City of Hamilton
BOARD OF HEALTH

Meeting #: 18-001
Date: January 15, 2018
Time: 1:30 p.m.
Location: Council Chambers, Hamilton City Hall, 71 Main Street West

Loren Kolar, Legislative Coordinator (905) 546-2424 ext. 2604

Pages

1. APPROVAL OF AGENDA

   (Added Items, if applicable, will be noted with *)

2. DECLARATIONS OF INTEREST

3. APPROVAL OF MINUTES OF PREVIOUS MEETING

   3.1 December 4, 2017 — 3

4. DELEGATION REQUESTS

5. CONSENT ITEMS

   5.1 Public Health Services 2017 Department Operational Work Plan (BOH17002(b)) (City Wide) — 13

   5.2 Ontario Public Health Standards Modernization - Organizational Requirements Compliance Assessment (BOH17010(c)) (City Wide) — 69

   5.3 Ontario Public Health Standards Modernization - Annual Service Plan & Budget Template (BOH17010(d)) (City Wide) — 102

6. PUBLIC HEARINGS / DELEGATIONS

   6.1 Susan Creer, respecting Secondhand Smoke in CityHousing Hamilton Buildings (approved at the October 16, 2017 meeting)

7. STAFF PRESENTATIONS

8. DISCUSSION ITEMS

9. MOTIONS

10. NOTICES OF MOTION

11. GENERAL INFORMATION / OTHER BUSINESS

12. PRIVATE AND CONFIDENTIAL

13. ADJOURNMENT

BOARD OF HEALTH
MINUTES 17-011

1:30 p.m.
Monday, December 4, 2017
Council Chambers
Hamilton City Hall

Present:	Mayor F. Eisenberger Councillors A. Johnson, J. Farr, S. Merulla, C. Collins, D. Skelly, T. Whitehead, D. Conley, M. Pearson, L. Ferguson, A. VanderBeek, R. Pasuta and J. Partridge
Absent with regrets:	Councillors M. Green and B. Johnson – City Business and Councillor T. Jackson – Personal

THE FOLLOWING ITEMS WERE REFERRED TO COUNCIL FOR CONSIDERATION:

1. Food Strategy Implementation Plan (BOH13001(f)) (City Wide) (Item 5.1)

(Pearson/Conley)
That Report BOH13001(f), respecting a Food Strategy Implementation Plan, be received.

CARRIED

2. Food Strategy Implementation Plan (BOH13001(g)) (City Wide) (Item 5.2)

(VanderBeek/Skelly)
That Report BOH13001(g), respecting a Food Strategy Implementation Plan, be received.

CARRIED

3. Equity for Trans and Gender Diverse People in Health Care (BOH17044) (City Wide) (Item 5.3)

(A. Johnson/Whithead)
That Report BOH17044, respecting Equity for Trans and Gender Diverse People in Health Care, be received.

CARRIED

4. Informed Decisions Empowering Adolescents (IDEAs) Update (BOH16059(a)) (City Wide) (Item 5.4)

(Partridge/VanderBeek)
That Report BOH16059(a), respecting Informed Decisions Empowering Adolescents (IDEAs) Update, be received.

CARRIED

5. Supervised Injection Site Study Update (BOH17004(a)) (City Wide) (Item 7.1)

(Farr/Merulla)
That Report BOH17004(a) respecting Supervised Injection Site Study Update, be received.

CARRIED

6. Supervised Injection Site Study Update (BOH17004(b)) (City Wide) (Item 7.2)

(Farr/Merulla)

(a) That the Board of Health express support for community organizations that are submitting an exemption application to Health Canada and the Ministry of Health and Long-Term care to operate a Supervised Injection Site if:

(i) Their application falls in line with the recommendations of the Hamilton Supervised Injection Site Needs Assessment and Feasibility Study;

(ii) It includes practices, policies and procedures to ensure community safety and order, for the community and immediate area surrounding the site; and,

(iii) It includes plans for ongoing community engagement and feedback, and evaluation of the site;

(b) That the Board of Health endorse recommendations of the report “Hamilton Supervised Injection Site Needs Assessment & Feasibility Study”:

(i) Hamilton would benefit from one or more supervised injection sites;

(ii) Hamilton should implement one integrated supervised injection site located in the area flanked by Queen Street (west), Barton Street (north), Ferguson Ave (east) and Main Street (south):

1. The site should be integrated within an existing health or social service agency that already provides harm reduction services to people who inject drugs.

2. The lead organization of the site should determine optimal hours of operation based on resources, capacity, and need, understanding that surveyed users would prefer to access a site between 8 a.m. to 12 noon and 8 p.m. to 12 midnight.

3. The site should provide harm reduction and basic health services.

(iii) Additional integrated sites should be considered based on implementation of the first site, monitoring for need, and the interest and willingness of service providers and users to have additional locations:

1. Potential areas to monitor include the East End and Mountain.

(iv) Geographic areas outside of Hamilton's downtown core could be serviced with a mobile supervised injection site under the following conditions:

1. Further investigation should be conducted to understand the optimal route and timing;

2. Ways to incorporate integrated services into a mobile service delivery model should be further explored;

3. The potential for additional mobile units should be considered based on monitoring for need and the interest and willingness of service providers and users to have additional units.

(v) Implementation and evaluation plans should be developed by the lead service agency for the Supervised Injection Site in consultation with other service providers, potential clients, and the community; and,

(c) That the Board of Health endorse Public Health Services to support a Supervised Injection Site with the provision of in-kind harm-reduction resources and staff support. Any identified staffing and resource implications would be brought back to the Board of Health for approval and/or endorsement.

CARRIED

7. Nurse-Family Partnership Request to Maintain Current Service Levels (BOH07035(g)) (Item 8.1)

(Whitehead/Merulla)
That the Board of Health authorize and direct the Medical Officer of Health to extend the agreement and accept funding from the Hamilton Community Foundation in the amount of $32,000 to support the Nurse Family Partnership© program operational requirements for 2018.

CARRIED

8. Public Health Funding and Accountability Agreement (BOH17045) (City Wide) (Item 8.2)

(Merulla/Skelly)
That Report BOH17045, respecting a Public Health Funding and Accountability Agreement, be received.

CARRIED

9. Correspondence from Donna Cripps, Chief Executive Officer, Hamilton Niagara Haldimand Brant Local Health Integration Network, respecting Response to letter of November 20, 2017 regarding Equity for Transgender and Gender Diverse People in the Healthcare System (Added Item 11.2)

(A. Johnson/Merulla)
That the Correspondence from Donna Cripps, Chief Executive Officer, Hamilton Niagara Haldimand Brant Local Health Integration Network, respecting Response to letter of November 20, 2017 regarding Equity for Transgender and Gender Diverse People in the Healthcare System, be received.

CARRIED

10. Correspondence from the Corporation of the City of Kingston, respecting a Motion passed at the Kingston City Council Meeting on November 7, 2017 regarding Naloxone (Added Item 11.3)

(A. Johnson/Merulla)
That the Correspondence from the Corporation of the City of Kingston, respecting a Motion passed at the Kingston City Council Meeting on November 7, 2017 regarding Naloxone, be received ***and referred to the Medical Officer of Health and the General Manager, Community and Emergency Services.***

Main Motion *as Amended* CARRIED

FOR INFORMATION:

(a) CHANGES TO THE AGENDA (Item 1)

The Clerk advised the Board of the following changes:

1. ADDED DELEGATION REQUESTS (Item 4)

4.2 Dean Waterfield, Director of Housing and Homelessness, Wesley Urban Ministries, respecting the Supervised Injection Site Study Update (BOH17004(b)) (City Wide) (for today's meeting).

4.3 Tim McClemont, The AIDS Network, respecting the Supervised Injection Site Study Update (BOH17004(b)) (City Wide) (for today's meeting).

4.4 Tim O'Shea, Hamilton Health Sciences, respecting the Supervised Injection Site Study Update (BOH17004(b)) (City Wide) (for today's meeting).

2. ADDED GENERAL INFORMATION/OTHER BUSINESS (Item 11)

11.2 Correspondence from Donna Cripps, Chief Executive Officer, Hamilton Niagara Haldimand Brant Local Health Integration Network, respecting Response to letter of November 20, 2017 regarding Equity for Transgender and Gender Diverse People in the Healthcare System.

Recommendation: Be received.

11.3 Correspondence from the Corporation of the City of Kingston, respecting a Motion passed at the Kingston City Council Meeting on November 7, 2017 regarding Naloxone.

Recommendation: Be received.

(Partridge/Pearson)
That the agenda for the December 4, 2017 Board of Health be approved, as amended.

CARRIED

(b) DECLARATIONS OF INTEREST (Item 2)

None.

(c) APPROVAL OF MINUTES OF PREVIOUS MEETING (Item 3)

(i) November 13, 2017 (Item 3.1)

(A. Johnson/Pasuta)
That the Minutes of the November 13, 2017 meeting of the Board of Health be received, as presented.

CARRIED

(d) DELEGATION REQUESTS (Item 4)

(Whitehead/Farr)
That Items 4.1 to 4.4, Delegation Requests from the following individuals, be approved, for the December 4, 2017 meeting:

(i) Tammy Burgess, to tell Brookelynne's story, with hopes of achieving Safe Injection Sites (SIS) in Hamilton (Item 4.1)

(ii) Dean Waterfield, Director of Housing and Homelessness, Wesley Urban Ministries, respecting the Supervised Injection Site Study Update (BOH17004(b)) (City Wide) (Added Item 4.2)

(iii) Tim McClemont, The AIDS Network, respecting the Supervised Injection Site Study Update (BOH17004(b)) (City Wide) (Added Item 4.3)

(iv) Tim O'Shea, Hamilton Health Sciences, respecting the Supervised Injection Site Study Update (BOH17004(b)) (City Wide) (Added Item 4.4)

CARRIED

(e) DELEGATIONS (Item 6)

(i) Tammy Burgess, to tell Brookelynne's story, with hopes of achieving Safe Injection Sites (SIS) in Hamilton (Item 6.1)

Tammy Burgess addressed the Board of Health in support of Report BOH17004(b), Supervised Injection Site Study Update, by telling the story of her daughter Brookelynne and her struggles with drugs and subsequent overdose.

(Farr/A. Johnson)
That the delegation from Tammy Burgess, to tell Brookelynne's story, with hopes of achieving Safe Injection Sites (SIS) in Hamilton, be received.

CARRIED

For further disposition of this matter, refer to Item 6.

(ii) Dean Waterfield, Director of Housing and Homelessness, Wesley Urban Ministries, respecting the Supervised Injection Site Study Update (BOH17004(b)) (City Wide) (Added Item 6.2)

Dean Waterfield, Director of Housing and Homelessness, Wesley Urban Ministries, addressed the Board of Health in support of Report BOH17004(b), respecting the Supervised Injection Site Study Update, with the aid of speaking notes. These speaking notes have been added to the official record.

(Skelly/Merulla)
That the delegation from Dean Waterfield, Director of Housing and Homelessness, Wesley Urban Ministries, respecting the Supervised Injection Site Study Update (BOH17004(b)), be received.

CARRIED

A copy of the speaking notes are available at www.hamilton.ca

For further disposition of this matter, refer to Item 6.

(iii) Tim McClemont and Chrissy Hawkins, The AIDS Network, respecting the Supervised Injection Site Study Update (BOH17004(b)) (City Wide) (Added Item 6.3)

Tim McClemont, The AIDS Network, addressed the Board of Health in support of Report BOH17004(b), respecting the Supervised Injection Site Study Update, with the aid of speaking notes. These speaking notes have been added to the official record.

Chrissy Hawkins, a volunteer with the AIDS Network, addressed the addressed the Board of Health in support of Report BOH17004(b), respecting the Supervised Injection Site Study Update.

(Farr/Merulla)
That the delegation from Tim McClemont and Chrissy Hawkins, The AIDS Network, respecting the Supervised Injection Site Study Update (BOH17004(b)), be received.

CARRIED

A copy of the speaking notes are available at www.hamilton.ca

For further disposition of this matter, refer to Item 6.

(iv) Tim O'Shea, Hamilton Health Sciences, respecting the Supervised Injection Site Study Update (BOH17004(b)) (City Wide) (Added Item 6.4)

Tim O'Shea, Hamilton Health Sciences, addressed the Board of Health in support of Report BOH17004(b), respecting the Supervised Injection Site Study Update, with the aid of speaking notes. These speaking notes have been added to the official record.

(Skelly/Merulla)
That the delegation from Tim O'Shea, Hamilton Health Sciences, respecting the Supervised Injection Site Study Update (BOH17004(b)), be received.

CARRIED

A copy of the speaking notes are available at www.hamilton.ca

For further disposition of this matter, refer to Item 6.

(f) PRESENTATIONS (Item 7)

(i) Supervised Injection Site Study Update (BOH17004(a)) (City Wide) (Item 7.1)

Dr. Laura Bourns, Public Health Physician and Dr. Elizabeth Richardson, Medical Officer of Health, addressed the Board of Health with an overview of Report BOH17004(a) respecting a Supervised Injection Site Study Update, with the aid of a PowerPoint presentation. A copy of the presentation has been included in the official record.

(Whitehead/Conley)
That the presentation on Report BOH17004(a) respecting a Supervised Injection Site Study Update, be received.

CARRIED

For further disposition, refer to Item 5 .

A copy of the presentation is available at www.hamilton.ca

(ii) Supervised Injection Site Study Update (BOH17004(b)) (City Wide) (Item 7.2)

Dr. Elizabeth Richardson, Medical Officer of Health, addressed the Board of Health with an overview of Report BOH17004(b) respecting a Supervised Injection Site Study Update, with the aid of a PowerPoint presentation. A copy of the presentation has been included in the official record.

Deputy Chief Dan Kinsella, Hamilton Police Services, addressed the Board of Health with his experiences of touring existing Safe Injection Sites in Vancouver, British Columbia.

(Whitehead/Skelly)
That the presentation on Report BOH17004(b) respecting a Supervised Injection Site Study Update, be received.

CARRIED

The Main Motion, shown as Item 6, CARRIED on the following Standing Recorded Voted:

Yeas:	Eisenberger, A. Johnson, Farr, Merulla, Skelly, Whitehead, Conley, Pearson, VanderBeek, Pasuta
Total:	10
Nays:	None
Total:	0
Absent:	Green, Collins, Jackson, B. Johnson, Ferguson, Partridge
Total:	6

A copy of the presentation is available at www.hamilton.ca

For further disposition, refer to Item 6.

(g) DISCUSSION ITEMS (Item 8)

(i) Nurse-Family Partnership Request to Maintain Current Service Levels (BOH07035(g)) (Item 8.1)

Jennifer Vickers-Manzin, Director, Family Health addressed the Board with an overview of Report BOH07035(g), respecting the Nurse-Family Partnership Request to Maintain Current Service Levels.

For further disposition, refer to Item 7.

(h) GENERAL INFORMATION / OTHER BUSINESS (Item 11)

(i) Amendments to the Outstanding Business List (Item 11.1)

(Pearson/Merulla)
That the following amendments to the Outstanding Business List, be approved:

Items to be Removed:

Item M - Food Strategy Priority Actions 4 & 5 (BOH August 11, 2016, Item 7.1)
(Addressed in Item 5.2 of this agenda)

Item N - Food Strategy Priority Actions Implementation Plan (BOH August 11, 2016, Item 7.1)
(Addressed in Item 5.1 of this agenda)

Item V - Supervised Injection Site Community Advisory Group (BOH March 20, 2017, Item 9.2)
(Addressed in Items 7.1 and 7.2 of this agenda)

Item HH - Equity for Trans and Gender Non-Conforming People in Regional Health Care (BOH September 18, 2017, Added Item 9.1)
(Addressed in Item 5.3 of this agenda)

CARRIED

(ii) Correspondence from the Corporation of the City of Kingston, respecting a Motion passed at the Kingston City Council Meeting on November 7, 2017 regarding Naloxone (Added Item 11.3)

(A. Johnson/Merulla)
That the recommendation respecting Correspondence from the Corporation of the City of Kingston, regarding a Motion passed at the Kingston City Council Meeting on November 7, 2017 regarding Naloxone, be amended as follows:

That the Correspondence from the Corporation of the City of Kingston, respecting a Motion passed at the Kingston City Council Meeting on November 7, 2017 regarding Naloxone, be received ***and referred to the Medical Officer of Health and the General Manager, Community and Emergency Services.***

Amendment **CARRIED**

For further disposition, refer to Item 10.

(i) ADJOURNMENT (Item 13)

(Pearson/A. Johnson)
That, there being no further business, the Board of Health be adjourned at 4:49 p.m.
CARRIED

Respectfully submitted,

Mayor F. Eisenberger
Chair, Board of Health

Loren Kolar
Legislative Coordinator
Office of the City Clerk

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	January 15, 2018
SUBJECT/REPORT NO:	Public Health Services 2017 Department Operational Work Plan BOH17002(b) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Jennifer Hohol (905) 546-2424, Ext. 6004
SUBMITTED BY & SIGNATURE:	Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services Department

Council Direction:

Not applicable

Information:

In January 2017, Report BOH17002 highlighted three priority areas of focus for Public Health Services (PHS) in the upcoming year. These priorities included:

- Health System Integration;
- Poverty Reduction; and
- PHS Workplace Culture.

As work began, emerging priorities presented themselves in addition to those originally selected as priority areas of focus including:

- Opioid Response;
- Improved City Services for Vulnerable Populations; and
- Public Health System Change.

Report BOH17002(a) provided a mid-year update on the progress made within each priority area. Additional progress since the last update is provided in the report below.

HEALTH SYSTEM INTEGRATION

PHS continues to focus on engaging with community partners in pursuit of health, improving population health outcomes and addressing health inequities in the community. Strong support for this work has been established through the creation of the Sub-Region Anchor Table for the Hamilton Sub-Region of the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN). The Sub-Region Anchor Table is a collaborative group made up of health and social service leaders working to better integrate services and improve health outcomes in Hamilton. The mandate of the Sub-Region Anchor Table closely aligns with the goals of Patients First and the requirements for public health units to build partnerships within the community, including the LHIN, as established in the new Ontario Public Health Standards (Standards). In addition to PHS, membership on the Sub-Region Anchor Table includes Hamilton Health Sciences, St. Joseph's Healthcare Hamilton, McMaster Department of Family Medicine, McMaster Family Health Team, City of Hamilton Community and Emergency Services Department, Hamilton Community Foundation, HNHB LHIN, McMaster University, community physicians and members of the community.

One of the deliverables of the Sub-Region Anchor Table is to use an integrated population health approach to assess the health and social needs, access and provider capacity in Hamilton. PHS has played a key role within the Sub-Region Anchor Table to create a shared understanding of using a population health approach planning service delivery. PHS has also worked to provide the LHIN and Sub-Region Anchor Table with population health data to bring about a greater understanding of the health and social needs within the Hamilton community. PHS will continue to support the Sub-Region Anchor Table in using population health data to identify shared priorities and deliverables of focus as the work of this group progresses.

Additional information on the Sub-Region Anchor Table and 2018 areas of focus are provided in Appendix A.

POVERTY REDUCTION

With investment on quality and quantity of affordable housing, Community and Emergency Services has taken the lead in implementation of the City of Hamilton's Poverty Reduction Investment Plan. PHS continues to support poverty reduction efforts by developing a pilot of the Families First program (BOH17024) and a communitywide Financial Empowerment Strategy.

The Families First program aims to build opportunities for lone parents and their children to break the cycle of poverty through improved: family stability, mental and physical health, income, and education outcomes. This innovative program will integrate supports between home visiting, child care, Ontario Works, employment, and recreation. A funding application submitted to the Ontario Local Poverty Reduction Fund in June was unsuccessful. Staff across PHS and Community and Emergency

Services are currently developing a program delivery and evaluation plan to pilot the program in 2018 using existing resources.

PHS has collaborated with Community and Emergency Services and a coalition of many community partners, with shared leadership through the Hamilton Roundtable for Poverty Reduction, Social Planning and Research Council, and United Way Halton & Hamilton, to launch a community-wide Financial Empowerment Strategy. Partnership networks have identified more than $42 million annually available through federal and provincial tax benefits not currently accessed by Hamiltonians with low income. In 2017, staff and partners launched a campaign to promote access to tax filing so Hamilton residents can access the full range of their entitled benefits. With the Social Planning and Research Council as the lead applicant, PHS staff applied for and secured $734,400 over three years, through Ontario Trillium Foundation, to support implementation of the Financial Empowerment Problem Solving model in Hamilton. The Financial Empowerment Problem Solving model builds on existing work to reduce system barriers and build cross-sector capacity to ensure Hamiltonians with low income are accessing benefits, information, and resources needed to achieve financial independence.

PUBLIC HEALTH SERVICES WORKPLACE CULTURE

In 2017, the PHS Culture Action Work Group supported the rollout of the City of Hamilton's Our People Survey. This involved the promotion of the survey to all staff and the use of creative ways to encourage and support participation and completion of the survey. As a result, PHS achieved a response rate to the Our People Survey of 88%. Moving forward, the Culture Action Work Group will help to build action plans to implement recommendations based on the results of the survey.

In the area of performance excellence and accountability, PHS has worked to develop a performance measurement plan. This includes the identification of indicators and performance measures to be used to inform the submission of the PHS Annual Service Plan and Budget to the Ministry of Health and Long-Term Care in March 2018. The performance measurement plan will also help to identify gaps where no measurements are in place and use the Results Based Accountability framework to identify ways to continue to measure performance. Indicators within the performance measurement plan will continue to support evidence informed decision making in program planning, identify opportunities for continuous improvement within programs, divisions, or across the department and inform provincial and corporate reporting requirements.

OPIOID RESPONSE

In collaboration with community partners, PHS has continued work to address the opioid crisis based on the three components of the Ministry of Health and Long-Term Care's Harm Reduction Program Enhancement.

The first component focuses on early warning and surveillance of opioid overdoses. An Opioid Surge Response Group with a focus on immediate, short term response actions during surges in opioid activity in Hamilton has been established with representation from PHS, Emergency Medical Services, Hamilton Police Services, Hamilton Health Sciences, St Joseph's Healthcare Hamilton, the HNHB LHIN as well as ad-hoc members as needed.

The second component involves expansion of naloxone distribution and training. As a result of the Harm Reduction Program Enhancement, PHS has been able to expand service hours of the Van Needle Exchange Program. In addition, PHS is working to create an application process where community organizations can apply to receive and be trained to distribute provincially funded naloxone which would increase distribution throughout the community.

Finally, PHS continues to focus on the local opioid response through collaboration with community partners to develop a citywide drug strategy. The collaborative group recently established a governance structure to ensure sustainability of efforts with work groups organized under the four pillars of prevention, harm reduction, treatment and social justice.

IMPROVED CITY SERVICES FOR VULNERABLE POPULATIONS

To continue to understand the needs of the population in Hamilton and support a population health approach, PHS developed a Population Health Assessment and Surveillance Strategy. The goal of this strategy is to use population health information to guide the planning and delivery programs and services within an integrated health system. In 2017, knowledge exchange with key partners on a population health assessment approach to planning and communication and sharing of priority populations through population health assessment products has been a key focus. This has involved the delivery of population health assessment presentations and products to key stakeholders including the City of Hamilton Senior Leadership Team, City of Hamilton Department Leadership Teams, the Board of Health (BOH17030) and the Sub-Region Anchor Table.

In addition, work continues through the City Manager's Office to combine the functions of PHS and Community and Emergency Services with a goal to better serve the citizens of Hamilton through integrated service delivery to achieve the City of Hamilton's Strategy priority of promoting Healthy & Safe Communities.

PUBLIC HEALTH SYSTEM CHANGE

Public health system transformation continues in support of a more integrated role for public health within the health care system. Three major provincial public health transformation initiatives include:

- Modernization of the Ontario Public Health Standards to direct public health program and service delivery;
- Public Health Work Stream to provide guidance on engagement and formalizing relationships between public health units and LHINs; and,
- Expert Panel on Public Health to consider how Public Health is best organized within an integrated health system.

Modernization of the Ontario Public Health Standards

In 2017, PHS staff worked to review the new Standards, collect the best available evidence and make service delivery recommendations based on evidence to ensure Board of Health compliance BOH17010(b).

In addition, to support submission of the Annual Service Plan and Budget BOH17010(d), work has been done to develop:

- A PHS Stakeholder Engagement Plan;
- A PHS Risk Management Framework BOH17039(a);
- Action plans to ensure compliance with the Public Health Accountability Framework and Organizational Requirements (BOH18002); and
- An annual operational planning process to support continued compliance.

PHS will continue to review and assess the impact of newly released protocols and guidelines within the OPHS used to direct service delivery. Implications of these documents will be considered for the 2019 planning process.

Public Health Work Stream

As part of the public health system transformation, a Public Health Work Stream was established to define the expectations for formal engagement between boards of health and the LHIN established within the Patients First Act, 2016. Following consultation, a Report Back from the Public Health Work Stream (Appendix B) was released which will form the basis for the new requirement and associated guideline for Board of Health and LHIN engagement within the Standards.

The Report Back from the Public Health Work Stream, finalized a framework for board of health and LHIN engagement focused on:

- Population health assessment through the collection and analysis of population health data to support health system planning;
- Joint planning for health services to address population needs where public health intersects with broader health care system; and
- Identification of population health initiatives and opportunities to improve population health and equity.

Based on response through the consultation, the preferred approach for board of health governance engagement with the LHIN was through a collaborative model with

representation from all boards of health that are mostly contained within the LHIN boundary. PHS will continue to work with the LHIN and other public health units within the LHIN boundaries to strengthen relationships as per the guidelines provided.

Expert Panel on Public Health

In early 2017, an Expert Panel on Public Health (Expert Panel) was established by the Minister of Health and Long-Term Care to make recommendations for an optimal organizational structure for public health in Ontario and how to best govern and staff this structure. As outlined in Report (BOH17034), the recommendations made by the Expert Panel include proposed organizational change with the creation of fourteen regional public health agencies through the amalgamation of existing public health units. To support a regional organizational structure, a consistent approach to governance would be implemented through the creation of fourteen regional boards of health.

Careful consideration went into reviewing the recommendations made by the Expert Panel and a response for submission to the Minister of Health and Long-Term Care on behalf of Public Health Services was informed by consideration of various position statements from public health and health system partners, deliberations of the Governance Sub-Committee and discussion with the Chair of the Board of Health and the Public Health Champions. The PHS response to the Expert Panel endorsed by the Board of Health is outlined in BOH17034(b) and focused on addressing issues in the public health system, maintaining public health function and maintaining local responsiveness. The Ministry of Health and Long-Term Care is currently considering all feedback that was received as part of the consultation process and will decide on next steps for action.

APPENDICES

Appendix A to Report 17002(b) – Sub-Region Anchor Table Project Charter

Appendix B to Report 17002(b) – Report Back from Public Health Work Stream

Hamilton Community Health Working Group (HCHWG) Anchor Table
Project Charter FINAL (September 18th, 2017)

Background:

The traditional siloed, program-based structures has been shown to lead to isolated treatment by multiple health and social service providers, making it challenging to coordinate care plans, share information to optimize care and ultimately impact patient outcomes.

As a result, the Hamilton Community Health Working Group (HCHWG) was formed in 2016; a collaboration between health and social services leaders, to better integrate health and social services and improve health outcomes using an integrated population health approach.

The HCHWG's integrated population health based approach is well aligned with the Patients First Act and goals of the HNHB LHIN; therefore the HCHWG will be leveraged to achieve the "Patients First" transformational mandate, and become the Anchor Table in the Hamilton sub-region. The Patients First Act focuses on strengthening the role of patients and families in the planning of their own health care needs; and was designed to enable system transformation with a focus on sub-regions[1] as the focal point for: integrated service planning, delivery and equity; primary care; home and community care; public health; and cultural sensitivity in the delivery of health care services to Indigenous peoples and French speaking people.

Project Vision and Objectives:

The HCHWG vision is that: "The health status of the citizens of Hamilton will be amongst the highest in Canada and will be supported by an integrated health care and social support system"

The objective is to use an integrated population health approach (see Appendix A for definition and diagram) to design and deliver health and social services with a person and community focus, to achieve the following outcomes:

- **Strengthen people and caregiver voices** in their own health and social planning to enable person-centred care.
- **Ensure individuals and caregivers can easily navigate through the system** by offering integrated services that break down silos across primary care providers, inter-professional health care teams, hospitals, public health, social services (housing, child care, job skills, income support, recreation) and home and community care.
- **Streamline services** by establishing accountability structures that emphasize continuity of care and fluid team communication.

[1] A sub-region is a geographic area, within a LHIN used for health service planning and evaluation. Sub-Regions will enable health planners and providers to better identify and respond to health care needs of local communities, to ensure that patients are able to access the care they need, when and where they need it.

- **Ensure public health is involved** in the planning and delivery of an integrated population health approach from the individual to the system level, with primary care and local health leaders.
- **Enhance coordination of primary care with other providers** to enable high quality care and increased integration with social and community services.
- **Improve understanding of outcomes and implement a learning and continuous improvement culture** enabled through a clearly defined process for measuring, evaluating and improving services and outcomes.
- **Increase the focus on health promotion, poverty reduction, disease and injury prevention, self-management, and care** for chronic disease and complex needs.
- **Increased focus on the equity of health care service delivery and overall health** for all Hamiltonians. This includes equitable access to care services as well as equity across the social determinants of health.

Project Benefits: The **primary benefits** will be to Hamiltonians and their family/caregivers, who will:

- Feel respected and included in their health and social service system that provides them with care and service; which will be easy to navigate.
- Have access to their primary care provider; their first point of contact to address patient needs, as well as to the broader health and social systems.
- Receive a person focused approach that is tailored to their needs to maximize their health and wellness;
    - And when people do fall ill a range of holistic resources (health and social) will be available in a coordinated, integrated, timely and consistent manner; that is equitable across diverse populations.

A **secondary benefit** will be to the stakeholders (providers, clinicians, social services, funders) and the system with:

- Better optimization and alignment of goals and efforts across organizations to maximize capacity and resources.
- Shared understanding of our community across sectors and our collective challenges, needs, and assets.
- Simplified access to care and services.
- Improved provider experience.
- Ability to facilitate the high quality outcomes desired for patients/clients.
- The ability to create conditions in our community for people to thrive.
- Achieving the vision and outcomes as outlined in this charter.

Project Scope: The HCHWG Anchor Table will primarily be focused on residents in the Hamilton sub-region, initially focusing on three neighbourhoods: Dundas, Rolston, and Stipley.

Project Linkages: This Hamilton sub-region work build on current assets and participating entities; and will link all health and social services, including, but not limited to: academic teaching hospitals, primary

care, public health, social services, the HNHB LHIN, the City of Hamilton, mental health and addictions, child and youth services, affordable housing, homeless shelters, Indigenous services, and police. Ultimately patient needs will determine which services and hence which providers will need to be included (e.g. emergency medical services, rehabilitation, pharmacy, diagnostic services, home and community care, education and Francophone).

Project Deliverables:

1) Use an **integrated population health approach** to holistically assess Hamilton health and social needs, access, and provider capacity, which will result in **identifying key priorities and deliverables,** in alignment with the Ministers Mandate[2] and key policy papers[3],[4],[5]. This will be achieved by:
    a. Forming sub-committees or leveraging existing committees as required to:
        - Operationalize the key priorities including setting goals and work plans
        - Tactically implement the priorities
        - Critically review data, information and community input.
    b. Creating opportunities for partnership and for stakeholders in the sub-region (patients, family/caregivers, Indigenous Peoples, Francophone, health and social providers, and other diverse representatives of Hamilton communities) to interact and provide input.
    c. Testing innovative approaches to care/service delivery by breaking down silos and eliminating fragmentation within and between sectors.
    d. Identifying shared metrics and outcomes for patients, providers and the system; which will be shared with each partners organization and board and be key areas of focus.
    e. Confirming funding and resource requirements to deliver key priorities/deliverables; including alignment of resources.
    f. Completing a stock take of committees and working groups (mandate and deliverables) to ensure awareness, alignment and decision making (pause/continue/integrate) in alignment with the Hamilton sub-region priorities and focus.
    g. Start each meeting with a provider/patient story that crosses both health and social services – keeping all members focused on our shared and collective vision.

2) Patients will be able to access primary care, with an initial focus on the three selected neighbourhoods.

3) Primary care will be aware of and be able to access health and social services when required to support their patients in maximizing their well-being. Potential areas of focus to achieve this deliverable include:

[2] Ministers Mandate Letter - http://www.hnhblhin.on.ca/accountability.aspx
[3] Bringing Care Home - http://health.gov.on.ca/en/public/programs/lhin/docs/hcc_report.pdf
[4] Mapping Wellness: Ontario's Route to Healthier Communities - http://www.health.gov.on.ca/en/common/ministry/publications/reports/cmoh_15/docs/cmoh_15.pdf
[5] Moving Forward:" Better Mental Health means Better Health - http://www.health.gov.on.ca/en/common/ministry/publications/reports/bmhmbh_2016/moving_forward_2016.pdf

a. Development/strengthening of 'community health homes'.
b. Enhanced role of care coordination/access to care coordination imbedded in primary care.
c. Development of whole-person and care pathways.
d. Development of population health asset maps.

Principles guiding the actions of the partnership: The following key principles are endorsed and supported by the HCHWG Partner Organizations:

- **Integrated service delivery**: The model will foster integration of all services contributing to the population's health, inclusive of health care, community care and social services.
- **End-to-end responsibility for a defined population**: The model will ensure that the population's needs are considered holistically, enabling a holistic view of our community's health, as well as the systems and services that influence and service them.
- **Incentivize accountability**: The model will create incentives and formalize inter-organizational commitments that establish accountability for delivery health outcomes.
- **Strong measurement and continuous improvement**: The model will need sophisticated performance measurement focused on monitoring population health and continuous improvement framework to ensure efficient, effective delivery of services.
- We will be **respectful** in our work together recognizing that we may not always agree and will need to have some difficult conversations
- We will be **transparent** in sharing information and data
- We will be **accountable** for our decisions and actions.

Roles and Responsibilities

The transformational nature of this initiative will require leadership and a collective willingness to test new concepts and funding/resource arrangements in a timely and agile way to meet the vision and objectives of the HCHWG Anchor Table and its sub-committees.

Hamilton Community Health Working Group (HCHWG) Anchor Table – The CEOs/Presidents/Executive Directors from the Partner Organizations (Appendix B) will comprise the HCHWG Anchor Table (see Appendix C for the structure) which will:

- Focus at the MACRO level (see Appendix D for a description of population health system approaches at the Macro, Meso and Micro level).
- Set the vision, key priorities, and outcome measures in alignment with the Minister's Mandate.
    - Priorities will be tested with the appropriate communities, stakeholders and providers to ensure bi-directional feedback, and modifications will be made as required.
- Be co-chaired by an "honest broker" – who is action and outcome oriented.
- Identify the structure (including sub-committees) required to operationalize and tactically implement the approved priorities; and dedicate members from each partner organization to comprise membership on required sub-committees.

    - Over time this will result in a shift from a "working board" to a "policy board".
- Accept sub-committee recommendations for actions (e.g. solutions), which may result in partnership and/or funding agreements and alignment of resources.
- Openness and willingness to discuss opportunities for both horizontal and vertical integration.
- Receive regular (quarterly) reports on progress from the sub-committees.
- Develop communications including work plans to keep partner Boards and their organization informed.
- Monitor issues, risks and potential unintended consequences and determine resolution as required.
- Identify legislative and policy barriers to the HNHB LHIN/MOH.
- Ensure there are processes in place to sustain relationships and commitment to the project across sectors.

MESO Level Operations Table –The HCHWG Anchor table may determine the need for a MESO level Operations Table to operationalize their key priorities; the structure will evolve depending on the priorities selected and roles and responsibilities may include:

- Be comprised of leaders (with decision making authority) from the partner organizations (Appendix B), and will report to the HCHWG Anchor Table.
    - Recommend and recruit additional members for the Operations Table as required.
- Develop and execute annual work plans and initiatives in alignment with the HCHWG Anchor Table vision, priorities and deliverables, including the formation of MICRO level Action Tables to implement approved initiatives/projects.
    - Recommend and recruit members for the Action Tables.
    - Seek advice and input regarding system redesign, innovation and ideation from the Action Tables.
- Utilize a collective impact approach that values and encourages diverse participation and will include input from partners, patients, and family/caregivers to:
    - Assess local population health needs, access and provider capacity.
    - Identify and implement sub-region initiatives to address gaps and improve patient experience and outcomes.
    - Build partnerships and create opportunities to provide input into integrated health system plans.
- Monitor dashboards and submit quarterly reports on activity and progress to the HCHWG Anchor Table and LHIN leadership via Hamilton Sub-Region Director.

MICRO Level Action Tables – The HCHWG Anchor table may determine the need for MICRO Level Action Tables to tactically implement the approved priorities and outcomes. The Action Tables will be led by a strategic leader and be comprised of local representatives, including patients, family/caregivers and organizations impacted/involved in the approved initiatives/projects, which will report to the HCHWG Anchor Table and/or Operation Table, and will:

- Provide feedback and input to the HCHWG and/or Operations Table regarding proposed priorities, outcomes and deliverables.
    - Ability to test ideas quickly with neighbourhoods/impacted communities, stakeholders and providers.
- Be encouraged and supported to redesign, innovate, and ideate.
- Use a population health based approach.
- Be responsible for tactically implementing the approved priorities as outlined by the HCHWG Anchor Table and/or Operations Table.
- Have a solid understanding of the larger system (health and social) and context, including the Ministers Mandate.

