City of Hamilton
BOARD OF HEALTH

Meeting #: 18-008
Date: December 10, 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

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1. CEREMONIAL ACTIVITIES

2. APPROVAL OF AGENDA

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

3. DECLARATIONS OF INTEREST

4. APPROVAL OF MINUTES OF PREVIOUS MEETING

4.1 September 17, 2018

5. COMMUNICATIONS

5.1 Child Visual Health and Vision Screening Protocol, 2018: Forms

Due to the bulk of this correspondence, the attachments will be available only online

6. DELEGATION REQUESTS

7. CONSENT ITEMS

7.1 Food Advisory Committee Minutes

7.1.a May 9, 2018

7.1.b September 11, 2018

7.1.c October 16, 2018

7.2 Alcohol, Drug & Gambling Services and Community Mental Health Promotion Program Budget 2018-2019 (BOH18003(a)) (City Wide)

8. PUBLIC HEARINGS / DELEGATIONS

8.1 Halima Al-Hatimy, respecting a FemCare Community Health Initiative (approved at the July 12, 2018 meeting)

9. STAFF PRESENTATIONS

9.1 Clean Air Hamilton 2017 Progress Report (BOH18038) (City Wide)

9.2 Board of Health Orientation (BOH18037) (City Wide)

Presentation to be distributed

10. DISCUSSION ITEMS

10.1 Hamilton Drug Strategy (BOH18015) (City Wide)

11. MOTIONS

11.1 Interview Sub-Committee to the Board of Health

12. NOTICES OF MOTION

13. GENERAL INFORMATION / OTHER BUSINESS

13.1 Review of the Outstanding Business List, as of September 17, 2018

14. PRIVATE AND CONFIDENTIAL

15. ADJOURNMENT

BOARD OF HEALTH
MINUTES 18-007

1:30 p.m.
Monday, September 17, 2018
Council Chambers
Hamilton City Hall

Present: Mayor F. Eisenberger
Councillors J. Farr, M. Green, S. Merulla, C. Collins, T. Jackson, T. Anderson, T. Whitehead, M. Pearson, B. Johnson, L. Ferguson, A. VanderBeek, R. Pasuta and J. Partridge

Absent with regrets: Councillors A. Johnson and D. Conley – Personal

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THE FOLLOWING ITEMS WERE REFERRED TO COUNCIL FOR CONSIDERATION:

1. Vaccine Program Review (BOH18022) (City Wide) (Item 5.1)

(Pearson/Partridge)
That Report BOH18022, respecting a Vaccine Program Review, be received.

CARRIED

2. Infectious Disease and Environmental Health Semi-Annual Report (BOH18028) (City Wide) (Item 5.2)

(Pearson/Partridge)
That Report BOH18028, respecting an Infectious Disease and Environmental Health Semi-Annual Report, be received.

CARRIED

3. 2018 Annual Service Plan & Budget Performance Report (Q1 & Q2) (BOH18029) (City Wide) (Item 5.3)

(Pearson/Partridge)
That Report BOH18029, respecting the 2018 Annual Service Plan & Budget Performance Report (Q1 & Q2), be received.

CARRIED

4. Ontario Public Health Standards Transparency Framework (BOH18030) (City Wide) (Item 5.4)

(Pearson/Partridge)
That Report BOH18030, respecting an Ontario Public Health Standards Transparency Framework, be received.

CARRIED

5. Board of Health Self-Evaluation Results (BOH18011(a)) (City Wide) (Item 5.5)

(Whitehead/Anderson)
That Report BOH 18011(a), Board of Health Self-Evaluation Results, be received and referred to the Governance Review Sub-committee to consider the appointment of a Vice-Chair for the Board of Health for a 1 year period, on an on-going basis.

CARRIED

6. Supervised Consumption Sites (Added Item 6.1)

(Farr/Merulla)
WHEREAS, Supervised Consumption Sites (SCS) have a proven track record as a harm reduction measure

WHEREAS, Supervised Consumption Sites are a proven investment with respect to both saving lives and 14 million dollars in health costs over 10 years; and

WHEREAS, The Board of Health has historically overwhelmingly supported Safe consumption sites in the City of Hamilton where there are currently many unsafe consumption sites in our parks and public places, and where deaths due to addiction are far greater than the Provincial average;

THEREFORE BE IT RESOLVED;

(a) That the Board of Health reaffirm support for Supervised Consumption Sites in Hamilton;

(b) That a letter be sent to the Christine Elliot, Minister of Health, expressing both the Board of Health's support for Supervised Consumption Sites and the business case for Supervised Consumption Sites, signed by each of the Councillors; and

(c) That a letter be sent to the Federal Minister of Health, reaffirming our support of Supervised Consumption Sites and any associated applications for a permanent Supervised Consumption Sites facility in the City of Hamilton.

CARRIED

7. A Public Health Strategy for Non-Medical Cannabis (BOH18031) (City Wide) (Item 7.1)

(Whitehead/Anderson)
That Report BOH18031, respecting A Public Health Strategy for Non-Medical Cannabis, be received.

CARRIED

8. Public Health Risk Management Plan (BOH18032) (City Wide) (Item 8.1)

(Whitehead/Pearson)
(a) That Appendix A to Report BOH18032 Public Health 2019 Risk Management Plan, be approved; and,

(b) That the Medical Officer of Health be directed to submit Appendix A Public Health 2019 Risk Management Plan to the Ministry of Health and Long-Term Care to fulfil risk reporting requirements.

CARRIED

9. Alcohol, Drug and Gambling Services and Hamilton Health Sciences Addiction Initiative (BOH18034) (City Wide) (Item 8.2)

(Whitehead/Farr)
(a) That the Board of Health authorize and direct the Medical Officer of Health to receive, utilize and report on funding from Hamilton Health Sciences for up to a 1.2 FTE social work position in the Alcohol, Drug & Gambling Services program, and enter into an agreement between the City of Hamilton and Hamilton Health Sciences for an ongoing addiction position, satisfactory in form to the City Solicitor; and,

(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 1.2 FTE, for the term of the agreement and the time of renewal.

CARRIED

10. Correspondence from Iris M. Balodis, Assistant Professor, DeGroote School of Medicine, respecting funding for a knowledge translation project in the area of problem gambling, with the Peter Boris Centre for Addiction Research (Added Item 11.1)

(Farr/Whitehead)
(a) That the Correspondence from Iris M. Balodis, Assistant Professor, DeGroote School of Medicine, respecting funding for a knowledge translation project in the area of problem gambling, with the Peter Boris Centre for Addiction Research , be received; and

(b) That the Medical Officer of Health be directed to accept the funding and enter into any related agreements with the Peter Boris Centre for Addiction Research.

CARRIED

11. Correspondence from the City of Toronto, Board of Health, respecting "A Public Approach to Drug Policy" (Item HL28.2) (Added Item 11.2)

(Partridge/B. Johnson)
That the Correspondence from the City of Toronto, Board of Health, respecting "A Public Approach to Drug Policy" (Item HL28.2) be received, with a report back from staff in Q1 2019.

CARRIED

12. Correspondence from the City of Toronto, Board of Health, respecting a Student Nutrition Program: Impact of Municipal Plan 2013-2018 (Item HL28.5) (Added Item 11.3)

(Anderson/Green)
That the Correspondence from the City of Toronto, Board of Health, respecting a Student Nutrition Program: Impact of Municipal Plan 2013-2018 (Item HL28.5), be received.

CARRIED

13. Correspondence from the City of Toronto, Board of Health, respecting the Toronto Overdose Action Plan: Status Report 2018 (Item HL27.1) (Added Item 11.4)

(Anderson/Green)
That the Correspondence from the City of Toronto, Board of Health, respecting the Toronto Overdose Action Plan: Status Report 2018 (Item HL27.1), be received.

CARRIED

14. Correspondence from Henry Clarke, Chair, Board of Health, City of Peterborough, respecting the Ontario Basic Income Pilot Project (Added Item 11.5)

(Partridge/B. Johnson)
That the Correspondence from Henry Clarke, Chair, Board of Health, City of Peterborough, respecting the Ontario Basic Income Pilot Project, be received.

CARRIED

15. Correspondence from Rene Lapierre, Chair, Board of Health for Public Health Sudbury and Districts, respecting the Ontario Basic Income Research Project and the Reduction in the Scheduled Social Assistance Rate Increase (Added Item 11.6)

(Partridge/B. Johnson)
That the Correspondence from Rene Lapierre, Chair, Board of Health for Public Health Sudbury and Districts, respecting the Ontario Basic Income Research Project and the Reduction in the Scheduled Social Assistance Rate Increase, be received.

CARRIED

16. Correspondence from Scott Warnock, Chair, Board of Health, Simcoe Muskoka District Health Unit, respecting the Canadian Public Health Association 2017 Position Statement regarding the decriminalization of illicit psychoactive substances (Added Item 11.7)

(Pearson/Whitehead)
That the Correspondence from Scott Warnock, Chair, Board of Health, Simcoe Muskoka District Health Unit, respecting the Canadian Public Health Association 2017 Position Statement regarding the decriminalization of illicit psychoactive substances, be received, with a report back from staff in Q1 2019.

CARRIED

FOR INFORMATION:

(a) CHANGES TO THE AGENDA (Item 1)

The Clerk advised the Board of the following changes:

1. ADDED DELEGATION REQUESTS

   4.1 Shannon Brent, McMaster Medical School Students, respecting Supervised Consumption Sites

2. ADDED GENERAL INFORMATION / OTHER BUSINESS

   11.1 Correspondence from Iris M. Balodis, Assistant Professor, DeGroote School of Medicine, respecting funding for a knowledge translation project in the area of problem gambling, with the Peter Boris Centre for Addiction Research

   Recommendation: That the Medical Officer of Health be directed to accept the funding and enter into any related agreements with the Peter Boris Centre for Addiction Research.

   11.2 Correspondence from the City of Toronto, Board of Health, respecting "A Public Approach to Drug Policy" (Item HL28.2)

   Recommendation: Recommendation: Be received, with a report back from staff in Q1 2019

   11.3 Correspondence from the City of Toronto, Board of Health, respecting a Student Nutrition Program: Impact of Municipal Plan 2013-2018 (ItemHL28.5)

   Recommendation: Be received.

   11.4 Correspondence from the City of Toronto, Board of Health, respecting the Toronto Overdose Action Plan: Status Report 2018 (Item HL27.1)

   Recommendation: Be received.

11.5 Correspondence from Henry Clarke, Chair, Board of Health, City of Peterborough, respecting the Ontario Basic Income Pilot Project

Recommendation: Be received.

11.6 Correspondence from Rene Lapierre, Chair, Board of Health for Public Health Sudbury and Districts, respecting the Ontario Basic Income Research Project and the Reduction in the Scheduled Social Assistance Rate Increase

Recommendation: Be received.

11.7 Correspondence from Scott Warnock, Chair, Board of Health, Simcoe Muskoka District Health Unit, respecting the Canadian Public Health Association 2017 Position Statement regarding the decriminalization of illicit psychoactive substances

Recommendation: Be received, with a report back from staff in Q1 2019

(Green/Merulla)
That the agenda for the September 17, 2018 Board of Health be approved, as amended.

CARRIED

(b) DECLARATIONS OF INTEREST (Item 2)

There were no declarations of interest.

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

(i) July 12, 2018 (Item 3.1)

(Partridge/B. Johnson)
That the Minutes of the July 12, 2018 meeting of the Board of Health be received, as presented.

