspections (e.g., as necessary for relicensing requirements)

Outbreak management:

- Leading outbreak management teams (unless delegated by Public Health Unit)
- Defining isolation periods for residents during an outbreak
- Declaring outbreaks / declaring outbreaks over

Degree of Coverage:

- Evening and weekend on-call support

The ministry is mindful that a transition period is likely required to stop providing some of the out-of-scope functions / services. If required, this transition should be discussed with the ministry.

The IPAC Hubs will operate during regular business hours. On-call and weekend coverage is not required. There may be unique emergent situations where after hours support is required and in these situations the ministry should be notified for situational awareness.

At all times, the congregate living organization will retain responsibility and accountability for their organization's IPAC program.

One-time funding must be used for the provision of expertise, education, and support related to the work of the IPAC Hubs to congregate care settings and be subject to review by the ministry. Funding must be used as directed by the ministry and may not be used for other programs or flow through to other organizations outside of the Board of Health without the expressed written permission by the ministry. As appropriate to the jurisdiction, other health partners may also be engaged (e.g., Public Health Ontario and other Public Health Units).

In addition, the Board of Health (Hub) will be required to provide status reports, per the requirements in Schedule C.

Admissible expenditures are those considered by the ministry to be reasonable and necessary for IPAC Hubs to achieve and/or maintain ongoing IPAC support for CLSs in their region.

Type of Funding	***One-Time Funding***

One-Time funding may be used for:

- IPAC Hub staff salaries, wages, and benefits
- Overhead costs associated with IPAC Hub delivery services such as: administrative overhead; building occupancy costs; PPE for IPAC Hub staff
- Professional development for IPAC staff (e.g., membership in IPAC Canada, tuition for IPAC course, CIC reimbursement, conferences, etc.)
- Office equipment, communication, and I & IT
- Mileage costs / car rentals / meal allowance as indicated

Non-admissible expenditures are those considered by the ministry to be unrelated to the provision of work of the IPAC Hubs. Examples of non-admissible expenditures include, but are not limited to:

- **Administrative Services on Behalf of Third Parties** – Ministry policy does not permit the use of ministry funds to provide administrative services on behalf of third parties (e.g., payroll).
- **Alcoholic Beverages** – Any expenses related to alcoholic beverages are not considered to be an admissible expense and will not be funded. IPAC Hubs will follow their host organizations Travel, Meal and Hospitality Expenses Directive.
- **Capital expenditures** – any costs related to capital infrastructure.
- **Grants to stakeholders / organizations** - Grants flowed or given to stakeholders/organizations
- **Depreciation on Capital Assets / Amortization** – All types of depreciation and amortization are non-admissible expenses and will not be funded.
- **Donations to Individuals or Organizations** – Ministry policy does not permit the use of government funds to provide donations.
- **Physical items provided to CLSs** (e.g., UV lights for monitoring of environmental cleaning; PPE).

School-Focused Nurses Initiative (100%)

The School-Focused Nurses Initiative was created to support additional nursing FTE capacity in every Board of Health to provide rapid-response support to school boards and schools, child care, and camps in facilitating public health preventative measures related to the COVID-19, including screening, testing, tracing, vaccination, education and mitigation strategies.

The school-focused nurses contribute to the following activities in support of school boards and schools:

- Providing support in the development and implementation of COVID-19 health and safety plans;

Type of Funding	***One-Time Funding***

- Providing sector specific support for infection prevention; vaccinations, surveillance, screening and testing; outbreak management; case and contact management; and,
- Supporting communication and engagement with local school communities, as well as the broader health care sector.

While the priority focus is on the COVID-19 response, the additional nurses may also support the fulfilment of Board of Health requirements to improve the health of school-aged children and youth as per the School Health Program Standard and related guidelines and protocols under the Ontario Public Health Standards. The additional FTEs may also support childcare centres, home childcare premises and other priority settings relating to the health of school-aged children and youth.

The initiative is being implemented with the following considerations:

- Recruitment of Registered Nurses to the extent possible;
- French language and Indigenous (First Nation, Métis, Inuit) service needs;
- Capacity for both in-person and virtual delivery;
- Consistency with existing collective agreements; and,
- Leveraging the Chief Nursing Officer role as applicable in implementing this initiative, as well as coordinating with existing school health, nursing, and related programs and structures within the Board of Health (e.g., School Health Teams, Social Determinants of Health Nurses, Infection Prevention and Control Nurses, and school-based programs such as immunization, oral and vision screening, reproductive health, etc.).

Qualifications required for these positions are:

- Current registration with the College of Nurses of Ontario (i.e., Registered Nurse, Registered Practical Nurse, or Registered Nurse in the Extended Class).

One-time funding must be used to continue the new temporary FTEs for school-focused nurses as specified in Schedule A of the Agreement. Funding is for nursing salaries, wages, and benefits only and cannot be used to support other operating costs. Additional costs incurred by the Board of Health to support school re-opening initiatives that cannot be managed within the existing budget of the Board of Health, are admissible through the COVID-19 extraordinary costs process.

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.

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. Infection Prevention and Control Hubs	For the period of April 1, 2023 to March 31, 2024	As directed by the Province
6. MOH / AMOH Compensation Initiative Application	For the entire Board of Health Funding Year	As directed by the Province
7. 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.

COVID-19 Reporting

- The Board of Health shall complete and submit actual and forecasted expenditures associated with COVID-19 extraordinary costs (for both the COVID-19 Vaccine Program and the COVID-19 General Program) through the submission of a COVID-19 Expense Form as part of financial reports to the Province.
- Reports shall be signed on behalf of the Board of Health by an authorized signing officer.

SCHEDULE C
REPORTING REQUIREMENTS

Infection Prevention and Control (IPAC) Hub Reports

- The Board of Health shall provide to the Province quarterly status reports for one-time funding provided for the Infection Prevention and Control (IPAC) Hub in addition to identifying concerns and emerging issues in a timely way and contribute to shared problem solving. Reports will include:
    - Operational targets and progress; and
    - Changes in human resources within the IPAC Hub.

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.

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.