Hamilton Sub-Region Director – This full time role will support the Hamilton Sub-Region Planning and Integration work. Responsibilities include:

- Providing secretariat support to the HCHWG Anchor Table.
- Co-chairing the Hamilton Operations Table and Action Table(s).
- Providing leadership and oversight to support the development, implementation, and evaluation of the approved initiatives/projects.
- Lead the development and monitor the effectiveness of plans that outline how the project will achieve performance targets set by the HCHWG Anchor Table and its sub-committees.
- Establish relationships through open consultation with acute care, primary care, public health, home and community, Indigenous leaders, health links, city of Hamilton, and other stakeholders as identified.
- Gather, analyze and interpret data related to performance on an ongoing basis,
- In partnership with providers, identify and translate best practices across HNHB LHIN sub-regions.
- Prepare reports and ensure deliverables and timelines are met.

Partner Organizations

- The partner organizations (Appendix B) are fully committed to the success of this project and will provide clear leadership, focus, and resources to meet the goals of the project, which will include:
    - Providing leads for the HCHWG Anchor Table and its sub-committees (e.g. Operations and Action Tables; and physician lead and other team members with skill sets - as required.
    - Identify assets, gaps and opportunities for integration and alignment to achieve the HCHWG Anchor Table vision and MOH priorities and mandates.
    - Actively engage their respective board and quality committee in the development, implementation, and evaluation of the approved initiatives/ projects.
    - Full participation and contribution to patient and family engagement activities.
    - Provide data and information for review and analysis as required and to support the performance/quality improvement component of the project.

HNHB LHIN – The HNHB LHIN has committed to take an active and engaged role including membership on the HCHWG Anchor Table and a leadership role on each of sub-committees. The LHIN will also provide leadership regarding sub-region planning and to achieve the Ministers Mandate.

Hamilton Public Health Services (PHS) – in addition to the roles identified for all partners of the HCHWG, PHS will support the Hamilton Sub-Region Planning and Integration work in alignment with the Patients First Act. Responsibilities include:

- Population Health Assessment - Population health data and analysis to support health system planning, including:
    - Analyses and interpretation of provincially defined/provided core sets of population health indicators to inform sub-region planning ;
    - Additional locally determined analyses to address information needs and planning. Data for these analyses may include data collected federally, provincially or locally by HCHWG partners;
    - Providing knowledge and expertise to interpret and translate health information into health intelligence to inform integrated planning.
- Population Health Initiatives - Identifying opportunities and enabling action to improve population health and equity. Initiatives would address individual, organizational, community and policy levels as appropriate, based on identified need, and supported by evidence, and expected to make a meaningful impact on population health at the sub-region level.

Project Management and Governance

- The project structure is outlined in Appendix C.
- Decisions will be based on consensus. If consensus is not possible, the Chair may call a vote. Each partner organization will be provided one vote/organization. Decisions arrived at by voting will be recorded with the percentage in favor of the decision and the content of any opposing positions. Decisions by consensus or vote require a quorum, set at 50% of members. Ex-officio members will not be eligible for voting.
- The addition of new partners and removal of existing partners will be recommended and endorsed by the HCHWG Anchor Table or recommended by the Operations Table to the HCHWG Anchor Table for review and approval.
- The Project Charter will be reviewed annually and the Director, Sub-Region Planning & Improvement will identify amendments for review/approval by the HCHWG Anchor Table.

Project Milestones and Reporting

Table A provides an overview of the high level project milestones and timelines for the first 24 months (to be updated annually):

Table A. High Level Project Milestones and Timelines

High Level Project Milestones	Q2 FY17	Q3 FY17	Q4 FY17	Q1 FY18	Q2-Q4 FY18
1) Finalize governance, committee structures, project charter and membership	Aug/Sept				
2) Funding request to MOH for operational support	Sept				
3) Identify data committee and request population health review for Hamilton	Sept				
4) Confirm funding for operational support and recruit support (if applicable)	Sept	Oct			
5) 2nd Charrette – Community Engagement and consultation on priorities areas					
6) Priority setting meetings of HCHWG – select up to 3 focused priorities					
7) Stock take of committee's (mandate and deliverables) by all committee organizations to ensure awareness, alignment and decision making (pause/continue/ consolidate) in alignment with the priorities and focus of the HCHWG, LHIN and MOH					
8) Patient/Caregiver/Citizen Engagement					
9) Develop "roadmap" in alignment with sub-region framework (Appendix E) and Ministers Mandate					
10) Develop partnership agreements required to support approved initiatives					
11) Develop common (process and outcome) and shared metrics of performance.					
12) Implement "road map					
13) Confirm IT requirements					
14) Execute communication plan					
15) Data monitoring and reporting					

Metrics The HCHWG Anchor Table will collaborate on indicators and corresponding reporting timelines once priority initiatives have been selected and approved (Table B).

Table B. Indicators (process and outcome) - For Demonstration Purposes**;** to be refined once priority initiatives selected and approved.

Performance Measure	Potential Metric
Patient Experience	Patient Satisfaction % attached to primary care provider Access (e.g. % access primary care after hours, weekends, weekend; same day/next day access)
Provider Satisfaction	Provider satisfaction with ease of referral process Provider satisfaction with availability of resources Provider uptake (# engaged in new model of care)
Population Health	Self-reported indicators (e.g. self-reported health status) Low birth weight rates Economic measures (e.g. # people housed, have obtained jobs etc.)
Cost per patient/person	Hospital days/1000 patients Decrease hospital utilization Decrease social service costs e.g. Ontario Works, subsidized housing, child care

Budget and Resources

This project has submitted a proposal to the MOH for a budget of $475K (one-time) to support the development of whole-person care priorities and pathways, to develop and advance the concept of Community Health Homes, develop implementation plans for 3-4 care pathways and to develop population health asset maps. In the absence of MOH funding, the HCHWG Anchor Table will determine how to proceed and provide operational funding to support the work of the HCHWG Anchor Table and sub-committees.

The HNHB LHIN will provide the following resources to support this project/model:

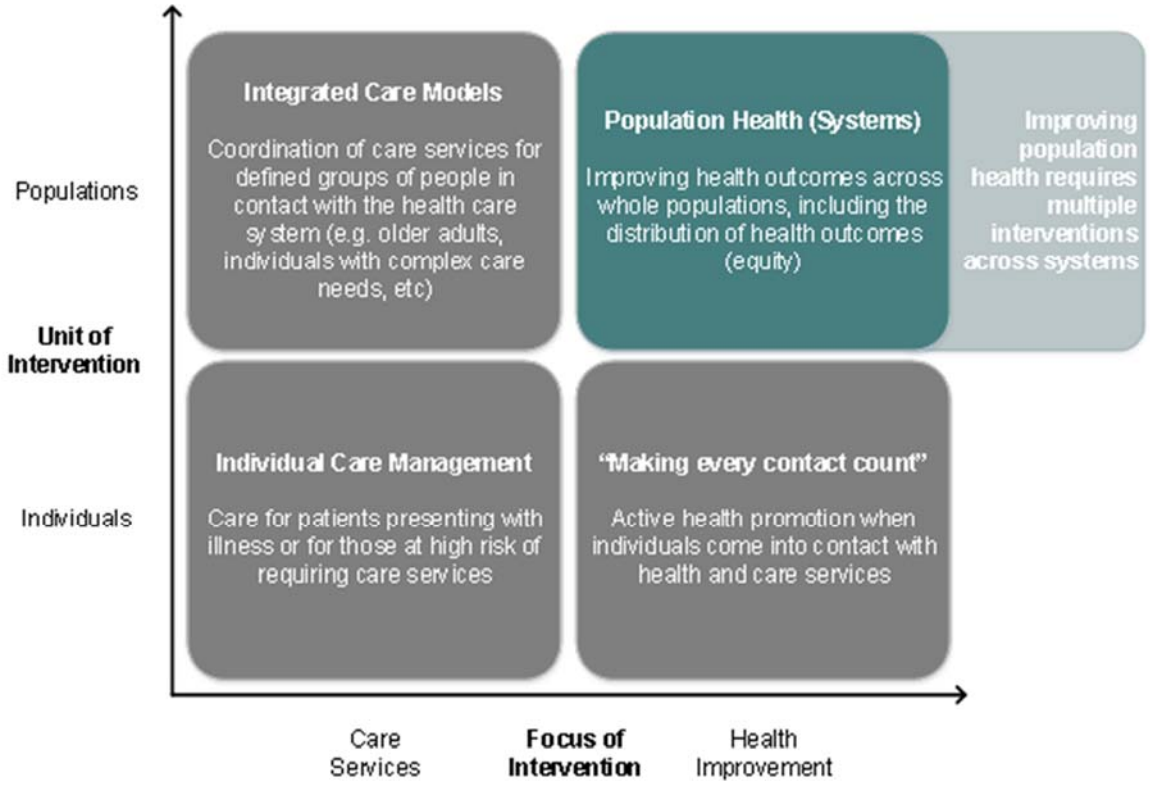
- Director, Sub-Region Planning & Integration (1 FTE);
- Executive support and leadership by the VP Health System Strategy and Integration; and
- Additional support as required by:
    - Hamilton Director, Home and Community
    - Hamilton Sub-Region Clinical Lead.

Approval

- Project Charter dated September 18th, 2017 was approved at the August 21st 2017 Hamilton Community Health Working Group (HCHWG) Anchor Table; with minor revisions requested at the September 18th meeting.

Appendix A. Definition of Integrated Population Health Approach

- Focuses on both the individual and population needs, with a focus on policy and legislation to improve prevention, health promotion, health and well-being and reduce inequities; with improved coordination and participation from system leaders across sectors.
- The person/consumer is engaged and wishing to pursue the outcomes of a population health agenda
- A fundamental shift away from traditionally siloed, activity based model to 'demand driven' where providers are jointly accountable for the outcomes that matter to patients and the broader population within and between sectors.
- Includes comprehensive and holistic health services, interventions on the social determinants of health (e.g. poverty, homelessness, hunger) and linkages to the appropriate services across the community.
- Action and alignment across different ministries, local communities and individuals; including alignment of resources.



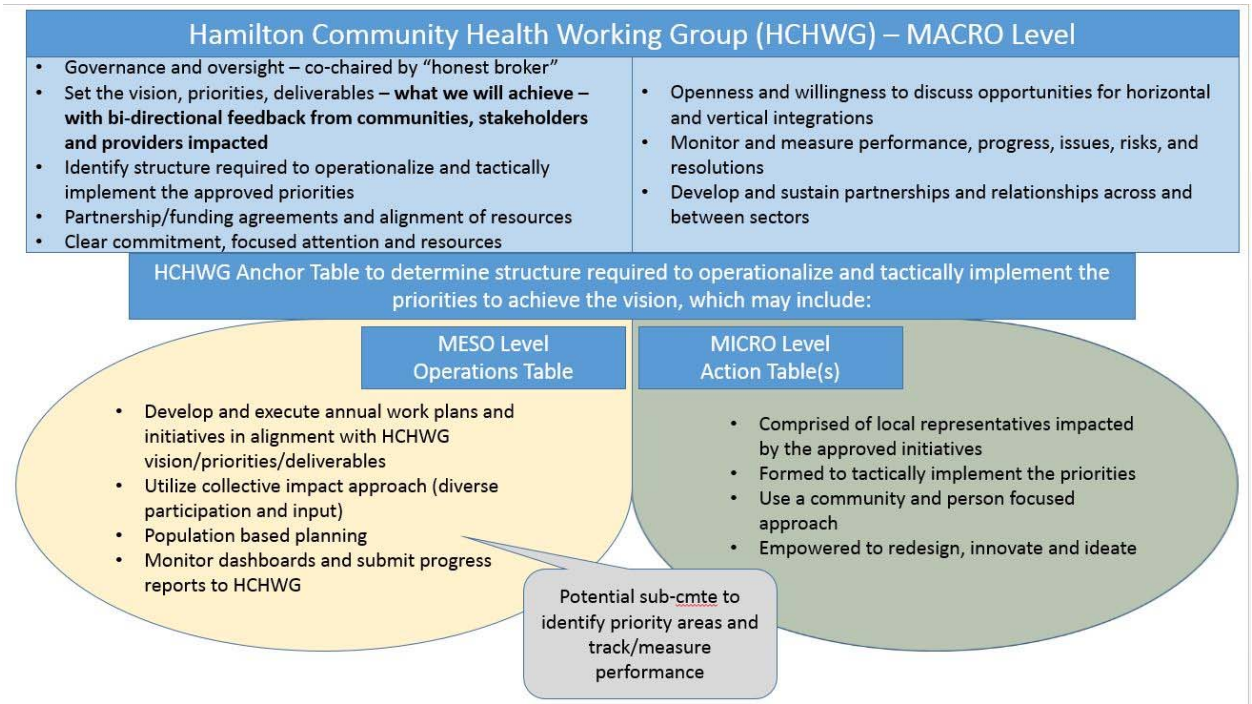
Adapted from Alderwick, H., Ham, C., and Buck, D. 2015. Population health systems: Going beyond integrated care.

Appendix B. Hamilton Community Health Working Group Anchor Table Membership

Sector	Organization	HCHWG Anchor Table Name/Role
Acute Care	Hamilton Health Sciences (HHS)	Rob MacIsaac (President & CEO) Dick McLean (EVP and CME) Sharon Pierson (VP) Sandra Ramelli (Director)
Acute Care	St. Joseph's Healthcare Hamilton (SJHH)	Kevin Smith (CEO) Dr. David Higgins (President)
Primary Care	Department of Family Medicine, McMaster University and HHS	David Price (Professor and Chair)
Primary Care	Hamilton Family Health Team	Terry McCarthy(ED) Monica De Benedetti (Lead Physician)
Primary Care	McMaster Family Health Team & McMaster Family Practice	Cathy Risdon (Co-Lead and Co-Director)
Primary Care	Community Physician	Tammy Packer (Community Family Physician)
Child & Youth Mental Health and Addictions (MCYS/ Lead Agency)	Lynwood Charlton Centre	Alex Thomson (Executive Director)
Public Health	City of Hamilton	Elizabeth Richardson (Medical Officer of Health)
Municipality/Region	City of Hamilton	Chris Murray (City Manager)
Ministry of Children and Youth Services/Ministry of Community and Social Services/Ministry of Education	City of Hamilton	Grace Mater (Community and Emergency Services Department, Children's and Home Management Services Division) Vicki Woodcox (Acting General Manager for Community Emergency Services – City of Hamilton
Social Services	Hamilton Community Foundation	Terry Cooke (President & CEO)
Local Health Integration Network	Hamilton, Niagara, Haldimand, Brant (HNHB)	Donna Cripps (CEO) Martina Rozsa (VP, Home and Community) Rosalind Tarrant (VP, Health System Strategy & Integration) Laura Wheatley (Director, Hamilton Sub-Region)
University/Education	McMaster University	Jim Dunn (Professor, Dept. Chair of the Dept. of Health, Aging & Society; Director, McMaster Institute for Healthier Environments)
Community Members		Jackie Aird Carolann Fernandes Ross Rosier

*Note: The HCHWG recognizes the importance of engaging diverse stakeholders, and that membership will evolve over time and at different levels. As a result, multiple strategies will be used to ensure stakeholders are included in the planning, implementation and evaluation of the priority areas of focus.

Appendix C. Structure for HCHWG Anchor Table



Appendix D. Description of the Macro, Meso and Micro Level Approaches to Population Health

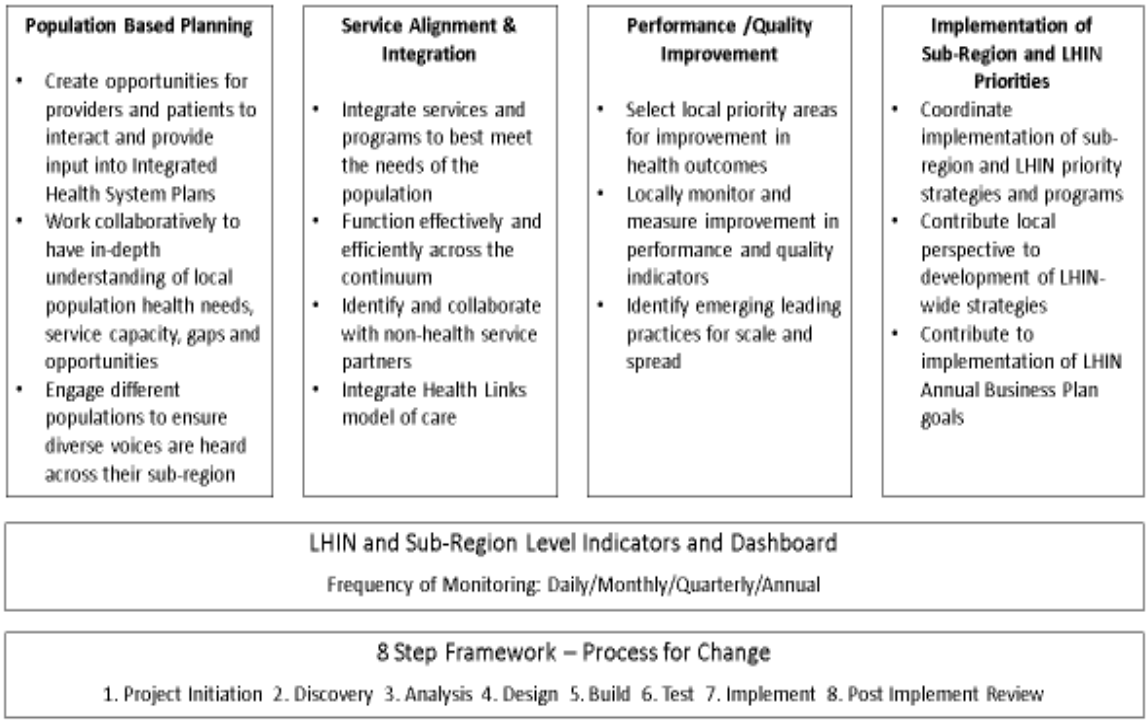
MACRO Level:
- Population level data to understand needs across populations and track health outcomes (big dots)
- Involve a range of partners across systems to improve health outcomes for defined population groups
- Balance improving health across whole of population + targeting specific interventions for most deprived groups (e.g. 3 neighbourhoods, frail elderly, mentally ill)
- Community involvement

MESO Level
- Population segmentation and risk stratification to identify then needs of different groups within the population
- Targeted strategies for improving the health of different population segments
- Developing 'systems within systems' with relevant organizations, services and stakeholders to focus on different aspects of population health

MICRO Level Interventions aimed at improving the health of individuals within the populations they service (e.g. case management, housing support etc)
- Integrated health record to coordinate people's care services
- Scaled up primary care systems that provide access to wide range of services and coordinate effectively with other services
- Close working across organizations and systems
- Close working with individuals to understand the outcomes and services that matter to them

Adapted from Alderwick, H., Ham, C., and Buck, D. 2015. Population health systems: Going beyond integrated care.

Appendix E. HNHB LHIN Sub-Region Framework



Appendix F. Charter Endorsement – Signatures of HCHWG Anchor Table members

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: Hamilton Community Foundation

Terry Cooke

Terry Cooke
President & CEO
Hamilton Community Foundation
120 King Street West, Suite 700
Hamilton, ON L8P 4V2

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: Hamilton Niagara Haldimand Brant Local Health Integration Network

Donna Cripps

Donna Cripps
Chief Executive Office
HNHB LHIN

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: McMaster Institute for Healthier Environments

James R. Dunn, Ph.D.
Director
McMaster Institute for Healthier Environments
McMaster University KTH 226
1280 Main St. West, Hamilton, ON L8S 4M4

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: St. Joseph's Healthcare Hamilton

Name Dr. David Higgins
Title President
Affiliated Organization Name and Address
St. Joseph's Healthcare
Hamilton, Ontario L8N 4A6

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: HAMILTON HEALTH SCIENCES CORPORATION

[Insert signature(s)]

Name: Rob MacIsaac
Title: President and CEO
Affiliated Organization Name and Address: Hamilton Health Sciences Corporation
King West Site
P.O. Box 2000
Hamilton, ON L8P 1A3

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: CITY OF HAMILTON

[Insert signature(s)]

Name GRACE MATER
Title DIRECTOR
Affiliated Organization Name and Address CITY OF HAMILTON
28 James St N 4th Fl.
HAMILTON ON PO 2040
L8P 4Y5

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: Hamilton Family Health Team

Name Terry McCarthy
Title Executive Director
Affiliated Organization Name and Address Hamilton Family Health Team
123 James Street North, 3rd Floor
Hamilton, ON L8R 2K8

Name Dr. Monica De Benedetti
Title Lead Physician
Affiliated Organization Name and Address Hamilton Family Health Team
123 James Street North, 3rd Floor
Hamilton, ON L8R 2K8

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: Hamilton Health Sciences

Name Dr. Richard McLean
Title EVP and Chief Medical Executive
Affiliated Organization Name and Address
- Hamilton Health Sciences, King West. Suite 23—P.O. Box 2000, Hamilton, ON L8N 3Z5

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: City of Hamilton

[Insert signature(s)]

Name Chris Murray
Title City Manager
Affiliated Organization Name and Address
City of Hamilton
71 Main Street West
Hamilton ON L8P 4Y5

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: Dr. Tamar Packer

[Insert signature(s)]

Name Dr. Tamar Packer
Title N/A
Affiliated Organization Name and Address
Individual Community Physician

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: Hamilton Health Sciences

Sharon Pierson
Vice President, Community Medicine & Population Health
Hamilton Health Sciences, St. Peter's Hospital
88 Maplewood Avenue, Hamilton, ON L8M 1W9

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: McMaster University

[Insert signature(s)]

Name DAVID PRICE
Title PROFESSOR & CHAIR, DEPT OF FAMILY MEDICINE
Affiliated Organization Name and Address

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: Hamilton Health Sciences

[Insert signature(s)] Sandra Ramelli

Name Sandra Ramelli
Title ~~Director, Office of the CEO~~ & Organizational Development
Affiliated Organization Name and Address

Hamilton Health Sciences
1200 Main St. West
Hamilton, ON
L8N 3Z5

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: City of Hamilton, Public Health Services

E. Richardson

Dr. Elizabeth Richardson, MD, MHSc, FRCPC
Medical Officer of Health

City of Hamilton, Public Health Services
110 King Street West, 2nd Floor
Hamilton, Ontario
L8P 4S6

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: McMaster Family Medicine
Department of Family Medicine

[Insert signature(s)]

Name DR. CATHY RISDON
Title ACTING CHAIR
Affiliated Organization Name and Address DEPT. OF FAMILY MEDICINE
McMASTER UNIVERSITY
100 MAIN ST. W. 6TH FL DBHSC
HAMILTON, ON L8P 1H6

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: Retired, Project Executive, IBM Canada's Healthcare Innovation Centre

In partnership with Hamilton Health Sciences

[Insert signature(s)]

Name Ross Rosier
Title: Community Member, Retired IBM Project Executive, IBM Hamilton Healthcare Innovation Centre, in Partnership with Hamilton Health Sciences.

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: HNHB LHIN

[Insert signature(s)]

Name MARTINA RUZSA
Title VP HEALTH SYSTEM STRATEGY & INTEGRATION.
Affiliated Organization Name and Address

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: St. Joseph's Healthcare Hamilton

[]

Name Kevin Smith
Title President and CEO
Affiliated Organization- St. Joseph's Healthcare Hamilton
50 Charlton Ave. E.
Hamilton, ON
L8N 4A6

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: Lynwood Charlton Centre, Lead Agency for MOMH –Hamilton Service Area

[Insert signature(s)]

Name G.P. Alex Thomson
Title Executive Director
Affiliated Organization Name and Address
Lynwood Charlton Centre
526 Upper Paradise Road
Hamilton, Ontario
L9C 5E3

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: HNHB LHIN

[Insert signature(s)]

Name Laura Wheatley
Title Director, Hamilton Sub-Region.
Affiliated Organization Name and Address

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: City of Hamilton

Name: Vicki Woodcox
Title: Acting General Manager, Community & Emergency Services Department
Address: 28 James St. N., 4th floor, Hamilton, ON L8R 2K1

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: HAMILTON NIAGARA HALDIMAND BRANT (HNHB) LOCAL HEALTH INTEGRATION NETWORK. (LHIN

[Insert signature(s)] Rosalind Tarrant

Name ROSALIND TARRANT
Title VP HEALTH SYSTEM STRATERGY + INTEGRATION
Affiliated Organization Name and Address
HNHB LHIN
211 PRITCHARD RD
HAMILTON L8J 0G5

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: Community Member.

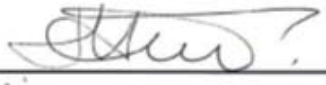
[Insert signature(s)] Carolann Fernandes.

Name Carolann Fernandes
Title Community member
Affiliated Organization Name and Address

Endorsement for the Hamilton Community Health Working Group (HCHWG) Anchor Table Project Charter

The following organization endorses the HCHWG Anchor Table Project Charter

Name of Organization: _____

[Insert signature(s)] 

Name Jacqueline AIRD
Title Community Member
Affiliated Organization Name and Address

Ministry of Health and Long-Term Care

Assistant Deputy Minister's Office

Population and Public Health Division
777 Bay Street, 19th Floor,
Toronto ON M7A 1S5

Telephone: (416) 212-8119
Facsimile: (416) 212-2200

Ministère de la Santé et des Soins de longue durée

Bureau du sous-ministre adjoint

Division de la santé de la population et de la santé publique
777, rue Bay, 19e étage
Toronto ON M7A 1S5

Téléphone: (416) 212-8119
Télécopieur: (416) 212-2200

November 15th, 2017

MEMORANDUM TO : Ontario Medical Officers of Health
Board of Health Chairs

FROM : Roselle Martino
Assistant Deputy Minister, Population and Public Health Division,
Ministry of Health and Long-Term Care

SUBJECT: Release of the Public Health Work Stream Report Back

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I am pleased to share with you the *Report Back from the Public Health Work Stream*. As you are aware, the *Patients First Act, 2016* introduced new requirements for Medical Officers of Health (MOH) and the Chief Executive Officers (CEO) of Local Health Integration Networks (LHINs) to support the integration of a population health approach into the broader health system.

The Public Health Work Stream was established to define parameters and expectations for implementing formal engagement between boards of health and LHINs. Consultation with MOHs and LHIN CEOs on a draft of the document occurred throughout the summer and fall and informed the final version of the *Report Back from the Public Health Work Stream*. Thank you for your participation in the consultation

Please note that the Public Health Work Stream Report Back will form the basis of the requirement and associated guideline for Boards of Health in the modernized standards. In addition, work is currently underway with Public Health Ontario to oversee the development of provincially defined and centrally provided population health indicators to inform public health and LHIN collaboration.

I also wish to acknowledge the contributions of Michael Barrett as the co-chair of the Public Health Work Stream and thank the Public Health Work Stream members listed below for their advice and input.

- Chantale LeClerc, CEO, Champlain LHIN
- Margery Konan, Pan-LHIN Lead
- Elizabeth Salvaterra, Pan-LHIN Lead
- Dr. Penny Sutcliffe, Council of Medical Officers of Health
- Dr. David McKeown, Associate CMOH, MOHLTC
- Dr. Liana Nolan, MOH, Region of Waterloo
- Linda Stewart, Executive Director, Association of Local Public Health Agencies

I look forward to continuing our work together as we strengthen the connection between public health and the health system.

Sincerely,

Roselle Martino
Assistant Deputy Minister
Population and Public Health Division
(Co-Chair, Public Health Work Stream)

Report Back from the Public Health Work Stream

November 2017

Ministry of Health and Long-Term Care

Ontario

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Executive Summary

The Public Health Work Stream was established to define parameters and expectations for implementing formal engagement between boards of health and LHINs, as a result of the *Patients First Act, 2016.*

The Public Health Work Stream has developed initial guidance to support implementation, considering:

- Across the province there is **variability** among boards of health and LHINs and in their existing relationships
- There is a need to provincially define **minimum expectations** for the scope and intensity of the relationship while promoting **innovative thinking** among boards of health and LHINs.
- The relationship between LHINs and boards of health will be iterative and **evolve over time,** however guidance is needed to help get started and to achieve a level of consistency across the province.
- Processes and structures put in place should be sufficiently **flexible** to adapt to change over time.
- LHINs and boards of health require **ongoing commitment and support** to foster productive and strong relationships.

The Public Health Work Stream has developed a framework for board of health and LHIN engagement:

1. **Population Health Assessment:** Population health data and analysis to support health system planning, which includes:
    - Provincially defined and centrally provided core set of population health indicators to inform public health and LHIN collaborations.
    - At the local level, additional public health and LHIN defined analyses to address information needs.
    - Knowledge and expertise that interprets and translates health information to inform integrated planning.

2. **Joint Planning for Health Services:** Orienting health services to address population needs. This includes:

- Planning for programs and services where public health has traditionally intersected with the broader health care system (e.g. immunization, sexual health).
- Influencing all types of health system planning and decision making to reflect population needs.

3. **Population Health Initiatives**: Identifying opportunities and enabling action to improve population health and equity.

The Public Health Work Stream developed options for an initial approach to structuring the relationship between boards of health and LHINs that promote engagement of all boards of health within a LHIN boundary, and apply to as many LHINs and boards of health as possible.

The preferred approach that emerged through consultation was for a **collaborative model with representation from all boards of health that are mostly contained within the LHIN boundary**.

Introduction

The *Patients First Act, 2016* introduced new requirements for Medical Officers of Health (MOHs) and the Chief Executive Officers (CEOs) of Local Health Integration Networks (LHINs) to support the integration of a population health approach into the broader health system.

The Public Health Work Stream, made up of a project team with representation from public health, LHINs and the Ministry of Health and Long-Term Care, was established to define parameters and expectations for implementing formal engagement between boards of health and LHINs (see membership in Appendix 1).

As part of its work, the Work Stream is outlining an initial approach to support MOHs and LHIN CEOs as they begin implementing the new requirements.

The term "boards of health" refers to the local public health agencies which are legislatively obligated to deliver public health services as per *the Health Protection and Promotion Act, 1990*. While boards of health are often referred to as "public health units," a public health unit is legally defined as the geographic area that is served by a board of health.

Legislative Context

The *Patients First Act 2016* aims to strengthen links between population and public health and the health system to achieve:

- Health service delivery that better reflects population needs
- Public health and health care service delivery that is better integrated
- Social determinants of health and health equity incorporated into care planning
- Stronger linkages between disease prevention, health promotion and care

To do this, the *Patients First Act, 2016* included parallel amendments to the *Health Protection and Promotion Act,1990* (HPPA) and the *Local Health System Integration Act, 2006* (LHSIA) to mandate the establishment of formal linkages between MOHs and LHIN CEOs. The *Patients First Act, 2016,* specifies a requirement between MOHs and LHIN CEOs. It is expected that engagement will occur at multiple levels between boards of health and LHINs (e.g. staff, management and governance), as appropriate.

Legislative Amendements

Health Protection and Promotion Act	Local Health System Integration Act
The medical officer of health of a board of health shall engage on issues relating to local health system planning, funding and service delivery with the chief executive officer or chief executive officers of the local health integration network or networks whose geographic area or areas cover the health unit served by the board of health.	A local health integration network shall ensure that its chief executive officer engages with each medical officer of health for any health unit located in whole or in part within the geographic area of the network, or with the medical officer of health's delegate, on an ongoing basis on issues related to local health system planning, funding and service delivery.

The *Patients First Act, 2016* also included amendments to LHSIA to integrate a population health approach into the objects of LHINs, including:

- to promote health equity, including equitable health outcomes, to reduce or eliminate health disparities and inequities, to recognize the impact of social determinants of health, and to respect the diversity of communities and the requirements of the French Language Services Act in the planning, design, delivery and evaluation of services
- to participate in the development and implementation of health promotion strategies in cooperation with primary health care services, public health services and community-based services to support population health improvement and outcomes

Implementation

In 2017, structural changes to the health system are taking effect as a result of the *Patients First Act, 2016.* This includes the transfer of Community Care Access Centre services and staff to LHINs. Alongside these changes, MOHs and LHIN CEOs are to begin establishing their formal linkages between themselves and their respective organizations.

The Public Health Work Stream has identified the following factors that impact implementation of the requirement to establish formal linkages:

- Across the province there is **variability** among boards of health and LHINs and in their existing relationships.
- There is a need to provincially define **minimum expectations** for the scope and intensity of the relationship while promoting **innovative thinking** among boards of health and LHINs.
- The relationship between LHINs and boards of health will be iterative and **evolve over time,** however guidance is needed to help get started and to achieve a level of consistency across the province.

- Processes and structures put in place should be sufficiently **flexible** to adapt to change over time.
- LHINs and boards of health require **ongoing commitment and support** to foster productive and strong relationships.

Based on these considerations, the Public Health Work Stream has developed initial guidance to support implementation of this requirement, including a framework for board of health and LHIN engagement and options for the structure of the relationship.

The proposed framework for board of health and LHIN engagement has been developed considering the current structure and organization of public health. The timing of the Public Health Work Stream was concurrent with the Expert Panel on Public Health, which had a mandate to provide advice to the minister on the structure, organization and governance for public health. The Public Health Work Stream provided its advice on MOH and LHIN CEO engagement independent of the Expert Panel process.

Framework for Board of Health and LHIN Engagement

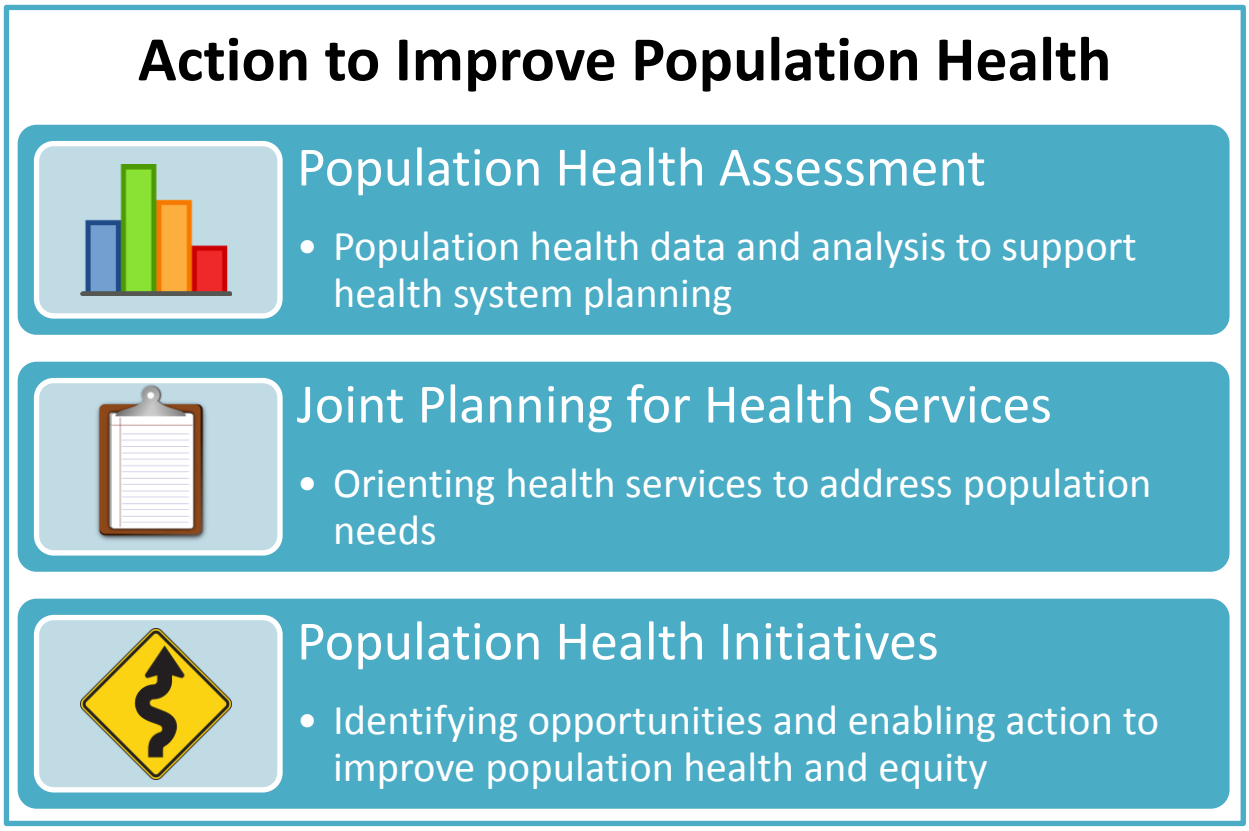
The framework for board of health and LHIN engagement provides guidance on how MOHs and LHIN CEOs can implement the requirement in the *Patients First Act, 2016* for formal engagement, and support LHINs in implementing their new objects related to health equity and health promotion. To this relationship, boards of health bring a population health perspective, population health assessment skills, and knowledge of local communities' needs, assets and opportunities to inform health system planning. Public health's equity focus can articulate and highlight trends and drivers in the differences in health among population groups, while bringing intelligence and insights on the social factors that underlie health, disease, and the use of health services. The public health sector has fostered strong relationships with non-health sector actors including municipalities, education, and social services, which are essential to protecting and promoting the health of local populations.

LHINs bring their own set of strengths to the relationship, in their role in planning, funding, and integrating the local health system. For example, LHINs may be able to bring health system partners to the table to support initiatives that reduce duplication

and improve health service delivery for the population. A population health perspective can be translated into areas of impact that LHINs oversee and build on their existing work related to health equity and health promotion.

The intent of the requirement is for LHIN CEOs and MOHs to make a commitment for engagement that has weight and significance and includes regular opportunities to meet, inform and influence their organizations' work. The engagement is meant to be mutually beneficial. Boards of health and LHINs should contribute to each other's mandates, where relevant and helpful.

The following outlines the three primary components of the framework for board of health and LHIN engagement.



Population Health Assessment

Population health assessment provides the evidence and information to support the integration of a population health approach into health system planning and evaluation.