CARRIED

(d) DELEGATION REQUESTS (Item 4)

(i) Shannon Brent, McMaster Medical School Students, respecting Supervised Consumption Sites (for today's meeting) (Added Item 4.1)

(VanderBeek/Whitehead)
That the delegation request from Shannon Brent, McMaster Medical School Students, respecting Supervised Consumption Sites, be approved, for today's meeting.

CARRIED

(e) CONSENT ITEMS (Item 5)

(i) Board of Health Self-Evaluation Results (BOH18011(a)) (City Wide) (Item 5.5)

Councillors Pearson, B. Johnson and Green wished to be recorded as OPPOSED to the disposition of Item 5.

For disposition of this matter, refer to Item 5.

(f) DELEGATION (Item 6)

(i) Shannon Brent, McMaster Medical School Students, respecting Supervised Consumption Sites (Added Item 6.1)

Shannon Brent, Donna Brace, and Felipe Fajardo, McMaster Medical School Students, addressed to the Board of Health respecting Safe Injection Sites, with the aid of PowerPoint presentation. A copy of the presentation has been included in the official record.

The motion respecting Supervised Consumption Sites was CARRIED on the following standing recorded vote:

Yes: Farr, Green, Merulla, Collins, Jackson, Whitehead, VanderBeek, Eisenberger, Partridge, Pasuta, Ferguson, B. Johnson, Pearson
Total: 13
Absent: A. Johnson, Conley
Nays 0

For disposition of this matter, refer to Item 6.

The presentation is available at www.hamilton.ca

(g) STAFF PRESENTATION (Item 7)

(i) A Public Health Strategy for Non-Medical Cannabis (BOH18031) (City Wide) (Item 7.1)

Dr. Elizabeth Richardson, Medical Officer of Health, addressed the Board with an overview of A Public Health Strategy for Non-Medical Cannabis (BOH18031), with the aid of a PowerPoint presentation. A copy of the presentation has been included in the official record.

Dr. Richardson introduced Dr. James MacKillop, McMaster University who also addressed the Board with an overview of A Public Health Strategy for Non-Medical Cannabis (BOH18031).

For disposition of this matter, refer to Item 7.

The presentation is available at www.hamilton.ca

(h) ADJOURNMENT (Item 13)

(Whitehead/Pearson)
That, there being no further business, the Board of Health be adjourned at 3:26 p.m.

CARRIED

Respectfully submitted,

Mayor F. Eisenberger
Chair, Board of Health

Loren Kolar
Legislative Coordinator
Office of the City Clerk

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

October 1, 2018

MEMORANDUM

TO: **Medical Officers of Health, CEOs, and Board Chairs**

RE: Child Visual Health and Vision Screening Protocol, 2018: Forms

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Dear Colleagues,

As you know, under the modernized *Ontario Public Health Standards: Requirements for Programs, Services, and Accountability* and related documents, boards of health are required to provide or ensure the provision of vision screening for Senior Kindergarten students in all schools annually, beginning in the 2018/19 school year.

Further to the release of the *Child Visual Health and Vision Screening Protocol, 2018* ("the Protocol"), and as outlined in the ministry's vision screening training webinars for public health units that took place in August 2018, the ministry is now issuing the following Forms (in English and French) to support implementation of the vision screening program:

- Post-screening Parent Notification Forms (A and B) and the reminder letter, referenced in Requirement 3 of the Protocol; and
- A Vision Screening Assessment Form, referenced in Requirements 8 and 9 of the Protocol Appendix.

If you have any questions, please do not hesitate to contact Dianne Alexander, Director, Health Promotion and Prevention Policy and Programs Branch, at Dianne.Alexander@ontario.ca.

Thank you all for your continued support and collaboration.

Sincerely,

Original signed by

Roselle Martino
Assistant Deputy Minister
Population and Public Health Division

Ontario

Ministry of Health and Long-Term Care

Child Vision Screening: Reminder Letter

Public Health Unit: _____
Address: _____
_____
Phone: _____ Fax: _____
Client's school: _____
Date of issue: _____

PHU Use Only
Client's Name: _____
Screening date: _____
Screening location: _____
By: _____
Date received: _____

Dear Parent/Guardian of _____

Your child had a vision screening at school on the date indicated above. The screening results indicated that **there may be issues with your child's vision.**

If you have not already done so, please book an appointment with an optometrist now for a comprehensive eye examination. The optometrist will determine if any further treatment is needed, including whether your child needs eye glasses.

Comprehensive eye examinations are important to detect vision problems that may interfere with a child's eye health, learning and social development. In rare cases, some untreated problems can lead to permanent vision loss/vision disorders.

Please note that Ontario Health Insurance Plan (OHIP) covers the cost of a comprehensive eye examination once every 12 months for all children (0-19 years) who have a valid OHIP card.

If you require more information, including if you need assistance finding an optometrist, or if your child does not have a valid OHIP card, please contact the public health unit at the top of this page.

To find a local optometrist, please go to: www.findaneyedoctor.ca.

NOTE: If your child has had a comprehensive eye examination within the past 12 months, please check first with your optometrist to determine if an appointment is necessary.

Ontario

Ministère de la Santé et des Soins de longue durée

Dépistage des problèmes de la vue chez l'enfant : lettre de rappel

Bureau de santé publique : _____
Adresse : _____
_____
Téléphone : _____ Télécopieur : _____
École du patient : _____
Date d'émission : _____

Bureau de santé publique uniquement
Nom du patient : _____
Date du test de dépistage : _____
Lieu du test de dépistage : _____
Par : _____
Date de réception : _____

À l'attention des parents ou tuteurs de _____

Votre enfant a subi un dépistage des problèmes de la vue à l'école à la date indiquée ci-dessus. Les résultats du dépistage ont indiqué **qu'il pourrait y avoir des problèmes de vision chez votre enfant.**

Si vous ne l'avez pas déjà fait, veuillez prendre rendez-vous chez un optométriste dès maintenant pour un examen complet de la vue. L'optométriste déterminera si d'autres traitements sont nécessaires, notamment si votre enfant a besoin de lunettes.

Les examens complets de la vue sont importants pour détecter les problèmes de vision qui peuvent nuire à la santé des yeux, à l'apprentissage et au développement social de l'enfant. Dans de rares cas, certains problèmes non traités peuvent entraîner une perte de vision ou des troubles de la vision permanents.

Veuillez noter que le Régime d'assurance-santé de l'Ontario couvre le coût d'un examen complet de la vue tous les 12 mois pour tous les enfants (de 0 à 19 ans) qui ont une carte de l'Assurance-santé de l'Ontario valide.

Si vous avez besoin de plus amples renseignements, notamment pour trouver un optométriste, ou si votre enfant n'a pas de carte de l'Assurance-santé de l'Ontario valide, veuillez communiquer avec le service de santé publique indiqué en haut de cette page.

Pour trouver un optométriste près de chez vous, consultez le site Web : www.findaneyedoctor.ca.

REMARQUE : Si votre enfant a subi un examen complet de la vue au cours des 12 derniers mois, veuillez d'abord consulter votre optométriste pour déterminer si un rendez-vous est nécessaire.

Ontario

Ministry of Health and Long-Term Care

Child Vision Screening Parent Notification Form-A (PNF-A) Instructions

Public Health Unit: _____
Address: _____
_____
Phone: _____ Fax: _____
Client's school: _____
Date of issue: _____

PHU Use Only
Client's Name: _____
Screening date: _____
Screening location: _____
By: _____
Date received: _____

Dear Parent/Guardian of _____

Your child had a vision screening at school today. The screening results indicated that **there may be issues with your child's vision**. We urge you to please book an appointment now for your child to see an optometrist for a comprehensive eye examination.

Comprehensive eye examinations are important to detect vision problems that may interfere with a child's eye health, learning and social development. In rare cases, some untreated problems can lead to permanent vision loss/vision disorders.

Ontario Health Insurance Plan (OHIP) covers the cost of a comprehensive eye examination once every 12 months for all children (0-19 years) who have a valid OHIP card.

A comprehensive eye examination includes:

- Reviewing your child's health history and the family history of eye problems;
- Checking visual acuity and 3D vision;
- Checking eye alignment;
- Checking eye focusing ability (i.e., how well the eye muscles can focus at various distances);
- Checking eye health (e.g. allergies, infections);
- Identifying if your child is meeting visual developmental milestones; and
- Determining if your child needs eye glasses or other treatment (e.g., eye drops, vision therapy, a referral to a healthcare provider, etc.)

If you require more information, including if you need assistance finding an optometrist, or if your child does not have a valid OHIP card, please contact the public health unit at the top of this page.

To find a local optometrist, please go to: www.findaneyedoctor.ca.

NOTE: If your child has had a comprehensive eye examination within the past 12 months, please check first with your optometrist to determine if an appointment is necessary.

Ministère de la Santé et des Soins de longue durée

Dépistage des problèmes de la vue chez l'enfant – Instructions relatives au formulaire d'avis à l'intention des parents (PNF-A)

Bureau de santé publique : _____
Adresse : _____
_____
Téléphone : _____ Télécopieur : _____
École du patient : _____
Date d'émission : _____

Bureau de santé publique uniquement
Nom du patient : _____
Date du test de dépistage : _____
Lieu du test de dépistage : _____
Par : _____
Date de réception : _____

À l'attention des parents ou tuteurs de _____

Votre enfant a subi un dépistage des problèmes de la vue à l'école aujourd'hui. Les résultats du dépistage ont indiqué **qu'il pourrait y avoir des problèmes de vision chez votre enfant.** Nous vous demandons de prendre rendez-vous dès maintenant pour que votre enfant puisse consulter un optométriste afin de passer un examen complet de la vue.

Les examens complets de la vue sont importants pour détecter les problèmes de vision qui peuvent nuire à la santé des yeux, à l'apprentissage et au développement social de l'enfant. Dans de rares cas, certains problèmes non traités peuvent entraîner une perte de vision ou des troubles de la vision permanents.

Le Régime d'assurance-santé de l'Ontario couvre le coût d'un examen complet de la vue tous les 12 mois pour tous les enfants (de 0 à 19 ans) qui ont une carte de l'Assurance-santé de l'Ontario valide.

Un examen complet de la vue se déroule comme suit :

- Passer en revue les antécédents de santé de votre enfant et les antécédents familiaux concernant les troubles oculaires;
- Vérifier l'acuité visuelle et la vision 3D;
- Vérifier l'alignement des yeux;
- Vérifier la capacité des yeux à faire la mise au point (p. ex., dans quelle mesure les muscles oculaires peuvent se concentrer à différentes distances);
- Vérifier la santé des yeux (p. ex., allergies, infections);
- Déterminer si les étapes de croissance de la vision de votre enfant se déroulent normalement;
- Déterminer si votre enfant a besoin de lunettes ou d'autres traitements (p. ex., gouttes ophtalmiques, thérapie visuelle, aiguillage vers un fournisseur de soins de santé, etc.)

Si vous avez besoin de plus amples renseignements, notamment pour trouver un optométriste, ou

si votre enfant n'a pas de carte de l'Assurance-santé de l'Ontario valide, veuillez communiquer avec le service de santé publique indiqué en haut de cette page.

Pour trouver un optométriste près de chez vous, consultez le site Web : www.findaneyedoctor.ca.

REMARQUE : Si votre enfant a subi un examen complet de la vue au cours des 12 derniers mois, veuillez d'abord consulter votre optométriste pour déterminer si un rendez-vous est nécessaire.

Ontario

Ministry of Health and Long-Term Care

Child Vision Screening Parent Notification Form-B (PNF-B) Instructions

Public Health Unit: _____
Address: _____
_____
Phone: _____ Fax: _____
Client's school: _____
Date of issue: _____

PHU Use Only
Client's Name: _____
Screening date: _____
Screening location: _____
By: _____
Date received: _____

Dear Parent/Guardian of _____

Your child had a vision screening at school today. While no vision issues were identified during the vision screening, it should be noted that a screening is not designed to detect all vision problems. For this reason, we encourage you to contact an optometrist regarding the need to book a routine comprehensive eye exam for your child.

Ontario Health Insurance Plan (OHIP) covers the cost of a comprehensive eye examination once every 12 months for all children (0-19 years) who have a valid OHIP card.

Comprehensive eye examinations are important to detect vision problems that may interfere with a child's eye health, learning and social development. In rare cases, some untreated problems can lead to permanent vision loss/vision disorders.

A comprehensive eye examination includes:

- Reviewing your child's health history and the family history of eye problems;
- Checking visual acuity and 3D vision;
- Checking eye alignment;
- Checking eye focusing ability (i.e., how well the eye muscles can focus at various distances);
- Checking eye health (e.g. allergies, infections);
- Identifying if your child is meeting visual developmental milestones; and
- Determining if your child needs eye glasses or other treatment (e.g., eye drops, vision therapy, a referral to a healthcare provider, etc.)

If you require more information, including if you need assistance finding an optometrist, or if your child does not have a valid OHIP card, please contact the public health unit at the top of this page.

To find a local optometrist, please go to: www.findaneyedoctor.ca.

Ontario

Ministère de la Santé et des Soins de longue durée

Dépistage des problèmes de la vue chez l'enfant – Instructions relatives au formulaire d'avis à l'intention des parents (PNF-B)

Bureau de santé publique : _____
Adresse : _____
_____
Téléphone : _____ Télécopieur : _____
École du patient : _____
Date d'émission : _____

Bureau de santé publique uniquement
Nom du patient : _____
Date du test de dépistage : _____
Lieu du test de dépistage : _____
Par : _____
Date de réception : _____

À l'attention des parents ou tuteurs de _____

Votre enfant a subi un dépistage des problèmes de la vue à l'école aujourd'hui. Même si aucun problème de vision n'a été relevé pendant le test de dépistage, il convient de noter que ce type d'examen n'est pas conçu pour détecter tous les troubles de la vue. Pour cette raison, nous vous encourageons à communiquer avec un optométriste au sujet de la nécessité de faire passer un examen de routine complet de la vue pour votre enfant.

Le Régime d'assurance-santé de l'Ontario couvre le coût d'un examen complet de la vue tous les 12 mois pour tous les enfants (de 0 à 19 ans) qui ont une carte de l'Assurance-santé de l'Ontario valide.

Les examens complets de la vue sont importants pour détecter les problèmes de vision qui peuvent nuire à la santé des yeux, à l'apprentissage et au développement social de l'enfant. Dans de rares cas, certains problèmes non traités peuvent entraîner une perte de vision ou des troubles de la vision permanents.

Un examen complet de la vue se déroule comme suit :

- Passer en revue les antécédents de santé de votre enfant et les antécédents familiaux concernant les troubles oculaires;
- Vérifier l'acuité visuelle et la vision 3D;
- Vérifier l'alignement des yeux;
- Vérifier la capacité des yeux à faire la mise au point (p. ex., dans quelle mesure les muscles oculaires peuvent se concentrer à différentes distances);
- Vérifier la santé des yeux (p. ex., allergies, infections);
- Déterminer si les étapes de croissance de la vision de votre enfant se déroulent normalement;
- Déterminer si votre enfant a besoin de lunettes ou d'autres traitements (p. ex., gouttes ophtalmiques, thérapie visuelle, aiguillage vers un fournisseur de soins de santé, etc.)

Si vous avez besoin de plus amples renseignements, notamment pour trouver un optométriste, ou

si votre enfant n’a pas de carte de l’Assurance-santé de l’Ontario valide, veuillez communiquer avec le service de santé publique indiqué en haut de cette page.

Pour trouver un optométriste près de chez vous, consultez le site Web : www.findaneyedoctor.ca.

Hamilton

Minutes
FOOD ADVISORY COMMITTEE

May 9, 2018,
7:00 – 9:00 p.m.
City Hall, Room 264, 2nd Floor
71 Main Street West, Hamilton

Present: Luc Peters (Chair), Clare Wagner, Kate Flynn, Laurie Nielsen, Bill Wilcox, Hannah Pahuta, Steve Robinson, Lynn Gates (Recorder), Sandy Skrzypczyk (Staff Liaison)

Absent with Regrets: Nancy Henley, Bill Slowka

Guests: Sarah Cellini (Recreation), Romas Keliacius (Recreation), Suzanne Neumann (Public Health)

1. **CHANGES TO THE AGENDA**
   None

2. **DECLARATIONS OF INTEREST**
   There were no declarations of interest.

3. **APPROVAL OF MINUTES OF PREVIOUS MEETING**
   (H. Pahuta/L. Nielsen)
   Minutes from April 11th, 2018 were approved as presented.

   CARRIED

4. **CONSENT ITEMS**
   None

5. **5. PRESENTATIONS**

5.1 Recreation Centres & Food - Sarah Cellini (Recreation), Romas Keliacius (Recreation), Suzanne Neumann (Public Health)

Riverdale Community Hub Proposal
Presentation regarding the *Riverdale Community Hub Proposal*, which combines affordable housing (48 units) with a recreation centre located near the Centennial Parkway. Staff have worked with the School Board to package the proposal as a Community Hub, as the Lake Avenue Elementary School is already operating as a 'hub.' The area around Eastgate Mall has a dense population of marginalized people.

The proposal includes a kitchen, office space, a library, and an area for seniors' programming. The top floor of the tower will be allocated for Seniors Activity Programs.

A revised report will be prepared for the Hamilton District School Board Liaison Committee, scheduled for June 1st.

This project and the Riverdale Hub proposal align with two of the Food Strategy Goals regarding increasing food literacy and food friendly neighbourhoods to improve access to healthy food for all. Riverdale has a *Neighbourhood Action Plan*, which includes a goal to increase the food security of residents. Their Food Security objectives include:

1. Locate a new food bank in Riverdale that has extended hours.
2. Enhance the quality and type of food available in the neighbourhood.
3. Develop other food security programs such as Community Gardens, Community Kitchens, and Educational Programs.

Operational challenges have included:

- Pest Management for Residents and the Community Kitchen - Food Handler Training will be required.
- Developing Engaging Programs - Services need to be well-attended to be sustainable. Attracting youth has been particularly difficult. Project Champions will be required. The Committee recommended utilizing existing data on food security programs rather than spending additional time and money to hire consultants to determine the type of programming to offer; instead, use this money for program delivery.
- Cost of Infrastructure - If approved by Council, construction will begin in 4-5 years.

Recreation's Healthy Food and Beverage Action Plan

The Recreation Department (RD) has one full-service kitchen in operation. In June 2017 staff decided to enhance promotion of healthier choices and less bottled water usage. Recommendation 9 of the Food Strategy includes actions to increase healthy food choices within public spaces, such as recreation centres. Concerns have been raised about the availability of sugary drinks and plastic water bottles, and a *2017 Arena Survey* identified that most of the respondents were dissatisfied with the low availability of healthy foods.

The guiding principles of the Project for decision-making are:

1. Access to healthy food and beverages.
2. Free and convenient access to tap water.
3. Environmentally sustainable drinking water.
4. Financially sustainable food services.
5. Availability of information.
6. Socially responsible marketing

The *Cold Vending and Beverages Contract* with the City end at the same time as the three year Recreation Plan. The Department is now issuing RFPs for *Snack Vending.* The *Concession Contracts* involves five different contracts. The hockey season starts in September and recreation centres are expected to provide food for tournament participants. Refrigerators are now in place to store fruit, etc. and have pilot tested the selling of fruit smoothies. Upcoming actions include:

- The Food and Beverage Guidelines uses a stoplight approach to categorize foods. A potential recommendation may be to increase prices on food items in the "Red" group.

- A “Tap Into Your Water” campaign will be launched to encourage the use of water bottle stations.

6. MEMBER UPDATES
No updates

7. DISCUSSION ITEMS

7.1 Food Strategy Update - Sandy Skrzypczyk, Public Health Services

Several delegates have signed up to speak regarding the report about banning bottled water on city property.

The Emergency Food Network Chair, Karen Randall, has resigned from her workplace; therefore, she is no longer the Chair of this Network and not able to attend tonight’s meeting. Karen will ask the Network if another representative can attend the Food Advisory Committee’s June meeting.

7.2 2018 Work Plan

100in1Day Hamilton
Sandy distributed an outline to post on the 100in1Day Hamilton website describing our initiative. Bill S. confirmed that space is available at the downtown Farmers Market on June 2nd.

ACTIONS
1. Sandy, Luc, Laurie, and Claire will staff promotional poster board about the Food Strategy.
2. Sandy will look into creating a summarized handout of the Food Strategy Goals as a handout at the 100in1 Day event.

MOTION
(C. Wagner/L. Gates)
That a maximum of $250 be allocated for supplies for the 100in1Day Hamilton event.

CARRIED

Delegation to Board of Health
The Committee’s request to delegate will be discussed at the May 14th meeting. Kate will revise previous presentation and forward to everyone for comment. The main message will be that the Committee approves the public health approach to poverty reduction that emphasizes that changes in financial and housing policies are required. A potential recommendation could be that a process be developed by Public Health outlining how revisions to the Food Strategy would be made to ensure transparency and consistency in the future.

Annual Report
An annual report will be drafted to highlight accomplishments by the Committee and will be included in the 2019 Budget Request report.

ACTION:
Sandy will use past discussions, minutes, and notes to draft the report and circulate to the members for their revisions/input.

8. NOTICES OF MOTION
None

9. GENERAL INFORMATION & OTHER BUSINESS
None

10. ADJOURNMENT (B. Wilcox/C. Pahuta)
Meeting adjourned at 9:23 p.m.

CARRIED

Hamilton

Minutes
FOOD ADVISORY COMMITTEE

September 11, 2018,
7:00 – 9:00 p.m.
City Hall, Room 264, 2nd Floor
71 Main Street West, Hamilton

Present: Luc Peters (Chair), Krista D'aoust, Kate Flynn, Lynn Gates (Recorder), Nancy Henley, Laurie Nielsen, Hannah Pahuta, Steve Robinson, Bill Slowka, Bill Wilcox, Sandy Skrzypczyk (Staff Liaison), Vivian Underdown (non-member)

Guests: Andrea McDowell, Public Health Services, Healthy and Safe Communities, City of Hamilton

1. CHANGES TO THE AGENDA
None

2. DECLARATIONS OF INTEREST
There were no declarations of interest.

3. APPROVAL OF MINUTES OF PREVIOUS MEETING
(H. Pahuta/L. Nielsen)

Minutes from May 9th, 2018 were approved as presented.

CARRIED

4. CONSENT ITEMS
None

5. PRESENTATION

Presentation by Andrea McDowell, Climate Change and Community Climate Change Planning: Agriculture and Food presentation by Andrea McDowell, Public Health Services, Healthy and Safe Communities, City of Hamilton, was received by the Committee and the PPT was shared with the members.

Members expressed interest in keeping the lines of communication open between Andrea's climate change work related to food and this Committee, and being involved in some capacity as work evolves.