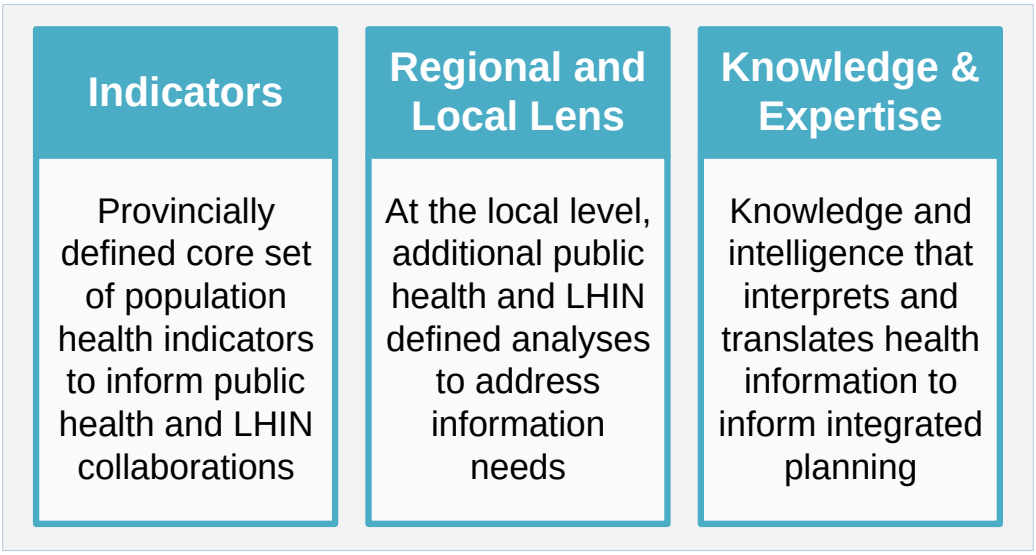
Both LHINs and boards of health, among other health system actors, play a role in population health assessment. Population health assessment promotes the use of data and evidence on population health, equity and the upstream determinants as important criteria in LHIN and board of health priority setting and decision making. For more information on the population health approach and population health assessment see Appendix 2.

Joint work on population health assessment should inform planning at all levels, including LHIN region and sub-region levels, and public health unit.

- At the LHIN region level, population health assessment should inform priority setting and decision making on implementation of health services, design of new health services and resource allocation over the LHIN region to address the population health and equity needs.
- At the LHIN sub-region level, population health assessment should influence the same decisions within the sub-region including the integration of health service providers to better meet the health service needs of local communities and improve equity.
- At the public health unit level, population health assessment should draw on health system data to inform planning for program and service delivery.

A sub-region is a smaller geographic planning region within each LHIN to help LHINs better understand and address patient needs at the local level. Sub-regions enable a more focused approach to assessing population health need and service capacity, help identify variation in health disparities and health system performance, assist in identifying local factors that inhibit health system improvement, and provide a structure to public and provider engagement.

The following figure outlines the core components of population health assessment within the context of the board of health and LHIN relationship.



- There will be a provincially defined and centrally provided set of **population health indicators** to help inform public health and LHIN collaboration. A core data set will be provided to LHINs and all boards of health that fall within the geographic boundaries of the LHIN. The population health indicators reflect core population health domains and will be broken out by socio- demographic stratifiers, if available. See Appendix 3 for more information on proposed population health indicators.

The ministry will be working together with Public Health Ontario (PHO) to oversee development of provincially defined and centrally provided population health indicators to inform board of health and LHIN collaboration.

- Boards of health and LHINs will apply their **regional and local lenses** in their joint work by using additional, locally defined data and analyses that are needed to inform planning and decision-making. Data for these analyses may include data collected federally, provincially or locally by the board of health or LHIN.
- Both boards of health and LHINs will bring their **knowledge and expertise** to population health assessment. This knowledge and intelligence can be applied to interpret and translate the data and analyses to inform integrated planning that reflects a population health approach.

Joint Planning for Health Services

The relationships between MOHs and LHIN CEOs set the foundation for joint planning on health service delivery for both health care services and public health services. Public health programs and services have traditionally intersected with the broader health care system in a number of specific areas (see examples below). Joint planning can occur at these intersection points. This can facilitate the alignment of public health and health care service delivery to address the population needs specific to LHIN and LHIN sub-regions, and public health units. This planning may address clinical services traditionally provided by public health and whether boards of health are the service provider best positioned to fill service gaps within the health unit area. It could also include identifying and leveraging synergies in health service delivery that exist among LHINs, boards of health and their partners.

Examples of Public Health and Health Care Intersections

- Maternal and child health
- Falls prevention
- Chronic disease prevention, including diabetes
- Sexual health
- Emergency planning
- Outbreak management
- Immunization
- Infectious and communicable disease prevention and control
- Primary care
- Referral pathways
- Harm reduction
- Opioid strategy
- Vulnerable and priority populations

The population health perspective should influence health system planning and decision making, as appropriate, to orient health service delivery in response to population needs

identified through population health assessment. Joint planning should include a focus on equity and the drivers of health inequities in the LHIN region, sub-region, and public health unit areas. The needs of priority populations, including Indigenous and Francophone communities, should be considered and addressed. Planning activities can include priority setting and decision making on the implementation of health services, design of new health services and resource allocation over the LHIN region to address the population health and equity needs. Boards of health and LHINs should be engaged in the development of one another's strategic plans.

Population Health Initiatives

Working collectively, boards of health and LHINs should identify opportunities to improve the health of the population. The relationship between LHINs and boards of health promotes the inclusion of diverse perspectives and ideas into planning structures to identify actionable solutions to population health issues. Population health initiatives may draw on the levers and expertise that LHINs have that public health has not been able to benefit from, and vice versa. Both LHINs and boards of health have relationships and collaborations with other system actors that could be drawn upon to support joint work on population health.

LHINs and boards of health may choose to take action at different levels to improve population health, including at the individual, organizational, community and policy levels, as appropriate. Initiatives should address an identified need, supported by evidence, which is recognized by both the LHINs and boards of health and that would benefit from the involvement of both organizations. Solutions identified should be expected to make a meaningful impact on population health in the LHIN region, sub-region or public health unit.

Examples of initiatives LHINs and boards of health may take are provided below. It is expected that as the relationship between boards of health and LHINs is strengthened, more diverse and innovative actions will be undertaken.

Examples of Action to Improve Population Health

- Generation of locally specific population health data to support both LHIN and public health service planning and evaluation
- Collaboration on intersectoral action to address the social determinants of health

- Leveraging the influence that LHINs have as a funder of health service provider agencies, each of which is an employer of staff with a potential to institute health promoting workplace policies
- Implementing organizational learning to develop competencies of staff and a workplace culture that is attuned to population health, health equity and the determinants of health

Board of Health and LHIN Engagement Model

The Public Health Work Stream deliberated on approaches and considerations to strengthen the relationship between boards of health and LHINs. Proposed options for engagement were developed based on the following principles:

- To ensure engagement of all boards of health within a LHIN boundary.
- Applicable in as many LHINs and boards of health as possible to establish a level of consistency.
- Offering an initial approach to strengthening the relationship between LHINs and boards of health.

A number of options for structuring engagement between LHINs and boards of health were proposed during consultation with medical officers of health and LHIN CEO's. The preferred approach that emerged was for a **collaborative model with representation from all boards of health that are mostly contained within the LHIN boundary**. This model will allow each board of health to have a direct relationship with their LHIN partners.

Next steps

- **For public health:** This report back will be developed into a Guideline, as part of the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability, to provide direction on how boards of health must approach the new requirement to engage with LHINs, as outlined in the HPPA.
    - The ministry is working together with Public Health Ontario (PHO) to oversee development of provincially defined and centrally provided population health indicators to inform board of health and LHIN collaboration. The intention is to work from the initial population health indicator categories as proposed in this report back and facilitate access

to a suite of population health indicators that will support PHUs and LHIN engagement.
    - A committee is being established and will have representation from PHO, the Association of Public Health Epidemiologists of Ontario, LHINs, public health units, and the ministry's Population and Public Health Division and Health Analytics Branch.

- A LHIN/Board of Health Relationship Working Group through LHIN Renewal Transformation will continue to support ongoing engagement between public health and LHINs

- **For LHINs:** This report back will provide guidance on how to achieve their new legislative requirements to engage with MOHs, as outlined in LHSIA.
    - The Performance and Data Work Stream has also developed a report-back discussion paper with recommendations for developing LHIN accountability measures, which include public health. This paper will serve as an input into the existing ministry and LHIN process for negotiating a refreshed Ministry-LHIN Accountability Agreement (MLAA) for 2018-19 and beyond. Including a parallel and reciprocal requirement in the MLAA, as was done in the public health standards, demonstrates that the relationship between Boards of Health and LHINs can be actualized.

Appendix 1: Public Health Work Stream Membership

Co-Chairs

- Michael Barrett, CEO, South West LHIN
- Roselle Martino, Assistant Deputy Minister, Population and Public Health Division (PPHD), MOHLTC

Members

- Chantale LeClerc, CEO, Champlain LHIN
- Margery Konan, Pan-LHIN Lead
- Elizabeth Salvaterra, Pan-LHIN Lead
- Dr. Penny Sutcliffe, Council of Medical Officers of Health
- Dr. Liana Nolan, MOH, Region of Waterloo
- Dr. David McKeown, Associate CMOH, MOHLTC
- Linda Stewart, Executive Director, Association of Local Public Health Agencies
- Jackie Wood, Director, Planning & Performance Branch, PPHD
- Colleen Kiel, Manager, Systems Planning & Integrated Strategy, PPHD

Appendix 2: Population Health Approach and Population Health Assessment

The Public Health Agency of Canada (PHAC) defines population health as, "an approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups"[1] Taking a population health approach means the focus is on the health of populations and sub-populations, including those who are patients, those who use health services, and those who do not. A population health approach recognizes the full range of factors that influence health and disease, including the social, economic and environmental determinants. As a result, upstream actions and investments, at the root causes of health and disease, are considered to have a greater potential for improvements in population health.

A population health **approach** is an overall perspective that puts the health and equity needs of the population and communities at the centre of planning, so that decision-making and health system changes address those needs. The Public Health Agency of Canada has developed an organizing framework that outlines eight elements of the population health approach. See http://cbpp-pcpe.phac-aspc.gc.ca/population-health-approach-organizing-framework/#acc for more information.

Population health **assessment** is one mechanism in which that perspective is applied. Population health assessment provides the evidence and information to support the integration of a population health approach into health system planning. Population health assessment is defined as "understanding the health of communities or specific populations, as well as the factors that underlie good health or pose potential risks, to produce better policies and services."[2] It includes the measurement, monitoring, analysis, and interpretation of population health data, knowledge and intelligence on the health status of populations and sub populations, including the social determinants of health and health inequities.

[1] http://www.phac-aspc.gc.ca/ph-sp/approach-approche/index-eng.php

[2] http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2008/fr-rc/cphorsphc-respcacsp05a-eng.php

Appendix 3: Population Health Indicator Categories

Categories for a Proposed Initial Set of Indicators

Population	Social Environment	Built and Natural Environment	Mortality and Morbidity	Chronic Disease and Mental Health
• Population Demographics • Population Growth • Language	• Labour Force/ Employment • Income/Wealth • Housing and Food Security • Family Arrangements • Education	• Population Density • Physical Activity and Recreation Environments • Environmental Degradation	• Mortality by Cause • Life and Health Expectancy • Self-Rated Health • Disability	• Screening • Cancer • Other Chronic Diseases • Depression

Injury and Substance Use	Behaviour	Reproductive Health	Child Health	Infectious Diseases
• Injury by cause • Falls • Drugs • Suicide and Self-Harm	• Smoking • Alcohol • Physical Activity • Unsafe Sex	• Birth and fertility • Birth outcomes • Pregnancy	• Early Development • Well-Baby Visit	• Immunization • Influenza • Gastrointestinal Disease • STIs

Appendix 4: Relationship Building between LHINs and Boards of Health

This appendix outlines how LHINs and boards of health can build a strong working relationship, in alignment with the objectives set forth in the *Patients First Act, 2016.* The stages of relationship building outline below is intended to promote collaboration and information sharing for an enhanced understanding of each other's roles, responsibilities and areas of mutual interest.

Stages of Relationship Building

No.	Stage	Description
1	Starting the conversation	LHIN CEO and MOH(s) introduction, LHIN and board of health overview, including organizational structure, existing and future committees, councils and tables, planning cycle, current initiatives; identify options for terms of engagement, including how multiple boards of health will be engaged (if applicable), and frequency of MOH(s) and LHIN CEO meeting
2	Knowledge transfer	Sharing strategic plans, operational plans, key priorities, and current partnerships
3	Taking action	Identifying opportunities and options for joint initiatives (for example, IHSP, local population health assessment)
4	Consensus building	Developing a formal agreement or MOU for planned joint initiatives
5	Issues management	Managing problems, emerging issues and developing the relationship

LHIN-hosted committees, councils and tables:

The following list is an inventory of LHIN-hosted committees, councils and tables that are possible conduits for public health engagement. However there is significant variation based on local needs, and varying provider communities and local leadership:

- LHIN Boards (and committees of the board)
- Patient and Family Advisory Council (forthcoming)
- Health Professionals Advisory Council

The following tables are not mandated, but are convening in similar ways across LHINs in support of planning and integration goals:

- Senior management team
- Sub-region integration tables
- Health Links leadership tables at the regional LHIN level
- Sector-based planning tables at the regional LHIN level (e.g. Hospital, Community Support Services, Community Mental Health, CHC, Primary Care, CCAC)
- Program-based planning tables (e.g. Child & Maternal Health, Telemedicine, Indigenous Engagement Tables)
- Project-based tables at the regional LHIN level (e.g. Reducing readmissions to hospital, integrated funding models)
- Pan-LHIN tables have been formed as well across leadership roles and program area (may currently be on hold, pending refreshed organizational charts across the LHINs)

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	January 15, 2018
SUBJECT/REPORT NO:	Ontario Public Health Standards Modernization - Organizational Requirements Compliance Assessment BOH17010(c) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Jennifer Hohol, (905) 546-2424, Ext. 6004
SUBMITTED BY & SIGNATURE:	Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services Department

Council Direction:

Not Applicable.

Information:

Background

As outlined in BOH17010(b), in addition to the new Ontario Public Health Standards (Standards), the Ministry of Health and Long-Term Care (MOHLTC) has developed a Public Health Accountability Framework and organizational requirements to ensure boards of health have the necessary foundations in place to successfully carry out public health work and achieve population health outcomes. The Public Health Accountability Framework and organizational requirements are included within Chapter 3: Strengthened Accountability of the most recent version of the Standards released in November 2017 (Appendix A).

The organizational requirements fall within the four domains of:

- Delivery of Programs and Services;
- Fiduciary Requirements;
- Good Governance and Management Practices; and,
- Public Health Practice.

An assessment was conducted by staff to determine Hamilton Public Health Services' (PHS) Board of Health compliance with the organizational requirements. Overall, the Board of Health was compliant with the majority of the requirements throughout all domains. Many of the areas identified as partially compliant will be become fully compliant upon submission of the Annual Service Plan and Budget to the MOHLTC in March 2018. Further compliance will be achieved through the development and implementation of a formal annual planning process within PHS to inform public health program and service delivery. Areas of partial or non-compliance are outlined in the report below with action plans for compliance will be achieved. The full assessment of compliance is provided in Appendix B.

Organizational Requirements Compliance Assessment

Domain One: Delivery of Programs and Services

Requirement	Action for Compliance
Undertake population health assessment including identification of priority populations, social determinants of health and health inequities, and measure and report on them.	Will be compliant by ensuring that population health assessment and health equity are built into new annual planning process as well as implementation of the PHS Population Health Assessment and Surveillance Strategy (PHAS). The goal of the PHAS Strategy is to use population health information to guide the planning and delivery of public health programs and services within an integrated health system. In order to achieve this, the strategy focuses on: Understanding the health of Hamiltonians, sharing information on health status within PHS and with community partners, providing leadership to facilitate decision making in public health program and health system planning and strengthening the community to ensure everyone has the same opportunity for wellness.
Describe programs of public health intervention and the information used to inform them.	Will be compliant following submission of the Annual Service Plan and Budget in March 2018.
Publicly disclose results of all inspections or other required information.	PHS is working to make required inspection results publicly available through the Open Data Work Group at the City of Hamilton.
Collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities, and report and disseminate the data and information.	Will be compliant by ensuring that monitoring of indicators and performance measures will be built into new annual planning process. Execution of the PHAS Strategy will support reporting and dissemination of data and information.

Requirement	Action for Compliance
Strategic plan that establishes priorities over 3-5 years includes input from staff, clients, and community partners	Future iterations of multi-year business plan will include input from clients and community partners, supported by the PHS Stakeholder Engagement Plan.

Domain Two: Fiduciary Requirements

The Board of Health is currently meeting all requirements within this domain.

Domain Three: Good Governance and Management Practices

Requirement	Action for Compliance
Board of Health members shall disclosure to the ministry an actual, potential, or perceived conflict of interest.	PHS is working with the MOHLTC to understand and establish a process for disclosure moving forward.
Establish human resource strategy.	Additional work throughout 2018 focused on workforce assessment and development will increase compliance.
Human resource policies and procedures that are regularly reviewed and revised, and include the date of the last review / revision.	Establish regular review / revisions of policies through future Service Level Agreements with Human Resources.
Engage in relationships with Indigenous communities in a way that is meaningful for them.	Will look to the City of Hamilton Urban Indigenous Strategy to inform meaningful engagement.
Provide population health information to stakeholders.	Execution of the PHAS Strategy as previously described.
Develop and implement policies / by-laws (delegation of the medical officer of health duties during short absences such as during vacation / coverage plan).	Department policy in development.
Ensure by-laws and policies and procedures are reviewed and revised at least every two years.	Department policies will be reviewed every two years. Service Level Agreements with Finance & Administration, Information Technology Services and Human Resources will be updated to include expectation to update policies every two years for those policies developed within shared service areas.
Implement policies / procedures for privacy and security, data collection and records management.	Update and approval of department privacy, data collection and records management policies.

Domain Four: Public Health Practice

Requirement	Action for Compliance
Systematic process to plan public health programs and services.	Will be compliant with the development and implementation of a PHS annual planning process.
Employ qualified public health professionals in accordance with the Qualifications for Public Health Professionals Protocol, 2018.	Protocol in development by Ministry. Will review protocol for compliance when it becomes available.
Support a culture of excellence in professional practice and ensure a culture of quality and continuous organizational self-improvement.	Implementation of a PHS Continuous Quality Improvement Framework, build review of performance measures into annual planning and develop process to measure client, community and stakeholder / partner experience.

Common to All Domains

Requirement	Action for Compliance
Submit an Annual Service Plan and Budget.	Will be compliant following submission of the Annual Service Plan and Budget in March 2018.
Produce an annual financial and performance report to the general public.	Plan in place to develop annual report for 2017. Posting of report to City of Hamilton website following Board of Health approval in April 2018.

Transparency and Demonstrating Impact

In the most recent version of the Standards, a new chapter entitled Transparency and Demonstrating Impact was introduced. As part of this chapter, a draft Public Health Indicator Framework was developed by the province as a way to monitor progress and measure the success of boards of health. The Public Health Indicator Framework includes indicators used to measure program performance and assess public health's contribution to population health outcomes. At this time few details are known regarding the Public Health Indicator Framework including whether the identified indicators will be mandatory for reporting, if there will be provincial coordination for data collection and if these indicators will replace the Accountability Agreement Indicators previously reported on. Feedback on the Public Health Indicator Framework was encouraged by the MOHLTC and a response was submitted on behalf of PHS.

In addition, a draft Transparency Framework was also introduced to promote public confidence in the public health system through mandatory disclosure of the work that public health does to protect and promote individual and community health. As outlined

in the Transparency Framework, boards of health would be required to post on their public websites results of routine and complaint based inspections of:

- Food premises;
- Public pools and spas;
- Recreational water facilities;
- Personal services settings;
- Tanning beds;
- Recreational camps;
- Licensed child care settings; and,
- Small drinking water systems.

Boards of health will also be expected to post on their public websites:

- Convictions of tobacco and e-cigarette retailers;
- Infection prevention and control lapses;
- Drinking water advisories for small drinking water systems; and,
- Status of beach water quality.

Currently, routine inspection data for food premises, infection prevention and control lapses, drinking water advisories for small drinking water systems and the status of beach water quality are available to the public. All other inspection data identified for mandatory disclosure within the Transparency Framework is not made available to the public at this time. PHS is working in collaboration with the Open Data Work Group at the City of Hamilton to develop processes to make available all identified inspection and conviction data to the public.

The Transparency Framework will also require boards of health to demonstrate to the public how they are responding to local community needs through the public posting of the public health unit's strategic plan and an annual performance and financial report. The City of Hamilton's strategic plan is available on the City of Hamilton website and the PHS multi-year business plan will be made available publicly through the budget process. An annual performance and financial report for 2017 is in development and will be posted on the City of Hamilton website following approval by the Board of Health in April 2018.

APPENDICES

Appendix A to BOH17010(c) – Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (Chapters 3 and 4)

Appendix B to BOH17010(c) – Organizational Requirements Compliance Assessment

Strengthened Accountability

Strengthened Accountability

Public Health Accountability Framework

The **Public Health Accountability Framework** (Figure 5) outlines the parameters and requirements to hold boards of health accountable for the work they do, how they do it, and the results achieved. It articulates the expectations of the ministry of boards of health to promote a transparent and effective accountability relationship. Enhanced accountability supports the implementation of public health programs and services by ensuring boards of health have the necessary foundations related to the delivery of programs and services, financial management, governance, and public health practice. It also supports a strong public health sector that can provide evidence of the value of public health and its contribution to population health outcomes leading to better health for Ontarians.

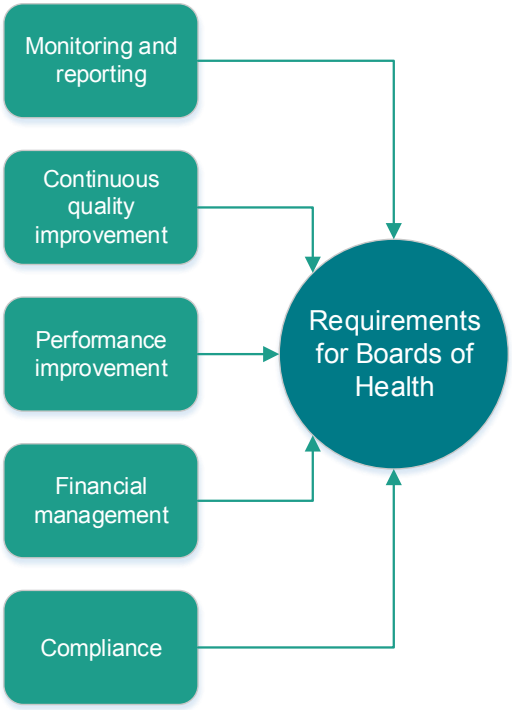
The Organizational Requirements specify the requirements where monitoring and/or reporting are required of boards of health to demonstrate accountability to the ministry. They are organized according to the following four domains of the accountability framework:

- Delivery of Programs and Services;
- Fiduciary Requirements;
- Good Governance and Management Practices; and
- Public Health Practice.

Figure 5: Public Health Accountability Framework

The Accountability Framework is composed of four Domains				
Domain	**Delivery of Programs and Services**	**Fiduciary Requirements**	**Good Governance and Management Practices**	**Public Health Practice**
Objectives of Domain	Boards of health will be held accountable for the delivery of public health programs and services and achieving program outcomes in accordance with ministry published standards, protocols, and guidelines.	Boards of health will be held accountable for using ministry funding efficiently for its intended purpose.	Boards of health will be held accountable for executing good governance practices to ensure effective functioning of boards of health and management of public health units.	Boards of health will be held accountable for achieving a high standard and quality of practice in the delivery of public health programs and services.

Organizational Requirements incorporate one or more of the following functions:



The Accountability Framework is supported by:	
Accountability Documents	• **Organizational Requirements:** Set out requirements against which boards of health will be held accountable across all four domains. • **Ministry-Board of Health Accountability Agreement:** Establishes key operational and funding requirements for boards of health.
Planning Documents	• **Board of Health Strategic Plan:** Sets out the 3 to 5 year local vision, priorities and strategic directions for the board of health. • **Board of Health Annual Service Plan and Budget Submission:** Outlines how the board of health will operationalize the strategic directions and priorities in its strategic plan in accordance with the Standards.
Reporting Documents	• **Performance Reports:** Boards of health provide to the ministry regular performance reports (programmatic and financial) on program achievements, finances, and local challenges/issues in meeting outcomes. • **Annual Report:** Boards of health provide to the ministry a report after year-end on the affairs and operations, including how they are performing on requirements (programmatic and financial), delivering quality public health programs and services, practicing good governance, and complying with various legislative requirements.

Organizational Requirements incorporate one or more of the following functions:

- **Monitoring and reporting** to measure the activities and achievements of boards of health and assess the results (to demonstrate value and contribution of public health);
- **Continuous quality improvement** to encourage changes in processes, address identified problems, and improve efficiency and effectiveness;
- **Performance improvement** to ensure boards of health achieve the best results possible and contribute to local, provincial, and population health outcomes;
- **Financial management** to ensure that resources are used efficiently and in line with local and provincial requirements; and
- **Compliance** to ensure boards of health meet ministry expectations for required activities articulated in legislation, standards, funding agreements, and policies.

Accountability across the domains is demonstrated through accountability, planning, and reporting tools, including: Ministry-Board of Health Accountability Agreements; Board of Health Strategic Plan; Board of Health Annual Service Plan and Budget Submission; performance and other ad hoc reports; and an annual report. These tools enable boards of health to demonstrate that they comply with all legal requirements and provide appropriate oversight for public funding and resources. They also support the achievement of a high standard and quality of public health practice and good governance and management practices that provide the foundation for the effective delivery of public health programs and service. Furthermore, they demonstrate the value that Ontarians receive for the funding invested in public health, and how that investment contributes to population health outcomes for all Ontarians.

Organizational Requirements

The Organizational Requirements are those requirements where reporting and/or monitoring are required of boards of health to demonstrate accountability to the ministry.

The ministry uses a range of reporting and measurement approaches to assess board of health compliance with these requirements, including:

- Routine board of health audits and year-end attestations;
- Narrative reports and documentation; and
- Indicators and other metrics.

Delivery of Programs and Services Domain

Boards of health are held accountable for the delivery of public health programs and services and achievement of program outcomes in accordance with the Foundational and Program Standards and incorporated protocols and guidelines.

Objective of Requirements

The ministry has a responsibility to ensure that boards of health are delivering mandated programs and services that reflect a level of provincial consistency and local flexibility, and that the services delivered are effective in achieving their intended purposes.

Requirements

1. The board of health shall deliver programs and services in compliance with the Foundational and Program Standards.
2. The board of health shall comply with programs provided for in the *Health Protection and Promotion Act*.
3. The board of health shall undertake population health assessments including identification of priority populations, social determinants of health and health inequities, and measure and report on them.
4. The board of health shall describe the program of public health interventions and the information used to inform them including how health inequities will be addressed.

5. The board of health shall publicly disclose results of all inspections or other required information in accordance with the Foundational and Program Standards.
6. The board of health shall 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.
7. The board of health shall collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities, and report and disseminate the data and information in accordance with the Foundational and Program Standards.
8. The board of health shall have a strategic plan that establishes strategic priorities over 3 to 5 years, includes input from staff, clients, and community partners, and is reviewed at least every other year.

Fiduciary Requirements Domain

Boards of health are held accountable for using ministry funding efficiently for its intended purpose.

Objective of Requirements

The ministry has a responsibility to ensure that public health funding is used in accordance with accepted accounting principles, legislative requirements, and government policy expectations.

The ministry must also ensure that boards of health make efficient use of public resources by delivering high quality, effective program interventions, ensuring value for money.

Requirements

1. The board of health shall comply with the terms and conditions of the Ministry-Board of Health Accountability Agreement.
2. The board of health shall provide costing information by program.
3. The board of health shall submit budget submissions, quarterly financial reports, annual settlement reports, and other financial reports as requested.
4. The board of health shall place the grant provided by the ministry in an interest bearing account at a Canadian financial institution and report interest earned to the ministry if the ministry provides the grant to boards of health prior to their immediate need for the grant.
5. The board of health shall report all revenues it collects for programs or services in accordance with the direction provided in writing by the ministry.
6. The board of health shall report any part of the grant that has not been used or accounted for in a manner requested by the ministry.
7. The board of health shall repay ministry funding as requested by the ministry.
8. The board of health shall ensure that expenditure forecasts are as accurate as possible.
9. The board of health shall keep a record of financial affairs, invoices, receipts and other documents, and shall prepare annual statements of their financial affairs.
10. The board of health shall comply with the financial requirements of the *Health Protection and Promotion Act* (e.g., remuneration, informing municipalities of financial obligations, passing by-laws, etc.), and all other applicable legislation and regulations.
11. The board of health shall use the grant only for the purposes of the *Health Protection and Promotion Act* and to provide or ensure the provision of programs

and services in accordance with the *Health Protection and Promotion Act*, Foundational and Program Standards, and Ministry-Board of Health Accountability Agreement.

12. The board of health shall spend the grant only on admissible expenditures.
13. The board of health shall comply with the *Municipal Act, 2001* which requires that boards of health ensure that the administration adopts policies with respect to its procurement of goods and services. All procurement of goods and services should normally be through an open and competitive process.
14. The board of health shall ensure that the administration implements appropriate financial management and oversight which ensures the following are in place:
    a) A plan for the management of physical and financial resources;
    b) A process for internal financial controls which is based on generally accepted accounting principles;
    c) A process to ensure that areas of variance are addressed and corrected;
    d) A procedure to ensure that the procurement policy is followed across all programs/services areas;
    e) A process to ensure the regular evaluation of the quality of service provided by contracted services in accordance with contract standards; and
    f) A process to inform the board of health regarding resource allocation plans and decisions, both financial and workforce related, that are required to address shifts in need and capacity.
15. The board of health shall negotiate service level agreements for corporately provided services.
16. The board of health shall have and maintain insurance.
17. The board of health shall maintain an inventory of all tangible capital assets developed or acquired with a value exceeding $5,000 or a value determined locally that is appropriate under the circumstances.
18. The board of health shall not dispose of an asset which exceeds $100,000 in value without the ministry's prior written confirmation.
19. The board of health shall not carry over the grant from one year to the next, unless pre-authorized in writing by the ministry.
20. The board of health shall maintain a capital funding plan, which includes policies and procedures to ensure that funding for capital projects is appropriately managed and reported.
21. The board of health shall comply with the Community Health Capital Programs policy.

Good Governance and Management Practices Domain

Boards of health are held accountable for executing good governance practices to ensure effective functioning of boards of health and management of public health units.

Objective of Requirements

The organizational requirements within this domain support the use of recommended best practices in governance and organizational processes. By adhering to these practices, boards of health are able to improve the quality and effectiveness of programs and services, prioritize the allocation of resources, improve efficiency, and strive for resiliency in their organizational culture.

Requirements

1. The board of health shall submit a list of board members.
2. The board of health shall operate in a transparent and accountable manner, and provide accurate and complete information to the ministry.
3. The board of health shall ensure that members are aware of their roles and responsibilities and emerging issues and trends by ensuring the development and implementation of a comprehensive orientation plan for new board members and a continuing education program for board members.
4. The board of health shall carry out its obligations without a conflict of interest and shall disclose to the ministry an actual, potential, or perceived conflict of interest.
5. The board of health shall comply with the governance requirements of the *Health Protection and Promotion Act* (e.g., number of members, election of chair, remuneration, quorum, passing by-laws, etc.), and all other applicable legislation and regulations.
6. The board of health shall comply with the medical officer of health appointments requirements of the *Health Protection and Promotion Act*, and the ministry's policy framework on medical officer of health appointments, reporting, and compensation.
7. The board of health shall ensure that the administration establishes a human resources strategy, which considers the competencies, composition and size of the workforce, as well as community composition, and includes initiatives for the recruitment, retention, professional development, and leadership development of the public health unit workforce.
8. The board of health shall ensure that the administration establishes and implements written human resource policies and procedures which are made

available to staff, students, and volunteers. All policies and procedures shall be regularly reviewed and revised, and include the date of the last review/revision.

9. The board of health shall engage in community and multi-sectoral collaboration with LHINs and other relevant stakeholders in decreasing health inequities.
10. The board of health shall engage in relationships with Indigenous communities in a way that is meaningful for them.
11. The board of health shall provide population health information, including social determinants of health and health inequities, to the public, community partners, LHINs, and health care providers in accordance with the Foundational and Program Standards.
12. The board of health shall develop and implement policies or by-laws regarding the functioning of the governing body, including:
    a) Use and establishment of sub-committees;
    b) Rules of order and frequency of meetings;
    c) Preparation of meeting agenda, materials, minutes, and other record keeping;
    d) Selection of officers;
    e) Selection of board of health members based on skills, knowledge, competencies and representatives of the community, where boards of health are able to recommend the recruitment of members to the appointing body;
    f) Remuneration and allowable expenses for board members;
    g) Procurement of external advisors to the board such as lawyers and auditors (if applicable);
    h) Conflict of interest;
    i) Confidentiality;
    j) Medical officer of health and executive officers (where applicable) selection process, remuneration, and performance review; and
    k) Delegation of the medical officer of health duties during short absences such as during a vacation/coverage plan.
13. The board of health shall ensure that by-laws, policies and procedures are reviewed and revised as necessary, and at least every two years.
14. The board of health shall provide governance direction to the administration and ensure that the board of health remains informed about the activities of the organization on the following:
    a) Delivery of programs and services;
    b) Organizational effectiveness through evaluation of the organization and strategic planning;
    c) Stakeholder relations and partnership building;

d) Research and evaluation;

e) Compliance with all applicable legislation and regulations;

f) Workforce issues, including recruitment of medical officer of health and any other senior executives;

g) Financial management, including procurement policies and practices; and

h) Risk management.

15. The board of health shall have a self-evaluation process of its governance practices and outcomes that is completed at least every other year. Completion includes an analysis of the results, board of health discussion, and implementation of feasible recommendations for improvement, if any.

16. The board of health shall ensure the administration develops and implements a set of client service standards.

17. The board of health shall ensure that the medical officer of health, as the designated health information custodian, maintains information systems and implements policies/procedures for privacy and security, data collection and records management.

Public Health Practice Domain

Boards of health are held accountable for achieving a high standard and quality of practice in the delivery of public health programs and services.

Objective of Requirements

The organizational requirements within this domain include some of the key requirements of the Effective Public Health Practice Standard within the Foundational Standards, and support the fostering of a culture of excellence in professional practice with boards of health.

A culture of quality and continuous organizational self-improvement is part of effective public health practice, which underpins effective program interventions, and therefore is necessary for the achievement of the desired goals and outcomes of public health programs and services.

Requirements

1. The board of heath shall ensure that the administration establishes, maintains, and implements policies and procedures related to research ethics.
2. The board of health shall designate a Chief Nursing Officer.
3. The board of health shall demonstrate the use of a systematic process to plan public health programs and services to assess and report on the health of local populations describing the existence and impact of health inequities and identifying effective local strategies to decrease health inequities.
4. The board of health shall employ qualified public health professionals in accordance with the *Qualifications for Public Health Professionals Protocol, 2018* (or as current).
5. The board of health shall support a culture of excellence in professional practice and ensure a culture of quality and continuous organizational self-improvement. This may include:
    a) Measurement of client, community, and stakeholder/partner experience to inform transparency and accountability; and
    b) Regular review of outcome data that includes variances from performance expectations and implementation of remediation plans.

Common to All Domains

The following list of organizational requirements contains those that are relevant to all four domains of the Public Health Accountability Framework, and have been grouped together here to avoid duplication.

Requirements

1. The board of health shall submit an Annual Service Plan and Budget Submission to include all programs and services delivered by boards of health and program costing for ministry-funded programs.
2. The board of health shall submit action plans as requested to address any compliance or performance issues.
3. The board of health shall submit all reports as requested by the ministry.
4. The board of health shall have a formal risk management framework in place that identifies, assesses, and addresses risks.
5. The board of health shall produce an annual financial and performance report to the general public.
6. The board of health shall comply with all legal and statutory requirements.

Transparency and Demonstrating Impact

4

Transparency and Demonstrating Impact

In addition to the accountability planning and reporting tools, the ministry uses indicators to monitor progress and measure success of boards of health. The **Public Health Indicator Framework** (Figure 6) describes the indicators that are used to monitor progress in the delivery of public health programs and services, measure achievement of program outcomes, and assess public health's contributions to population health outcomes.

Measurement at the program outcome level measures the impacts achieved through direct delivery of public health programs and services by boards of health (i.e., by meeting the requirements in the Foundational and Program Standards). Impacts can include changes in awareness, knowledge, skills, and behaviors of populations, service delivery agents, and community partners, as well as changes in environments and policies. Indicators that will be used at the provincial level to measure achievement of outcomes per standard are listed in the **Public Health Indicator Framework** (Figure 6). Boards of health shall establish program outcome indicators locally for those standards that allow for variability to respond to local needs, priorities, and contexts (i.e., Chronic Disease Prevention and Well-Being, Healthy Growth and Development, School Health, and Substance Use and Injury Prevention). The Foundational Standards underlie and support all Program Standards; therefore, it is expected that the outcomes of the Foundational Standards will be achieved through the effective delivery of programs and services.

It is expected that the achievement of program outcomes will contribute to the achievement of population health outcomes. Measurement at the population health outcome level includes measures of improved health and quality of life, reduced morbidity and premature mortality, and reduced health inequities amoung population groups as articulated in the **Framework for Public Health Programs and Services** (Figure 2).