6. MEMBER UPDATES

H. Pahuta provided an update on Indwell's Parkdale Landing affordable housing development, which is scheduled to open in approximately two weeks. There is a full

commercial kitchen that will be used to provide meals to the tenants, with the aim to implement other food programing in the future.

L. Peters reported that Humble Bee's bees are experiencing more pesticide exposure in the urban area in comparison to the past, but they are not sure why. This pesticide exposure seems to be across the City, not just one area of the City.

K. Flynn reported that Mohawk's online Local Food Certificate program has been launched and encouraged everyone to take a look at the program and consider enrolling https://www.mohawkcollege.ca/ce/programs/hospitality-home-and-garden/sustainable-local-foods-certificate-937

7. DISCUSSION ITEMS

7.1 Food Strategy Update - Sandy Skrzypczyk, Public Health Services

Food Literacy Month is coming up in October; approximately 40 food related events have been accepted so far. Public Health dietitians are still trying to work with the Art Gallery of Hamilton to run a film and panel event, and if this doesn't work they will look for another venue. Suggestions for panelists were discussed and potential questions.

MOTION
(H. Pahuta/K. Flynn)
That the remaining Committee funds be used to support Food Literacy Month.

CARRIED

Postcards are still available to promote the City's online local food map.

The Emergency Food Network (EFN) has drafted their revision for the Food Strategy Report pages 42-43 and sent it to Public Health. The Food Advisory Committee has the opportunity to review and comment on it. Initial concerns are:

1. that it's not clear what sections on pages 42-43 will be removed, stay, or be replaced;
2. that it is critical that the information that income is the solution to address food insecurity must stay in the report;
3. that the Food Strategy already has a Vision that was based on community input and other programs/organizations do not have their mission and vision in the Food Strategy report - highlighting the EFN's mission and vision could confuse readers.

MOTION
(H. Pahuta/K. Flynn)
That the Committee draft a response to Public Health and the Emergency Food Network regarding our concerns about the proposed replacement pages to the Food Strategy Report pages 42-42.

CARRIED

ACTION

- Sandy to get clarification from management about what is being removed and what is staying on pages 42-42 within the Food Strategy report and when the Committee's feedback is due to Public Health.

- Everyone to review the revision and provide feedback to Sandy by September 31. Sandy will collate and provide the Committee's feedback to Public Health Management.

7.2 2018 Annual Report

At the end of August, Sandy sent an electronic draft of the Committee's annual report for everyone to review. The Committee needs to ensure that it reflects your past accomplishments and recommendations going forward. 100inOne Day event top three dotmocracy results have been included in the draft report. Suggested that the Committee present at the time that the Annual report goes to Board of Health in place of the past delegation request. This would give the Committee ten minutes to present versus the five minute delegation

ACTION

- Everyone to provide their feedback/revisions to the FAC Annual report to Sandy by September 31. Sandy will collate and recirculate to the Committee to finalize the FAC Annual Report; the final report needs to be submitted to Public Health management by late October.

8. NOTICES OF MOTION

None

9. GENERAL INFORMATION & OTHER BUSINESS

None

10. ADJOURNMENT (L. Neilson/K. D'aoust)

Meeting adjourned at 9:10 p.m.

CARRIED

Hamilton

Minutes
FOOD ADVISORY COMMITTEE

October 16, 2018,
7:00 – 9:00 p.m.
City Hall, Room 264, 2nd Floor
71 Main Street West, Hamilton

Present: Luc Peters (Chair), Krista D'aoust, Lynn Gates (Recorder), Laurie Nielsen, Hannah Pahuta, Bill Wilcox, Sandy Skrzypczyk (Staff Liaison)
Regrets: Kate Flynn, Steve Robinson, Bill Slowka, Nancy Henley, Vivian Underdown (non-member)

1. CHANGES TO THE AGENDA
None

2. DECLARATIONS OF INTEREST
There were no declarations of interest.

3. APPROVAL OF MINUTES OF PREVIOUS MEETING
(L. Nielsen/B. Wilcox)

Minutes from September 11th, 2018 were approved as presented.

CARRIED

4. CONSENT ITEMS
None

5. PRESENTATION
None

6. MEMBER UPDATES

H. Pahuta announced that she has received approval to proceed with developing and implementing a Culinary Academy for adults looking to re-enter the workforce. Indwell's Parkdale Landing's full commercial kitchen will be used as the training site. The program chef for Indwell will be involved in the cooking skills training. Further logistics are to be determined. Students will be prepared so that they will be appropriate for "Pre-Apprenticeship" level positions.

There was a brief discussion of currently available food skills training opportunities to enter Food Service. Mohawk College does not include Culinary Skills in their Trades Program. The Liaison College is relatively expensive and presents a barrier for vulnerable populations.

L. Peters presented at the Ontario Science Centre on bee farming.

Krista reported that youth involved with the John Howard Society are holding group meetings at the Community Food Centre.

Food Literacy Month Events: Over 60 events are occurring during the month. The *Food Literacy Month* web page is posted on the City of Hamilton site. Over 20 events have been planned by Mohawk Nutrition students.https://www.hamilton.ca/city-initiatives/strategies-actions/food-literacy-month-events

Krista reported that the Edible Education Guide will be launched at the 310 Limeridge West site of N2N as part of Food Literacy Month.

The *Before the Plate* film and panel discussion event will happen on Oct. 26th from 6:00 pm - 10:00 pm at the Zoetic theatre. The film screening will be followed by the panel discussion with chef/owner Manny Ferreira from Mezcal, local farmer Hugh Drummond from Drummond Farms, and food educator still to be determined. Proceeds from the $5 admission will be donated to *Tastebuds*. Luc agreed to moderate the panel discussion and Sandy will introduce the event as co-sponsored by the Food Advisory Committee and Public Health Dietitians, and encourage the audience to consider applying to be a member on the next Committee term. Funding is available for Committee members to attend.

7. DISCUSSION ITEMS

7.1 Food Strategy Update - Sandy Skrzypczyk, Public Health Services

Food Strategy Revisions: Sandy distributed the latest version for the revision of pages 42-43 in the Food Strategy report. This version incorporates the Committee's recommended edits and the revision proposed by the Hamilton Emergency Food Network. This version is a compromise for all stakeholders involved; respects the Network's work; recognizes that other non-profit organizations may also be involved but are not part of the Network; and acknowledges that everyone needs an income to become food secure. This collaborative effort aims to incorporate all stakeholders' perspectives and information, while still fitting into the writing style and format of the Food Strategy report. This version has been forwarded to Sandy's manager, who has sent it to the Network; however, no response has come from the Network yet. The revised pages will be incorporated into the on-line Hamilton Food Strategy document available on the City of Hamilton website.

Committee members congratulated Sandy on the excellent work she did to rewrite the pages and supports this version forwarded to Public Health management and the Network.

2019 Budget Report: Based on the Committee's work plan for 2019, Sandy has included a recommendation for an additional $1,000 to increase the Committee's budget to $2,500 in order to accomplish future plans. This is subject to approval by the Board of Health.

Sandy reported that the *Keep Hamilton Clean and Green Advisory Committee* are involved in providing small grants for community gardens. Members expressed an interest in learning more about how other Advisory Committees operate and how they can possibly collaborate to support the Food Strategy.

ACTION
Sandy will invite the *Keep Hamilton Clean and Green Advisory Committee* Staff Liaison and interested members to the next meeting.

7.2 2018 Annual Report and Presentation

As the Committee work plan for the next steps are operational in nature, they do not need to be presented as recommendations for approval by the Board of Health. The Committee's annual report will be incorporated into the Committee's 2019 Budget Request report (subject to approval by the Board of Health/Council). The report is scheduled for the Dec. 10th Board of Health meeting but may be bumped to January 2019 due to the recent municipal elections and a new Board of Health/Council convening for the first time in December.

Nancy's feedback on the draft report included a suggestion to incorporate a definition of food as "a nutrition substance." As the Committee has not yet had a discussion about establishing a definition, this definition will not be included in the report. Discussion about this will be added to the next agenda.

ACTIONS
Sandy will edit the draft report to make it more concise, and then send out for final review; everyone to provide their feedback to Sandy by **October 25th**. Sandy will also make further edits to the presentation that was circulated earlier and recirculate to the Committee for final review.

Hannah and Luc will co-present at the Board of Health when this report in on the agenda.

7.3 Future 2019 Food Strategy Reports

The first Board of Health report for 2019 will be an update on the Food Strategy's Priority Actions 2 and 3, which focus on food skills & employability programming, and community/neighbourhood infrastructure to support food literacy initiatives. Sandy will discuss barrier issues for organizations who want to offer food skills training with her colleague in Economic Development.

8. NOTICES OF MOTION
None

9. GENERAL INFORMATION & OTHER BUSINESS
None

10. ADJOURNMENT (H. Pahuta/K. D'aoust)
Meeting adjourned at 8:53 p.m.

CARRIED

CITY OF HAMILTON

PUBLIC HEALTH SERVICES

Epidemiology, Wellness and Communicable Disease Control Division

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	December 10, 2018
SUBJECT/REPORT NO:	Alcohol, Drug & Gambling Services and Community Mental Health Promotion Program Budget 2018-2019 (BOH18003(a)) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Susan Boyd (905) 546-2424, Ext. 2888
SUBMITTED BY: **SIGNATURE:**	Michelle Baird Director, Epidemiology, Wellness and Communicable Disease Control Division Public Health Services

RECOMMENDATION

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

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

(c) That the Board approve the 0.4 FTE increase for the Community Mental Health Promotion Program, and a 0.1 FTE decrease for the Alcohol, Drug & Gambling Services, Problem Gambling Program; and,

(d) 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 provincially funded program that provides comprehensive assessments, outpatient counselling, referrals for treatment, and collaborative service delilvery with other agencies in the community. The Community Mental Health Promotion Program (CMHPP) is a provincially funded program that provides mental health case management and outreach services to the Hamilton community.

In May 2018 the Hamilton Niagara Haldimand Brant, Local Health Integration Network (HNHB LHIN) provided notice that there would be an increase to base budget in 2018-2019 for both programs. There would be an increase to the CMHPP budget of $16,500; the ADGS Substance Abuse Program of $17,500; and $7,500 to the ADGS Problem Gambling budget.

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. To increase the capacity for concurrent disorders work, staffing has been adjusted accordingly with the increased funding.

Alternatives for Consideration – Not Applicable

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: There has been an increase to the base budget for each of the programs: CMHPP budget increase of $16,500; ADGS Substance Abuse Program budget increase of $17,500; and ADGS Problem Gambling budget increase of $7,500.

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	$700,429*	$683,929	5.6**	5.2**	0.4

HNHB – LHIN; ADGS Substance Use	$730,191	$712,691	6.4	6.4	0
HNHB – LHIN; ADGS Problem Gambling	$315, 091	$307,591	2.4	2.5	(0.1)
Total Budget and FTE	**$1,745,711***	**$1,704,211**	**14.4**	**14.1**	**0.3**

*This budget line includes CMHPP sessional fees funding and targeted psychiatric consultation, but does not include the base budget.
**1 additional Outreach staff, hired through external agency

Staffing: There is an overall increase in FTE of 0.3 for 2018-2019. There has been a slight change in FTE's between programs to meet administrative model changes and continued work towards building concurrent disorders capacity between the programs. There will be a 0.2 FTE increase to administrative staffing, clerk/receptionist position, and a 0.1FTE increase to clinical staff, social worker position.

Legal: No new legal implications for these programs.

HISTORICAL BACKGROUND

Both ADGS and the CMHPP had experienced eight years of no increase to base budget and the recent base budget increase from the HNHB LHIN has been needed. 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 & 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.

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

Not Applicable.

Form: Request to Speak to Committee of Council
Submitted on Friday, June 29, 2018 - 6:15 pm

==Committee Requested==
Committee: Board of Health

==Requestor Information==
Name of Individual: Halima Al-Hatimy

Name of Organization: FemCare Community Health Initiative

Contact Number: [redacted]

Email Address: [redacted]

Mailing Address:

[redacted]

Reason(s) for delegation request:

FemCare Community Health Initiative is a registered non-profit social enterprise with a mandate to shape women's health policy and community-programming.

We started with menstrual hygiene management drives where we assembled kits and distributed them on the streets and to women's shelters. In 2018, we registered it as a non-profit organization that seeks to harmonize the relationship between women's mental and reproductive health through education, community-programming and influencing policy and research.

In 2016, I was personally invited to the provincial pre-budget consultation by the Associate Minister of Finance, Mitzie Hunter, to talk about FemCare and the urgency of funding menstrual hygiene

management products for homeless women (and other genders) who menstruate.

Recently, Councillor Wong Tam of ward 27 in Toronto, ON announced a motion for the city to fund menstrual hygiene management products for disenfranchised women. Because of my background as a women's health advocate and organizer, women in the community have approached me and asked if I would champion this cause in Hamilton and bring this delegation forward to Hamilton Council.

Will you be requesting funds from the City? No

Will you be submitting a formal presentation? Yes

CleanAir HAMILTON

Clean Air Hamilton

2017 Air Quality Progress Report

December 2018

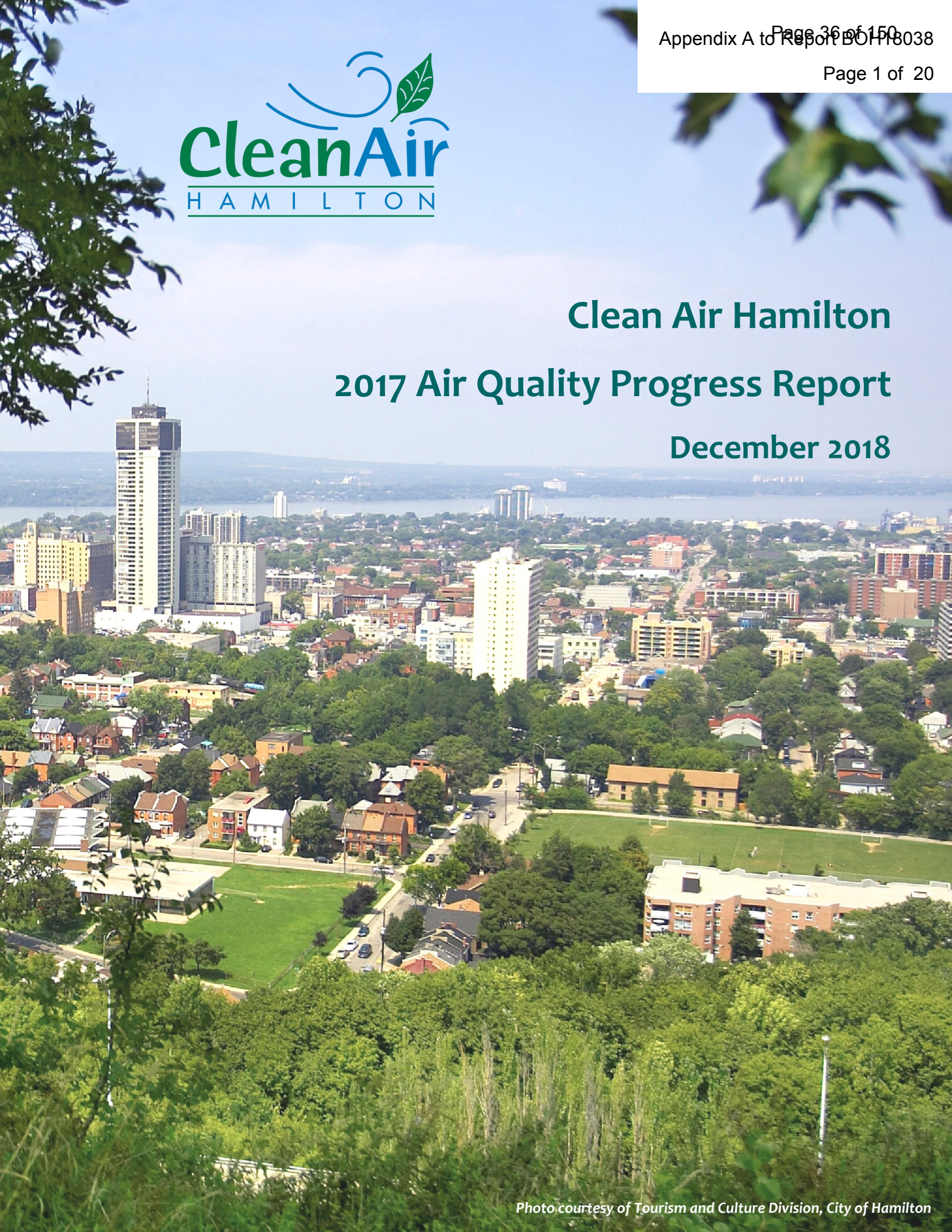

Photo courtesy of Tourism and Culture Division, City of Hamilton

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Top Row (left to right): George McKibbon, Brian Jantzi, Susan Chapman, Dr. Fran Scott, Trevor Imhoff (coordinator), Christine Borselli, Ed Cocchiarella, Robert Clacket
Bottom Row (left to right): Dr. Lynda Lukasik, Elise Desjardins, Shelley Rogers, Dr. Bruce Newbold (Chair) Peter Chernets, John Lundrigan,
Missing: Karen Logan, Rachel Johnson, Dr. Matthew Adams, Dan Dobrin, Adriano Mena, Ted Mitchell, Dr. Sally Radisic, Andrew Sebestyn, Dr. Denis Corr (Outgoing Chair), Sean Angel, Michael Gemmell,

Dr. Denis Corr was the outgoing Chair for Clean Air Hamilton in 2017. He served as Chair from 2013—2017. and remains a member of Clean Air Hamilton. Dr. Corr continues to contribute to the community through research and providing education, including the Enhanced Fresh Air For Kids Program in partnership with Green Venture.

Message from the Chair

I am pleased to provide the Clean Air Hamilton 2017 report which provides annual air quality trends and our on-going work to improve air quality in Hamilton. The following is our Clean Air Hamilton 2017 report. For previous years' activities go to: http://www.cleanairhamilton.ca.

Over the past year, we continued to learn more about the local air quality and to make improvements to Hamilton's air quality. Clean Air Hamilton worked closely with Golder Associates on the Hamilton Airshed Modelling System (HAMS), with the model to be released in 2018. The model will help us better understand questions such as: Where is our air pollution coming from? How important are sources external to the city? How much does air pollution vary across the city? Answering these questions will provide us new insights into our local air quality, and ultimately new directions to address air quality in the City of Hamilton.

The Provincial government has also continued to recognize the need to improve air quality through legislation, with the province proposing new regulations that would recognize the combined effects of pollution sources such as benzene in 2017. Members from Clean Air Hamilton along with other stakeholders were involved in the consultations around this legislation, and we look forward to bringing these changes to our City.

Our mandate includes involving and informing our citizens of all these issues and giving sound, science based advice and recommendations. Over the past year, we started to plan for the 2018 Upwind-Downwind conference – our 10th Upwind-Downwind conference. We also worked closely with local partner groups including Environment Hamilton, Green Venture and the Active Sustainable School Transportation committee on projects that have raised awareness amongst local citizens about air quality issues, as well as working to improve local air quality. Together, Clean Air Hamilton and its various partners are working to reduce emissions as well as our personal exposures and live healthier lives. Clean Air Hamilton's special projects and this report help us to do that.

We thank Healthy and Safe Communities and City Council for their ongoing support of Clean Air Hamilton and its special projects. Special thanks go to Trevor Imhoff and the committee for their hard work in making our report a reality. Finally, as the new Chair of Clean Air Hamilton, I would like to thank Dr. Denis Corr for his long-term leadership and commitment to Clean Air Hamilton. Much of Clean Air Hamilton's success is due to his work, and I look forward to continuing this in the coming years.

Bruce Newbold, Ph.D.
Chair, Clean Air Hamilton

Strategic Activities

Clean Air Hamilton is dedicated to improving air quality across the City of Hamilton. This will be accomplished through sound science based decision making, using the most up-to-date information and tools available, such as the Hamilton Airshed Model. Clean Air Hamilton has identified these issues for research, communication and program activities in collaboration with our partners:

Governance & Structure:

To remain a multi-stakeholder group dedicated to improving air quality by increasing public perception and expanding Clean Air Hamilton membership while providing communication and promotion of realistic, science based decision making and sustainable practices

Air Zone Management:

Comply with the Ministry of the Environment , Conservation and Parks (MECP) (formally the Ministry of the Environment and Climate Change) and Canadian Ambient Air Quality Standards. This will be done through implementation of a systems level approach and support towards an industrial mandatory monitoring regulation.

Transportation:

To encourage and facilitate more use of public and active transportation through commentary on transportation related matters, supporting educational programs and localized monitoring leading to detailed information to encourage changes in behaviour.

Air Monitoring:

To improve air monitoring activities across the City of Hamilton by providing support for additional portable air monitors and fixed air monitors that provide real-time monitoring for contaminants of concern in Hamilton.

Dust & $PM_{2.5}$ Mitigation:

Lower concentrations of $PM_{2.5}$ across the City of Hamilton below Canadian Ambient Air Quality Standards by effectively utilizing the airshed model to create partnerships and pollution inventory specific to street sweeper and dust mitigation programs.