Figure 6: Draft Public Health Indicator Framework[22]

Goal	To provide an evidence-informed basis for monitoring progress and measuring success of boards of health in achieving program outcomes, and understanding the contribution to population health outcomes
Objectives	• Monitoring progress in the delivery of public health programs and services • Measuring board of health success in achieving program outcomes • Assessing public health's contributions to population health outcomes

Indicator and Information

Contribution to Population Health Outcomes	Program Outcomes	
Improved Health & Quality of Life • Adoption of healthy lifestyle behaviours • Perceived health • Health expectancy • Life satisfaction	**Chronic Disease Prevention and Well-Being; Healthy Growth and Development; School Health; Substance Use and Injury Prevention**	• Locally determined program outcome indicators • Indicators will be developed in accordance with locally determined programs of public health interventions
	Food Safety	• # of reported cases of foodborne illness • % reported cases of foodborne illness attributed to exposure settings of (i.e., food premises, daycares, homes, etc.) • % of food handlers trained and certified in food safety • % food-borne illness caused by unsafe food handling in the home
Reduced Morbidity and Mortality • Overweight/Obesity • Incidence and prevalence of chronic diseases • Chronic disease and substance use related morbidity and mortality • Life expectancy • Avoidable deaths • Infant mortality • Small for gestational age • Rate per 100,000 of VPD outbreaks by disease • Incidence rates of reportable VPDs • % of the public with confidence in immunization programs	**Healthy Environments**	• % of the public with knowledge of the impact of climate change locally, particularly heat related illness • % of the public with knowledge of and positive behaviours related to the impact of air quality on health using the AQHI • % of the public with awareness and knowledge about the health risks of radon in indoor air quality • % of the public with awareness of the risk of cancer related to exposure to solar ultraviolet radiation • % of priority populations who are aware of increased risk for adverse health effects related to high heat events
	Immunization	• % of doses wasted by publicly funded vaccine annually • % of 7 and 17 year olds vaccinated for all ISPA designated diseases • % of students with a valid religious or conscience exemption by ISPA designated disease annually • % of immunization providers of publicly funded vaccines indicating they have adequate information to support optimal immunization practices • % of inspected vaccine storage locations that meet storage and handling requirements

Reducing Health Inequities among Population Groups
• Relative index of inequality associated with:
  ○ Chronic Diseases
  ○ Injuries
  ○ Substance Use
  ○ Healthy Growth and Development
• Vulnerability associated with:
  ○ Early development
  ○ School readiness
• Deprivation Index
• Food Security
• Disability Rates
	Infectious and Communicable Diseases Prevention and Control	• # of Ceftriaxone prescriptions distributed for treatment of gonorrhea annually
		• # and type of IPAC lapse by sector (PSS, dental office, community laboratories or independent health facility)
		• # and rate per 100,000 of new active TB infections annually
		• # of cases of acquired drug-resistance among active TB cases
		• # of cases of identified LTBI that are initiating prophylaxis and/or the number completing treatment
		• # of potential rabies exposures investigated by health units annually
		• # of animals investigated that are current on their rabies vaccination
		• # of persons given rabies post-exposure prophylaxis (PEP)

	Safe Water	• # of days that fluoride levels were below recommended levels at municipal drinking water systems that add fluoride • # of drinking water advisories (DWAs) and boil water advisories (BWA) issued by days advisories were in effect • % of the public who use private drinking water supplies (e.g., private wells) who are aware of how to safely manage their own drinking water systems • # of small drinking water systems where risk categories change from high risk to moderate or low risk indicating improvement in system performance • % of days per season beaches are posted

[22]The Indicator Framework is draft and subject to change.

To support enhanced transparency in the public sector and promote public confidence in the public health system, boards of health are required to ensure public access to pertinent information through disclosure. The purposes of public disclosure include: helping the public to make informed decisions to protect their health; and sharing information about the work of boards of health and associated level of investment. The **Transparency Framework** (Figure 7) summarizes the types of information that boards of health are required to publicly disclose in accordance with the Foundational and Program Standards and Organizational Requirements.

Figure 7: Draft Transparency Framework[23]

Goal	Promote awareness, understanding, and public confidence in Ontario's public health system.	
Domains	**Protecting the Public's Health**	**Public Reporting**
Objectives	The public knows of the work of public health to protect and promote individual and community health	The public knows how Boards of Health are responding to local community needs

BOH Responsibilities	Post on the board of health website:
	• Results of routine and complaint based inspections of:
	  ○ Food Premises
	  ○ Public Pools and Spas
	  ○ Recreational Water Facilities
	  ○ Personal Services Settings
	  ○ Tanning Beds
	  ○ Recreational Camps
	  ○ Licensed Child Care Settings
	  ○ Small Drinking Water Systems
	• Convictions of tobacco and e-cigarette retailers
	• Infection prevention and control lapses
	• Drinking water advisories for small drinking water systems
	• Status of beach water quality
		Post on the board of health website:
		• Strategic Plan
		• Annual performance and financial report

[23]The Transparency Framework is draft and subject to change.

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Ontario Public Health Standards: Organizational Requirements Compliance Assessment

The Organizational Requirements are those requirements where reporting and/or monitoring are required of boards of health to demonstrate accountability to the ministry. The Organizational Requirements are part of the Ontario Public Health Standards within Chapter 3: Strengthened Accountability.

The legend below was used to assess Hamilton Public Health Services' Board of Health compliance with the Organizational Requirements.

Exceeding – Actions exceed expectations of the requirement.
Meeting – All aspects of the requirement are being met.
Partial Compliance – Some aspects of the requirement are being met.
Non-Compliant – The requirement is not being met.

Domain One: Delivery of Programs and Services

Boards of health are held accountable for the delivery of public health programs and services and achievement of program outcomes in accordance with the Foundational and Program Standards and incorporated protocols and guidelines.

The ministry has a responsibility to ensure that boards of health are delivering mandated programs and services that reflect a level of provincial consistency and local flexibility, and that the services delivered are effective in achieving their intended purposes.

Organizational Requirement	Compliance	Evidence to Support Compliance / Action
The board of health shall deliver programs and services in compliance with the Foundational and Program Standards.		Staff have reviewed requirements within the Standards and have proposed recommendations for action to move into compliance where requirements are not met.
The boards of health shall comply with programs provided for in the Health Protection and Promotion Act (HPPA).		Ongoing compliance maintained.
The board of health shall undertake population health assessments including identification of priority populations, social determinants of health and health inequities, and measure and report on them.		Staff have identified priority populations and assessed health equity. This information will inform the Annual Service Plan & Budget submission as well as other reporting requirements as requested by the ministry. **Action:** Will be compliant by ensuring that population health assessment and health equity are built into proposed annual planning process.

Organizational Requirement	Compliance	Evidence to Support Compliance / Action
The board of health shall describe the program of public health interventions and the information used to inform them including how health inequities will be addressed.		Documentation and evidence collected through standards review used to describe the program(s) of interventions and the information used to inform them. **Action:** Program interventions are required to be described and submitted to the ministry through the Annual Service Plan and Budget. Will be compliant following submission of the Annual Service Plan and Budget in March 2018.
The board of health shall publicly disclose results of all inspections or other required information in accordance with the Foundational and Program Standards.		Currently disclosure food safety inspections through Food Safety Zone. Need to disclose all inspections or information in accordance with identified protocols. **Action:** PHS is working to make inspection results publicly available through the open data work within the City of Hamilton.
The board of health shall 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.		Review of emergency preparedness and response practices was completed through standards review.
The board of health shall collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities, and report and disseminate the data and information in accordance with the Foundational and Program Standards.		This work has begun through the standards review. **Action:** The Epidemiology & Evaluation team at PHS will continue to develop indicators and performance measures to monitor population inequities. Monitoring of these indicators and performance measures will also be embedded into future annual planning processes.
The board of health shall have a strategic plan that establishes strategic priorities over 3 to 5 years, includes input from staff, clients, and community partners, and reviewed at least every other year.		City of Hamilton Multi-Year Business Plan for Public Health Services will act as the public health strategic plan as it covers a 4 year timeframe (2018-2021) and is reviewed annually. For 2018, input was collected from standards review work groups to inform the Multi-Year Business Plan. No input from clients, community and partners was included. **Action:** In future iterations of strategic plan, will need to include input from clients and community partners as captured within the Public Health Services' Stakeholder Engagement Plan.

Domain Two: Fiduciary Requirements

Boards of health are held accountable for using ministry funding efficiently for its intended purpose.

The ministry has a responsibility to ensure that public health funding is used in accordance with accepted accounting principles, legislative requirements, and government policy expectations. The ministry must also ensure that boards of health make efficient use of public resources by delivery high quality, effective program interventions, ensuring value for money.

Accountability Framework Requirement	Compliance	Evidence to Support Compliance / Action
The board of health shall comply with the terms and conditions of the Ministry-Board of Health Accountability Agreement.		Compliant with current Accountability Agreement. Will review future agreements and develop action plans as needed to address gaps.
The board of health shall provide costing information by program.		Costing information is currently provided based on FTE resourcing and operating through Program Based Grants.
The board of health shall submit budget submissions, quarterly financial reports, annual settlement reports, and other financial reports as requested.		Have submitted required financial reporting documents in the past and will continue to do so for new reporting requirements moving forward.
The board of health shall place the grant provided by the ministry in an interest bearing account at a Canadian financial institution and report interest earned to the ministry fi the ministry provides the grant to boards of health prior to their immediate need for the grant.		Compliant as applicable.
The board of health shall report all revenues it collects for programs or services in accordance with the direction provided in writing by the ministry.		Compliant as applicable.
The board of health shall report any part of the grant that has not been used or accounted for in a manner requested by the ministry.		Compliant as applicable.
The board of health shall repay ministry funding as requested by the ministry.		Compliant as applicable.
The board of health shall ensure that expenditure forecasts are as accurate as possible.		Compliant as per City of Hamilton financial policies, procedures and processes.
The board of health shall keep a record of its financial affairs, invoices, receipts and other documents, and shall prepare annual statements of their financial affairs.		Compliant as per City of Hamilton financial policies, procedures and processes.
The board of health shall comply with the financial requirements of the HPPA (e.g., remuneration, informing municipalities of financial obligations, passing by-laws, etc.), and all other applicable legislation and regulations.		Compliant as per City of Hamilton financial policies, procedures and processes.
The board of health shall use the grant only for the purposes of the HPPA and to provide or ensure the provision of programs and services in accordance with the HPPA, Foundational and Program Standards, and Ministry-Board of Health Accountability Agreement.		Compliant and demonstrated through completion of required financial reports submitted to the ministry.
The boards of health shall spend the grant only on admissible expenditures.		Compliant and demonstrated through completion of required financial reports submitted to the ministry.

Accountability Framework Requirement	Compliance	Evidence to Support Compliance / Action
The board of health shall comply with the *Municipal Act, 2001* which requires that boards of health ensure that the administration adopts policies with respect to its procurement of goods and services. All procurement of goods and services should normally be through an open and competitive process.		As per City of Hamilton procurement policies and procedures.
Boards of health shall ensure that the administration implements appropriate financial management and oversight which ensures the following are in place: • A plan for the management of physical and financial resources; • A process for internal financial controls which is based on generally accepted accounting principles; • A process to ensure that areas of variance are addressed and corrected; • A procedure to ensure that the procurement policy is followed across all programs / services areas; • A process to ensure the regular evaluation of the quality of service provided by contracted services in accordance with contract standards; • A process to inform the board of health regarding resource allocation plans and decisions, both financial and workforce related, that are required to address shifts in need and capacity. .		As per City of Hamilton financial and procurement policies, procedures and processes.
The board of health shall negotiate service level agreements for corporately provided services.		Compliant through established Service Level Agreements between Public Health Services and Human Resources, Information Technology.
The boards of health shall have and maintain insurance.		As per City of Hamilton financial policies, procedures and processes.
The board of health shall maintain an inventory of all tangible capital assets developed or acquired with a value exceeding $5,000 or a value determined locally that is appropriate under the circumstances.		As per City of Hamilton financial policies, procedures and processes.
The board of health shall not dispose of an asset which exceeded $100,000 in value without the ministry's prior written confirmation.		Compliant as applicable.
The board of health shall not carry over the grant from one year to the next, unless pre-authorized in writing by the ministry.		Compliant as applicable.
The board of health shall maintain a capital funding plan, which includes policies and procedures to ensure that funding for capital projects is appropriately managed and reported.		As per City of Hamilton financial policies, procedures and processes.

Accountability Framework Requirement	Compliance	Evidence to Support Compliance / Action
The board of health shall comply with the Community Health Capital Programs policy.		Compliant as applicable.

Domain Three: Good Governance and Management Practices

Boards of health are held accountable for executing good governance practices to ensure effective functioning of boards of health and management of public health units.

The organizational requirements within this domain support the use of recommended best practices in governance and organizational processes. By adhering to these practices, boards of health are able to improve the quality and effectiveness of programs and services, prioritize the allocation of resources, improve the efficiency, and strive for resiliency in their organizational culture.

Accountability Framework Requirement	Compliance	Evidence to Support Compliance / Action
The board of health shall submit a list of board members.		Submitted annually. Will continue to be submitted as part of the Annual Service Plan & Budget.
The board of health shall operate in a transparent and accountable manner, and provide truthful and complete information to the ministry.		As per City of Hamilton governance policies and procedures.
The board of health shall ensure that members are aware of their roles and responsibilities and emerging issues and trends by ensuring the development and implementation of a comprehensive orientation plan for new board members and a continuing education program for continuing board members.		Board of Health orientation is provided for all board members conducted once every four years following election of new Council. Ongoing education is provided through board of health reports and presentations based on emerging issues or by request.
The board of health shall carry out its obligations without a conflict of interest and shall disclose to the ministry an actual, potential, or perceived conflict of interest.		Conflicts of interests are required to be disclosed at Board of Health meetings as per City of Hamilton governance policies and procedures. At this time, no formal disclosures of conflict of interest are reported to the ministry. **Action:** PHS will work with the ministry to establish a process for disclosure moving forward.
The board of health shall comply with the governance requirements of the HPPA (e.g., number of members, election of chair, remuneration, quorum, passing by-laws, etc.), and all other applicable legislation and regulations.		As per City of Hamilton governance policies and procedures.
The board of health shall comply with the medical officer of health appointments requirements of the HPPA, and the ministry's policy framework on medical officer of health appointments, reporting, and compensation.		Compliant as per policy.

Accountability Framework Requirement	Compliance	Evidence to Support Compliance / Action
The board of health shall ensure that the administration establishes a human resources strategy, which considers the competencies, composition and size of the workforce, as well as community composition, and includes initiatives for the recruitment, retention, professional development, and leadership development of the public health unit workforce.		Ongoing work to support workforce planning, succession planning and competency development. **Action:** Additional work is being done in 2018 focused on workforce assessment and development that will further bring PHS into compliance with this requirement.
The board of health shall ensure that the administration establishes and implements written human resource policies and procedures which are made available to staff, students, and volunteers. All policies and procedures shall be regularly reviewed and revised, and include the date of the last review/revision.		As per City of Hamilton human resource strategies, policies, and procedures. All human resource policies are made available to staff through the intranet. **Action:** Policies and procedures are maintained by the City of Hamilton Human Resources division and may or may not be regularly reviewed and revised. The regular review of these policies will be established through future Service Level Agreements.
The board of health shall engage in community and multi-sectoral collaboration with LHINs and other relevant stakeholders in decreasing health inequities.		The newly developed PHS Stakeholder Engagement Plan addresses working with a variety of stakeholders to decrease health inequities including collaboration with the LHIN through the Hamilton Community Work Group.
The board of health shall engage in relationships with Indigenous communities in a way that is meaningful for them.		Some previous work by PHS to engage in relationships with Indigenous communities. **Action:** Will look to City of Hamilton Urban Indigenous Strategy to inform meaningful engagement.
The board of health shall provide population health information, including social determinants of health and health inequities, to the public, community partners, LHINs, and health care providers in accordance with the Foundational and Program Standards.		A Population Health Assessment Strategy and a Stakeholder Engagement Plan has been developed with both plans addressing the sharing of population health information with partners. **Action:** Implementation of the Population Health Assessment Strategy and the Stakeholder Engagement Plan will help to come into full compliance with this requirement through the sharing of population health information. In addition, PHS will continue to provide data intelligence to stakeholders such as the Hamilton Community Work Group to help establish cross-sector objectives to improve population health outcomes.

Accountability Framework Requirement	Compliance	Evidence to Support Compliance / Action
The board of health shall develop and implement policies or by-laws regarding the functioning of the governing body, including: • Use and establishment of sub-committees; • Rules of order and frequency of meetings; • Preparation of meeting agenda, materials, minutes, and other record keeping; • Selection of officers; • Selection of board members based on skills, knowledge, competencies and representatives of the community, where boards of health are able to recommend the recruitment of members to the appointing body; • Remuneration and allowable expenses for board members; • Procurement of external advisors to the board such as lawyers and auditors (if applicable); • Conflict of interest; • Confidentiality; • Medical officer of health and executive officers (where applicable) selection process, remuneration, and performance review; • Delegation of the medical officer of health duties during short absences such as during a vacation/coverage plan.		Many policies and by-laws regarding the functioning of the governing body are established through the City of Hamilton governance policies and procedures. **Action:** Compliance gap with delegation of the medical officer of health duties during short absences such as during a vacation / coverage plan. Policy to be developed to address this area.
The board of health shall ensure that by-laws and policies and procedures are reviewed and revised as necessary, and at least every two years.		Council Procedures (By-law No. 14-300) and Council Code of Conduct (By-law No. 16-290) have been updated within the last two years. If policy and procedure is in reference to organizational policies and procedures, these documents are not reviewed every two years. **Action:** PHS department policies will be reviewed every two years moving forward. Service Level Agreements will be updated to include expectation to update policies every two years for those policies developed within shared service areas.

Accountability Framework Requirement	Compliance	Evidence to Support Compliance / Action
The board of health shall provide governance direction to the administration and ensure that the board remains informed about the activities of the organization on the following: • Delivery of programs and services; • Organizational effectiveness through evaluation of the organization and strategic planning; • Stakeholder relations and partnership building; • Research and evaluation; • Compliance with all applicable legislation and regulations; • Workforce issues, including recruitment of medical officer of health and any other senior executives; • Financial management, including procurement policies and practices; and • Risk management.		Compliant through ongoing information and recommendations reports brought forward to the Board of Health during monthly board meetings.
The board of health shall have a self-evaluation process of its governance practices and outcomes that is completed at least every other year. Completion includes an analysis of the results, board of health discussion, and implementation of feasible recommendations, if any.		Board of Health self-evaluation was completed in 2014 and 2016. Next self-evaluation planned for 2018.
The board of health shall ensure the administration develops and implements a set of client service standards.		As per City of Hamilton policy, Access & Equity has developed Customer Service Standards policies and procedures focused on assistive devices, communication, disruption notice, service animals, support persons for persons with disability, resident and visitor feedback and complaints, training. **Action:** Build upon work started in Healthy Environments to establish client service standards in setting service delivery expectations (e.g. follow-up response time).
The board of health shall ensure that the medical officer of health, as the designated health information custodian, maintains information systems and implements policies/procedures for privacy and security, data collection and records management.		Many new policies and procedures developed for privacy and security, data collection and records management. **Action:** Need to update and approve outstanding privacy and security, data collection and records management policies that are out of date (e.g. Public Health Services section of Records Retention By-law).

Domain Four: Public Health Practice

Boards of health are held accountable for achieving a high standard and quality of practice in the delivery of public health programs and services.

The organizational requirements within this domain include some of the key requirements of the Effective Public Health Practice Standard within the Foundational Standards, and support the fostering of a culture of excellence in professional practice with boards of health. A culture of quality and continuous organizational self-improvement is part of effective public health practice, which underpins effective program interventions, and therefore is necessary for the achievement of the desired goals and outcomes of public health programs and services.

Accountability Framework Requirement	Compliance	Evidence to Support Compliance / Action
The boards of heath shall ensure that the administration establishes, maintains and implements policies and procedures related to research ethics.		As per department policy 07-01 Research Project Application and Registration.
The board of health shall designate a Chief Nursing Officer.		A Chief Nursing Officer is in place with supporting policy to establish qualifications and expectations of the role within PHS.
The board of health shall demonstrate the use of a systematic process to plan public health programs and services to assess and report on the health of local populations describing the existence and impact of health inequities and identifying effective local strategies to decrease health inequities.		The standards review process provided a systematic process to plan public health programs and services and will inform future annual planning process at PHS. **Action:** Will be compliant following completion of the standards review ensuring that population health assessment and health equity are built into the annual planning process moving forward.
The board of health shall employ qualified public health professionals in accordance with the *Qualifications for Public Health Professionals Protocol, 2018 (*or as current).		*Qualifications for Public Health Professionals Protocol, 2018* is in development. Unknown at this time whether organization will be in compliance with expectations within the protocol. **Action:** Review protocol upon release to assess organizational compliance. Develop action plans to address compliance gaps as needed.
The boards of health shall support a culture of excellence in professional practice and ensure a culture of quality and continuous organizational self-improvement. This may include: • Measurement of client, community, and stakeholder/partner experience to inform transparency and accountability; and • Regular review of outcome data that includes variances from performance expectations and implementation of remediation plans.		Both department and corporate initiatives to ensure a culture of quality and continuous organizational self-improvement. Initial work at the corporate level through the Citizen Survey to measure client satisfaction, but only covers a small scope of the work of PHS. **Action:** Implementation of a PHS Continuous Quality Improvement Framework in 2018. Build regular review of performance measures into annual planning process moving forward. Hold leadership forum on Results Based Accountability to increase awareness and knowledge of performance measures. Develop process to measure more broadly client, community and stakeholder / partner experience.

Common to All Domains

The following list of organizational requirements contains those that are relevant to all four domains of the Public Health Accountability Framework, and have been grouped together here to avoid duplication.

Accountability Framework Requirement	Compliance	Evidence to Support Compliance / Action
The board of health shall submit an Annual Service Plan and Budget Submission to include all programs and services delivered by boards of health and program costing for ministry-funded programs.		Plan in place to submit Annual Service Plan and Budget by March 2, 2018 deadline. **Action:** Will be compliant upon March submission.
The board of health shall submit action plans as requested to address any compliance or performance issues.		Have submitted all previously requested action plans to address compliance or performance issues to the Ministry of Health and Long-Term Care and will continue to do so for requests moving forward.
The board of health shall submit all reports as requested by the ministry.		Have submitted all previously requested reports to the Ministry of Health and Long-Term Care and will continue to do so for requests moving forward.
The board of health shall have a formal risk management framework in place that identifies, assesses and addresses risks.		Risk management plan and process for annual review approved by the Board of Health November 2017.
The board of health shall produce an annual financial and performance report to the general public.		Plan in place to draft and complete an annual financial and performance report to the general public for 2017. **Action:** Annual report will go to the Board of Health in April 2018 and will be posted publicly following approval.
The board of health shall comply with all legal and statutory requirements.		Compliant as per established legal and statutory requirements.

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	January 15, 2018
SUBJECT/REPORT NO:	Ontario Public Health Standards Modernization - Annual Service Plan & Budget Template BOH17010(d) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Glenda McArthur (905) 546-2424, Ext. 6607
SUBMITTED BY & SIGNATURE:	Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services Department

Council Direction:

Not applicable

Information:

As outlined in BOH Report BOH17010(b), as part of the modernized Ontario Public Health Standards (Standards), the Ministry of Health and Long-Term Care (MOHLTC) has released the final Ontario Public Health Standards (Standards) (Appendix A) for implementation January 1, 2018. MOHLTC has developed a detailed Annual Service Plan and Budget template (ASP) (Appendix B) process for boards of health to communicate their program plans and budgeted expenditures for a given year.

The ASP requires an additional level of detail that is new for Boards of Health, requiring a detailed narrative of programs and services offered under each Standard. The blank ASP template in Appendix B will be a very large document when all program information is added. MOHLTC expects Board of Health approval before submission March 1, 2018. The completed ASP for 2018 will be submitted to Board of Health for approval February 22, 2018.

Information provided in the ASP will describe the programs and services Boards of Health are planning to deliver in accordance with the Standards, as follows.

Requirements for Programs, Services, and Accountability (Standards) based on local needs and budgets at the program level. The ASP replaces the Program-Based Grants

Budget Submission template. The ASP requires that Boards of Health provide both narrative program plan details and budgeted financial data.

Community Needs Assessment

The introductory narrative provides a high-level description of Hamilton. This information is intended to enable the MOHLTC to understand program and service delivery decisions and appreciate unique priorities, opportunities, and challenges. This section could include information regarding local population health issues, priority populations (including Indigenous populations), community assets and needs, political climate, and public engagement.

Foundational and Program Standards Plans

There are four Foundational Standards and nine Program Standards that require a narrative to describe local need, priorities and partnerships that address the goals of each Standard. The ASP is expected to describe the needs of the population served, using the most recent available data. This information is critical to prioritizing programs and services for the community as a whole, and ensuring that identified populations receive tailored support as required. The Standards allow for greater flexibility in program delivery in several program standards to address local need, including, Chronic Disease Prevention and Well-Being; Healthy Growth and Development; School Health; and Substance Use and Injury Prevention.

Program Plans

All MOHLTC funded programs and services offered by Hamilton Public Health Services have been listed under the relevant Standard. This also includes other MOHLTC funded programs that support a specific standard. Related programs include, but are not limited to: the Electronic Cigarettes Act: Protection and Enforcement, Enhanced Food Safety and Enhanced Safe Water Initiatives, Harm Reduction Program Enhancement, and Healthy Smiles Ontario Program. Programs and interventions that apply to multiple Program Standards are listed separately within each relevant standard.

Each program plan must include:

Description: Description of the program including the population(s) to be served and identification of a priority population with supporting data, if relevant;

Objectives: Identification of program objectives, expected outcomes and timelines;

Indicators for Success: List of indicators or data elements used to monitor the program and understand its impact;

Budget Summary: FTE and other expenses; and,

Public Health Interventions: Specific activities that are delivered through the program.

At full implementation, the reporting cycle will begin with the submission of the ASP to the MOHLTC prior to the beginning of the program year. Public Health Services will work to ensure the alignment of MOHLTC reporting processes and timelines where possible with new City of Hamilton processes including multi-year business plans and budgets.

Appendices and Schedules Attached:

Appendix A to Report BOH17010(d) – Ontario Public Health Standards

Appendix B to Report BOH17010(d) - 2018 Annual Service Plan and Budget Submission

Ministry of Health and Long-Term Care

Protecting and Promoting the Health of Ontarians

Ontario Public Health Standards: Requirements for Programs, Services, and Accountability

The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability are published as the guidelines for the provision of mandatory health programs and services by the Minister of Health and Long-Term Care, pursuant to Section 7 of the *Health Protection and Promotion Act*.

Release Date: November 16, 2017

Effective Date: January 1, 2018

ONTARIO PUBLIC HEALTH STANDARDS, 2008, AND INCORPORATED PROTOCOLS REMAIN IN EFFECT UNTIL DECEMBER 31, 2017

Ontario

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Policy and Legislative Context

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Policy and Legislative Context

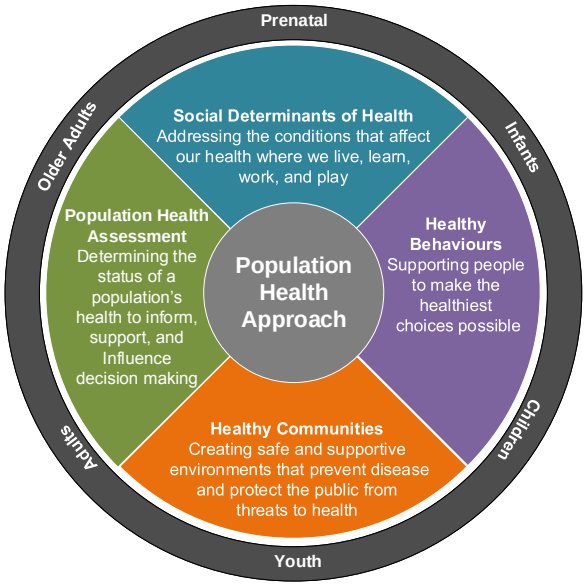
What is Public Health?

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

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

Our public health system reflects the diversity of Ontario's population. Boards of health serve populations large and small, in urban and rural settings. Each has responsibility for delivering local public health programs and services within its geographic borders. Public health does this in partnership with many other entities including governmental, non-governmental, and community organizations. Public health also builds partnerships with Indigenous communities (inclusive of First Nations [Status and Non-Status], Métis, Inuit, and those who self-identify as Indigenous) to work together to address their public health needs.

Figure 1: What is Public Health?



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

Policy Framework for Public Health Programs and Services

The work of public health is diverse, multi-faceted, and expansive. The **Policy Framework for Public Health Programs and Services** (Figure 2) brings focus to core functions of public health (i.e., assessment and surveillance, health promotion and policy development, health protection, disease prevention, and emergency management) and highlights the unique approach to our work. It articulates our shared goal and objectives, and outlines the contribution of our work in reaching population health outcomes related to health and health equity.

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

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

- Social Determinants of Health;
- Healthy Behaviours;
- Healthy Communities; and
- Population Health Assessment.

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

The public health sector achieves its objectives and ultimately improves population health outcomes through the delivery of public health programs and services. Our programs and services reach all Ontarians, with a special focus on those at greater risk of poor health outcomes. Boards of health are guided by the principles of Need; Impact; Capacity; and Partnership, Collaboration, and Engagement. The application of these principles ensures that boards of health assess, plan, deliver, manage, and evaluate public health programs and services to meet local needs, while also working towards common outcomes.

Figure 2: Policy Framework for Public Health Programs and Services

Goal	To improve and protect the health and well-being of the population of Ontario and reduce health inequities			
Population Health Outcomes	• Improved health and quality of life • Reduced morbidity and premature mortality • Reduced health inequity among population groups			
Domains	**Social Determinants of Health**	**Healthy Behaviours**	**Healthy Communities**	**Population Health Assessment**
Objectives	To reduce the negative impact of social determinants that contribute to health inequities	To increase knowledge and opportunities that lead to healthy behaviours	To increase policies, partnerships and practices that create safe, supportive and healthy environments	To increase the use of population health information to guide the planning and delivery of programs and services in an integrated health system
Programs and Services	**Goals** • To increase the use of public health knowledge and expertise in the planning and delivery of programs and services within an integrated health system • To reduce health inequities with equity focused public health practice • To increase the use of current and emerging evidence to support effective public health practice • To improve behaviours, communities and policies that promote health and well-being • To improve growth and development for infants, children and adolescents • To reduce disease and death related to infectious, communicable and chronic diseases of public health importance • To reduce disease and death related to vaccine preventable diseases • To reduce disease and death related to food, water and other environmental hazards • To reduce the impact of emergencies on health			
Principles	**Need** • Assess the distribution of social determinants of health and health status • Tailor programs and services to address needs of the health unit population	**Impact** • Assess, plan, deliver, and manage programs and services by considering evidence, effectiveness, barriers, and performance measures	**Capacity** • Make the best use of available resources to achieve the capacity required to meet the needs of the health unit population	**Partnership, Collaboration and Engagement** • Engage with multiple sectors, partners, communities, priority populations, and citizens • Build and further develop the relationship with Indigenous communities. These relationships may take many forms and need to be undertaken in a way that is meaningful to the particular community and/or organization

Statutory Basis for the Standards

Authority for the establishment of boards of health is provided under Part VI, Section 49, of the *Health Protection and Promotion Act*. The *Health Protection and Promotion Act* specifies that there shall be a board of health for each health unit. A health unit is defined in the *Health Protection and Promotion Act*, in part I, section 1(1), as the "...area of jurisdiction of the board of health". In order to respect the board of health as the body that is accountable to the ministry, while also respecting the delegation of authority for the day-to-day management and administrative tasks to the medical officer of health, the requirements for the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (the Standards) have been written as "The board of health shall...".

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

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

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

Where there is a reference to the *Health Protection and Promotion Act* within the Standards, the reference is deemed to include the *Health Protection and Promotion Act* and its regulations.

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

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

Boards of health need to be knowledgeable about their duties and responsibilities as specified in other applicable Ontario laws, including but not limited to: the *Building Code Act, 1992;* the *Child Care and Early Years Act, 2014*; the *Employment Standards Act*,

2000; the *Immunization of School Pupils Act*; the *Healthy Menu Choices Act, 2015*; the *Smoke Free Ontario Act*; the *Electronic Cigarettes Act, 2015*; the *Skin Cancer Prevention Act (Tanning Beds), 2013*; the *Occupational Health and Safety Act*; and the *Personal Health Information Protection Act, 2004*.

Purpose and Scope of the Standards

The role of boards of health is to support and protect the physical and mental health and well-being, resiliency and social connectedness of the health unit population, with a focus on promoting the protective factors and addressing the risk factors associated with health outcomes. The Standards define the responsibilities of boards of health in an integrated health system and are informed by the core public health functions, which include:

- Assessment and Surveillance;
- Health Promotion and Policy Development;
- Health Protection;
- Disease Prevention; and
- Emergency Management.

Boards of health are responsible for programs and services in all core function areas, demonstrating accountability to the ministry, and monitoring and measuring the effectiveness, impact and success of their programs and services. The Standards articulate the ministry's expectations for boards of health in these three areas.

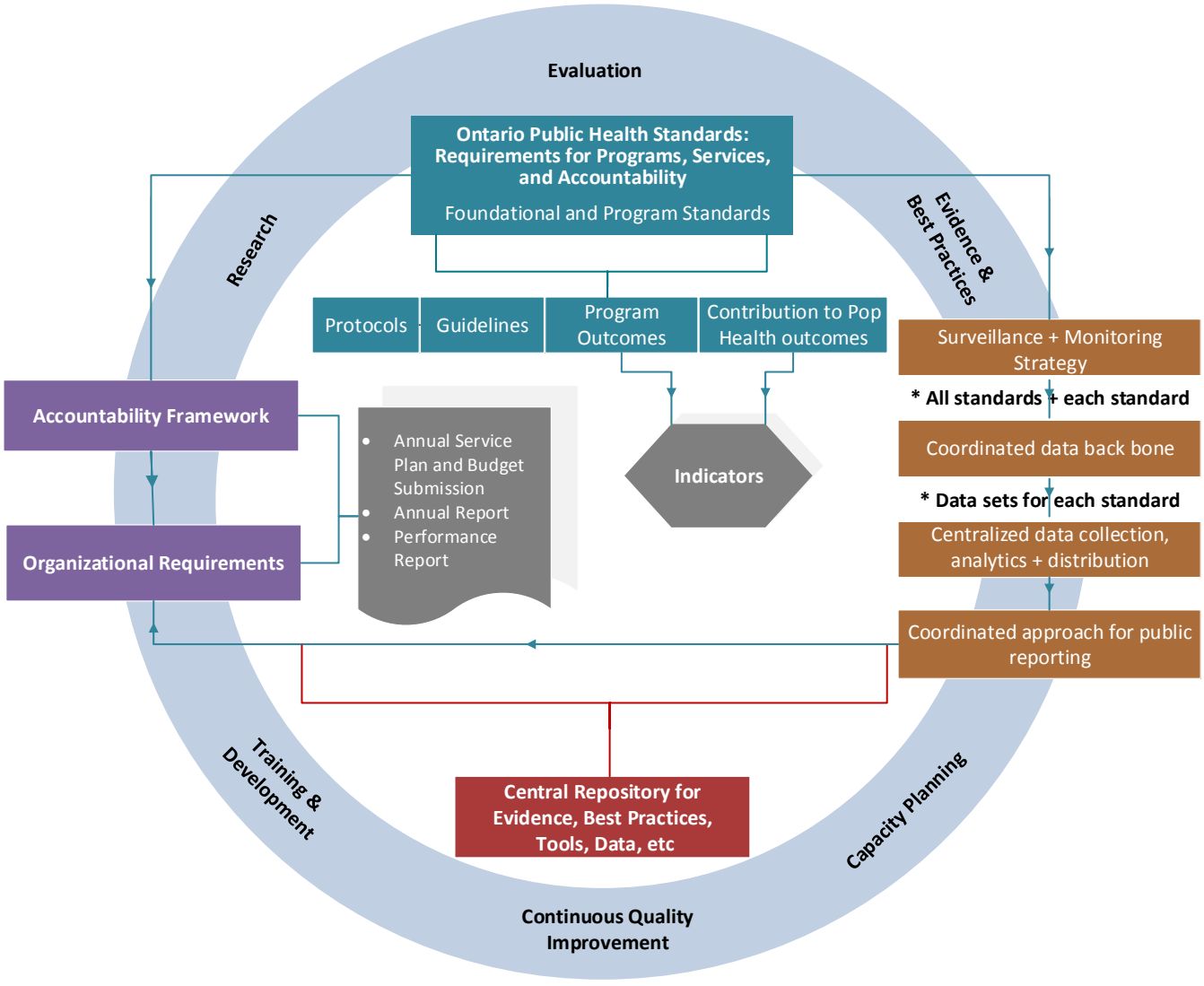
The Standards consist of the following sections:

- Defining the work that public health does, which includes the Foundational and Program Standards;
- Strengthened the accountability, which includes the Public Health Accountability Framework and Organizational Requirements; and
- Transparency and demonstrating impact, which includes the Public Health Indicator Framework and Transparency Framework.

A Coordinated Approach to the Standards and Accountability

The **Coordinated Approach** (Figure 3) diagram illustrates how specific processes and tools will enable and support the implementation of the Standards and ensure that implementation is informed by research, evidence, and best practices.

Figure 3: Coordinated Approach



Defining the Work: What Public Health Does

Boards of health are responsible for the assessment, planning, delivery, management, and evaluation of a range of public health programs and services that address multiple health needs and respond to the contexts in which these needs occur. The Foundational and Program Standards articulate only those programs and services that all boards of health shall provide and are not intended to encompass the total potential scope of public health programming in Ontario. They include a broad range of population-based activities designed to promote and protect the health of the population as a whole and reduce health inequities.

Many of the requirements in the Foundational and Program Standards are supported by protocols and guidelines. Protocols and guidelines are program and topic specific documents which provide direction on how boards of health shall operationalize or approach specific requirements.