Clean Air Hamilton Meetings

Clean Air Hamilton meetings are held usually on the second Monday of each month located at 71 Main Street West, City Hall, Room 192/93

2017 Meetings	2018 Meetings
January 9, 2017	January 8, 2018
February 13, 2017	February 12, 2018
March 13, 2017	April 9, 2018
April 10, 2017	May 14, 2018
May 8, 2017	June 11, 2018
June 12, 2017	July 9, 2018
July 10, 2017	August 13, 2018
August 14, 2017	September 8, 2018
September 11, 2017	October 15, 2018
October 2, 2017	November 12, 2018
November 13, 2017	December 10, 2018
December 11, 2017	

Photo courtesy of Tourism and Culture Division, City of Hamilton

Clean Air Hamilton (CAH) - 2017

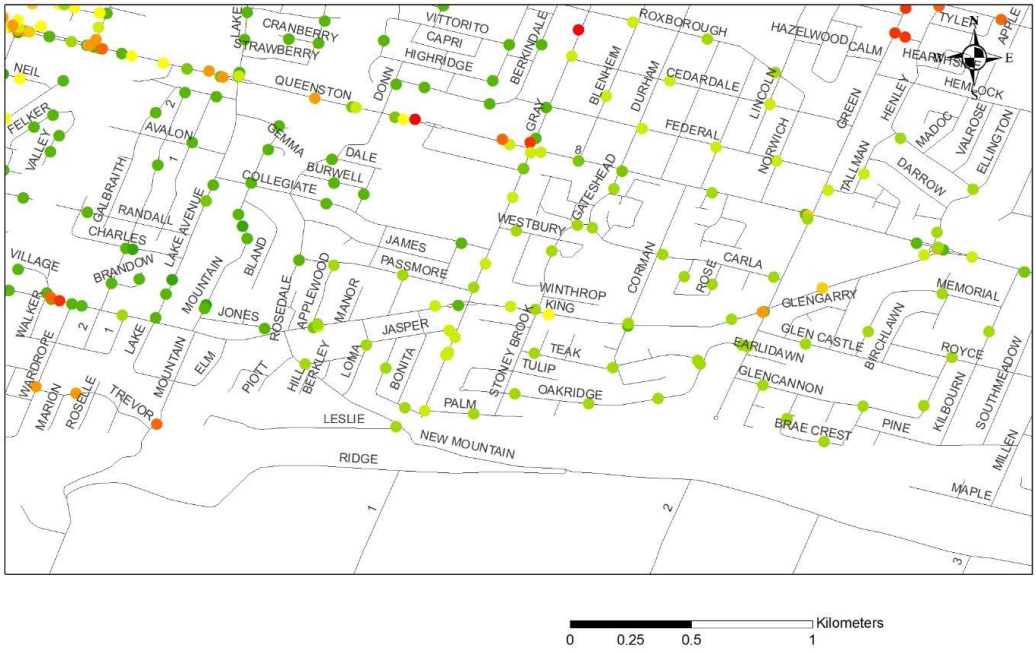
Clean Air Hamilton is an innovative, multi-stakeholder agent of change dedicated to improving air quality in our community. In 2017, Hamilton Public Health Services provided $27,150 to fund projects resulting in air quality improvement and awareness. These projects reach thousands of school aged children and contribute to improving Hamilton's air quality through monitoring and promotion. Clean Air Hamilton is proud to support the 2017 funded projects.

Enhanced Fresh Air for Kids

In 2017, Green Venture and Corr Research teamed up to provide the Enhanced Fresh Air for Kids program to five Hamilton elementary schools. The focus of the project is to educate students, teachers and the public about air quality around schools and the impact of engine idling. The program was delivered to St. Martin of Tours, Lawfield, Cathy Wever, Hillcrest and Adelaide Hoodless elementary schools, with classroom work, in-the–field air monitoring and at-school anti-idling awareness campaigns.

Students were educated on the importance of air quality, the Air Quality Health Index and gained an awareness of how their actions can impact and improve the air in their neighbourhoods. Students measured PM2.5 and PM10 in their neighbourhoods. The MECP Mobile Air Monitoring van was also used to monitor air quality in the vicinity of the schools. These data were developed into air quality maps (see below) which students used to decide on their best ways to travel to and from their school .

St. Martin of Tours School, Mobile Air Monitoring



Clean Air Hamilton 2017 Funded Projects Cont'd...

Enhanced Fresh Air for Kids Cont'd...

The 2017 Enhanced Fresh Air for Kids program featured an enhanced anti-idling campaign. The program included anti-idling education where Green Venture led classrooms in the development of banners, pamphlets, key chains and other advertising material. Blitzes were included to set a measureable baseline for the success of the program. The initial blitzes took place at the beginning of the program in the Fall and follow-up blitzes the following Spring after the campaign was complete. Four of the five schools completed the secondary blitzes and the collected data was used to form the conclusion of the success of the project. The schools found a 25% decrease in the number of cars idling between the blitzes, Cathy Wever showing the largest decrease of 54%.

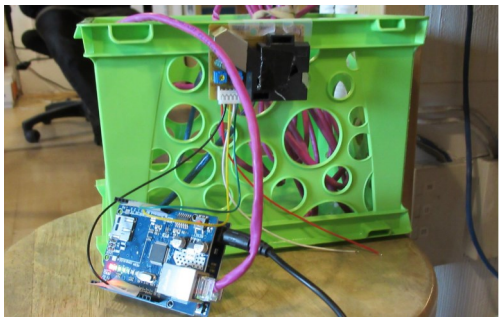
The number of cars during between the Fall and Spring blitzes increased, however the number of cars idling dropped.

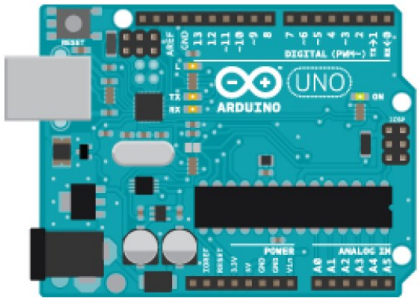
The estimated reduction of greenhouse gas emissions equates to 7858 kg CO_2 annually.

The City of Hamilton **Anti-Idling By-law No. 07-160** can be found on the City's Bylaw website at:

https://www.hamilton.ca/government-information/by-laws-and-enforcement/city-hamilton-by-laws

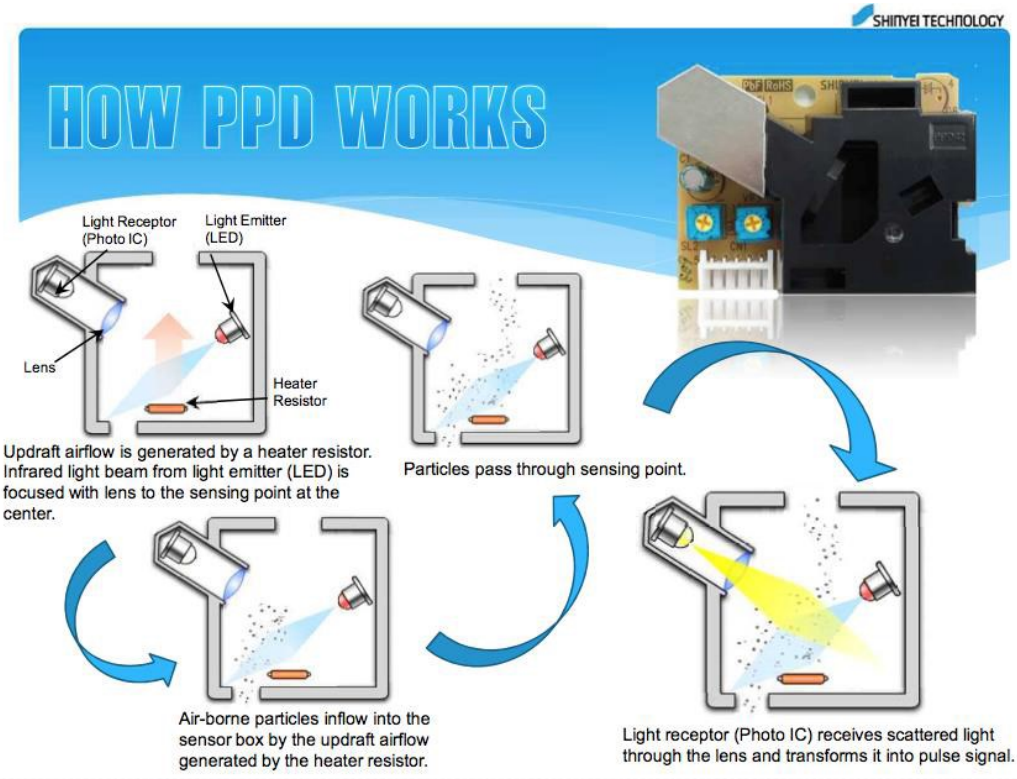
Building Community Awareness & Action Regarding Respirable Particulate Pollution in Hamilton





Environment Hamilton is a Hamilton based not-for-profit organization that promotes environmental protection. In 2017, Clean Air Hamilton provided funding to Environment Hamilton to initiate their Building Community Awareness & Action Regarding Respirable Particulate Pollution in Hamilton plan. The goal of the plan was to assemble a group of volunteers to assist in building low cost particulate matter sensors to be deployed in stationary locations across the lower city. The information collected can be viewed on Environment Hamilton's online air mapping system, which can be found at www.inhalemap.com.

Environment Hamilton used Arduino sensors to collect data. The sensors use infrared light and heat resistors to measure the amount of PM in the air. Arduino is an open-source electronics platform that can be modified to perform interactive



Hamilton Air Quality Health Index Mapping

Prof. Matthew Adams with Ryerson University/University of Toronto, performed an extensive update on the Hamilton AQHI website in 2016. Mobile air pollution data was uploaded that was collected during the most recent round of neighbourhood air quality monitoring by **Corr Research Inc.**

Now citizens can access hourly conditions during the past five years, as well as selected events (e.g. highest concentrations). This feature is best demonstrated when a person notes some personal effect, such as an odour or news about elevated concentrations.

www.hamiltonaqhi.com

Citizens can go on the website and look up the AQHI for the time they were affected. This interaction should lead to more interest in additional resources such as:

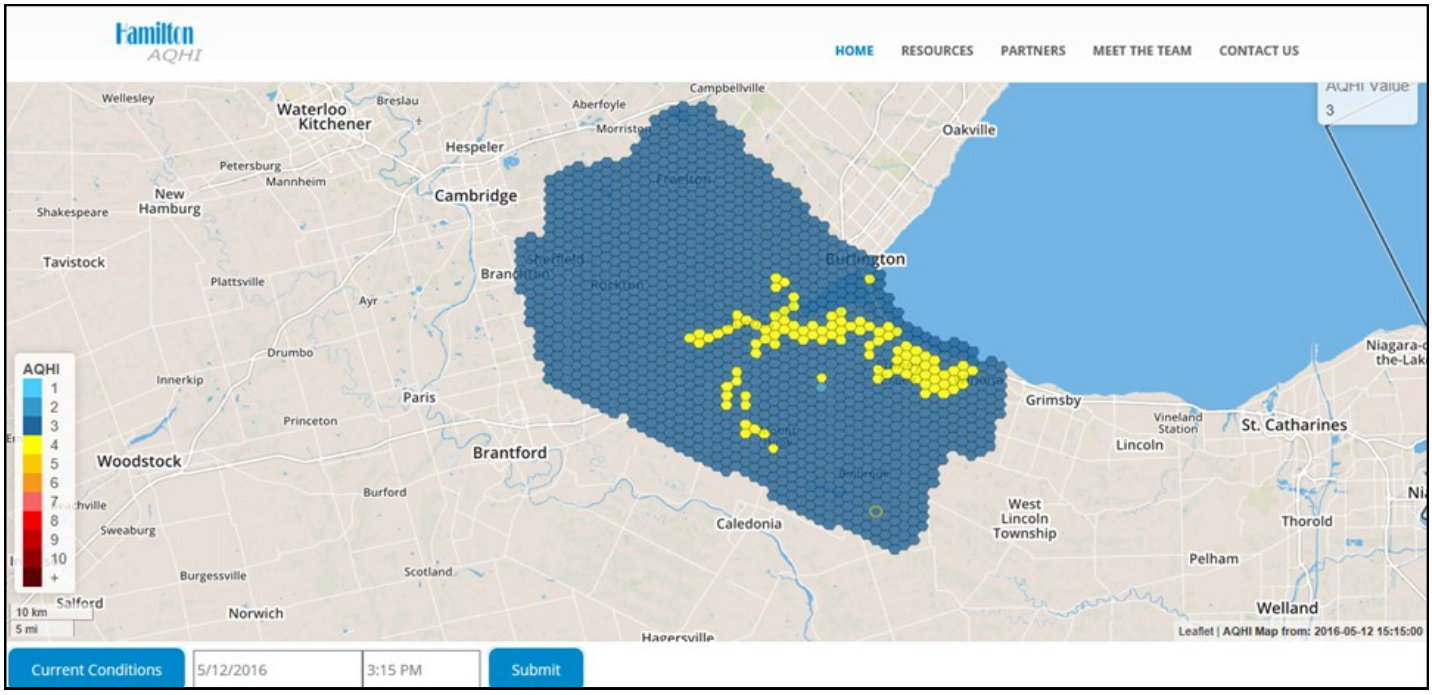
Environment and Climate Change Canada Air Quality Health Index; or

Air Quality Ontario

Reduction of air pollution exposure is a key component of improving overall public health. The importance of reducing exposure will increase due to our ageing population and incidences of compromised respiratory and cardiac function.

Current AQHI systems utilized by government agencies can be limited in geographical context. This website presents community air quality information to residents of the City of Hamilton that will help behavioural change to reduce air pollutant exposure.

Hamilton AQHI May 12, 2016

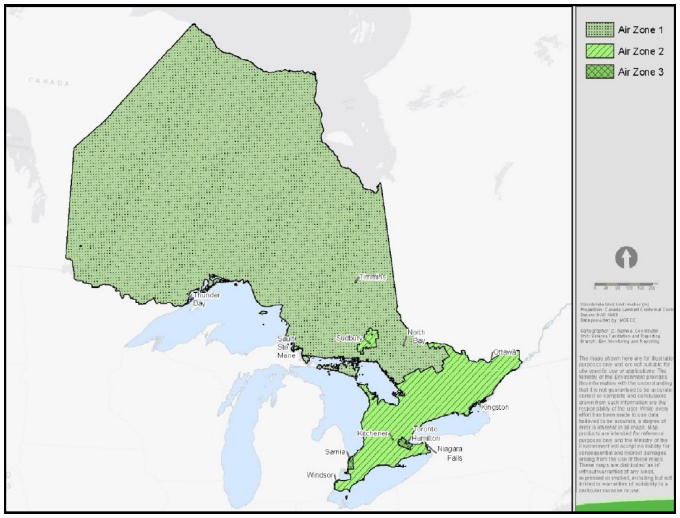


Delineation of Ontario Air Zones

Ontario is implementing the Air Quality Management System (AQMS), a flexible cross-Canada framework developed through the Canadian Council of Ministers of the Environment. The AQMS is a comprehensive approach consisting of an interconnected set of drivers and mechanisms to achieve continuous improvements to overall air quality using an all sources approach[1].

Ontario has finalized its decision to delineate its air zones into three zones:

Air Zone 1—Areas with limited pollution from either point or non-point sources or transboundary influence; where air quality management activities are focused on maintaining good air quality.



Air Zone 2—Areas under pressure from multiple sources including some or all of the following: non-point sources, smaller point sources, individual large industrial point sources, transboundary influences; where air quality management activities are focused on multiple broad-based initiatives targeting many sources.

Air Zone 3—Areas with a concentration of large industrial sources; where air quality management activities are focused on the abatement of local industrial emissions as well as non-industrial sources[1].

Hamilton is classified as Air Zone 3, Clean Air Hamilton continues to work with Ministry of the Environment Conservation and Parks staff on the new Air Quality Management System approach to improve the overall air quality across Hamilton.

[1]Government of Ontario.(2016). Environmental Registry. Retrieved from: https://www.ebr.gov.on.ca/ERS-WEB-External/displaynoticecontent.do?noticeId=MTI1MjE2&statusId=MTkzMDMw

Clean Air Hamilton Member Good News Stories

Friendly Streets

Friendly Streets Hamilton, an initiative of Environment Hamilton and Cycle Hamilton, has been working to support and engage community stakeholders in securing safer cycling and walking conditions in urban Hamilton which in turn improves local air quality. The work in this project encourages and supports Hamiltonians in critically reflecting on how they move around the city and whether personal choices can be made that will contribute to improving urban air quality.

The 2017 pilot phase focused on areas around Hamilton General Hospital on Barton Street. Over the course of 2017, the pilot phase focused on the area around the Hamilton General Hospital (HGH) on Barton Street and radiated out to the Beasley, Keith, and Gibson-Landsdale neighbourhoods. This location was chosen because community members who live, work, and play in the neighbourhoods have raised concerns about the need for street-level changes that encourage more active mobility. .

Street audit conducted through International Village BIA with residents from First Place in September 2017.

Clean Air Hamilton Member Good News Stories Cont...

Stelco Canada Grant

In 2017, the Ontario Centres of Excellence and Walkers Environmental awarded Stelco Canada $5 million and $5.5 million respectively to switch to using bio-carbon for coke production in steel making. This process replaces up to three per-cent of coal use by diverting disposed railway ties from landfills or incineration to be used in the steel making process. The ties are ground up and used as a bio-carbon fuel. This process reduces Stelco's GHG emissions by 64,000 tonnes using this biomass substitute for coal. Another environ-mental benefit of the project is that the creosote preservative on the railway ties is recycled back into tar through the by-product plant.

Clean Air Hamilton Website

In 2017, The City of Hamilton enlisted the services of 2Gen Interactive to create a new Clean Air Hamilton Website. City staff are responsible for maintenance and upkeep of Clean Air Hamilton's website.

The services of 2Gen Interactive were recruited to create an updated, informative, easy to use website. The Website contains Hamilton specific air quality information, health information, projects and programs of Clean Air Hamilton, resources, meeting minutes and current events within Hamilton related to air quality.

To visit the new website, go to: www.cleanairhamilton.ca .

Message from the Ministry of the Environment Conservation and Parks (Formally the Ministry of the Environment and Climate Change)

Today, the people of Hamilton are breathing cleaner air than a decade ago.

Air quality in Hamilton continues to improve significantly with large reductions in the levels of many harmful pollutants.

In fact, no smog days or Air Health Advisories were issued for Hamilton in 2017.

Delivering on clean air and reducing air pollution is a commitment of the Ontario government.

We are working to ensure industry continues to improve its environmental performance and invest in new technology.

Additionally, the ministry is expanding our air monitoring capabilities in Hamilton with more sophisticated equipment to understand priority areas and better target our efforts.

The City of Hamilton is a leader in developing collaborative approaches to improving air quality, monitoring, research and sharing information with the broader community.

We look forward to our continued work with Clean Air Hamilton, and ensuring cleaner air for the people of Hamilton.

Ambient Air Quality Trends and Comparisons

Pollutant Percent Reduction From Regression Trends 2017

- Total suspended particulate (TSP) – 57% total reduction over 20 years
- Inhalable particulate matter (PM_{10}) – 37% total reduction over 20 years
- Respirable particulate matter ($PM_{2.5}$) – 26% total reduction over 18 years
- Nitrogen dioxide (NO_2) – 54% total reduction over 20 years
- Sulphur dioxide (SO_2) – 46% total reduction over 20 years
- Total reduced sulphur odours – 98% total reduction over 20 years*
- Benzene – 89% total reduction over 20 years**
- Polycyclic aromatic hydrocarbons (PAH) measured as benzo[a]pyrene – 78% total reduction over 20 years.**

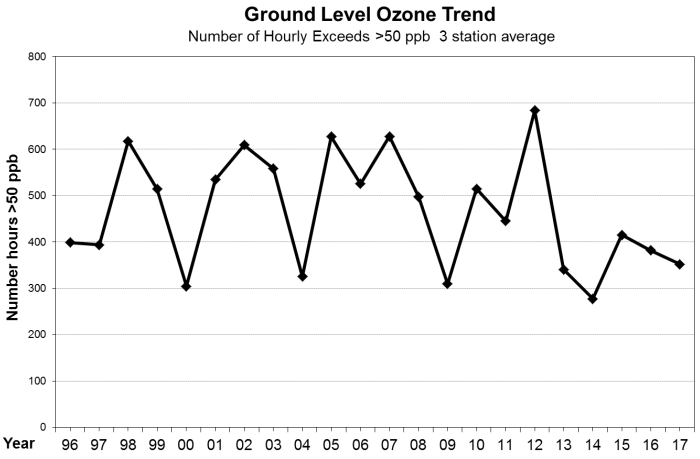
Ministry of the Environment, Conservation and Parks, Hamilton Downtown Station (Station 29000)
*Expressed as number of hours above 10 ppb threshold
**Benzene and PAH not available from Station 29000 for 2017 yet

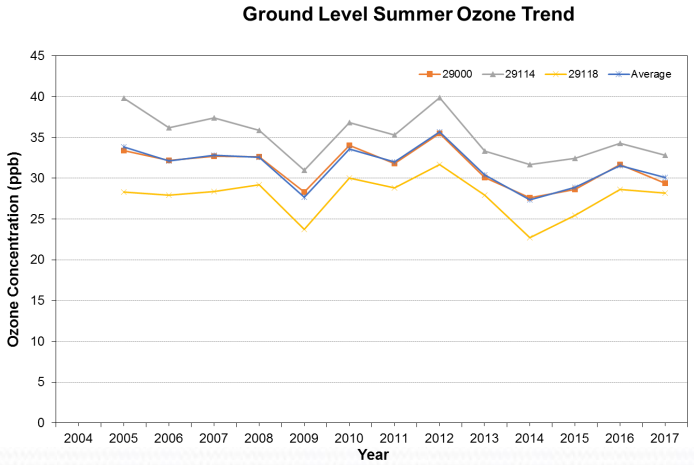
Ground Level Ozone (O_3)

Ground level ozone (O_3 or tropospheric ozone) is formed when pollutants are emitted and react with the presence of sunlight. This is why O_3 concentrations are higher during summer months. Sources include: coal-fired power plants, vehicles and urban activities.

The trend in O_3 shows that concentrations have been highly variable in the past 20 years. O_3 is a main contributor for Hamilton's Special Air Health Advisories (SAHA) and Special Air Quality Statements (SAQS) and unlike other pollutants the majority of O_3 comes from sources upwind of Hamilton and are expected to originate in the Midwest Ohio Valley region. Sources from Hamilton contributing to O_3 pollution will affect areas downwind of Hamilton which makes lowering O_3 emissions very important.

The Government of Ontario has been dedicated to lowering O_3 precursor emissions by eliminating all coal-fired power plants in Ontario.



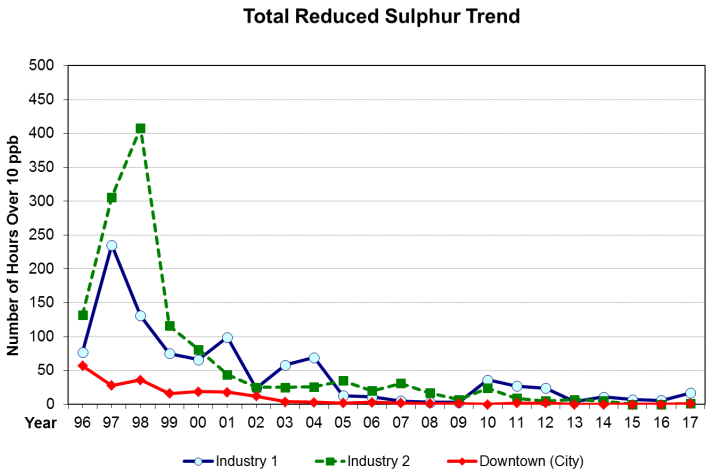


Ambient Air Quality Trends and Comparisons

Total Reduced Sulphur (TRS)

Total Reduced Sulphur (TRS) is a measure of the volatile, sulphur-containing compounds that are the basis of many of the odour complaints related to steel mill operations. An odour threshold has been set at 10 parts per billion (ppb) TRS because at this level about one-half of any group of people can detect an odour similar to the smell of rotten eggs.