Strengthened Accountability

The Public Health Accountability Framework articulates the scope of the accountability relationship between boards of health and the ministry and establishes expectations for boards of health in the domains of Delivery of Programs and Services; Fiduciary Requirements; Good Governance and Management Practices; and Public Health Practice. The ministry's expectation is that boards of health are accountable for meeting all requirements included in legislation (e.g., *Health Protection and Promotion Act*, *Financial Administration Act*, etc.) and the documents that operationalize them (e.g., the Standards, Ministry-Board of Health Accountability Agreement, etc.). The Organizational Requirements specify those requirements where reporting and/or monitoring are required by boards of health to demonstrate accountability to the ministry.

Accountability is demonstrated through the submission of planning and reporting tools by boards of health to the ministry, including the Board of Health Annual Service Plan and Budget Submission, performance reports, and an annual report. These tools enable boards of health to demonstrate that they are meeting defined expectations and provide appropriate oversight for public funding and resources.

Transparency and Demonstrating Impact

The Foundational and Program Standards identify requirements that should result in specified program outcomes and ultimately contribute to population-based goals and population health outcomes.[1] The achievement of goals and population health outcomes builds on achievements by boards of health, along with those of many other

[1]Refer to Figure 4 for a definition of program outcomes and goals. The population health outcomes are specified in the Policy Framework for Public Health Programs and Services (Figure 2).

organizations, governmental bodies, and community partners. Measurement of program outcomes and population health outcomes will help to assess the impact and success of public health programs and services and demonstrate the collective contribution towards population health outcomes. The Public Health Indicator Framework describes the indicators that will be used to monitor our work and measure our success.

An integrated surveillance and monitoring strategy enables the planning, implementation, monitoring, and evaluation of public health programs and services. Identification of common measures and centralized coordination of data access, collection, analysis and distribution facilitates efficient utilization of resources and effective, coordinated actions.

Enhanced transparency is a key priority for the ministry and public sector in general. Boards of health are required to ensure public access to key organizational documents that demonstrate responsible use of public funds and information that allows the public to make informed decisions about their health. The Transparency Framework articulates the expectations of public disclosure by boards of health to support enhanced transparency and promote public confidence in Ontario’s public health system.

Bringing available data together with other information, such as best practice and research evidence, in a central repository assists with analytics required at provincial, regional, and local levels. This can support each board of health in managing its own governance, administration, and effective program and service planning, as well as demonstrating the value of public health and impact on overall health and wellness of the population.

Defining the Work: What Public Health Does

2

Defining the Work: What Public Health Does

Foundational and Program Standards

This section includes the Foundational and Program Standards. The Foundational Standards articulate specific requirements that underlie and support all Program Standards. Population health assessment and surveillance requirements are also included in each Program Standard. The Foundational Standards include:

- Population Health Assessment
- Health Equity
- Effective Public Health Practice, which is divided into three sections:
    - Program Planning, Evaluation, and Evidence-Informed Decision-Making
    - Research, Knowledge Exchange, and Communication
    - Quality and Transparency
- Emergency Management

The Program Standards are grouped thematically to address Chronic Disease Prevention and Well-Being; Food Safety; Healthy Environments; Healthy Growth and Development; Immunization; Infectious and Communicable Diseases Prevention and Control; Safe Water; School Health; and Substance Use and Injury Prevention. Boards of health shall assess, plan, deliver, manage, and evaluate programs and services cohesively across thematic areas, impacting multiple settings and meeting needs across the lifespan.

Both the Foundational and Program Standards articulate broad population-based goals and program outcomes, and specific requirements. These concepts are described in Figure 4.

Figure 4: Description of the Components of each Standard

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

The requirements in the Standards balance the need for standardization across the province, with the need for variability to respond to local needs, priorities, and contexts. This flexible approach accommodates greater variability where there is an opportunity to plan programs to decrease health inequities and address the needs of priority populations.

[2]Priority populations as defined in the Population Health Assessment Standard.

Foundational Standards

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

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

Population Health Assessment

Population health assessment includes the measurement, monitoring, analysis, and interpretation of population health data and knowledge and intelligence about the health status of populations and subpopulations, including social determinants of health and health inequities. Population health assessment provides the information necessary to understand the health of populations through the collaborative development and ongoing maintenance of population health profiles, identification of challenges and opportunities, and monitoring of the health impacts of public health practice.

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

Goal

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

Program Outcomes

- The board of health is aware of and uses data to influence and inform the development of local healthy public policy and its programs and services.
- Planning and delivery of local public health programs and services align with the identified needs of the local population, including priority populations.
- Resources are allocated to reflect public health priorities and reallocated, as feasible, to reflect emergent public health priorities.
- Relevant public health practitioners and community partners receive timely information regarding risks in order to take appropriate action.
- The public, Local Health Integration Networks (LHINs), community partners, and health care providers are aware of relevant and current population health information.
- LHINs and other relevant community partners have population health information, including information on health inequities, necessary for planning, delivering, and monitoring health services that are responsive to population health needs.

Requirements

1. The board of health shall conduct surveillance, including the ongoing collection, collation, analysis, and periodic reporting of population health information, as required by the *Health Protection and Promotion Act* and in accordance with the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).
2. The board of health shall interpret and use surveillance data to communicate information on risks to relevant audiences in accordance with the *Healthy Environments and Climate Change Guideline, 2018* (or as current); the *Infectious Diseases Protocol, 2018* (or as current); and the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).
3. The board of health shall assess current health status, health behaviours, preventive health practices, risk and protective factors, health care utilization relevant to public health, and demographic indicators, including the assessment of trends and changes, in accordance with the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).
4. The board of health shall use population health, social determinants of health, health inequities, and other sources of information to assess the needs of the local population, including the identification of populations at risk of negative health outcomes, in order to determine those groups that would benefit most from public health programs and services (i.e., priority populations).[3]
5. The board of health shall tailor public health programs and services to meet identified local population health needs, including those of priority populations.
6. The board of health shall provide population health information, including social determinants of health, health inequities, and other relevant sources to the public, community partners, and other health care providers in accordance with the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).
7. The medical officer of health of a board of health shall formally engage with the chief executive officer from each LHIN within the geographic boundaries of the health unit on population health assessment, joint planning for health services, and population health initiatives in accordance with the *Board of Health and Local Health Integration Network Engagement Guideline, 2018* (or as current).

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

Health Equity

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

Health inequities are health differences that are:

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

Health equity means that all people can reach their full health potential and are not disadvantaged from attaining it because of their race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance.

The social determinants of health can be used to gain a deeper understanding of the population health needs of communities. Data can be used to examine various health outcomes (e.g., childhood obesity) from the perspective of social determinants of health (e.g., family income, family education level, etc.) and this information helps boards of health identify priority populations. Programs and services tailored to meet the needs of priority populations, policy work aimed at reducing barriers to positive health outcomes, and activities that facilitate positive behaviour changes to optimize health for everyone, are all important components of a program of public health interventions. By assessing the social determinants of health, boards of health have a better understanding of the impact of various social constructs within their communities, and are better able to plan programs and services that can help address health inequities. In some instances, there is sufficient data to demonstrate disparities in health outcomes for populations at the provincial level, such as Francophone and Indigenous communities.

Indigenous Communities and Organizations

The Indigenous population in Ontario is comprised of First Nations, Métis, and Inuit people. There are many different Indigenous communities across the province, including many different First Nation governments each with their own histories, cultures, organizational approaches, and jurisdictional realities that need to be considered.

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

One important first step for boards of health in beginning to build and/or further develop their relationships with Indigenous communities and organizations is to ensure it is done in a culturally safe way. The *Relationship with Indigenous Communities Guideline, 2018* (or as current) provides boards of health with information about the different Indigenous communities that may be within the area of jurisdiction of the board of health.

Goal

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

Program Outcomes

- The board of health achieves timely and effective detection and identification of health inequities, associated risk factors, and emerging trends.
- Community partners, including LHINs and the public, are aware of local health inequities, their causes, and impacts.
- There is an increased awareness on the part of the LHINs and other community partners of the impact of social determinants of health on health outcomes and increased support for actions to decrease health inequities.
- Boards of health implement strategies to reduce health inequities.
- Community partners, including LHINs, implement strategies to reduce health inequities.
- Priority populations are meaningfully engaged in the planning of public health interventions.

- Indigenous communities are engaged in a way that is meaningful for them.
- Multi-sectoral collaboration informs development of local strategies to decrease health inequities.

Requirements

1. The board of health shall assess and report on the health of local populations describing the existence and impact of health inequities and identifying effective local strategies that decrease health inequities in accordance with the *Health Equity Guideline, 2018* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).
2. The board of health shall modify and orient public health interventions to decrease health inequities in accordance with the *Health Equity Guideline, 2018* (or as current), and by:
   a) Engaging priority populations in order to understand their unique needs, histories, cultures, and capacities; and
   b) Designing strategies to improve the health of the entire population while decreasing the health inequities experienced by priority populations.
3. The board of health shall engage in multi-sectoral collaboration with municipalities, LHINs, and other relevant stakeholders in decreasing health inequities in accordance with the *Health Equity Guideline, 2018* (or as current). Engagement with Indigenous communities and organizations, as well as with First Nation communities striving to reconcile jurisdictional issues, shall include the fostering and creation of meaningful relationships, starting with engagement through to collaborative partnerships, in accordance with the *Relationship with Indigenous Communities Guideline, 2018* (or as current).
4. The board of health shall lead, support, and participate with other stakeholders in health equity analysis, policy development, and advancing healthy public policies that decrease health inequities in accordance with the *Health Equity Guideline, 2018* (or as current).

Effective Public Health Practice

Goal

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

Program Outcomes

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

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

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

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

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

Evidence-informed decision-making is the process of analyzing and using the best available evidence from research, context, and experience to inform decisions on development and delivery of public health programs and services. Evidence to inform the decision-making process may come from a variety sources including: key facts, findings, trends, and recommendations from published scientific research; data and analyses obtained from population health assessment and surveillance; legal and political environments; stakeholder perspectives; public engagement; and recommendations based on past experiences including program evaluation information.

Requirements

1. The board of health shall develop and implement a Board of Health Annual Service Plan and Budget Submission which:
    a) Demonstrates the use of a systematic process to plan public health programs and services to address the needs of the community by integrating the best available research and evaluation evidence with contextual factors such as local population health issues, priority populations, community assets and needs, political climate, public engagement, and available resources; and
    b) Describes the public health programs and services planned for implementation and the information which informed it.
2. The board of health shall routinely monitor program activities and outcomes to assess and improve the implementation and effectiveness of programs and services, including collection, analysis, and periodic reporting of indicators related to inputs, resources, implementation processes, reach, outputs, and outcomes.
3. The board of health shall ensure a culture of on-going program improvement and evaluation, and shall conduct formal program evaluations where required.
4. The board of health shall ensure all programs and services are informed by evidence.

Research, Knowledge Exchange, and Communication

Exploring an issue or investigating a question is accomplished through research - the organized and purposeful collection, analysis, and interpretation of data. Research may involve the primary collection of new data or the analysis or synthesis of existing data and findings.

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

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

Requirements

5. The board of health shall engage in knowledge exchange activities with public health practitioners across the province, policy-makers, academic and community partners, health care providers, and the public regarding factors that determine the health of the population as informed by population health assessment, surveillance, research, and program evaluation.
6. The board of health shall foster relationships with community researchers, academic partners, and other appropriate organizations to support public health research[4] and knowledge exchange activities, which may include those conducted by the board of health alone or in partnership or collaboration with other organizations.
7. The board of health shall use a variety of communication modalities, including social media, taking advantage of existing resources where possible, and complementing national/provincial health communications strategies.

Quality and Transparency

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

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

Requirements

8. The board of health shall ensure a culture of quality and continuous organizational self-improvement that underpins programs and services and public health practice, and demonstrates transparency and accountability to clients, the public, and other stakeholders. This may include:
   a) Identification and use of tools, structures, processes and priorities to measure and improve the quality of programs and services, such as the establishment of a Quality/Practice Committee and/or the development and monitoring of a Quality Improvement Plan;
   b) Measurement of client, community, community partner and stakeholder experience to inform transparency and accountability;
   c) Routine review of outcome data that includes variances from performance expectations and implementation of remediation plans; and
   d) Use of external peer reviews, such as accreditation.
9. The board of health shall publicly disclose results of all inspections or information in accordance with the *Electronic Cigarettes Protocol, 2018* (or as current); the *Food Safety Protocol, 2018* (or as current); the *Health Hazard Response Protocol, 2018* (or as current); the *Infection Prevention and Control Complaint Protocol, 2018* (or as current); the *Infection Prevention and Control Disclosure Protocol, 2018* (or as current); the *Infection Prevention and Control Protocol, 2018* (or as current); the *Recreational Water Protocol, 2018* (or as current); the *Safe Drinking Water and Fluoride Monitoring Protocol, 2018* (or as current); the *Tanning Beds Protocol, 2018* (or as current); and the *Tobacco Protocol, 2018* (or as current).

Emergency Management

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

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

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

Goal

To enable consistent and effective management of emergency situations.

Program Outcome

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

Requirement

1. The board of health shall effectively prepare for emergencies to ensure 24/7 timely, integrated, safe, and effective response to, and recovery from emergencies with public health impacts, in accordance with ministry policy and guidelines.[5]

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

Program Standards

Chronic Disease Prevention and Well-Being

Goal

To reduce the burden of chronic diseases of public health importance[6] and improve well-being.

Program Outcomes

- The board of health is aware of and uses data to influence and inform the development of local healthy public policy and its programs and services for the prevention of chronic diseases.
- Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with the prevention of chronic diseases.
- Priority populations and health inequities related to chronic diseases have been identified and relevant data have been communicated to community partners.
- There is a reduction in population health inequities related to chronic diseases.
- Community partners are aware of healthy behaviours associated with the prevention of chronic diseases.
- Community partners have knowledge of and increased capacity to act on the factors associated with the prevention of chronic diseases and promotion of well-being, including healthy living behaviours, healthy public policy, and creating supportive environments.
- Community partners, policy-makers, and the public, including priority populations, are meaningfully engaged in the planning, implementation, development and evaluation of programs and services for the prevention of chronic diseases.
- There is increased public awareness of the impact of risk factors, protective factors and healthy behaviours associated with chronic diseases.

[6]Chronic diseases of public health importance include, but are not limited to, obesity, cardiovascular diseases, respiratory disease, cancer, diabetes, intermediate health states (such as metabolic syndrome and prediabetes), hypertension, dementia, mental illness, and addictions.

- There is an increased adoption of healthy living behaviours among populations targeted through program interventions for the prevention of chronic diseases.
- Youth have decreased exposure to ultraviolet (UV) radiation, including reduced access to tanning beds.
- Tanning bed operators are in compliance with the *Skin Cancer Prevention Act (Tanning Beds), 2013*.
- Food premises are in compliance with the *Healthy Menu Choices Act, 2015*.

Requirements

1. The board of health shall collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities related to chronic diseases and report and disseminate the data and information in accordance with the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).
2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses chronic diseases risk and protective factors to reduce the burden of illness from chronic diseases in the health unit population.
   a) The program of public health interventions shall be informed by:
      i. An assessment of the risk and protective factors for, and distribution of, chronic diseases;
      ii. Consultation and collaboration with local stakeholders in the health, education, municipal, non-governmental, and other relevant sectors;
      iii. An assessment of existing programs and services within the area of jurisdiction of the board of health to build on community assets and minimize duplication;
      iv. Consideration of the following topics based on an assessment of local needs:
         - Built environment;
         - Healthy eating behaviours;
         - Healthy sexuality;
         - Mental health promotion;
         - Oral health;
         - Physical activity and sedentary behavior;
         - Sleep;

- Substance[7] use; and
- UV exposure.

v. Evidence of effectiveness of the interventions employed.

b) The program of public health interventions shall be implemented in accordance with relevant guidelines, including the *Chronic Disease Prevention Guideline, 2018* (or as current); the *Health Equity Guideline, 2018* (or as current); the *Mental Health Promotion Guideline, 2018* (or as current); and the *Substance Use Prevention and Harm Reduction Guideline, 2018* (or as current).[8]

3. The board of health shall enforce the *Skin Cancer Prevention Act (Tanning Beds), 2013* in accordance with the *Tanning Beds Protocol, 2018* (or as current).
4. The board of health shall enforce the *Healthy Menu Choices Act, 2015* in accordance with the *Menu Labelling Protocol, 2018* (or as current).

[7]Substance includes tobacco, e-cigarettes, alcohol, cannabis, opioids, illicit, other substances and emerging products.
[8]The *Substance Use Prevention and Harm Reduction Guideline, 2018* (or as current) provides guidance on alcohol, cannabis, opioids, and illicit substances.

Food Safety

Goal

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

Program Outcomes

- The board of health is aware of and uses data to influence and inform the development of local healthy public policy and its programs and services related to food safety.
- Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with food safety.
- Timely and effective detection, identification, and response to food-borne illnesses, their associated risk factors, emerging trends, and unsafe food offered for public consumption.
- Food-borne illness risks are mitigated.
- Food handlers are educated in food safety to handle and manage food for public consumption in a safe and sanitary manner.
- The public and community partners are aware of safe food-handling practices and food safety issues.
- The public and community partners have the knowledge and skills needed to handle food in a safe manner.
- There is reduced incidence of food-borne illnesses.

Requirements

1. The board of health shall:
   a) Conduct surveillance of suspected and confirmed food-borne illnesses, food premises, and food for public consumption;
   b) Conduct epidemiological analysis of surveillance data including monitoring of trends over time, emerging trends, and priority populations; and
   c) Respond by adapting programs and services

in accordance with the *Food Safety Protocol, 2018* (or as current); the *Operational Approaches for Food Safety Guideline, 2018* (or as current); and the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).

2. The board of health shall ensure food handlers in food premises have access to training in safe food-handling practices and principles in accordance with the *Food Safety Protocol, 2018* (or as current) and the *Operational Approaches for Food Safety Guideline, 2018* (or as current).
3. The board of health shall increase public awareness of food-borne illnesses and safe food-handling practices and principles in accordance with the *Food Safety Protocol, 2018* (or as current) and the *Operational Approaches for Food Safety Guideline, 2018* (or as current) by:
    a) Adapting and/or supplementing national/provincial food safety communications strategies where local assessment has identified a need; and/or
    b) Developing and implementing regional/local communications strategies where local assessment has identified a need.
4. The board of health shall provide all the components of the Food Safety Program in accordance with the *Food Safety Protocol, 2018* (or as current) and the *Operational Approaches for Food Safety Guideline, 2018* (or as current).
5. The board of health shall ensure 24/7 availability to receive reports of and respond to:
    a) Suspected and confirmed food-borne illnesses or outbreaks;
    b) Unsafe food-handling practices, food recalls, adulteration, and consumer complaints; and
    c) Food-related issues arising from floods, fires, power outages, or other situations that may affect food safety in accordance with the *Health Protection and Promotion Act*; the *Food Safety Protocol, 2018* (or as current); the *Infectious Diseases Protocol, 2018* (or as current); and the *Operational Approaches for Food Safety Guideline, 2018* (or as current).

Healthy Environments

Goal

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

Program Outcomes

- The board of health is aware of and uses data to influence and inform the development of local healthy public policy and its programs and services related to reducing exposure to health hazards and promoting healthy built and natural environments.
- Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with health hazards and healthy built and natural environments.
- There is a decrease in health inequities related to exposure to health hazards.
- Timely and effective detection, identification, and response to health hazards and associated public health risks, trends, and illnesses.
- The public and community partners are aware of the risks of health hazard incidents.
- The public and community partners are aware of health protection and prevention activities related to health hazards and conditions that create healthy built and natural environments.
- Community partners and the public are engaged in the planning, development, implementation, and evaluation of strategies to reduce exposure to health hazards and promote the creation of healthy natural and built environments.
- Community partners have the information necessary to create healthy public policies related to reducing exposure to health hazards and creating healthy built and natural environments.
- There is reduced public exposure to health hazards.

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

Requirements

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

   in accordance with the *Health Hazard Response Protocol, 2018* (or as current); the *Healthy Environments and Climate Change Guideline, 2018* (or as current); the *Infectious Diseases Protocol, 2018* (or as current); and the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).
2. The board of health shall identify risk factors and priority health needs in the built and natural environments.
3. The board of health shall assess health impacts related to climate change.
4. The board of health shall engage in community and multi-sectoral collaboration with municipal and other relevant partners to promote healthy built and natural environments.
5. The board of health shall collaborate with community partners to develop effective strategies to reduce exposure to health hazards and promote healthy built and natural environments in accordance with the *Health Hazard Response Protocol, 2018* (or as current) and the *Healthy Environments and Climate Change Guideline, 2018* (or as current).
6. The board of health shall implement a program of public health interventions to reduce exposure to health hazards and promote healthy built and natural environments.
7. The board of health shall, as part of its strategy to reduce exposure to health hazards and promote healthy natural and built environments, effectively communicate with the public by:
   a) Adapting and/or supplementing national/provincial health communications strategies where local assessment has identified a need;
   b) Developing and implementing regional/local communications strategies where local assessment has identified a need; and
   c) Addressing the following topics based on an assessment of local needs:
      - Built and natural environments;
      - Climate change;

- Exposure to hazardous environmental contaminants and biological agents;
- Exposure to radiation, including UV light and radon;
- Extreme weather;
- Indoor air pollutants;
- Outdoor air pollutants; and
- Other emerging environmental exposures.

8. The board of health shall assess and inspect facilities where there is an elevated risk of illness associated with exposures that are known or suspected to be associated with health hazards in accordance with the *Health Hazard Response Protocol, 2018* (or as current).
9. The board of health shall investigate potential health hazards and respond by preventing or reducing exposure to health hazards in accordance with the *Health Hazard Response Protocol, 2018* (or as current).
10. The board of health shall ensure 24/7 availability to receive reports of and respond to health hazards in accordance with the *Health Hazard Response Protocol, 2018* (or as current).

Healthy Growth and Development

Goal

To achieve optimal preconception, pregnancy, newborn, child, youth, parental, and family health.

Program Outcomes

- The board of health is aware of and uses data to influence and inform the development of local healthy public policy and its programs and services related to achieving optimal preconception, pregnancy, newborn, child, youth, parental, and family health.
- Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with healthy growth and development.
- There is a decrease in health inequities related to healthy growth and development.
- Community partners have knowledge of the factors associated with and effective programs for the promotion of healthy growth and development, as well as managing the stages of the family life cycle.
- The board of health collaborates with and fosters collaboration among community partners, children, youth, and parents in the planning, development, implementation and evaluation of programs, services, and policies, which positively impact the health of families and communities.
- Individuals and families are aware of the factors associated with healthy growth and development, and the importance of creating safe and supportive environments that promote healthy growth and development.
- Individuals and families have increased knowledge, skills and access to local supports to effectively foster healthy growth and development at different life stages, and progress through the transitions between these stages.
- Youth have knowledge of contraception, healthy sexuality, healthy fertility, and healthy pregnancies.

Requirements

1. The board of health shall collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities related to healthy growth

and development and report and disseminate the data and information in accordance with the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).

2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach to support healthy growth and development in the health unit population.

   a) The program of public health interventions shall be informed by:

      i. An assessment of risk and protective factors that influence healthy growth and development.

      ii. An assessment of existing programs and services within the area of jurisdiction of the board of health to build on community assets and minimize duplication.

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

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

      iv. Consideration of the following topics based on an assessment of local needs:

         - Breastfeeding;
         - Growth and development;
         - Healthy pregnancies;
         - Healthy sexuality;
         - Mental health promotion;
         - Oral Health;
         - Preconception health;
         - Pregnancy counselling;
         - Preparation for parenting;
         - Positive parenting; and

- Visual health.

v. Evidence of the effectiveness of the interventions.

b) The program of public health interventions shall be implemented in accordance with relevant guidelines, including the *Health Equity Guideline, 2018* (or as current); the *Healthy Growth and Development Guideline, 2018* (or as current); and the *Mental Health Promotion Guideline, 2018* (or as current).

3. The board of health shall provide all components of the Healthy Babies Healthy Children Program in accordance with the *Healthy Babies Healthy Children Protocol, 2018* (or as current) (Ministry of Children and Youth Services).

Immunization

Goal

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

Program Outcomes

- Timely and effective detection and identification of children susceptible to vaccine preventable diseases, their associated risk factors, and emerging trends.
- Children have up-to-date immunizations according to the current Publicly Funded Immunization Schedules for Ontario, and in accordance with the *Immunization of School Pupils Act* and the *Child Care and Early Years Act, 2014*.
- Timely and effective detection and identification of priority populations facing barriers to immunization, their associated risk factors, and emerging trends.
- Eligible persons, including underserved and priority populations, have access to provincially funded immunization programs and services.
- Improved uptake of provincially funded vaccines among Ontarians.
- Reduced incidence of vaccine preventable diseases.
- Effective inventory management for provincially funded vaccines.
- Health care providers report adverse events following immunization to the board of health.
- Timely and effective outbreak management related to vaccine preventable diseases.
- Increased public confidence in immunizations.

Requirements[10]

1. The board of health shall, in accordance with the *Immunization for Children in Schools and Licensed Child Care Settings Protocol, 2018* (or as current), assess, maintain records, and report on:
   a) The immunization status of children enrolled in licensed child care settings, as defined in the *Child Care and Early Years Act, 2014*;

[10]For requirements related to school-based immunization programs and services, refer to the School Health Standard.

b) The immunization status of children attending schools in accordance with the *Immunization of School Pupils Act;* and

c) Immunizations administered at board of health-based clinics as required in accordance with the *Immunization for Children in Schools and Licensed Child Care Settings Protocol, 2018* (or as current) and the *Infectious Diseases Protocol, 2018* (or as current).

2. The board of health shall conduct epidemiological analysis of surveillance data for vaccine preventable diseases, vaccine coverage, and adverse events following immunization, including monitoring of trends over time, emerging trends, and priority populations in accordance with the *Infectious Diseases Protocol, 2018* (or as current) and the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).

3. The board of health shall work with community partners to improve public knowledge and confidence in immunization programs and services by:

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

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

c) Addressing the following topics based on an assessment of local needs:

- Diseases that vaccines prevent;
- Immunization for travelers;
- Introduction of new provincially funded vaccines;
- Legislation related to immunizations;
- Promotion of childhood and adult immunization, including high-risk programs and services;
- Recommended immunization schedules for children and adults, and the importance of adhering to the schedules;
- Reporting immunization information to the board of health as required;
- The importance of immunization;
- The importance of maintaining a personal immunization record for all family members;
- The importance of reporting adverse events following immunization; and
- Vaccine safety.

4. The board of health shall provide consultation to community partners on immunization and immunization practices, based on local needs and as requested.
5. The board of health shall promote and provide provincially funded immunization programs and services to eligible persons in the health unit, including underserved and priority populations.
6. The board of health shall have a contingency plan to deploy board of health staff capable of providing vaccine preventable diseases outbreak management and control, such as mass immunization, in the event of a community outbreak.
7. The board of health shall provide comprehensive information and education to promote effective inventory management for provincially funded vaccines in accordance with the *Vaccine Storage and Handling Protocol, 2018* (or as current). This shall include:
   a) Training at the time of cold chain inspection;
   b) Distributing information to new health care providers who handle vaccines; and
   c) Providing ongoing support to health care providers who handle vaccines, including guidance on effective inventory management.
8. The board of health shall promote appropriate vaccine inventory management in accordance with the *Vaccine Storage and Handling Protocol, 2018* (or as current) in all premises where provincially funded vaccines are stored. This shall include:
   a) Prevention, management, and reporting of cold chain incidences; and
   b) Prevention, management, and reporting of vaccine wastage.
9. The board of health shall ensure that the storage and distribution of provincially funded vaccines, including to health care providers practicing within the health unit, is in accordance with the *Vaccine Storage and Handling Protocol, 2018* (or as current).
10. The board of health shall:
    a) Promote reporting of adverse events following immunization by health care providers to the local board of health in accordance with the *Health Protection and Promotion Act*; and
    b) Monitor, investigate, and document all suspected cases of adverse events following immunization that meet the provincial reporting criteria[11] and promptly report all cases.

[11]The provincial reporting criteria are specified in Appendix B – Provincial Case Definitions of the *Infectious Diseases Protocol, 2018* (or as current).

Infectious and Communicable Diseases Prevention and Control

Goal

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

Program Outcomes

- The board of health is aware of and uses local data to influence and inform the development of local healthy public policy and its programs and services for the prevention of infectious and communicable diseases.
- Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with infectious and communicable diseases.
- Timely and effective detection, identification, and management of exposures and local cases/outbreaks of infectious and communicable diseases of public health importance, including reportable diseases, their associated risk factors, and emerging trends.
- Effective case management results in limited secondary cases.
- Priority populations have increased access to sexual health and harm reduction services and supports that prevent exposure to and the transmission of sexually transmitted infections and blood-borne infections.
- Reduced transmission of infections and communicable diseases.
- Reduced progression from latent tuberculosis infection (LTBI) to active tuberculosis (TB) disease.
- Reduced development of acquired drug-resistance among active TB cases.

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

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

- The public, community partners, and health care providers report all potential rabies exposures.
- Effective and efficient management and mitigation of public health risks associated with infection prevention and control lapses.
- Increased awareness and use of infection prevention and control practices in settings that are required to be inspected.

Requirements

1. The board of health shall conduct population health assessment and surveillance regarding infectious and communicable diseases and their determinants. These efforts shall include:
   a) Reporting data elements in accordance with the *Health Protection and Promotion Act*; the *Infectious Diseases Protocol, 2018* (or as current)*;* the *Rabies Prevention and Control Protocol, 2018* (or as current)*;* the *Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol, 2018* (or as current)*;* and the *Tuberculosis Prevention and Control Protocol, 2018* (or as current);
   b) Conducting surveillance and epidemiological analysis, including the monitoring of trends over time, emerging trends, and priority populations in accordance with the *Infectious Diseases Protocol, 2018* (or as current); the *Population Health Assessment and Surveillance Protocol, 2018* (or as current); the *Rabies Prevention and Control Protocol, 2018* (or as current); the *Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol, 2018* (or as current); and the *Tuberculosis Prevention and Control Protocol, 2018* (or as current);
   c) Responding to international, Federal/Provincial/Territorial and local changes in diseases epidemiology by adapting programs and services; and
   d) Using the information obtained through assessment and surveillance to inform program development regarding communicable diseases and other infectious diseases of public health importance.
2. The board of health shall provide public education to increase awareness related to infection prevention and control measures, including respiratory etiquette, and hand hygiene. These efforts shall include:
   a) Adapting and/or supplementing national/provincial health education/ communications strategies where local assessment has identified a need; and/or
   b) Developing and implementing regional/local communications strategies where local assessment has identified a need.

3. The board of health shall work with community partners and service providers to determine and address the need for knowledge translation resources and supports in the area of infection prevention and control. These efforts shall include:
   a) Adapting and/or supplementing national/provincial health education/ communications strategies where local assessment has identified a need; and/or
   b) Developing and implementing regional/local communications strategies where local assessment has identified a need.
4. The board of health shall work with appropriate partners to increase awareness among relevant community partners, including correctional facilities, health care, and other service providers, of:
   a) The local epidemiology of communicable diseases and other infectious diseases of public health importance;
   b) Infection prevention and control practices; and
   c) Reporting requirements for reportable diseases, as specified in the *Health Protection and Promotion Act*.
5. The board of health shall communicate, in a timely and comprehensive manner, with all relevant health care providers and other partners about urgent and emerging infectious diseases issues.
6. The board of health shall, based on local epidemiology, supplement provincial efforts in managing risk communications to appropriate stakeholders on identified risks associated with infectious diseases and emerging diseases of public health importance.
7. The board of health shall use health promotion approaches to increase adoption of healthy behaviours among the population regarding sexual practices and injection drug use to prevent and reduce exposures to sexually transmitted and blood-borne infections by collaborating with and engaging health care providers, community and other relevant partners, and priority populations.
8. The board of health shall collaborate with health care providers and other relevant partners to ensure access to, or provide based on local assessment, clinical services (e.g., sexual health/sexually transmitted infection [STI] clinics) for priority populations to promote and support healthy sexual practices and the prevention and/or management of sexually transmitted infections and blood-borne infections.
9. The board of health shall collaborate with health care providers and other relevant partners to ensure access to, or provide based on local assessment, harm reduction programs in accordance with the *Substance Use Prevention and Harm Reduction Guideline, 2018* (or as current).

10. The board of health shall collaborate with health care providers and other relevant community partners to:
    a) Create supportive environments to promote healthy sexual practices,[14] access to sexual health services, and harm reduction programs and services for priority populations; and
    b) Achieve a comprehensive and consistent approach, based on local assessment and risk surveillance, to address and manage sexually transmitted infections and blood-borne infections in accordance with the *Sexual Health and Sexually Transmitted/Blood-Borne Infections Prevention and Control Protocol, 2018* (or as current).
11. The board of health shall provide public health management of cases, contacts, and outbreaks to minimize the public health risk in accordance with the *Infectious Diseases Protocol, 2018* (or as current); the *Institutional/Facility Outbreak Management Protocol, 2018* (or as current); the *Rabies Prevention and Control Protocol, 2018* (or as current); the *Sexual Health and Sexually Transmitted/ Blood-Borne Infections Prevention and Control Protocol, 2018* (or as current); and the *Tuberculosis Prevention and Control Protocol, 2018* (or as current).
12. The board of health shall facilitate timely identification of active cases of TB and referrals of persons through immigration medical surveillance in accordance with the *Tuberculosis Prevention and Control Protocol, 2018* (or as current), and shall provide or ensure access to TB medication at no cost to clients or providers.
13. The board of health shall receive and respond to all reported cases of potential rabies exposures received from the public, community partners, and health care providers in accordance with the *Health Protection and Promotion Act* and the *Rabies Prevention and Control Protocol, 2018* (or as current).
14. The board of health shall address the prevention and control of rabies threats as per a local Rabies Contingency Plan and in consultation with other relevant agencies[15] and orders of government, in accordance with the *Rabies Prevention and Control Protocol, 2018* (or as current).
15. The board of health shall develop a local vector-borne management strategy based on surveillance data and emerging trends in accordance with the *Infectious Diseases Protocol, 2018* (or as current).

[14]Healthy sexual practices include, but are not limited to, contraception and the prevention and/or management of sexually transmitted infections and blood-borne infections.
[15]Currently these agencies include the Ministry of Natural Resources and Forestry (MNRF), the Canadian Food Inspection Agency (CFIA) and the Ontario Ministry of Agriculture, Food and Rural Affairs (OMAFRA).

16. The board of health shall participate on committees, advisory bodies, or networks that address infection prevention and control practices[16] and policies of, but not limited to, hospitals and long-term care homes in accordance with the *Institutional/Facility Outbreak Management Protocol, 2018* (or as current).
17. The board of health shall receive reports of complaints regarding infection prevention and control practices and respond to and/or refer to appropriate regulatory bodies, including regulatory colleges[17], in accordance with applicable provincial legislation and in accordance with the *Infection Prevention and Control Complaint Protocol, 2018* (or as current) and the *Infection Prevention and Control Disclosure Protocol, 2018* (or as current).
18. The board of health shall receive and evaluate reports of complaints regarding infection prevention and control practices in settings for which no regulatory bodies or regulatory colleges exist, particularly personal services settings. This shall be done in accordance with the *Infection Prevention and Control Complaint Protocol, 2018* (or as current) and the *Infection Prevention and Control Disclosure Protocol, 2018* (or as current).
19. The board of health shall inspect settings associated with risk of infectious diseases of public health importance in accordance with the *Healthy Environments and Climate Change Guideline, 2018* (or as current); the *Infection Prevention and Control Complaint Protocol, 2018* (or as current); and the *Infection Prevention and Control Protocol, 2018* (or as current).
20. The board of health shall ensure 24/7 availability to receive reports of and respond to:
    a) Infectious diseases of public health importance in accordance with the *Health Protection and Promotion Act*; the *Mandatory Blood Testing Act, 2006*; the *Infectious Diseases Protocol, 2018* (or as current); and the *Institutional/ Facility Outbreak Management Protocol, 2018* (or as current); and
    b) Potential rabies exposures in accordance with the *Health Protection and Promotion Act* and the *Rabies Prevention and Control Protocol, 2018* (or as current).

[16]Infection prevention and control practices that may be addressed could include having current evidence-informed infection prevention and control policies and conducting regular staff education sessions to communicate and enhance awareness about the content of the policies.
[17]For the purposes of requirement 17, a “regulatory college” means the college of a health profession or group of health professions established or continued under a health professions Act named in Schedule 1 to the *Regulated Health Professions Act, 1991*.

Safe Water

Goals

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

Program Outcomes

- The board of health is aware of and uses data to influence and inform the development of local healthy public policy and its programs and services related to safe water.
- Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with safe water.
- Timely and effective detection, identification, and response to drinking water contaminants and illnesses, their associated risk factors, and emerging trends, including levels of fluoride outside the recommended range.
- Water-borne illness risks are mitigated.
- Members of the public who use private drinking water supplies (e.g., private wells) are aware of how to safely manage their own drinking water systems.
- The public is aware of drinking water safety, including the potential risk of illnesses related to unsafe drinking water.
- Owners/operators of recreational water facilities and owners/operators of small drinking water systems operate in a safe and sanitary manner.
- The public is aware of potential risk of illnesses and injuries related to recreational water facilities and public beach use.
- Public exposure to recreational water-related illnesses and hazards is reduced.

Requirements

1. The board of health shall:

   a) Conduct surveillance of:

- Drinking water systems and associated illnesses, risk factors, and emerging trends;
- Public beaches and water-borne illnesses associated with recreational water, risk factors, and emerging trends; and
- Recreational water facilities;

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

c) Use the information obtained to inform safe water programs and services

in accordance with the *Infectious Diseases Protocol, 2018* (or as current); the *Population Health Assessment and Surveillance Protocol, 2018* (or as current); the *Recreational Water Protocol, 2018* (or as current); the *Safe Drinking Water and Fluoride Monitoring Protocol, 2018* (or as current); and the *Small Drinking Water Systems Risk Assessment Guideline, 2018* (or as current).

2. The board of health shall provide information to private citizens who operate their own private drinking water supplies (e.g., private wells) to promote awareness of how to safely manage their own drinking water systems.
3. The board of health shall ensure the availability of education and training for owners/operators of small drinking water systems and recreational water facilities in accordance with the *Operational Approaches for Recreational Water Guideline, 2018* (or as current); the *Recreational Water Protocol, 2018* (or as current); the *Safe Drinking Water and Fluoride Monitoring Protocol, 2018* (or as current); and the *Small Drinking Water Systems Risk Assessment Guideline, 2018* (or as current).
4. The board of health shall increase public awareness of water-borne illnesses and safe drinking water by working with community partners and by:
   a) Adapting and/or supplementing national/provincial safe drinking water communications strategies, where local assessment has identified a need; and/or
   b) Developing and implementing regional/local communications strategies where local assessment has identified a need.
5. The board of health shall provide all the components of the Safe Water Program in accordance with:
   a) The *Safe Drinking Water and Fluoride Monitoring Protocol, 2018* (or as current) and all applicable statutes and regulations to protect the public from exposure to unsafe drinking water; and
   b) The *Operational Approaches for Recreational Water Guideline, 2018* (or as current) and the *Recreational Water Protocol, 2018* (or as current), to reduce

the risks of illness and injuries at public beaches and recreational water facilities.

6. The board of health shall inform the public about unsafe drinking water conditions and provide the necessary information to respond appropriately in accordance with the *Safe Drinking Water and Fluoride Monitoring Protocol, 2018* (or as current) and the *Small Drinking Water Systems Risk Assessment Guideline, 2018* (or as current).
7. The board of health shall review drinking water quality reports for its municipal drinking water supplies where fluoride is added in accordance with the *Safe Drinking Water and Fluoride Monitoring Protocol, 2018* (or as current).
8. The board of health shall ensure 24/7 availability to receive reports of and respond to:
   a) Adverse events related to safe water, such as reports of adverse drinking water of drinking water systems, governed under the *Health Protection and Promotion Act* or the *Safe Drinking Water Act, 2002*;
   b) Reports of water-borne illnesses or outbreaks;
   c) Safe water issues arising from floods, fires, power outages, or other situations that may affect water safety; and
   d) Safe water issues relating to recreational water use including public beaches in accordance with the *Infectious Diseases Protocol, 2018* (or as current); *Operational Approaches for Recreational Water Guideline, 2018* (or as current); the *Recreational Water Protocol, 2018* (or as current); the *Safe Drinking Water and Fluoride Monitoring Protocol, 2018* (or as current); and the *Small Drinking Water Systems Risk Assessment Guidelines, 2018* (or as current).

School Health

Goal

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

Program Outcomes

- The board of health is aware of and uses data to influence and inform the development of local healthy public policy and its programs and services related to the health of school-aged children and youth.
- Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with the health of school-aged children and youth.
- There is a decrease in health inequities related to the health of school-aged children and youth.
- School boards and schools are aware of relevant and current population health needs impacting students in their schools.
- School boards and schools are meaningfully engaged in the planning, development, implementation, and evaluation of public health programs and services relevant to school-aged children and youth.
- School boards and schools have the knowledge, skills, and capacity needed to act on the factors associated with the health of school-aged children and youth.
- School-based initiatives relevant to healthy living behaviours and healthy environments are informed by effective partnerships between boards of health, school boards, and schools.
- School-aged children, youth, and their families are aware of factors for healthy growth and development.
- There is an increased adoption of healthy living behaviours among school-aged children and youth.
- The board of health achieves timely and effective detection and identification of children and youth at risk of poor oral health outcomes, their associated risk factors, and emerging trends.
- Children and youth from low-income families have improved access to oral health care.
- The oral health of children and youth is improved.
- The board of health and parents/guardians are aware of the visual health needs

of school-aged children.

- Students and parents/gaurdians are aware of the importance of immunization.
- Children and youth have up-to-date immunizations according to the current Publicly Funded Immunization Schedules for Ontario and in accordance with the *Immunization of School Pupils Act*.

Requirements

1. The board of health shall collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities related to the health of school-aged children and youth and report and disseminate the data and information in accordance with the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).
2. The board of health shall provide population health information, including social determinants of health and health inequities, relevant to the school population to school boards and schools to identify public health needs in schools.
3. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach to improve the health of school-aged children and youth.
   a) The program of public health interventions shall be informed by:
      - An assessment of the local population, including the identification of priority populations in schools, as well as school communities at risk for increased health inequities and negative health outcomes;
      - Consultation and collaboration with school boards, principals, educators, parent groups, student leaders, and students;
      - A review of other relevant programs and services delivered by the board of health; and
      - Evidence of the effectiveness of the interventions employed.
   b) The program of public health interventions shall be implemented in accordance with relevant guidelines, including the *Chronic Disease Prevention Guideline, 2018* (or as current); the *Health Equity Guideline, 2018* (or as current); the *Injury Prevention Guideline, 2018* (or as current); the *Healthy Growth and Development Guideline, 2018* (or as current); the *Mental Health Promotion Guideline, 2018* (or as current); and the *Substance Use Prevention and Harm Reduction Guideline, 2018* (or as current).
4. The board of health shall offer support to school boards and schools to assist with the implementation of health-related curricula and health needs in schools, based on need and considering, but not limited to:
   a) Concussions and injury prevention;
   b) Healthy eating behaviors and food safety;

c) Healthy sexuality;

d) Immunization;

e) Infectious disease prevention (e.g., tick awareness, rabies prevention, and hand hygiene);

f) Life promotion, suicide risk and prevention;

g) Mental health promotion;

h) Oral health;

i) Physical activity and sedentary behaviour;

j) Road and off-road safety;

k) Substance[18] use and harm reduction;

l) UV exposure;

m) Violence and bullying; and

n) Visual Health.

Oral Health

5. The board of health shall conduct surveillance, oral screening, and report data and information in accordance with the *Oral Health Protocol, 2018* (or as current) and the *Population Health Assessment and Surveillance Protocol*, *2018* (or as current).
6. The board of health shall provide the Healthy Smiles Ontario (HSO) Program in accordance with the *Oral Health Protocol, 2018* (or as current).

Vision

7. The board of health shall provide, in collaboration with community partners, visual health supports and vision screening services in accordance with the *Child Visual Health and Vision Screening Protocol, 2018* (or as current).

Immunization

8. The board of health shall enforce the *Immunization of School Pupils Act* and assess the immunization status of children in accordance with the *Immunization for Children in Schools and Licensed Child Care Settings Protocol, 2018* (or as current).
9. The board of health shall work with school boards and schools to identify opportunities to improve public knowledge and confidence in immunization for school-aged children by:

[18]Substance includes tobacco, e-cigarettes, alcohol, cannabis, opioids, illicit, other substances and emerging products.

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

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

c) Addressing the following topics based on an assessment of local needs:

- Diseases that vaccines prevent;
- Introduction of new provincially funded vaccines;
- Legislation related to immunizations;
- Promotion of childhood immunization, including high-risk programs and services;
- Recommended immunization schedules for children, and the importance of adhering to the schedules;
- Reporting immunization information to the board of health as required;
- The importance of immunization;
- The importance of maintaining a personal immunization record for all family members;
- The importance of reporting adverse events following immunization; and
- Vaccine safety.

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

Substance Use and Injury Prevention

Goal

To reduce the burden of preventable injuries and substance[19] use.

Program Outcomes

- The board of health is aware of and uses data to influence and inform the development of local healthy public policy and its programs and services for preventing injuries, preventing substance use, and reducing harms[20] associated with substance use.
- Board of health programs and services are designed to address the identified needs of the community, including priority populations, associated with the prevention of injuries, preventing substance use, and reducing harms associated with substance use.
- Priority populations and health inequities related to injuries and substance use have been identified and relevant data have been communicated to community partners.
- There is a reduction in population health inequities related to injuries and substance use.
- Community partners are aware of healthy behaviours associated with the prevention of injuries and substance use, which includes reducing the harms associated with substance use.
- Community partners have knowledge of and increased capacity to act on the factors associated with the prevention of injuries, including healthy living behaviours, healthy public policy, and creating supportive environments.
- Community partners have knowledge of and increased capacity to act on the factors associated with preventing substance use, and reducing harms associated with substance use, including healthy living behaviours and developing personal skills, healthy public policy, and creating supportive environments.
- Community partners, policy-makers, and the public, including priority populations, are meaningfully engaged in the planning, implementation, development and evaluation of programs and services for preventing injuries and substance use, and harm reduction.

[19]Substance includes tobacco, e-cigarettes, alcohol, cannabis, opioids, illicit, other substances and emerging products.
[20]Harm reduction refers to policies, programs and practices that aim primarily to reduce the adverse health, social, and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption.

- There is increased public awareness of the impact of risk and protective factors associated with injuries and substance use.
- There is increased public awareness of the benefits of and access to harm reduction programs and services.
- There is an increased adoption of healthy living behaviours and personal skills among populations targeted through program interventions for preventing injuries, preventing substance use, and reducing harms associated with substance use.
- Youth have reduced access to tobacco products and e-cigarettes.
- Tobacco vendors and other organizations that are subject to the *Smoke-Free Ontario Act* are in compliance with the Act.
- E-cigarette vendors are in compliance with the *Electronic Cigarettes Act, 2015*.

Requirements

1. The board of health shall collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities related to injuries and substance use and report and disseminate the data and information in accordance with the *Population Health Assessment and Surveillance Protocol, 2018* (or as current).
2. The board of health shall develop and implement a program of public health interventions using a comprehensive health promotion approach that addresses risk and protective factors to reduce the burden of preventable injuries and substance use in the health unit population.

    a) The program of public health interventions shall be informed by:

        i. An assessment of the risk and protective factors for, and distribution of, injuries and substance use;

        ii. Consultation and collaboration with local stakeholders in the health, education, municipal, non-governmental, and other relevant sectors, including LHINs;

        iii. An assessment of existing programs and services within the area of jurisdiction of the board of health to build on community assets and minimize duplication;

        iv. Consideration of the following topics based on an assessment of local needs:

            - Comprehensive tobacco control;[21]

[21]Comprehensive tobacco control includes: preventing the initiation of tobacco; promoting quitting among young people and adults; eliminating exposure to environmental tobacco smoke; and identifying and eliminating disparities related to tobacco use and its societal outcomes among different population groups.

- Concussions;
- Falls;
- Life promotion, suicide risk and prevention;
- Mental health promotion;
- Off-road safety;
- Road safety; and
- Violence.

v. Evidence of the effectiveness of the interventions employed.

b) The program of public health interventions shall be implemented in accordance with relevant guidelines, including the *Health Equity Guideline, 2018* (or as current); the *Injury Prevention Guideline, 2018* (or as current); the *Mental Health Promotion Guideline, 2018* (or as current); and the *Substance Use Prevention and Harm Reduction Guideline, 2018* (or as current).

3. The board of health shall enforce the *Smoke-Free Ontario Act* in accordance with the *Tobacco Protocol, 2018* (or as current).
4. The board of health shall enforce the *Electronic Cigarettes Ac*t, *2015* in accordance with the *Electronic Cigarettes Protocol, 2018* (or as current).

Strengthened Accountability

Strengthened Accountability

Public Health Accountability Framework

The **Public Health Accountability Framework** (Figure 5) outlines the parameters and requirements to hold boards of health accountable for the work they do, how they do it, and the results achieved. It articulates the expectations of the ministry of boards of health to promote a transparent and effective accountability relationship. Enhanced accountability supports the implementation of public health programs and services by ensuring boards of health have the necessary foundations related to the delivery of programs and services, financial management, governance, and public health practice. It also supports a strong public health sector that can provide evidence of the value of public health and its contribution to population health outcomes leading to better health for Ontarians.

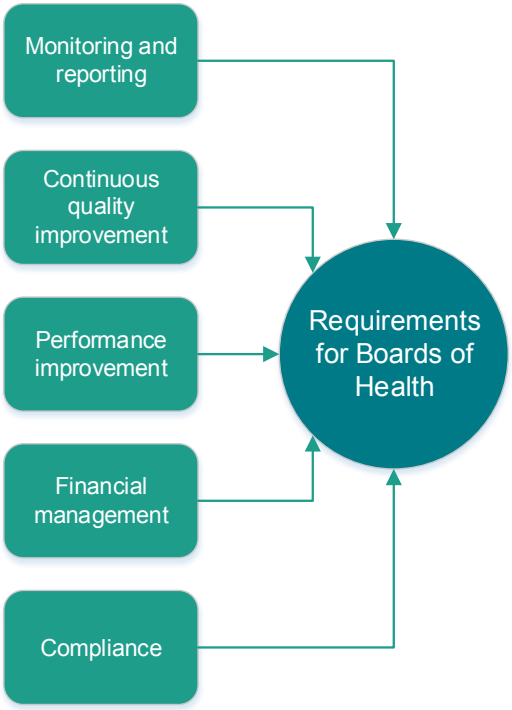
The Organizational Requirements specify the requirements where monitoring and/or reporting are required of boards of health to demonstrate accountability to the ministry. They are organized according to the following four domains of the accountability framework:

- Delivery of Programs and Services;
- Fiduciary Requirements;
- Good Governance and Management Practices; and
- Public Health Practice.

Figure 5: Public Health Accountability Framework

The Accountability Framework is composed of four Domains				
Domain	**Delivery of Programs and Services**	**Fiduciary Requirements**	**Good Governance and Management Practices**	**Public Health Practice**
Objectives of Domain	Boards of health will be held accountable for the delivery of public health programs and services and achieving program outcomes in accordance with ministry published standards, protocols, and guidelines.	Boards of health will be held accountable for using ministry funding efficiently for its intended purpose.	Boards of health will be held accountable for executing good governance practices to ensure effective functioning of boards of health and management of public health units.	Boards of health will be held accountable for achieving a high standard and quality of practice in the delivery of public health programs and services.

Organizational Requirements incorporate one or more of the following functions:



The Accountability Framework is supported by:	
Accountability Documents	• **Organizational Requirements:** Set out requirements against which boards of health will be held accountable across all four domains. • **Ministry-Board of Health Accountability Agreement:** Establishes key operational and funding requirements for boards of health.
Planning Documents	• **Board of Health Strategic Plan:** Sets out the 3 to 5 year local vision, priorities and strategic directions for the board of health. • **Board of Health Annual Service Plan and Budget Submission:** Outlines how the board of health will operationalize the strategic directions and priorities in its strategic plan in accordance with the Standards.
Reporting Documents	• **Performance Reports:** Boards of health provide to the ministry regular performance reports (programmatic and financial) on program achievements, finances, and local challenges/issues in meeting outcomes. • **Annual Report:** Boards of health provide to the ministry a report after year-end on the affairs and operations, including how they are performing on requirements (programmatic and financial), delivering quality public health programs and services, practicing good governance, and complying with various legislative requirements.

Organizational Requirements incorporate one or more of the following functions:

- **Monitoring and reporting** to measure the activities and achievements of boards of health and assess the results (to demonstrate value and contribution of public health);
- **Continuous quality improvement** to encourage changes in processes, address identified problems, and improve efficiency and effectiveness;
- **Performance improvement** to ensure boards of health achieve the best results possible and contribute to local, provincial, and population health outcomes;
- **Financial management** to ensure that resources are used efficiently and in line with local and provincial requirements; and
- **Compliance** to ensure boards of health meet ministry expectations for required activities articulated in legislation, standards, funding agreements, and policies.

Accountability across the domains is demonstrated through accountability, planning, and reporting tools, including: Ministry-Board of Health Accountability Agreements; Board of Health Strategic Plan; Board of Health Annual Service Plan and Budget Submission; performance and other ad hoc reports; and an annual report. These tools enable boards of health to demonstrate that they comply with all legal requirements and provide appropriate oversight for public funding and resources. They also support the achievement of a high standard and quality of public health practice and good governance and management practices that provide the foundation for the effective delivery of public health programs and service. Furthermore, they demonstrate the value that Ontarians receive for the funding invested in public health, and how that investment contributes to population health outcomes for all Ontarians.

Organizational Requirements

The Organizational Requirements are those requirements where reporting and/or monitoring are required of boards of health to demonstrate accountability to the ministry.

The ministry uses a range of reporting and measurement approaches to assess board of health compliance with these requirements, including:

- Routine board of health audits and year-end attestations;
- Narrative reports and documentation; and
- Indicators and other metrics.

Delivery of Programs and Services Domain

Boards of health are held accountable for the delivery of public health programs and services and achievement of program outcomes in accordance with the Foundational and Program Standards and incorporated protocols and guidelines.

Objective of Requirements

The ministry has a responsibility to ensure that boards of health are delivering mandated programs and services that reflect a level of provincial consistency and local flexibility, and that the services delivered are effective in achieving their intended purposes.

Requirements

1. The board of health shall deliver programs and services in compliance with the Foundational and Program Standards.
2. The board of health shall comply with programs provided for in the *Health Protection and Promotion Act*.
3. The board of health shall undertake population health assessments including identification of priority populations, social determinants of health and health inequities, and measure and report on them.
4. The board of health shall describe the program of public health interventions and the information used to inform them including how health inequities will be addressed.

5. The board of health shall publicly disclose results of all inspections or other required information in accordance with the Foundational and Program Standards.
6. The board of health shall 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.
7. The board of health shall collect and analyze relevant data to monitor trends over time, emerging trends, priorities, and health inequities, and report and disseminate the data and information in accordance with the Foundational and Program Standards.
8. The board of health shall have a strategic plan that establishes strategic priorities over 3 to 5 years, includes input from staff, clients, and community partners, and is reviewed at least every other year.

Fiduciary Requirements Domain

Boards of health are held accountable for using ministry funding efficiently for its intended purpose.

Objective of Requirements

The ministry has a responsibility to ensure that public health funding is used in accordance with accepted accounting principles, legislative requirements, and government policy expectations.

The ministry must also ensure that boards of health make efficient use of public resources by delivering high quality, effective program interventions, ensuring value for money.

Requirements

1. The board of health shall comply with the terms and conditions of the Ministry-Board of Health Accountability Agreement.
2. The board of health shall provide costing information by program.
3. The board of health shall submit budget submissions, quarterly financial reports, annual settlement reports, and other financial reports as requested.
4. The board of health shall place the grant provided by the ministry in an interest bearing account at a Canadian financial institution and report interest earned to the ministry if the ministry provides the grant to boards of health prior to their immediate need for the grant.
5. The board of health shall report all revenues it collects for programs or services in accordance with the direction provided in writing by the ministry.
6. The board of health shall report any part of the grant that has not been used or accounted for in a manner requested by the ministry.
7. The board of health shall repay ministry funding as requested by the ministry.
8. The board of health shall ensure that expenditure forecasts are as accurate as possible.
9. The board of health shall keep a record of financial affairs, invoices, receipts and other documents, and shall prepare annual statements of their financial affairs.
10. The board of health shall comply with the financial requirements of the *Health Protection and Promotion Act* (e.g., remuneration, informing municipalities of financial obligations, passing by-laws, etc.), and all other applicable legislation and regulations.
11. The board of health shall use the grant only for the purposes of the *Health Protection and Promotion Act* and to provide or ensure the provision of programs

and services in accordance with the *Health Protection and Promotion Act*, Foundational and Program Standards, and Ministry-Board of Health Accountability Agreement.

12. The board of health shall spend the grant only on admissible expenditures.
13. The board of health shall comply with the *Municipal Act, 2001* which requires that boards of health ensure that the administration adopts policies with respect to its procurement of goods and services. All procurement of goods and services should normally be through an open and competitive process.
14. The board of health shall ensure that the administration implements appropriate financial management and oversight which ensures the following are in place:
    a) A plan for the management of physical and financial resources;
    b) A process for internal financial controls which is based on generally accepted accounting principles;
    c) A process to ensure that areas of variance are addressed and corrected;
    d) A procedure to ensure that the procurement policy is followed across all programs/services areas;
    e) A process to ensure the regular evaluation of the quality of service provided by contracted services in accordance with contract standards; and
    f) A process to inform the board of health regarding resource allocation plans and decisions, both financial and workforce related, that are required to address shifts in need and capacity.
15. The board of health shall negotiate service level agreements for corporately provided services.
16. The board of health shall have and maintain insurance.
17. The board of health shall maintain an inventory of all tangible capital assets developed or acquired with a value exceeding $5,000 or a value determined locally that is appropriate under the circumstances.
18. The board of health shall not dispose of an asset which exceeds $100,000 in value without the ministry's prior written confirmation.
19. The board of health shall not carry over the grant from one year to the next, unless pre-authorized in writing by the ministry.
20. The board of health shall maintain a capital funding plan, which includes policies and procedures to ensure that funding for capital projects is appropriately managed and reported.
21. The board of health shall comply with the Community Health Capital Programs policy.

Good Governance and Management Practices Domain

Boards of health are held accountable for executing good governance practices to ensure effective functioning of boards of health and management of public health units.

Objective of Requirements

The organizational requirements within this domain support the use of recommended best practices in governance and organizational processes. By adhering to these practices, boards of health are able to improve the quality and effectiveness of programs and services, prioritize the allocation of resources, improve efficiency, and strive for resiliency in their organizational culture.

Requirements

1. The board of health shall submit a list of board members.
2. The board of health shall operate in a transparent and accountable manner, and provide accurate and complete information to the ministry.
3. The board of health shall ensure that members are aware of their roles and responsibilities and emerging issues and trends by ensuring the development and implementation of a comprehensive orientation plan for new board members and a continuing education program for board members.
4. The board of health shall carry out its obligations without a conflict of interest and shall disclose to the ministry an actual, potential, or perceived conflict of interest.
5. The board of health shall comply with the governance requirements of the *Health Protection and Promotion Act* (e.g., number of members, election of chair, remuneration, quorum, passing by-laws, etc.), and all other applicable legislation and regulations.
6. The board of health shall comply with the medical officer of health appointments requirements of the *Health Protection and Promotion Act*, and the ministry's policy framework on medical officer of health appointments, reporting, and compensation.
7. The board of health shall ensure that the administration establishes a human resources strategy, which considers the competencies, composition and size of the workforce, as well as community composition, and includes initiatives for the recruitment, retention, professional development, and leadership development of the public health unit workforce.
8. The board of health shall ensure that the administration establishes and implements written human resource policies and procedures which are made

available to staff, students, and volunteers. All policies and procedures shall be regularly reviewed and revised, and include the date of the last review/revision.

9. The board of health shall engage in community and multi-sectoral collaboration with LHINs and other relevant stakeholders in decreasing health inequities.
10. The board of health shall engage in relationships with Indigenous communities in a way that is meaningful for them.
11. The board of health shall provide population health information, including social determinants of health and health inequities, to the public, community partners, LHINs, and health care providers in accordance with the Foundational and Program Standards.
12. The board of health shall develop and implement policies or by-laws regarding the functioning of the governing body, including:
    a) Use and establishment of sub-committees;
    b) Rules of order and frequency of meetings;
    c) Preparation of meeting agenda, materials, minutes, and other record keeping;
    d) Selection of officers;
    e) Selection of board of health members based on skills, knowledge, competencies and representatives of the community, where boards of health are able to recommend the recruitment of members to the appointing body;
    f) Remuneration and allowable expenses for board members;
    g) Procurement of external advisors to the board such as lawyers and auditors (if applicable);
    h) Conflict of interest;
    i) Confidentiality;
    j) Medical officer of health and executive officers (where applicable) selection process, remuneration, and performance review; and
    k) Delegation of the medical officer of health duties during short absences such as during a vacation/coverage plan.
13. The board of health shall ensure that by-laws, policies and procedures are reviewed and revised as necessary, and at least every two years.
14. The board of health shall provide governance direction to the administration and ensure that the board of health remains informed about the activities of the organization on the following:
    a) Delivery of programs and services;
    b) Organizational effectiveness through evaluation of the organization and strategic planning;
    c) Stakeholder relations and partnership building;

d) Research and evaluation;

e) Compliance with all applicable legislation and regulations;

f) Workforce issues, including recruitment of medical officer of health and any other senior executives;

g) Financial management, including procurement policies and practices; and

h) Risk management.

15. The board of health shall have a self-evaluation process of its governance practices and outcomes that is completed at least every other year. Completion includes an analysis of the results, board of health discussion, and implementation of feasible recommendations for improvement, if any.

16. The board of health shall ensure the administration develops and implements a set of client service standards.

17. The board of health shall ensure that the medical officer of health, as the designated health information custodian, maintains information systems and implements policies/procedures for privacy and security, data collection and records management.

Public Health Practice Domain

Boards of health are held accountable for achieving a high standard and quality of practice in the delivery of public health programs and services.

Objective of Requirements

The organizational requirements within this domain include some of the key requirements of the Effective Public Health Practice Standard within the Foundational Standards, and support the fostering of a culture of excellence in professional practice with boards of health.

A culture of quality and continuous organizational self-improvement is part of effective public health practice, which underpins effective program interventions, and therefore is necessary for the achievement of the desired goals and outcomes of public health programs and services.

Requirements

1. The board of heath shall ensure that the administration establishes, maintains, and implements policies and procedures related to research ethics.
2. The board of health shall designate a Chief Nursing Officer.
3. The board of health shall demonstrate the use of a systematic process to plan public health programs and services to assess and report on the health of local populations describing the existence and impact of health inequities and identifying effective local strategies to decrease health inequities.
4. The board of health shall employ qualified public health professionals in accordance with the *Qualifications for Public Health Professionals Protocol, 2018* (or as current).
5. The board of health shall support a culture of excellence in professional practice and ensure a culture of quality and continuous organizational self-improvement. This may include:
    a) Measurement of client, community, and stakeholder/partner experience to inform transparency and accountability; and
    b) Regular review of outcome data that includes variances from performance expectations and implementation of remediation plans.

Common to All Domains

The following list of organizational requirements contains those that are relevant to all four domains of the Public Health Accountability Framework, and have been grouped together here to avoid duplication.

Requirements

1. The board of health shall submit an Annual Service Plan and Budget Submission to include all programs and services delivered by boards of health and program costing for ministry-funded programs.
2. The board of health shall submit action plans as requested to address any compliance or performance issues.
3. The board of health shall submit all reports as requested by the ministry.
4. The board of health shall have a formal risk management framework in place that identifies, assesses, and addresses risks.
5. The board of health shall produce an annual financial and performance report to the general public.
6. The board of health shall comply with all legal and statutory requirements.

Transparency and Demonstrating Impact

Transparency and Demonstrating Impact

In addition to the accountability planning and reporting tools, the ministry uses indicators to monitor progress and measure success of boards of health. The **Public Health Indicator Framework** (Figure 6) describes the indicators that are used to monitor progress in the delivery of public health programs and services, measure achievement of program outcomes, and assess public health's contributions to population health outcomes.

Measurement at the program outcome level measures the impacts achieved through direct delivery of public health programs and services by boards of health (i.e., by meeting the requirements in the Foundational and Program Standards). Impacts can include changes in awareness, knowledge, skills, and behaviors of populations, service delivery agents, and community partners, as well as changes in environments and policies. Indicators that will be used at the provincial level to measure achievement of outcomes per standard are listed in the **Public Health Indicator Framework** (Figure 6). Boards of health shall establish program outcome indicators locally for those standards that allow for variability to respond to local needs, priorities, and contexts (i.e., Chronic Disease Prevention and Well-Being, Healthy Growth and Development, School Health, and Substance Use and Injury Prevention). The Foundational Standards underlie and support all Program Standards; therefore, it is expected that the outcomes of the Foundational Standards will be achieved through the effective delivery of programs and services.

It is expected that the achievement of program outcomes will contribute to the achievement of population health outcomes. Measurement at the population health outcome level includes measures of improved health and quality of life, reduced morbidity and premature mortality, and reduced health inequities amoung population groups as articulated in the **Framework for Public Health Programs and Services** (Figure 2).

Figure 6: Draft Public Health Indicator Framework[22]

Goal	To provide an evidence-informed basis for monitoring progress and measuring success of boards of health in achieving program outcomes, and understanding the contribution to population health outcomes
Objectives	• Monitoring progress in the delivery of public health programs and services • Measuring board of health success in achieving program outcomes • Assessing public health's contributions to population health outcomes

Indicator and Information

Contribution to Population Health Outcomes	Program Outcomes	
Improved Health & Quality of Life • Adoption of healthy lifestyle behaviours • Perceived health • Health expectancy • Life satisfaction	**Chronic Disease Prevention and Well-Being; Healthy Growth and Development; School Health; Substance Use and Injury Prevention**	• Locally determined program outcome indicators • Indicators will be developed in accordance with locally determined programs of public health interventions
	Food Safety	• # of reported cases of foodborne illness • % reported cases of foodborne illness attributed to exposure settings of (i.e., food premises, daycares, homes, etc.) • % of food handlers trained and certified in food safety • % food-borne illness caused by unsafe food handling in the home
Reduced Morbidity and Mortality • Overweight/Obesity • Incidence and prevalence of chronic diseases • Chronic disease and substance use related morbidity and mortality • Life expectancy • Avoidable deaths • Infant mortality • Small for gestational age • Rate per 100,000 of VPD outbreaks by disease • Incidence rates of reportable VPDs • % of the public with confidence in immunization programs	**Healthy Environments**	• % of the public with knowledge of the impact of climate change locally, particularly heat related illness • % of the public with knowledge of and positive behaviours related to the impact of air quality on health using the AQHI • % of the public with awareness and knowledge about the health risks of radon in indoor air quality • % of the public with awareness of the risk of cancer related to exposure to solar ultraviolet radiation • % of priority populations who are aware of increased risk for adverse health effects related to high heat events
	Immunization	• % of doses wasted by publicly funded vaccine annually • % of 7 and 17 year olds vaccinated for all ISPA designated diseases • % of students with a valid religious or conscience exemption by ISPA designated disease annually • % of immunization providers of publicly funded vaccines indicating they have adequate information to support optimal immunization practices • % of inspected vaccine storage locations that meet storage and handling requirements

Reducing Health Inequities among Population Groups
• Relative index of inequality associated with:
  ○ Chronic Diseases
  ○ Injuries
  ○ Substance Use
  ○ Healthy Growth and Development
• Vulnerability associated with:
  ○ Early development
  ○ School readiness
• Deprivation Index
• Food Security
• Disability Rates
	Infectious and Communicable Diseases Prevention and Control	• # of Ceftriaxone prescriptions distributed for treatment of gonorrhea annually
		• # and type of IPAC lapse by sector (PSS, dental office, community laboratories or independent health facility)
		• # and rate per 100,000 of new active TB infections annually
		• # of cases of acquired drug-resistance among active TB cases
		• # of cases of identified LTBI that are initiating prophylaxis and/or the number completing treatment
		• # of potential rabies exposures investigated by health units annually
		• # of animals investigated that are current on their rabies vaccination
		• # of persons given rabies post-exposure prophylaxis (PEP)

	Safe Water	• # of days that fluoride levels were below recommended levels at municipal drinking water systems that add fluoride • # of drinking water advisories (DWAs) and boil water advisories (BWA) issued by days advisories were in effect • % of the public who use private drinking water supplies (e.g., private wells) who are aware of how to safely manage their own drinking water systems • # of small drinking water systems where risk categories change from high risk to moderate or low risk indicating improvement in system performance • % of days per season beaches are posted

[22]The Indicator Framework is draft and subject to change.

To support enhanced transparency in the public sector and promote public confidence in the public health system, boards of health are required to ensure public access to pertinent information through disclosure. The purposes of public disclosure include: helping the public to make informed decisions to protect their health; and sharing information about the work of boards of health and associated level of investment. The **Transparency Framework** (Figure 7) summarizes the types of information that boards of health are required to publicly disclose in accordance with the Foundational and Program Standards and Organizational Requirements.

Figure 7: Draft Transparency Framework[23]

Goal	Promote awareness, understanding, and public confidence in Ontario's public health system.	
Domains	**Protecting the Public's Health**	**Public Reporting**
Objectives	The public knows of the work of public health to protect and promote individual and community health	The public knows how Boards of Health are responding to local community needs

BOH Responsibilities	Post on the board of health website:
	• Results of routine and complaint based inspections of:
	  ○ Food Premises
	  ○ Public Pools and Spas
	  ○ Recreational Water Facilities
	  ○ Personal Services Settings
	  ○ Tanning Beds
	  ○ Recreational Camps
	  ○ Licensed Child Care Settings
	  ○ Small Drinking Water Systems
	• Convictions of tobacco and e-cigarette retailers
	• Infection prevention and control lapses
	• Drinking water advisories for small drinking water systems
	• Status of beach water quality
		Post on the board of health website:
		• Strategic Plan
		• Annual performance and financial report

[23]The Transparency Framework is draft and subject to change.

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Ministry of Health and Long-Term Care

2018
Annual Service Plan and Budget Submission

To be completed by
the Board of Health for the <Name of Public Health Unit>

Table of Contents

Part 1 - Introduction and Instructions

1.1 Introduction

The Annual Service Plan and Budget Submission (the "Annual Service Plan") is prepared by boards of health to communicate their program plans and budgeted expenditures for a given year. Information provided in the Annual Service Plan will describe the programs and services boards of health are planning to deliver in accordance with the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (the "Standards"), based on local needs and budgets at the program level. It is expected that the Annual Service Plan include board of health generated objectives and measures for monitoring achievements. The Annual Service Plan must reflect the requirements in the Standards.

As part of the Annual Service Plan, boards of health will describe the needs of the population they serve using the most recent available data. There is an opportunity for boards of health to provide high-level indices of the population they serve along with more specific data for unique sub-populations with common indicators of risk. This information is critical to prioritizing programs and services for the community as a whole and ensuring identified populations receive tailored support as required. The knowledge gained from implementation of the Foundational Standards will inform the preparation, implementation, and monitoring of the Annual Service Plan.

The Standards allow for greater flexibility in program delivery in several program standards including, but not limited to, Chronic Disease Prevention and Well-Being; Healthy Growth and Development; School Health; and, Substance Use and Injury Prevention. In the Annual Service Plan, boards of health will identify local priorities within each individual program area, and provide a summary of the data used to support their assessment of community need and their program delivery decisions, while also meeting all requirements under the Standards.

Please note that boards of health are required to include budget information and program plans on Ministry of Health and Long-Term Care (the ministry) funded programs only (both cost-shared and 100% funded programs), and must include 100% of budgeted expenditures (municipal and provincial portions) for these programs. Additionally, details provided in the Annual Service Plan should be based on the board of health's existing funding/budget and assume no change to the provincial base allocation (see Schedule A of your board of health's most recent Accountability Agreement). Any funding required over the existing provincial allocation must be requested in the Base and/or One-Time Requests worksheets provided in the Annual Service Plan.

The deadline to submit the 2018 Annual Service Plan and Budget Submission is March 1, 2018.

In order to assist boards of health in completing the Annual Service Plan, instructions and a glossary of terms have been provided in this worksheet.

1.2 Instructions

The Annual Service Plan is organized according to the order of the Foundational and Program Standards in the Standards. Boards of health are required to provide details on all programs and services planned under each Standard. Beginning in 2018, the Annual Service Plan template replaces the Program-Based Grants Budget Submission template, and now require that boards of health provide both narrative program plan details and budgeted financial data. For a list of admissible expenditures that can be included in the budget, refer to the current Public Health Funding and Accountability Agreement.

The Annual Service Plan includes multiple worksheets that have been colour-coded. In each worksheet, cells that require input have been colour-coded blue. Cells that are pre-populated with data previously inputted are colour-coded white.

The Annual Service Plan worksheets are organized as follows:

Table of Contents - The Table of Contents is organized according to the order of the Standards, followed by budget worksheets, base and one-time request worksheets, board of health membership, and key contacts and certification by the board of health. Each heading has been linked to the appropriate worksheet.

Part 1 - Introduction and Instructions

Part 1 - Introduction and Instructions - Provides an overview of the intent of the Annual Service Plan, instructions on how to complete the worksheets, a glossary to ensure consistency in the definition of specific terms, and sample examples of programs and public health interventions.

Part 2 - Community Assessment - Boards of health are required to provide a high-level description/overview of the community(ies) within their public health unit. Length of inputted content has been limited to the space provided (up to 4,000 characters).

Part 3 - Program Plans - This group of worksheets requires boards of health to provide a narrative and a summary budget for each program the board of health plans to deliver under each Standard.

The Program Plan worksheets are organized as follows:

3.0 - List of Programs - Boards of health are required to list all programs planned under each Program Standard before completing the Program Plan worksheets. The program names inputted on this form will pre-populate onto each Program Plan worksheet and applicable Budget worksheets. Boards of health can list up to ten (10) programs under each Program Standard, with the exception of Chronic Disease Prevention and Well-Being, which has space for twenty (20) programs. The number column to the left of the program name has been linked to the section of the program plan applicable to that program.

The List of Programs must also include any ministry funded "related" public health programs and services that support a specific Standard(s); with the exception of the MOH / AMOH Compensation Initiative. Related programs include, but are not limited to: the Chief Nursing Officer Initiaitve, *Electronic Cigarettes Act*: Protection and Enforcement, Enhanced Food Safety and Enhanced Safe Water Initiatives, Harm Reduction Program Enhancement, Healthy Smiles Ontario Program, Infection Prevention and Control Nurses, Infectious Diseases Control Initiative, Needle Exchange Program Initiative, Small Drinking Water Systems, Smoke-Free Ontario Strategy: Prosecution, Smoke-Free Ontario Strategy: Protection and Enforcement, Smoke-Free Ontario Strategy: Tobacco Control Coordination, and Vector-Borne Diseases Program.

Some public health programs, including related programs, may support all or multiple Standards. Boards of health are required to allocate these programs across all of the applicable Standards. If there is duplication of narrative details in the program plans, boards of health may avoid duplication in the narrative details by indicating the location in the Annual Service Plan where the information has already been provided.

If a related program is budgeted entirely as a funding source under Foundational Standards (e.g., Social Determinants of Health Nurses) in the Allocation of Expenditures worksheet, boards of health are required to provide a narrative description of their activities for that related program in the applicable Foundational Standards worksheets.

3.1 to 3.13 Program Plans - There is a worksheet for each Standard and sub-Section of a Standard, where appropriate. In each Program Plan worksheet, boards of health are required to provide summary narrative details on community needs/priorities, key partners/stakeholders, and programs/services that boards of health plan to deliver in 2018, including a list and descriptions of all public health interventions within each program (space for up to 10 public health interventions has been provided).

Each program includes a summary budget and sources of funding. Boards of health are not required to input data in these summaries as this data will pre-populate from budget data inputted by the board of health in the Budget worksheets. As noted above, boards of health must identify any ministry funded "related" program as a Program under the appropriate Program Standard and include a list and descriptions of all public health interventions within that "related" program.

Part 4 - Budget Allocation and Summaries - Includes a set of worksheets to allocate staffing and other expenditures for each Standard and program identified in the program plans, including "related" programs. Boards of health are required to identify sources of funding in the allocation of expenditures worksheet. This includes mandatory programs (cost-shared) as well as provincially funded "related" programs. Please see the Budget Summary worksheet for a list of provincially funded programs that are required to be reflected as programs and funding sources (or Schedule A of your most recent Accountability Agreement).

Part 1 - Introduction and Instructions

The Budget worksheets are organized as follows:

4.1 Staff Allocation to Standards - Boards of health are required to input the total number of full-time equivalents (FTEs) and total budget for each position in the blue coloured cells. Boards of health will then be required to allocate these FTEs to the applicable Standard until all unallocated FTEs have been allocated and there is no validation error in the Unallocated FTEs column. Cells across a position row will remain yellow until the total FTE amount for that position has been allocated correctly. Boards of health are also required to input the total FTEs and total budget for the medical officer of health position and each administrative position in this worksheet. Note that boards of health are not required to allocate the medical officer of health position and administrative positions across the Standards.

4.2 Staff Allocation to Programs - Total FTEs per position will pre-populate from worksheet 4.1 for each Standard. Boards of health are required to input the total FTEs for each program in that Standard.

4.3 Allocation of Expenditures - No data input is required for salaries/wages as this data will pre-populate from worksheet 4.2. Boards of health are required to enter a total percentage (%) of benefits for the entire organization (entered once under Foundational Standards). This % amount will calculate a portion of benefits for each program under each Standard automatically. All other expenditure categories require the input of data to allocate expenditures across each program as appropriate. Costs associated with the office of the medical officer of health, administration and other overhead/organizational costs are to be input into a table at the end of this worksheet as an indirect cost and are not to be allocated across the Standards or Programs. Formula cells related to benefits have been left unlocked should boards of health need to adjust the proportion of benefits per program to be more reflective of the actual costs.

4.4 Budget Summary - This worksheet summarizes budget data at 100% (municipal and provincial portions) and the provincial share. The budget summary is not a budget request for additional funding. Any requests for additional base or one-time funding must be included in the Base and/or One-Time Requests worksheets.

Part 5 - Base and One-Time Funding Requests - Any requests for additional base and/or one-time funding must be identified in the base and one-time funding requests worksheets in this Workbook. Each worksheet includes a limit of 10 requests each for base and one-time. A Summary worksheet automatically populates total base and one-time funding requested.

Funding requests for the MOH/AMOH Compensation Initiative and one-time funding requests for capital and infrastructure improvement projects should **not** be included in the Annual Service Plan.

Part 6 - Board of Health Membership - Details on board of health membership.

Part 7 - Key Contacts and Certification by the Board of Health - Details on key contacts and signatures required for the Annual Service Plan and Budget Submission template.

1.3 Glossary

Standard - The categories used in the Standards to describe the full range of public health programs and services that are required to be delivered by boards of health in Ontario.

Section - A sub-section of a Standard. Used only for those Standards where appropriate.

Program - A logical grouping of public health interventions related to a specific program. May be disease specific, topic specific, or population/age specific, or other.

Public Health Intervention - An organized set of public health actions to deliver a program or service. May be delivered in single or multiple locations.

Part 1 - Introduction and Instructions

Examples of a possible intervention per Program and per Standard are provided as follows:

Standard - Health Equity
Section - N/A
Program - Social Determinants of Health Nurses
Public Health Intervention - Modifying programs to address health equity

Standard - Chronic Disease Prevention and Well-Being
Section - N/A
Program - Healthy Living
Public Health Intervention - Healthy living workshops and education

Standard - Food Safety
Section - N/A
Program - Food Handler Certification
Public Health Intervention - Food-handler training courses

Standard - Healthy Environments
Section - N/A
Program - Health Hazards
Public Health Intervention - Engagement and advocacy

Standard - Healthy Growth and Development
Section - N/A
Program - Healthy families
Public Health Intervention - Prenatal education

Standard - Immunization
Section - N/A
Program - HPV Immunization
Public Health Intervention - Vaccine distribution

Standard - Infectious and Communicable Diseases Prevention and Control
Section - N/A
Program - Communicable Diseases
Public Health Intervention - Follow up on all reportable communicable diseases

Standard - Safe Water
Section - N/A
Program - Enhanced Safe Water
Public Health Intervention - Surveillance of recreational water facilities

Standard - School Health
Section - Oral Health
Program - Healthy Smiles Ontario
Public Health Intervention - Oral health screening

Standard - Substance Use and Injury Prevention
Section - Substance Use
Program - Alcohol and Substance Misuse
Public Health Intervention - Health promotion, communication and education

Part 2 - Community Assessment

Please use this section to provide a high-level description of the community(ies) within your public health unit. This information should provide sufficient detail to enable the ministry to understand program and service delivery decisions and appreciate unique priorities, opportunities, and challenges. This will provide the broad context in which all programs and services are delivered. Program specific contextual factors including priority population considerations may be provided here and/or within the individual program sections. This section may include information regarding local population health issues, priority populations (including Indigenous populations), community assets and needs, political climate, and public engagement.

Also, please include discussion of any unique challenges, issues or risks faced by your community(ies) which are influencing the work of your board of health.

Maximum 4,000 characters *Length = 0*

Part 3 - Program Plans

3.0 - List of Programs

Chronic Disease Prevention and Well-Being

#	Program Name	#	Program Name
1	Tobacco Control, Prevention and Cessation	11	Smoke Free Ontario - Tobacco Control Area Network - Prevention
2	Cancer Prevention	12	Smoke Free Ontario - Tobacco Control Coordination
3	Built Environment	13	Smoke Free Ontario - Youth Tobacco Use Prevention
4	Healthy Food Systems	14	
5	Mental Health Promotion	15	
6	Substance Use Prevention	16	
7	Harm Reduction	17	
8	Smoke Free Ontario - Prosecution	18	
9	Smoke Free Ontario - Protection and Enforcement	19	
10	Smoke Free Ontarion - Tobacco Control Area Network - Coordination	20	

Food Safety

#	Program Name
1	Food Safety
2	Enhanced Food Safety Initiative
3	
4	
5	
6	
7	
8	
9	
10	

Healthy Environments

#	Program Name
1	Health Hazards
2	Air Quality and Climate Change
3	
4	
5	
6	
7	
8	
9	
10	

Healthy Growth and Development

#	Program Name
1	Child Health
2	Reproductive Health
3	Sexual Health
4	
5	
6	
7	
8	
9	
10	

Immunization

#	Program Name
1	Vaccine Inventory Management
2	
3	
4	
5	
6	
7	
8	
9	
10	

Infectious and Communicable Diseases Prevention and Control

#	Program Name
1	Vector Borne Diseases
2	Infectious Disease Prevention and Control
3	Mental Health Promotion
4	Substance Use Prevention
5	Harm Reduction
6	Sexual Health
7	Infection Prevention and Control Nurses Initiative
8	Infectious Diseases Control Initiative
9	
10	

Safe Water

#	Program Name
1	Safe Water
2	Enhanced Safe Water Initiative
3	Small Drinking Water Systems
4	
5	
6	
7	
8	
9	
10	

School Health

School Health - Oral Health

#	Program Name
1	Oral Health Assessment
2	Healthy Smiles Ontario
3	
4	
5	
6	
7	
8	
9	
10	

School Health - Vision

#	Program Name
1	Child Visual Health and Vision Screening
2	
3	
4	
5	
6	
7	
8	
9	
10	

School Health - Immunization

#	Program Name
1	Immunization of School Pupils
2	
3	
4	
5	
6	
7	
8	
9	
10	

School Health - Other

#	Program Name
1	School Health
2	Tobacco Control, Prevention and Cessation
3	Injury Prevention
4	Chronic Disease Prevention
5	Mental Health Promotion
6	Substance Use Prevention
7	Harm Reduction
8	
9	
10	

Substance Use and Injury Prevention

Substance Use

#	Program Name
1	Tobacco Control, Prevention and Cessation
2	Harm Reduction
3	Substance Use Prevention
4	Electronic Cigarettes Act - Protection and Enforcement
5	Harm Reduction Program Enhancement
6	Needle Exchange Program Initiative
7	
8	
9	
10	

Injury Prevention

#	Program Name
1	Injury Prevention
2	
3	
4	
5	
6	
7	
8	
9	
10	

DRAFT Annual Service Plan and Budget Submission - Working Template

Updated 13 December 2017

2018 Public Health Program Plans and Budget Summaries
Foundational Standards include: Healthy Equity, Effective Public Health Practice, Population Health Assessment, and Emergency Management

A. Description

Please describe how the board of health plans to implement this Standard (maximum characters of 1,800):

B. Objectives

Please describe the objectives and what the board of health expects to achieve through delivery of this Standard. Only describe those objectives that will not also be reflected in other program plans in this template (maximum characters of 1,800).

DRAFT Annual Service Plan and Budget Submission - Working Template

Updated 13 December 2017

C. Stakeholders

Please information on the internal (e.g. board of health program areas) and external partners (e.g. LHINs, municipalities, etc.) the board of health will collaborate with to carry out programs/services under this Standard (maximum characters of 1,800).

D. Indicators of Success

List the indicators or data elements that the board of health will be using to monitor activities related to delivering on this Standard (maximum characters of 1,800).

E. Description of Related Programs

If a related program(s) is budgeted entirely as a funding source under Foundational Standards please describe the program(s) below including the populations to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported (maximum of 1,800 characters).

2018 Public Health Program Plans and Budget Summaries
Program Standards include: Chronic Disease Prevention & Well-being; Food Safety, Healthy Environment; Healthy Growth & Development; Immunization; Infectious & Communicable Diseases Prevention and Control; Safe Water; School Health – Oral Health, Immunization, Vision, Other; Substance Use and Injury Prevention;

A. Community Need and Priorities

Please provide a short summary of the following (maximum characters of 1,800):

a) The key data and information which demonstrates your communities' needs for public health interventions to address **<Program Standard>;** and,

b) Your board of health's determination of the local priorities for a program of public health interventions that addresses **<Program Standard>**

B. Key Partners/Stakeholders

Please provide a high level summary of the key internal and external partners you will collaborate with to deliver on this Standard. Please also describe any situations where the programming provided by external partners is sufficient so that you have not had to deliver similar programming under this Standard (maximum characters of 1,800).

C. Programs and Services

Program:

Description

Describe the program including the population(s) to be served. If a priority population has been identified for this program, please provide data and informational details that informed your decision, unless previously reported (maximum of 1,800 characters).

Objective

Describe the expected objectives of the program and what you expect to achieve, within specific timelines (maximum of 1,800 characters).

Indicators of Success

List the indicators or data elements you will be using to monitor your program and understand its impact. Also use this section to identify if a formal evaluation will be conducted at this time for this program (maximum of 1,800 characters)

Program Budget Summary		**Funding Sources Summary**	
Object of Expenditure	**Amount**	**Funding Source**	**Amount**

Public Health Intervention	**Description**
Input a title for each public health intervention under this Program (maximum of 100 characters)	Briefly describe the public health intervention (maximum of 1,800 characters)

CITY OF HAMILTON
PUBLIC HEALTH SERVICES
Communicable Disease Control and Wellness

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	January 15th, 2018
SUBJECT/REPORT NO:	One-time Funding for Alcohol, Drug & Gambling Services, Community Partnership Initiatives (BOH17046) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Susan Boyd (905) 546-2424, Ext. 2888
SUBMITTED BY & SIGNATURE:	Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services Department

RECOMMENDATION

(a) That the Board of Health authorize and direct the Medical Officer of Health to receive, use and report on one-time funding from the Hamilton Niagara Haldimand Brant Local Health Integration Network, of $14,158 for a 0.5 full time equivalent social work position in the Alcohol, Drug & Gambling Services program, for a 3 month pilot project from January 1, 2018 to March 31, 2018 providing on-site support at Towards Recovery and the Ontario Addiction Treatment Centre Clinics;

(b) That the Board of Health authorize and direct the Medical Officer of Health to increase the complement in Alcohol, Drug & Gambling Services program by 0.5 full time equivalent for the term of the above pilot;

(c) That the Board of Health authorize and direct the Medical Officer of Health to receive, utilize and report on one-time funding from the Hamilton Niagara Haldimand Brant Local Health Integration Network, of $14,158 for a 0.5 full time equivalent social work position in the Alcohol, Drug & Gambling Services program, for a 3 month pilot project from January 1, 2018 to March 31, 2018 to work with Hamilton Health Sciences to improve care for persons with repeat Emergency Department visits related to substance abuse; and,

(d) That the Board of Health authorize and direct the Medical Officer of Health to increase the complement in Alcohol, Drug & Gambling Services program by 0.5 full time equivalent, for the term of the above pilot.

EXECUTIVE SUMMARY

In October 2017, the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) approached organizations to inquire if there was capacity to increase services from mid-December to March 31, 2018 if one-time funding became available. There was potential for one-time funding to support addiction treatments, with a focus on opioid addiction and overdose that would increase access to counselling and case management services.

Alcohol, Drug & Gambling Services (ADGS) provides addiction counselling and case management in the Hamilton community and has experience providing specialized opioid case management services. ADGS also has experience working with community partners to improve access to addiction services. This has been accomplished by offering services off-site, from the ADGS main office, and by increasing the ability of front-line staff to work collaboratively together to provide care to individuals seeking supports.

Currently the Hamilton community is working to address significant consequences that individuals are experiencing related to the current opioid crisis, as well as, individuals who have repeat visits to the emergency department (ED) to address their substance use concerns. ADGS has been involved in developing initiatives, with community partners, to address the above issues and saw the one-time funding as an opportunity to pilot direct service projects in these areas.

ADGS had been working with the Towards Recovery Clinic (TRC) site, a local provider of opioid dependence treatment, and the need was identified to increase services to the second clinic site, Ontario Addiction Treatment Centre (OATC). The potential one-time funding call was viewed as an opportunity to expand services, evaluate the outcomes at the second clinic, as well as, provide more focused interventions for overdose prevention.

ADGS had also been involved in discussions with Hamilton Health Sciences Corporation (HHS) to implement a pilot utilizing the Health Links model to improve care for individuals with repeat ED visits related to substance use, including opioids. The one-time funding call was seen as an opportunity to secure funding to implement and evaluate the project model.

The two project initiatives were forwarded to the HNHB LHIN and approval of the one-time funding for the projects was received at the December 13, 2017 HNHB LHIN board meeting.

Alternatives for Consideration – Not Applicable

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: One-time funding of $28,316, $14,158 for each initiative, has been approved by the HNHB LHIN, for a period of mid-December to March 31, 2018.

Staffing: Funding will be used to backfill the two 0.5 FTE assignments by increasing existing part-time hours for the term of the agreement.

Legal: The HNHB LHIN has provided notice that the 2017-2018 Multi-Sector Services Accountability Agreement will be amended to reflect the additional one-time funding.

HISTORICAL BACKGROUND

Public Health Services, through the ADGS program, provides assessment, referral, case management, and treatment for individuals experiencing concerns with alcohol, drugs and gambling. Many individuals who access services experience acute and ongoing health concerns related to their use of substances. ADGS staff has expertise to assist individuals in working through potential barriers that may prevent them from being able to change their use of substances, as well as, to help people decide what services are right for them.

ADGS has a systems oriented and collaborative care approach to providing services. Addressing issues both at a community and individual level can be enhanced by working collaboratively with community partners. ADGS was previously approached by TRC and HHS to engage in two separate projects, however, both projects were focused on how to improve access to addiction treatment. They also shared the objectives of moving towards a more comprehensive and integrated addiction care model, making case management and counselling services more accessible, patient-centred and timely.

A pilot project, with limited hours, had been started with TRC and early results showed the following: individuals have been able to access services within 1-2 weeks of being referred by their physician, a significantly quicker access to services than through the ADGS main office; physicians in the clinic have indicated having counselling to refer to on-site is helpful; and the ADGS social worker has reported being on-site has been beneficial and increased co-ordinated care.

There has not been the opportunity to start the direct service work with the HHS project, however, work has been completed to develop the collaborative model and decide on outcomes to be measured.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

The one-time funding will be implemented in accordance with the terms and conditions outlined by the HNHB LHIN in the approval letter and the existing terms of the 2017-2018 Multi-Sector Services Accountability Agreement.

RELEVANT CONSULTATION

Finance was consulted to determine the cost for salary and benefits of the two ADGS Social Worker 0.5 FTE positions. The liaison contact with TRC and HHS were consulted re bringing forward the projects for the one-time funding opportunity.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

ADGS has a longstanding history of providing specialized services to individuals who misuse or abuse substances. The addiction services that both HHS and Towards Recovery Clinic are seeking for their patients are services currently provided by ADGS, however, the ability to offer these services in a timely manner needed for this initiative is limited. ADGS also has experience in providing off-site programming with current partnerships including: local Children Aids Societies, Hamilton Family Health Team, Addiction Services Initiative with Ontario Works and the Harm Reduction Program, and the Street Health Clinic.

Many individuals accessing services through the hospital system may have difficulty navigating and accessing services of a community addiction treatment agency following a hospital admission. The collaboration between ADGS and HHS would provide an opportunity to increase capacity to work more intensely with individuals to help them navigate care following a hospital contact, helping individuals connect with services that can help with recovery from substance use problems.

Individuals who are involved in opioid dependence treatment may continue to experience use of opioids and are at risk for consequences related to this use, including opioid overdose/poisoning. It will be beneficial to have an ADGS social worker at both TRC and the OATC that physicians can refer to, or, individuals can self-refer to, to receive addiction treatment and information about overdose/poisoning prevention.

ALIGNMENT TO THE 2016 – 2025 STRATEGIC PLAN

Healthy and Safe Communities
Hamilton is a safe and supportive city where people are active, healthy, and have a high quality of life.

APPENDICES AND SCHEDULES ATTACHED

None

CITY OF HAMILTON
PUBLIC HEALTH SERVICES
Communicable Disease Control and Wellness

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	January 15, 2018
SUBJECT/REPORT NO:	Alcohol, Drug & Gambling Services – Community Mental Health Promotion Program Budget 2018-2019 (BOH18003) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Susan Boyd (905) 546-3606, Ext. 2888
SUBMITTED BY & SIGNATURE:	Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services Department

RECOMMENDATION:

(a) That the Board of Health approve the 2018-2019 Alcohol, Drug & Gambling Services Hamilton Niagara Haldimand Brant, Local Health Integration Network budget; 100% funded by the Hamilton Niagara Haldimand Brant, Local Health Integration Network;

(b) That the Board of Health approve the 2018-2019 Community Mental Health Promotion Program Hamilton Niagara Haldimand Brant, Local Health Integration Network budget; 100% funded by the Hamilton Niagara Haldimand Brant, Local Health Integration Network; and,

(c) That the Medical Officer of Health or delegate be authorized and directed to receive, utilize and report on the use of these funds.

EXECUTIVE SUMMARY

Alcohol, Drug & Gambling Services (ADGS) is a 100% provincially funded program that provides comprehensive assessments, outpatient counselling, referrals for treatment, and collaborative service delivery with other agencies in the community. The Community Mental Health Promotion Program (CMHPP) is a 100% provincially funded program that provides mental health case management and outreach services to the Hamilton community.

There continues to be no increase to base budget for either program. For the upcoming fiscal year changes to the administrative staffing complement has off-set budget pressures and there is no change to the overall FTE. The administrative model has continued to be adjusted to provide support across both programs to manage administrative workload pressures. Continued efforts have also been made to implement continuous improvement initiatives to meet targets and service demands. However, it continues to be very difficult to find efficiencies to meet service targets.

Alternatives for Consideration – Not Applicable

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: There continues to be no increase to base budget in the Hamilton Niagara Haldimand Brant – Local Health Integration Network (HNHB – LHIN) budgets. The 2018-2019 CAPS was submitted and approved by the LHIN. The table below outlines the budget and FTE's for the budget year 2018-2019.

Community Mental Health Promotion Program, and Alcohol, Drug & Gambling Services Budget

Funding Source	Annual Budget 2018-2019	Annual Budget 2017-2018	FTE 2018-2019	FTE 2017-2018	Change in FTE Increase / (Decrease)
HNHB – LHIN; Community Mental Health Promotion Program	$683,929*	$683,929*	5.4	5.2	0.2
HNHB – LHIN; Substance Use	$712,691	$712,691	6.3	6.4	(0.1)
HNHB – LHIN; Problem Gambling	$307,591	$307,591	2.4	2.5	(0.1)
Total Budget and FTE	**$1,704,211***	**$1,704,211***	**14.1**	**14.1**	**0**

*This budget line includes sessional fees funding, targeted psychiatric consultation, not base budget.

Staffing: There are no overall FTE changes for 2018-2019. There has been a slight change in FTE's between programs to meet administrative model changes and continue to work towards building concurrent disorders capacity between the programs.

Legal: No new legal implications for these programs.

HISTORICAL BACKGROUND

Both ADGS and the CMHPP are entering the eighth year of no increase to base budget from the HNHB – LHIN. Both programs are engaged in continuous quality improvement initiatives in an effort to meet the needs of individuals who are accessing services. Historically, a staff person is shared between ADGS and the CMHPP to help address issues related to concurrent disorders and build capacity across the programs. This has been continued within the 2018-2019 budgets to enhance the quality of direct services provided to individuals accessing services. Continuing this year is the further development of a shared administrative model between the programs to accommodate the administrative workload.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

The HNHB – LHIN policy requires all funded programs, including ADGS and the CMHPP to submit a balanced budget, meet agreed upon targets and implement a Quality Plan.

RELEVANT CONSULTATION

Finance and Administration was consulted to review the budget numbers.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

Both ADGS and the CMHPP continue to provide assessment, case management, treatment, and outreach services within the community. The programs continue to meet established service level targets within the range set by accountability agreements, however, pressures continue within the programs to manage wait times for service, be responsive to emerging needs in the community, and provide the intensity of services required. ADGS and CMHPP will continue to engage in quality improvement initiatives to directly impact the quality of care provided to individuals accessing our services. It is important that quality improvement initiatives continue to be developed to meet the complex needs that individuals experience, and to aim to provide services in a timely manner. It is also important that each program be able to continue to provide service, as our services are an important part of the addictions, homelessness and mental health system in Hamilton.

ALTERNATIVES FOR CONSIDERATION

Not applicable

ALIGNMENT TO THE 2016 – 2025 STRATEGIC PLAN

Healthy and Safe Communities

Hamilton is a safe and supportive city where people are active, healthy, and have a high quality of life.

APPENDICES AND SCHEDULES ATTACHED:

None

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	December 4, 2017
SUBJECT/REPORT NO:	Food Strategy Implementation Plan BOH13001(f) (City Wide) (Outstanding Business List Item)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Sandy Skrzypczyk (905) 546-2424, Ext. 3523
SUBMITTED BY & SIGNATURE:	Kevin McDonald Acting Director, Healthy Environments Division Public Health Services Department

Council Direction:

The Board of Health at its meeting of August 11, 2016 approved the Food Strategy BOH13001(d) (City Wide) Recommendation Report, which included that:

(d) The Interdepartmental Food Strategy Steering Team be directed to develop an Implementation Plan for the Food Strategy Actions to be submitted to the Board of Health. The plan will include: identification of a corporate or community lead; estimated completion timelines; establish monitoring and evaluation measures; identification where policy changes or additional financial or staffing resources would be required; and,

(i) Actions that have policy, financial, or staffing implications will be required to report back to an appropriate Standing Committee for approval prior to implementation.

This Information Report provides the Food Strategy Implementation Plan and an overview of highlights achieved to date on the Food Strategy; and this item can be removed from the Outstanding Business List.

Information:

In August 2012, the Board of Health requested that a comprehensive Food Strategy be developed. In 2013, the Interdepartmental Food Strategy Steering Team formed, with representation from Public Health Services, Planning and Economic Development, Community and Emergency Services, and Public Works departments. After an extensive review of existing practices and evidence, a formal Food Strategy community engagement process was conducted in 2015, with over 2700 citizens providing input. In August 2016, the Board of Health received the BOH 13001(d) - Food Strategy Recommendation Report and endorsed the Hamilton Food Strategy: Healthy, Sustainable, and Just Food for All.

The Food Strategy provides the following vision for our community, "A city with a sustainable food system where all people at all times have economic and physical access to enough safe, nutritious food to meet their dietary needs and food preferences." Core principles, based on Hamilton's Food Charter, underpin the Strategy and the four overarching Goals, while 14 Recommendations and 46 Actions based on a food system framework identify initiatives to achieve the four goals. In 2016, five Priority Actions from the 46 Actions were identified to focus on first and have either been completed or are underway.

A Food Strategy Implementation Plan (attached as Appendix A) has been developed to guide the undertaking of the majority of the 46 Food Strategy's Actions over the next several years. Implementation activities for a few actions are still being finalized at this time or remain underdetermined. Going forward, there is a strong commitment to explore opportunities within the City and the community to ensure all 46 Actions are achieved.

Highlights of Food Strategy Achievements to Date

In addition to progress on the Food Strategy's Priority Actions, other Actions have been completed or initiated as highlighted below:

Food Strategy Goal(s)	Food Strategy Action Highlights from September 2016 to November 2017
Goal 1: Support food friendly neighbourhoods to improve access to healthy food for all residents	• In collaboration with Ryerson University's Centre for Studies in Food Security, Public Health Registered Dietitians are completing a kitchen scan to assess the availability of community facilities with kitchens that may be used by groups who wish to engage in food skills programs • Public Health Food Strategy staff are providing consultation for the incorporation of a kitchen into the renovation of Riverdale Recreation Centre

Food Strategy Goal(s)	Food Strategy Action Highlights from September 2016 to November 2017
	• Public Health Food Strategy staff are providing consultation support to a CityLAB project: Food Waste Recovery at McMaster University in conjunction with the Academic Sustainability Program
Goal 2: Increase food literacy to promote healthy eating and empower all residents	• A Food Literacy Network Forum was held October 2016, bringing together 27 community stakeholders who support learning about and working with food in order to share their work, as well as their ideas about food literacy and the formation of a Hamilton Food Literacy Network (HFLN); a core group stepped forward to guide the HFLN. • The core HFLN members have developed an action plan to advance the HFLN; the first priorities are to develop a communication mechanism to disseminate information and connect people involved in food literacy programs and initiatives. • In the upcoming 2018 winter term, McMaster University's DeGroote School of Business MBA Health Care and Marketing course term project will focus on best practices for digital tools to facilitate communication about food literacy. • Public Health Registered Dietitians developed healthy eating lesson plans and provided Train-the-Trainer in-service to Recreation Centre coordinators with food programs within their facilities.
Goal 3: Support local food and help grow the agri-food sector	• Planning staff completed Action 3.1: Create a toolkit to assist landowners to incorporate food system elements into developments. • In the 2017 winter term, McMaster University's DeGroote School of Business MBA Health Care and Marketing course term project focused on Hamilton's Farm Map. Results and recommendations from the MBA students' projects have informed the next version of the Farm Map. • By leveraging existing agricultural and culinary assets, staff from Public Health, Economic Development, Tourism, and IT is developing an enhanced Farm Map that will provide a more engaging web and social media experience. This will be the first phase in building a more comprehensive food-focused online portal to attract Hamiltonians and visitors to celebrate our local food and agricultural story. • Economic Development and Public Health staff are collaborating in partnership with Mohawk College's Sustainability Office to reach out to local farms to participate in

Food Strategy Goal(s)	Food Strategy Action Highlights from September 2016 to November 2017
	the Farm Map, which is expected to be available in Spring 2018 • NOSH is in its second year. This week-long celebration of Hamilton's culinary scene took place during National Small Business Week from October 16 to 22, 2017. • Public Health staff support the Mohawk College's Sustainability Office's local food procurement initiative. • Public Health Registered Dietitian responded to provincial consultations on land use planning documents (October 2016) highlighting the need to preserve agricultural land for growing nutritious food and improving access to local, healthy food.
Goal 4: Advocate for a healthy, sustainable, and just food system with partners and at all levels of government	• Priority Action 1 (Funding Criteria and Process) was completed and endorsed by Board of Health in June, 2017. • To address food insecurity/poverty reduction, PHS and CES staff on the Food Strategy Interdepartmental Steering Team have attended monthly meetings of Hamilton Basic Income to provide support and collaboration on activities where it aligns with our work. This has included - participation in the consultations related to the Ontario Basic Income Pilot (November 2016; January, June, August 2017) - responding to federal consultations on poverty reduction (February 2017) - joint coordination with the Hamilton Roundtable for Poverty Reduction of a Town Hall meeting on Basic Income on May 29, 2017 - planning and coordination of a community event "Basic Income: What Hamilton Homeowner Should Know" on October 23, 2017 • In November 2017, the BOH17041 Report recommends the continuation of Public Health Services' monitoring of the cost of the Nutritious Food Basket (NFB). PHS uses the NFB data as an education tool to increase awareness among the Board of Health, community partners, and the general public about health issues associated with food insecurity and to support health equity work by generating local evidence of food insecurity and the impacts of limited incomes.

Resources: Funding, Policy, and Staffing

Currently, identified implementation activities within the Food Strategy Implementation Plan are being carried out within existing allocated funding, policies, and staffing. Any future actions that have policy, financial, or staffing implications will be required to report back to an appropriate Standing Committee for approval prior to implementation.

Measuring the Food Strategy's Success

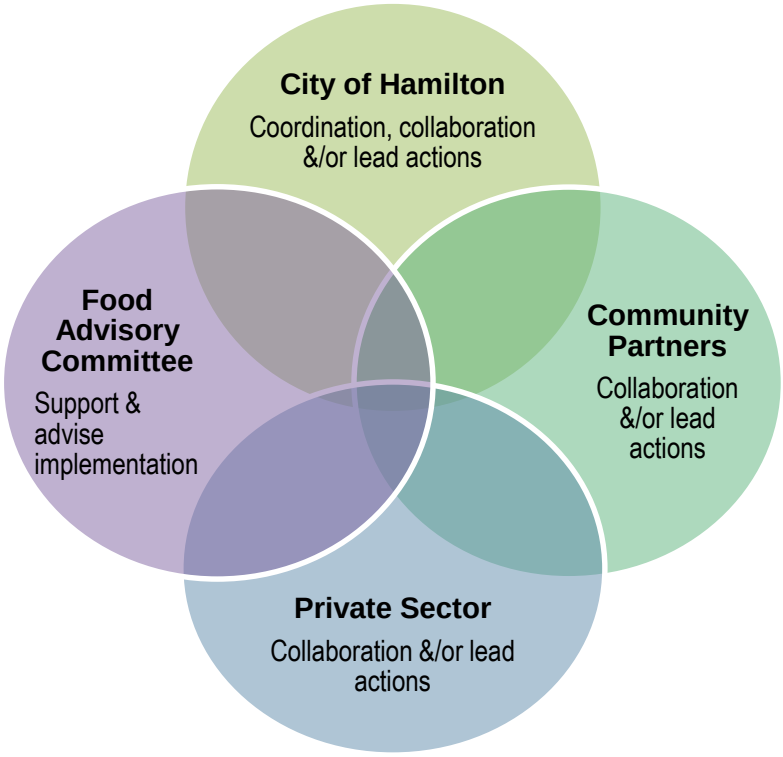
The availability of data impacts establishing baseline measures and indicators. Measurement tools change over time and the resources required to gather and update local data is not always available. With these factors in mind, attention has been given to creating indicators to help inform the monitoring and evaluation of the Food Strategy.

As work progresses throughout the implementation of the Food Strategy, modifications of the indicators may be required to ensure relevance to the current context. Indicators to track progress and evaluate effectiveness are outlined in the Food Strategy Implementation Plan.

Supporting the Implementation of the Food Strategy

The Food Strategy provides a single policy framework that integrates the full spectrum of the food system to coordinate existing and emerging food issues and actions. Active involvement of the City, citizens, and community partners strengthens coordination and collaboration, which results in better services, better use of resources, and better decision-making. Strong partnerships and collective responsibility ensures that food actions happen holistically across our local food system.

Everyone who has a stake in food systems initiatives, such as rural and urban agriculture, social enterprise, food procurement, food retail, etc., is instrumental in sharing their knowledge, learning and talking about, contributing to, and participating in the implementation of the Food Strategy.



The Interdepartmental Food Strategy Steering Team acknowledges that the successful implementation of the Food Strategy is dependent upon the efforts and cooperation of many people. Since the Board of Health endorsement of the Food Strategy in August 2016, several community stakeholders have connected to staff to explore and contribute to the Food Strategy Actions. Moving forward, staff is committed to keeping up this momentum by strengthening their engagement of the broader community, stakeholders, and partners in the implementation of Food Strategy. To guide this undertaking, any new Food Strategy implementation activities will be identified based on where there is existing momentum, opportunities for partnerships, and potential to add capacity.

Like any strategy or plan, the Food Strategy is considered a living document that is open to review and consideration of new opportunities with strong potential to ensure Hamilton has a healthy, sustainable, and just food system. In turn, the Food Strategy Implementation Plan is also a living document that is expected to evolve with changing needs and opportunities in the community. It will be regularly reviewed by the Interdepartmental Food Strategy Steering Team, with input from the Food Advisory Committee and other community partners. We acknowledge that the Food Strategy vision can only be met with the ongoing participation of all those who have contributed to date and new partners not yet realized.

Annual updates on the Food Strategy's progress will be provided to the Board of Health and the broader community on the Food Strategy's progress in creating a healthy, sustainable, and just food system for all.

Appendices/Schedules Attached:

Appendix A to Report BOH13001(f) – Hamilton Food Strategy Implementation Plan

Hamilton Food Strategy

Healthy, Sustainable, and Just Food for All

City of Hamilton

Implementation Plan

December 2017

Introduction & Background

In August 2016, the Board of Health endorsed the Hamilton Food Strategy: Healthy, Sustainable, and Just Food for All. The Food Strategy is a 10-year plan to help guide the food related work of City departments. The Food Strategy also supports collaboration and innovation within the City and with community partners from all sectors of the food system. It takes a holistic approach that looks at all the parts of a food system to optimize the allocation of resources for food actions. The Food Strategy is the result of extensive community engagement, in addition to being informed by evidence, best practices, and local existing work and expertise.

The Food Strategy provides the following vision for our community, “A city with a sustainable food system where all people at all times have economic and physical access to enough safe, nutritious food to meet their dietary needs and food preferences.” Core principles, based on Hamilton’s Food Charter, underpin the Strategy and the four overarching Goals, while 14 Recommendations and 46 Actions based on a food system framework identify initiatives to achieve the four goals. In 2016, five priority actions from the 46 Actions were identified to focus on first and have either been completed or are underway. A Food Strategy Implementation Plan has now been developed to guide the undertaking of the majority of the 46 Food Strategy’s Actions over the next several years. Implementation activities for a few actions are still being finalized at this time or remain underdetermined. Going forward, there is a strong commitment to explore opportunities within the City and the community to ensure all 46 Actions are achieved.

As with the development of the Food Strategy, the successful implementation of the Strategy is dependent on the efforts and collaboration of many people. The Food Strategy is grounded in the local context and a firm commitment to action. To guide this undertaking, the implementation activities within this Plan were identified based on where there is existing momentum, opportunities for partnerships, and potential to add capacity.

Like any strategy or plan, the Food Strategy is considered a living document that is open to review and consideration of new opportunities with strong potential to ensure Hamilton has a healthy, sustainable, and just food system. In turn, the Food Strategy Implementation Plan is also a living document that is expected to evolve with changing needs and opportunities in the community. It will be regularly reviewed by the Interdepartmental Food Strategy Steering Team, in collaboration with the Food Advisory Committee and other community partners. We acknowledge that the Food Strategy vision can only be met with the ongoing participation of everyone who has contributed to date and in the future.

To download a copy of the Food Strategy or learn more, please visit www.hamilton.ca/foodstrategy

Food Strategy Goals

1. Support food friendly neighbourhoods to improve access to healthy food for all residents
2. Increase food literacy to promote healthy eating and empower all residents
3. Support local food and help grow the agri-food sector
4. Advocate for a healthy, sustainable, and just food system with partners and at all levels of government

Legend

Food Strategy Actions	Set the direction and the focus of the Initiatives
Implementation Activities	Tangibles that are implemented to achieve the FS Actions
Lead	Internal/External Department or Organization leading the Initiative
Partners	Internal/external partners that are integral to achieving the Initiative
Timeline	Estimated start date and length of time to achieve the Initiative Short-term: 1-3 years Mid-term: 3-6 years Long-term: 6-10 years Ongoing, as needed

Funding, Policy, and Staffing

Identified implementation activities within the Food Strategy Implementation Plan are currently being carried out within existing allocated funding and staffing, and existing policies. Any future actions that have policy, financial, or staffing implications will be required to report back to an appropriate Standing Committee for approval prior to implementation.

Abbreviations

Interdepartmental Food Strategy Steering Team	FSST
Public Health Services	PHS
Healthy Food Systems	HFS
Planning and Economic Development	PED
Community and Emergency Services	CES
Children and Home Management Services	CHMS
Emergency Medical Services	EMS
Ontario Works	OW
CityHousing Hamilton	CHH
Information Technology	IT
Public Works	PW
Food Advisory Committee	FAC
Healthy Kids Community Challenge	HKCC
Hamilton Wentworth District School Board	HWDSB
Hamilton Wentworth Catholic District School Board	HWCDSB
Golden Horseshoe Food and Farming	GHFF
Hamilton Community Garden Network	HCGN
Human Resources (Corporate Services)	HR
Community Access to Child Health (CATCH) Program	CATCH
Environment Hamilton	EH
Hamilton Naturalist Club	HNC
Neighbour to Neighbour	N2N
Recreation Division – CES Dept	REC
City Housing Hamilton	CHH

System-Wide Actions

Food Strategy Goal Alignment: 2, 3, 4				
System-Wide Recommendation **1. Strengthen advocacy to eliminate poverty to improve individual and household food security.**				
Actions	**Implementation Activities**	**Internal Lead(s)**	**Partners**	**Timeline**
1.1 Work with local stakeholders and partners to advocate at all levels of government for adequate incomes	Advocacy • Monitor the cost of healthy eating in Hamilton • Support to Hamilton Basic Income • Basic Income Ontario Pilot – Provincial consultation • Participate in provincial activities regarding income responses to food insecurity • Support Hamilton Poverty Strategy	PHS		Ongoing
	• Work with early years organizations to ensure staff is paid a living wage • Develop a plan to embed living wage expectations into child care and Early Years' service agreements	CES - CHMS		Ongoing
1.2 Facilitate movement along the food security and economic spectrum with a focus on food skills, job creation, and fair wages.	• To Be Determined			

System-Wide Actions

Food Strategy Goal Alignment: 1, 2, 3, 4				
System-Wide Recommendation **2. Strengthen funding criteria for community food initiatives.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
2.1 Create a formal, transparent process for requests for municipal funding for community food initiatives/programs as they arise at any City of Hamilton subcommittee meetings, Council via Council motions, delegations, or staff direction.	• Food Strategy Steering Team developed the process and will be exploring the best approach for monitoring and evaluation methods BoH for endorsement	FSST	FAC	Short term
2.2 Establish criteria to ensure that community food initiatives/programs that receive municipal support (funding, staffing, etc.) align with the Food Strategy goals.	• Food Strategy Steering Team developed the criteria and process to respond to food action funding requests that the City receives outside of the established granting structure (e.g., City Enrichment Funds) **Action Competed: Presented and received at June 2017 Board of Health meeting**	FSST	FAC	Short term
2.3 Create a process by which municipal funding recommended for community food initiatives, such as programs, events, and activities comply with healthy eating guidelines.	• The City's corporate Healthy Food & Beverage Policy has been reviewed; next steps to be determined	PHS HR		Ongoing

System-Wide Actions

Food Strategy Goal Alignment: 1, 2, 3, 4				
System-Wide Recommendation **3. Ensure that food system enabling policies, tools, and other approaches are in place.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
3.1 Create a toolkit to assist landowners to incorporate food system elements into developments.	• Initial stage of the toolkit development is completed; next steps to be determined	PED		Short – Mid term
3.2 Continue to participate and support the Golden Horseshoe Agriculture & Agri-Food Strategy – Food & Farming: An Action Plan 2021.	• Representation on GHFF Alliance	PED	PHS	Ongoing
	• PHS representation on the GHFF Alliance – Facilitate connections and collaboration opportunities among participating local health units/clusters – Convene regional meetings with regional Public Health representatives involved in local food Initiatives	PED	PHS	Ongoing
3.3 The local food system is considered during consulting, planning, and implementing community initiatives.	• PHS Registered Dietitians respond to municipal, provincial, and federal food system consultations	PHS		Ongoing
3.4 Improve coordination among funders, stakeholders, and all levels of government to ensure reliable and sustainable financial support of neighbourhood based food initiatives, particularly those delivered by local food networks.	• To Be Determined			

Food Production Actions

Food Strategy Goal Alignment: 1, 3				
Food Production Recommendation **4. Build stronger City-Farm relationships to enhance the growth and development of local food.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
4.1 Strengthen access and opportunities to farm as a living, particularly for new farmers.	• OW community placement with McQuesten Urban farm; develop skills on volunteer basis then seek opportunities for OW participants to be employed in the farming industry	CES-OW Community Placement		Short to Med term
4.2 Encourage local farms to increase their production of food to meet the nutritional needs and cultural preferences of Hamiltonians.	• To Be Determined			

Food Production Actions

Food Strategy Goal Alignment: 2				
Food Production Recommendation **5. Improve children and youth's eating habits, food skills, and knowledge of food systems through food literacy.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
5.1 Incorporate food-system education in schools and in other learning programs.	• Work with Child & Family Centres to ensure that food education is embedded into programs, workshops, etc.	CES - CHMS	PHS	Short term
5.2 Expand school-to-farm learning opportunities.	• Launch of McQuesten Urban Farm school tour program; tied to curriculum, 30 school trips in fall 2017 funded by HKCC and then available in 2018 throughout the year	CES	N2N HWDSB HWCDSB	Short term

Food Production Actions

Food Strategy Goal Alignment: 1, 2, 3, 4				
Food Production Recommendation **6. Support and create diverse ways for people to grow food in the urban landscape and participation in urban agriculture activities.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
6.1 Strengthen the City's commitment to Hamilton's Rural Official Plan and Zoning By-law to support and protect agriculture through protection of land and allowing for innovative agricultural uses.	• To Be Determined			
6.2 Ensure planning policies and regulations are supportive of residents who want to grow food.	• Polices and regulations have been reviewed; next steps to be determined	PED - Planning		Ongoing
	• Lodges promote Resident gardening activities including assistance with the Victory Gardens	CES - Lodges		Ongoing
6.3 Expand community garden programs to promote community development opportunities with local schools and other local organizations as part of their education programs.	• Paramedic Community Garden at Limeridge Base established, now in 5th year of operation; partnership with seniors complex adjacent to station	CES - EMS		Ongoing
	• Macassa Lodge has 2 large Victory Gardens on-site and tended by volunteers-grown for use in the Local community	CES - Lodges	Victory Gardens	Ongoing
6.4 Promote the use of food-bearing plants and trees as part of landscaping for residential, commercial, and institutional uses.	• Develop plan to promote *Landscaping Toolkit* to landowners and implement plan	PED FSST		Mid term

Food Strategy Goal Alignment: 1, 2, 3, 4				
Food Production Recommendation **6. Support and create diverse ways for people to grow food in the urban landscape and participation in urban agriculture activities.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
6.5 Encourage the development of gardens to grow food at all local schools, city facilities, and new developments.	• Work with other Child & Family Centres to ensure that vegetable gardens are made available; Red Hill Family Centre has a very small vegetable garden in our playground; Children and teachers plant the seeds and vegetable plants purchased, water, record the growth; End of the season the vegetables are incorporated into the daily menu	CES - CHMS		Short term
	• Explore the feasibility to develop community gardens at recreation centres	CES - REC PW - Facilities/ Parks	PHS	Mid term
	• Continue and expand current initiatives at Community Housing sites (e.g., Purnell)	CHH		Ongoing
	• Paramedic Community Garden Limeridge Base	CES - EMS		Ongoing
6.6 Promote the use of environmental best practices to ensure healthy soil, air, and water are available for community gardens and urban and rural farms.	• Active promotion and resident education of organic gardening techniques and tools within CityHousing Hamilton properties.	CHH	N2N EH HNC	Ongoing
	• Paramedic Community Garden Limeridge Base gardening practices include hand weeding, no chemicals, all natural	CES - EMS		Ongoing

Food Strategy Goal Alignment: 1, 2, 3, 4				
Food Production Recommendation **6. Support and create diverse ways for people to grow food in the urban landscape and participation in urban agriculture activities.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
6.7 Strengthen access to community gardens, particularly for those who live in neighbourhoods that lack spaces to grow food or are food insecure.	• Ongoing support and coordination of Community Gardens Project within CityHousing Hamilton Portfolio • Community Garden Program in place since 2010 for creating gardens on City-owned land; CityHousing runs independent garden program for their properties; Supports for all existing and new gardens provided by Hamilton Community Garden Network; New gardens started in 3 Neighbourhood Action Strategy neighbourhoods in 2017	CHH	N2N EH HNC	Ongoing

Food Processing & Distribution Actions

Food Strategy Goal Alignment: 1, 2, 3				
Food Processing & Distribution Recommendation **7. Foster Hamilton's food innovation and entrepreneurial spirit.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
7.1 Create innovative ways to connect and support food initiatives and food organizations.	• To Be Determined			
7.2 Support businesses and social enterprises involved in processing and distribution of local, healthy, and sustainable food.	• Continued support through the Small Business Enterprise Centre including funding programs (Starter Company and Starter Company Plus)	PED	Province	Ongoing
7.3 Determine feasibility of a food business incubator to provide the space, training, resources, and distribution network for entrepreneurs to access wholesale or retail markets.	• Letter of Support and Participation at the table of the Incubation, Acceleration and Commercialization Agri-Food Collaborative (IAC) being led by the Agri-Food Management Institute and Greenbelt Fund	PED		Ongoing
7.4 Establish or strengthen programs to help entrepreneurs start a food related business.	• Development of Guidebooks as part of the Open for Business Initiative "Opening a Restaurant in Hamilton" and "Opening a Food Business in Hamilton" (Restaurant Guide is completed) • Development of The Food Forum by Innovation Factory – A peer group of entrepreneurs in the Food Products and Production industries will get together to talk about common challenges in the food industry and to learn best practices	PED	Innovation Factory	Short term and ongoing

Food Strategy Goal Alignment: 1, 2, 3				
Food Processing & Distribution Recommendation **7. Foster Hamilton's food innovation and entrepreneurial spirit.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
7.5 Address gaps in the infrastructure needed to support local and sustainable food processing and distribution.	• Update to The Golden Horseshoe Food and Farming Alliance Agri-Food Asset Mapping project to help identify gaps in infrastructure and supply chain of the agri-food industry	PED	GHFFA	Short term
7.6. Determine feasibility to establish a food terminal or hub for local food producers to distribute their products.	• To Be Determined			

Food Processing & Distribution Actions

Food Strategy Goal Alignment: 1, 3				
Food Processing & Distribution Recommendation **8. Enhance the promotion and marketing of Hamilton's local food industries.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
8.1 Expand marketing efforts to focus on Hamilton's local food and farming sector.	• Enhance the Hamilton Eat Local Farm Map & Directory and Hamilton Eat Local brand via Story Maps software program	PED PHS IT	Mohawk College – Sustainability Office	Short term
8.2 Enhance culinary tourism to promote local food businesses and events.	• Build/expand an online portal to incorporate local food, events, programs, etc. • Continued support of NOSH Hamilton, which occurs annually during Small business Week in October	PED PHS IT		Mid term

Food Access & Consumption Actions

Food Strategy Goal Alignment: 1, 3, 4				
Food Access & Consumption Recommendation **9. Increase the amount of healthy, local food in publicly owned facilities to make the healthy choice the easy choice.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
9.1 Reduce access to unhealthy foods in public facilities, particularly where vulnerable groups visit (e.g., children).	• Investigate the feasibility of creating healthy choice guidelines in recreation facilities that (1) aim to reduce sugary drinks and increase healthy options within vending machines and over-the-counter food service locations; (2) Address food and drink advertising, promotion, and display with a focus on healthy options	CES – REC PHS		Short - Mid term
9.2 Conduct an environmental scan to measure the percentage of healthy, local food that is procured by the City.	• To Be Determined			
9.3 Review policies and explore opportunities for City facilities to increase the percentage of healthy, local food purchased by their facilities.	• Review practices for Snack vending and events • Identify preferred produce vendors (RFP process)	CES – REC	PHS	Short – Mid term
9.4 Policies and programs are in place to increase healthy food options in publicly-owned, neighbourhood, and community facilities (e.g., recreation centres, workplaces, schools, etc.).	• Arena Concessions – adding vegetables and fruit as part of HKCC Theme 3 • Drinking water infrastructure • Investigate the feasibility of creating healthy choice guidelines in recreation facilities that (1) aim to reduce sugary drinks and increase healthy options within vending machines and over-the-counter food service locations; (2) Address food and	CES – REC	PHS	Ongoing

Food Strategy Goal Alignment: 1, 3, 4				
Food Access & Consumption Recommendation **9. Increase the amount of healthy, local food in publicly owned facilities to make the healthy choice the easy choice.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
	drink advertising, promotion, and display with a focus on healthy options • Increase healthy eating principles in Recreation cooking programs • City-run Events – SEAT: Explore the feasibility of having healthier options at large-scale events • After-school programs: Ministry healthy eating guidelines are followed • Parks: increase drinking water infrastructure • Breastfeeding support: REC currently supports breastfeeding; opportunity to partner with PHS for promotion of Baby-Friendly messaging			
	• Ensure that access to food is available at Child & Family Centres within the context of specific neighbourhood needs	CES		Ongoing
	• Food Cupboard at Quigley Road for participating parents and children; Food bank and the staff cook healthy meals and provide snacks through Taste Buds	CATCH CES - HM		Ongoing

Food Access & Consumption Actions

Food Strategy Goal Alignment: 1, 3, 4				
Food Access & Consumption Recommendation **10. Promote physical access to healthy food, local food in all neighbourhoods.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
10.1 Explore the feasibility of innovative ways to increase healthy food retail in neighbourhoods where it is limited (e.g., farmers markets, mobile produce truck, healthy corner stores, etc.).	• Conduct review of best practices and provide knowledge exchange with community partners	PHS	Indwell	Ongoing
10.2 Pilot and evaluate promising/evidence informed programs in partnership with community stakeholders that improve physical access to healthy food in neighbourhoods with limited healthy food retail options.	• Plan, implement, and evaluate a Healthy Corner Stores program within the McQuesten neighbourhood	Indwell	PHS	Short – Mid term
10.3 Tailor physical food access to the context of each neighbourhood/community (e.g., food delivery programs, bulk buying clubs, etc.).	• OW initiated a 'Food for Thought' program that provides healthy snacks to clients visiting OW offices who may be experiencing hunger • OW Addiction Services Initiatives (ASI) supports their clients with opportunities to participate in a collective kitchen and to annually plant a roof top garden; This assists to increase food security while providing therapeutic activities	CES - OW		Ongoing
	• Ensure that access to food is available at Child & Family Centres within the context of specific neighbourhood needs	CES - CHMS		Short term

Food Strategy Goal Alignment: 1, 3, 4				
Food Access & Consumption Recommendation **10. Promote physical access to healthy food, local food in all neighbourhoods.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
	• Wentworth Lodge provides daily Meals on Wheels program • Macassa Lodge Adult Day Program participates in Food Drives to support the community	CES - Lodges		Ongoing
	• Good Food Market at Hamilton Community Food Centre provides increased access to healthy food, increased community engagement and leadership	N2N	PHS	Ongoing

Food Access & Consumption Actions

Food Strategy Goal Alignment: 1, 2, 3, 4				
Food Access & Consumption Recommendation **11. Integrate food literacy and food systems training and education where residents live, learn, work, and play.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
11.1 Advocate for mandatory food literacy curriculum in schools.	• To Be Determined			
11.2 Facilitate comprehensive approaches to incorporate food skills, community kitchens, and other capacity-building programs in community settings, in addition to providing food.	• Develop and pilot a "Garden to Kitchen and Back" Food Literacy Toolkit, focusing on experiential learning; evaluate outcomes at different sites with various levels of infrastructure supportive of food literacy	PHS		Short term
11.3 Offer a food skills and employability program, particularly for vulnerable groups.	• Adapt and implement Toronto's Good Food Works Program, which includes food safety, nutrition/healthy living, and job seeking components	PHS	CES FAC	Short term
11.4 Provide and support food skills and nutrition education programs that are accessible to all Hamiltonians.	• Develop nutrition education and food skills resources (focused on vegetables and fruit) for Recreation Cooking Programs; pilot and evaluate; train REC Centre staff coordinators (supervise program leaders)	PHS	CES – REC	Short term
	• Food handler certification course available online • Education/marketing of healthy choices at recreation facilities	CES - REC		Short – Mid term

Food Access & Consumption Actions

Food Strategy Goal Alignment: 1, 2, 3, 4				
Food Access & Consumption Recommendation **12. Support the physical and social infrastructure needed to empower citizens to take action.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
12.1 Build, retro-fit, or re-purpose community and neighbour infrastructure to support food initiatives, such as community kitchens, food markets, community gardens, etc.	• Current infrastructure for Community Gardens and Community Kitchens is in place across several properties within the CityHousing Hamilton Portfolio	CES - CHH		Ongoing
	• Review the gaps and act on the opportunities to ensure infrastructure exists for food actions	PHS FSST		Ongoing
12.2 Facilitate the creation of food networks to assist in capacity building, information sharing, and ability to access community-based food programs.	• Support an engaged, active Hamilton Food Literacy Network (HFLN) • Establish and support the implementation of an annual Food Literacy Month	PHS	FAC HFLN	Ongoing
12.3 Assess the availability of community spaces with kitchens where people can learn and cook for themselves.	• Complete a Kitchen Scan to determine availability and accessibility of community kitchen infrastructure	PHS	FAC Ryerson University	Short term

Food Waste Management Actions

Food Strategy Goal Alignment: 1, 2				
Food Waste Management Recommendation **13. Foster innovation to reduce food waste through diversion and composting.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
13.1 Expand programs to increase the use of composting in all settings (e.g., apartments, workplaces, schools, etc.).	• Waste reduction/composting pilot project at City facilities to identify reduction and diversion opportunities during banquet type events • Create a new multi-residential strategy to improve recycling and composting in apartments and condos	PW	PHS	Short term
	• Encourage the use of rain barrels and compost bins at all Community Gardens across CityHousing Hamilton Portfolio	CES - CHH		Ongoing
13.2 Explore the feasibility of food recovery programs to divert edible food from being wasted or in landfill.	• Investigate partnerships with local educational institutions through the CityLab program to identify potential food recovery, reduction and diversion improvements	PW	PHS CityLab	Short term
	• Lodges to explore this opportunity	CES - Lodges	PW	Mid term
13.3 Investigate the feasibility of innovative ways to deal with food waste to ensure our environment is sustainable.	• Undertaken a Request for Information investigating opportunities for long term management of the Organics Management Program, including source separated organics and leaf and yard waste by exploring innovative technologies	PW		Mid term
	• Lodges to explore this opportunity	CES - Lodges		Mid term

Food Waste Management Actions

Food Strategy Goal Alignment: 2				
Food Waste Management Recommendation **14. Promote a culture that values healthy, local food to reduce food waste through food literacy.**				
Actions	**Implementation Activities**	**Lead**	**Partners**	**Timeline**
14.1 Enhance marketing and education programs to reduce food waste at home, work, school, and other public facilities.	• Waste management communications such as the "Green Your Routine Campaign" will be expanded to include food waste reduction messaging in 2018 • The 2018-2019 Garbage and Recycling Guide will incorporate food waste reduction messaging.	PW	PHS	Short term

Food Strategy Indicators

The availability of data impacts establishing baseline measures and indicators. Measurement tools change over time and the resources required to gather and update local data is not always available. Nonetheless, keeping these factors in mind, attention has been given to creating potential indicators to help inform the monitoring and evaluation of the Food Strategy.

As work progresses throughout the implementation of the Food Strategy, modifications of the indicators may be required to ensure relevance to the current context. Potential indicators to track progress and evaluate effectiveness are outlined below.

Food System Components	Indicators
System-Wide	• Amount of City budget allocated toward food initiatives/actions • Percent City resources allocated toward food initiatives in alignment with Food Strategy goals • Number of policies that consider community food security • Number of advocacy efforts undertaken to address food insecurity • Number of partners and stakeholders involved in community food security advocacy
Food Production	• Number and size of farms • Number of new farmers • Number of acres in production • Percent of agricultural land • Number of community gardens and edible landscaping projects • Number of urban farms
Processing & Distribution	• Number of infrastructure initiatives that support the agri-food sector • Number of food processors and by type, size • Number of jobs related to agriculture and agri-food sector • Number of farmers' markets • Percent of local food procurement within the broader public sector • Number of community kitchen programs
Access & Consumption	• Number of city Infrastructure food-related projects started or implemented • Number of residents participating in food literacy projects/programs • Number of residents consuming vegetables and fruit at least five times per day • Number/percent of residents relying on charitable food programs

	• Percent/number of households experiencing food insecurity • Cost of a nutritious food basket • Number of food banks
Food Waste	• Number of residents participating in the Green Bin program • Number of residents participating in backyard composting • Number of residents reporting less food waste within the home • Number of City facilities participating in composting programs • Percent of food waste within City facilities

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	December 4, 2017
SUBJECT/REPORT NO:	Food Strategy Implementation Plan BOH13001(g) (City Wide) (Outstanding Business Item)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Sandy Skrzypczyk (905) 546-2424, Ext. 3523
SUBMITTED BY & SIGNATURE:	Kevin McDonald Acting Director, Healthy Environments Division Public Health Services Department

Council Direction:

The Board of Health at its meeting of August 11, 2016 approved the Food Strategy BOH13001(d) (City Wide) Recommendation Report, including:

(b) That the Board of Health direct the Interdepartmental Food Strategy Steering Team, in collaboration with appropriate staff, to initiate the five Food Strategy Priority Actions attached

(iv) To implement Priority Actions 4 (Food Literacy Network) and 5 (Local Food Promotion) by the end of 2017 (attached hereto as Appendix A to Report BOH13001(g)).

This Information Report provides an update on the progress achieved on the Food Strategy's Priority Actions 4 and 5. This item can be removed from the Outstanding Business List.

Information:

In August 2012, the Board of Health requested a comprehensive Food Strategy be developed. In 2013, the Interdepartmental Food Strategy Steering Team formed, with representation from Public Health Services (PHS), Planning and Economic Development, Community and Emergency Services, and Public Works.
After an extensive review of existing practices and evidence, a formal Food Strategy community engagement process was conducted in 2015, with over 2700 citizens

providing input. In August 2016, the Board of Health received report BOH13001(d) Food Strategy Recommendation Report and endorsed the Hamilton Food Strategy "Healthy, Sustainable, and Just Food for All".

Hamilton's Food Strategy is a guide to help people think about, engage in, and implement effective food actions. Specifically, the intent of the Food Strategy is to present a ten year plan to guide the City and community stakeholders in decision-making for food initiatives that require resources, such as funds, infrastructure, policies, programs, and staffing. Like any strategy or plan, the Food Strategy is a living document that is open to consideration of new opportunities with strong potential to ensure Hamilton has a healthy, sustainable, and just food system.

From the Food Strategy's 46 Actions, five Food Strategy Priority Actions were identified as the focus for the first two to three years of implementation. Priority Action 1 (Funding Criteria and Process) was completed and endorsed by the Board of Health in June, 2017. Priority Actions 4 and 5 are outlined below:

- Priority Action 4: Facilitate the creation of food networks to assist in capacity building, information sharing, and ability to access community-based food initiatives; and,

- Priority Action 5: Expand marketing efforts to focus on Hamilton's local food and farming sectors, while enhancing culinary tourism to promote local food businesses and events.

Priority Action 4: Food Literacy Network

- The Food Literacy Network Forum was held in October 2016. The Forum brought together 27 community stakeholders, including community developers, food and agriculture educators, leaders of food programs, and other stakeholders who support learning about and working with food. The goal of the Forum was to guide the formation of a Hamilton Food Literacy Network (HFLN); a core group from the Forum stepped forward to guide the network.
- Since the Food Literacy Network Forum, the core HFLN members have developed an action plan to advance the HFLN.
- First two priorities for the HFLN are to develop a communication mechanism to disseminate information and connect people involved in food literacy programs/initiatives and host networking events.
- In the upcoming 2018 winter term, McMaster University's DeGroote School of Business MBA Health Care and Marketing course term project will focus on best practices for digital tools to facilitate communication about food literacy.
- In collaboration with Ryerson University's Centre for Studies in Food Security, Public Health Registered Dietitians are completing a kitchen scan (by 2018 Q1) to assess

the availability of community facilities with kitchens for use by community groups who wish to engage in food skills programs.

Next Steps for the Hamilton Food Literacy Network

- Increase communication and awareness about food literacy by exploring several options to achieve this, such as in-person meetings and events and a list serve;
- Continue the dialogue to come to an agreed upon working definition of food literacy that fits within the Hamilton context to help guide action specific to food literacy; and,
- Further develop relationships and partnerships to capitalize on opportunities and assets while mitigating the barriers and challenges to achieving food literacy for all Hamiltonians.

Public Health Registered Dietitians will continue to engage with community partners to support and grow the Hamilton Food Literacy Network. Initial planning is underway to implement an annual Food Literacy Month with various activities and events starting in 2018.

Priority Action 5: Hamilton Farm Map and NOSH

- In the 2017 winter term, McMaster University's DeGroote School of Business MBA Health Care and Marketing course term project focused on Hamilton's Farm Map. Results and recommendations from the MBA students' projects have informed the next version of the Farm Map.
- By leveraging existing agricultural and culinary assets, staff from PHS, Economic Development, Tourism, and Information Technology are developing an enhanced Farm Map that will provide a more engaging web and social media experience.
- Staff from PED and PHS are collaborating in partnership with Mohawk College's Sustainability Office to reach out to local farms to engage them to participate in the Farm Map, which is expected to be available in Spring 2018.
- NOSH is in its second year (http://noshhamilton.ca/). This week-long celebration of Hamilton's culinary scene took place during National Small Business Week from October 16 to 22, 2017.

Next Steps for Marketing Hamilton's Local Food and Culinary Industries

The online Farm Map will be the first phase in building a more comprehensive food-focused online portal to attract Hamiltonians and visitors to celebrate our local food and agricultural story. Staff will continue to seek opportunities and partnerships to support local food and culinary promotion and awareness in collaboration with community stakeholders.

APPENDICES ATTACHED

Appendix A to Report BOH13001(g) – Setting the Table to Move into Action (Appendix B to Report BOH13001(d))

Setting the Table to Move into Action

4 Food Strategy Goals

- Support food friendly neighbourhoods to improve access to healthy food for all
- Increase food literacy to promote healthy eating and empower all residents
- Support local food and help grow the agri-food sector
- Advocate for a healthy, sustainable, and just food system with partners and at all levels of government

14 Recommendations

- 3 System-Wide
- 3 Food Production
- 2 Distribution & Processing
- 4 Access & Consumption
- 2 Food Waste

All Contribute to Achieving 1 or More Food Strategy Goals

46 Actions

5 Priority Actions

- Funding Criteria Process
- Food Skills & Employability Program
- Community & Neighbourhood Infrastructure
- Food Literacy Network
- Local Food Promotion

4 Easy Low Hanging Fruit Actions

- Community Kitchen Scan
- Food Waste Messaging
- Food Business Programs
- Edible Landscaping Toolkit

3 Community Actions Underway

- Mohawk College Local Food Procurement
- Hamilton LTC Local Food Procurement
- Community Food Centre Funding

34 Mid to Long Term Actions

- Implementation Plan will be developed to achieve remaining actions

9.1

CITY OF HAMILTON
M OT I O N

Board of Health : January 15, 2018

MOVED BY COUNCILLOR C. COLLINS …...…….....

SECONDED BY COUNCILLOR ……..……...

Amendment to the City of Hamilton's Food Strategy

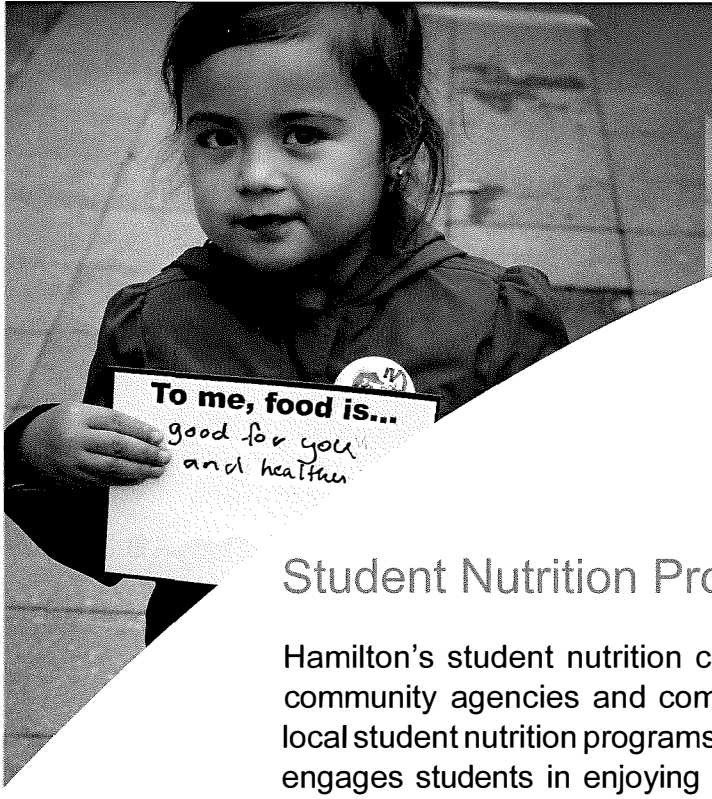
WHEREAS, the Emergency Food Providers' Network, in addition to the providing emergency food to the most vulnerable citizens in our community, member agencies also provide a wide-array of social programs and services designed to improve the overall health and quality of life of people living in poverty

THEREFORE BE IT RESOLVED:

(a) That Public Health Services' staff work with the Emergency Food Providers' Network to amend the City of Hamilton Food Strategy Report language pertaining to Emergency Food Provision on pages 42-43, attached hereto as Appendix "A", of the Food Strategy document;

(b) That the Board of Health recognizes the valuable work of the Emergency Food Providers' Network and its member agencies as assets in our community; and

(c) That the Board of Health encourages and welcomes the Emergency Food Providers' Network to identify and put forward a representative from the Network for consideration of service on the City's Food Advisory Committee during its next term.



Student Nutrition Programs

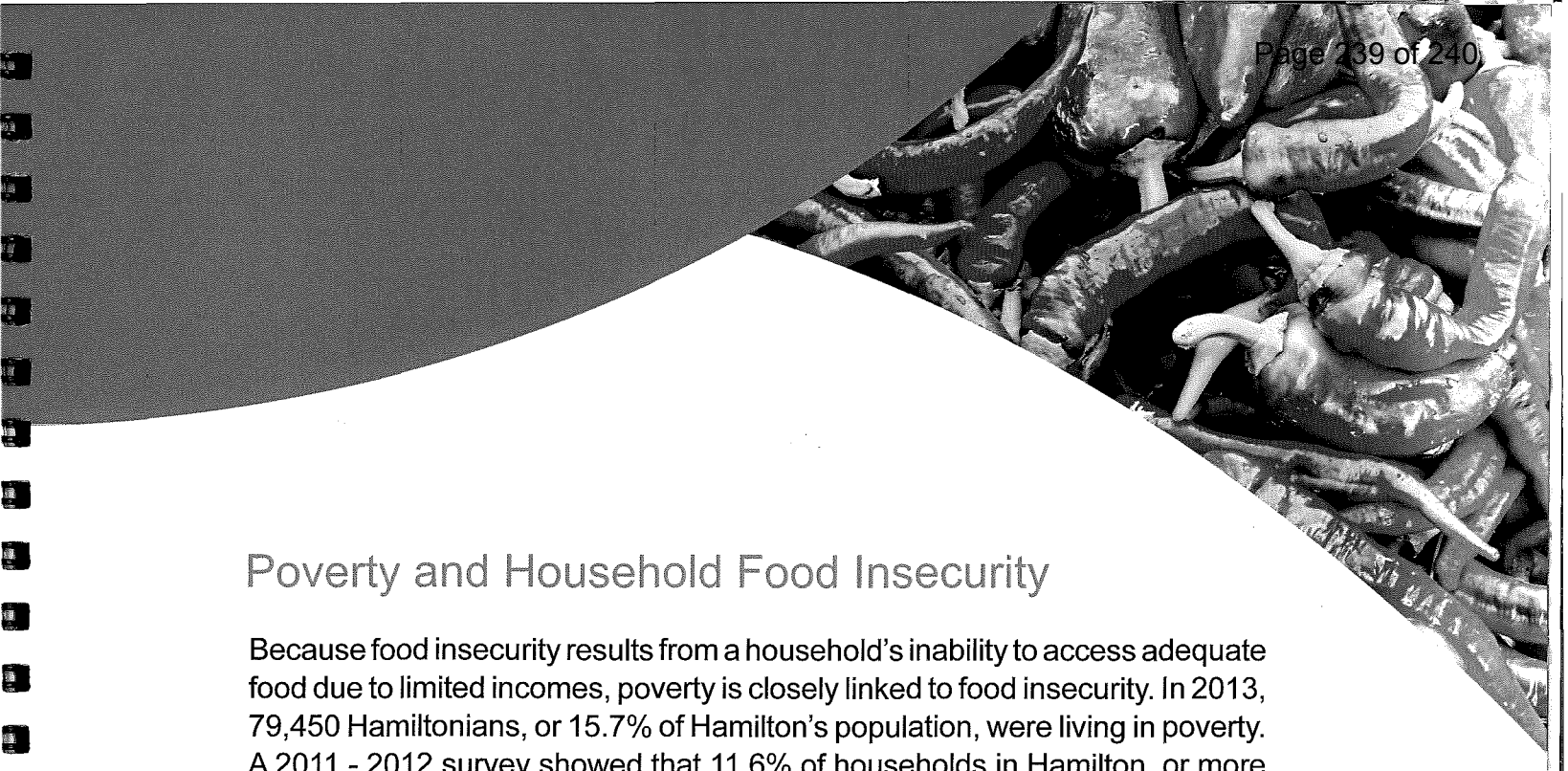
Hamilton's student nutrition collaborative (TasteBuds) is a partnership of community agencies and community members that support and facilitate local student nutrition programs for children and youth. The inclusive program engages students in enjoying meals and snacks in a welcoming setting to improve student success, support healthy growth, development, and lifelong eating habits. Priority is given to ensuring that programs are in place in vulnerable neighbourhoods, although the services are universal and open to all students. In 2016 in Hamilton, there were 172 Student Nutrition Programs at 120 sites. On average in 2014 - 2015, Tastebuds volunteers served healthy snacks to 30,082 students per day.

Charitable Food Programs

Not all Hamiltonians have enough income to purchase sufficient amounts of food for themselves or their families. Hamilton Food Share collaborates with local emergency food providers to make food accessible to residents who lack the income to access food in the mainstream food retail system. Hamilton's emergency food system operate food banks, free meal services, soup kitchens and pantries, with Hamilton Food Share co-ordinating the delivery of bulk quantities of food to 10 local organizations.

Improved incomes, through adequate social assistance rates, living wages, and other policies and programs that enhance household financial resources, along with increased access to affordable housing are the most important responses to household food insecurity. Addressing these issues must be foremost in advocacy efforts toward ensuring nutritious food is economically accessible to Hamilton's most vulnerable residents.

The majority of food that Hamilton Food Share distributes to emergency food providers is donated by the food industry, with a smaller percentage either purchased or obtained by community food drives. While food banks try to encourage donations of healthier options the food, unfortunately, donated food can include unhealthy options.



Poverty and Household Food Insecurity

Because food insecurity results from a household's inability to access adequate food due to limited incomes, poverty is closely linked to food insecurity. In 2013, 79,450 Hamiltonians, or 15.7% of Hamilton's population, were living in poverty. A 2011 - 2012 survey showed that 11.6% of households in Hamilton, or more than 1 in 9, experienced some degree of food insecurity. Food insecurity is categorized on three levels: worrying about running out of food (marginal food insecurity); compromising quantity or quality of food consumed (moderate food insecurity); or reducing food intake and disrupting eating patterns due to lack of food (severe food insecurity). For 8.2% of households in Hamilton, the degree of food insecurity was moderate or severe.

The annual Nutritious Food Basket (NFB) survey provides Hamilton data on the cost of nutritious food. In 2015, the estimated average cost for a family of four to buy basic nutritious food in Hamilton was $191 per week or $827 per month.

The cost of living can have a major impact on the amount of money available for purchasing food among lower-income households. NFB 2015 data combined with average market rate rental housing costs in Hamilton shows that households with minimum wage employment or receiving social assistance (Ontario Works or Ontario Disability Support Program) are likely to have incomes that are insufficient for basic living. For many living in poverty, certain fixed costs, such as paying for rent and utilities come before paying for food, which can lead to some degree of household food insecurity.

Charitable food programs and community food programs with a more dignified approach (for example, community gardens, collective kitchens, and Good Food Box programs) may offer some short-term relief. However, these programs do not reduce the prevalence of household food insecurity over the long-term because they do not address poverty.

The most effective way to ensure all Hamiltonians are food secure is through everyone having an adequate income. This approach is the most likely to reduce and eventually eliminate the charity food model because everyone would have the income to access food through other means.

11.1

From: Marilyn Halko [mailto:mhalko@rcdhu.com]
Sent: January-03-18 11:10 AM
To: Fernandes, Krislyn
Subject: RE: Renfrew County and District Board of Health's Resolution: #2 SB 2017-Dec-13

Krislyn,
At a Special Board Meeting held on Wednesday, December 13, 2017, Renfrew County and District
Board of Health passed the following resolution:

Resolution: #2 SB 2017-Dec-13
A motion by J. M. du Manoir; seconded by W. Matthews; be it resolved that the Board adopt a resolution that any increased obligations arising from the revised Ontario Public Health Standards trigger a commensurate increase in Ministry of Health and Long Term Care funding.

Carried

Marilyn

_ Marilyn Halko
Executive Assistant, Medical Officer of Health
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mhalko@rcdhu.com

"Optimal health for all in Renfrew County and District"

Renfrew County and District Health Unit