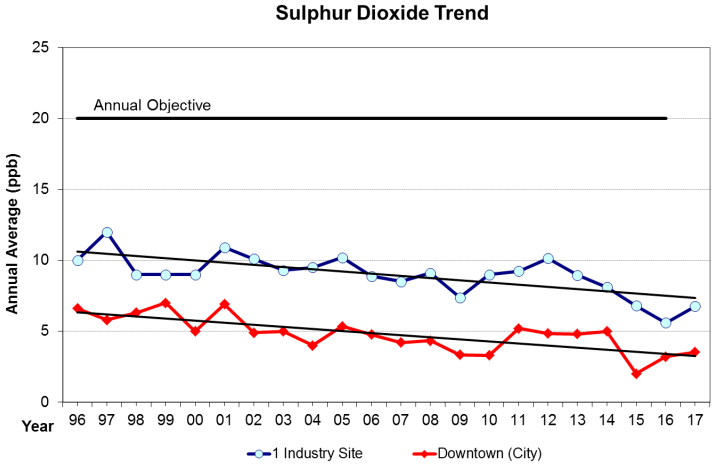
The number of hours per year in which measurements exceed 10 ppb have been reduced by over 90% since the mid-1990s. This is due to significant changes in the management and operation of the coke ovens, blast furnaces and slag quenching operations associated with steel mill operations.



Sulphur Dioxide (SO_2)

Sulphur Dioxide is the product of industrial activity with over 90% generated within the City. SO_2 is not only a respiratory irritant but is converted in the atmosphere over several hours to sulphuric acid (H_2SO_4), which is then converted to sulphate particles. These particles tend to be acidic in nature and cause lung irritation.

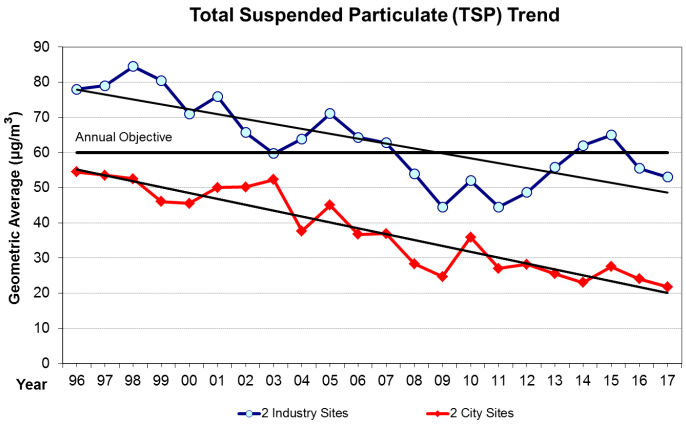
Significant reductions in air levels of SO_2 were made in the 1970s and 1980s. Since 1998, there has been a gradual and continuous decline in air levels of SO_2 besides the recent increase in 2016 and 2017.



Public Health Services Airpointer located at Sam Manson Park

Particulate Material: Total Suspended Particulate (TSP)

Total suspended particulate (TSP) includes all particulate material with diameters less than about 45 micrometers (µm). A substantial portion of TSP is composed of road dust, soil particles and emissions from industrial activities and transportation sources.

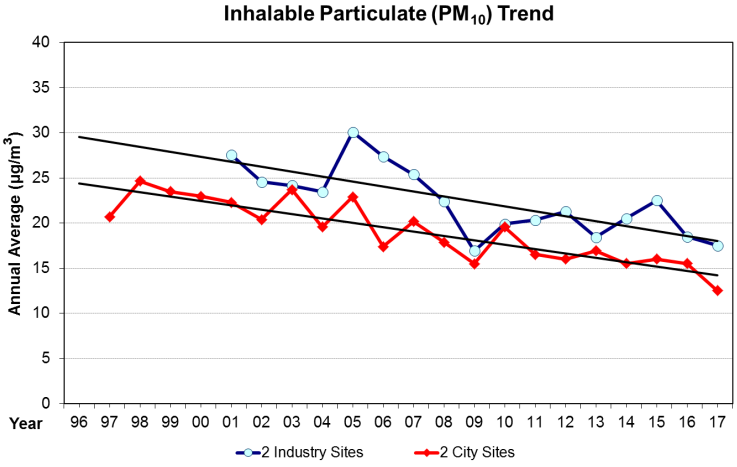


There has been a steady decline in TSP at City sites while levels have risen in previous years at industry sites. There was a decline in 2016 lowering emissions at industry sites below the annual objective.

Included in the TSP category are inhalable particulates (PM_{10}) and respirable particulates ($PM_{2.5}$). It is possible to determine the net amount of particulate material in the air with sizes between about
45 µm and 10 µm, by subtracting PM_{10} from the TSP value.

Particulate Material: Inhalable Particulate Matter (PM_{10})

Inhalable particulate matter (PM_{10}) has a diameter of 10 µm or less. PM_{10} makes up 40-50% of TSP in Hamilton and has been linked to respiratory, cardiovascular and other health impacts in humans.[1]



PM_{10} is primarily derived from vehicle exhaust emissions, industrial fugitive dusts, and the finer fraction of re-entrained road dust.

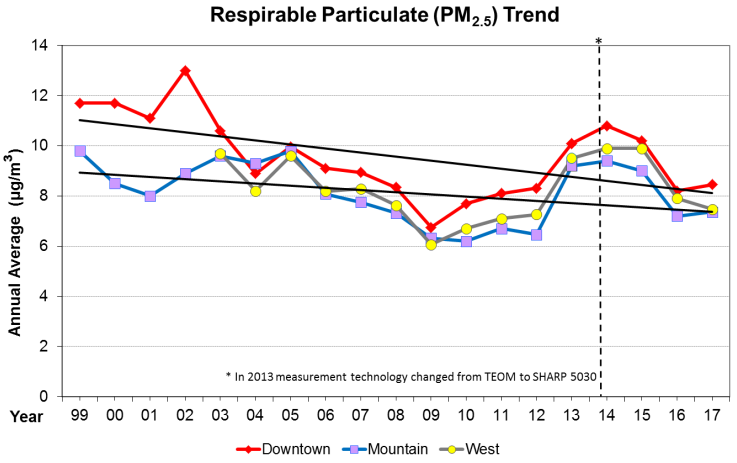
PM_{10} at City sites has decreased by about 21% over the past decade. This is likely a combination of better performance of vehicle fleets, better management of dust track-out by industries, and the use of better street sweepers and street sweeping practices by the City.

Ambient Air Quality Trends and Comparisons Cont'd...

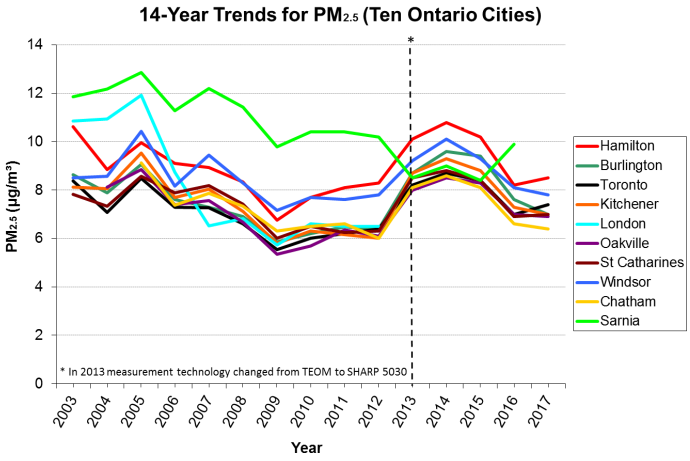
Particulate Matter: Respirable Particulate Matter ($PM_{2.5}$)

The Ontario government started measuring $PM_{2.5}$ across Ontario in 1999. $PM_{2.5}$ makes up about 60% of PM_{10} and is mostly derived in cities from vehicle emissions.

Scientists now agree that exposure to the small particles and the organic substances is the likely cause of the observed respiratory and cardiovascular health impacts attributed to particulate material exposure. [1]

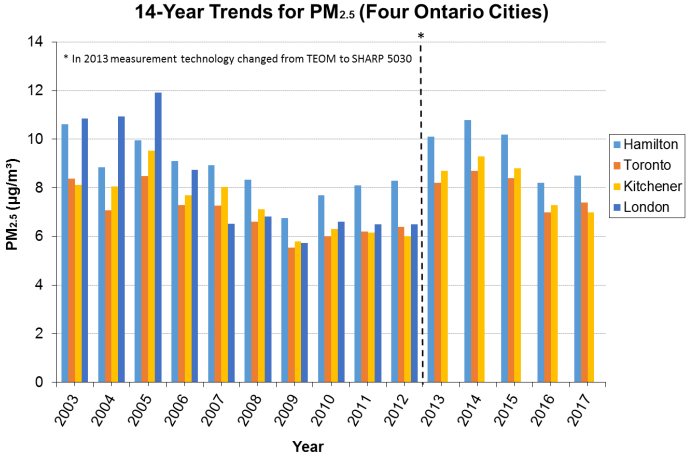


The trend in $PM_{2.5}$ showed a 3.5% decrease per year since 1999 until 2009 at the downtown and mountain AQHI sites. The apparent increase in 2013 is not reflective of a change in air quality but is a result of change in monitoring to a more sophisticated and sensitive $PM_{2.5}$ monitoring technology. There has been a decline in $PM_{2.5}$ concentrations across Hamilton with a slight peak on the Mountain and Downtown in 2017. The Mountain and West end remain below the Canadian Ambient Air Quality Standards (CAAQS). CAAQS are becoming more stringent in 2020 and therefore more work will be needed to meet the future standards.



Public Health Services Airpointer

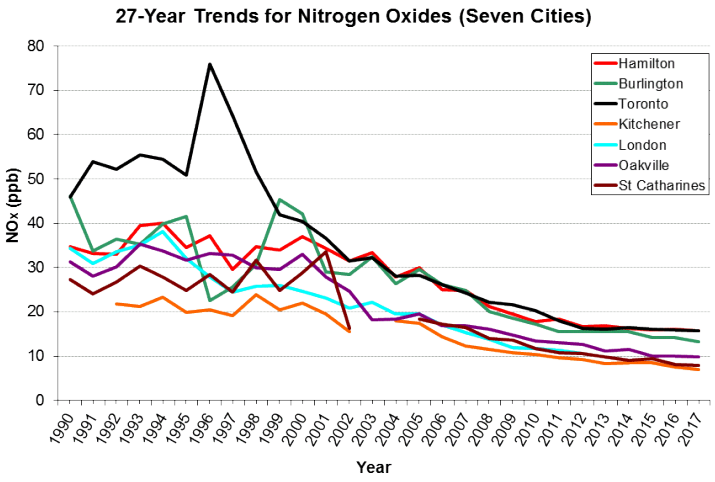
For more information contact Public Health Services (905) 546-2424 ext. 5288



[1] *SENES Consulting Ltd. (2011). Health Impacts Exposure to Outdoor Air Pollution in Hamilton, Ontario . Retrieved from www.cleanair.hamilton.ca/health-impact (i.e Inhalable particulate matter (PM10) is the airborne particles that have diameters of 10 µm or less. PM10 makes up 40-50% of TSP in Hamilton and has been linked to respiratory, cardiovascular and other health impacts in humans.)*

Nitrogen Oxides (NO_x)

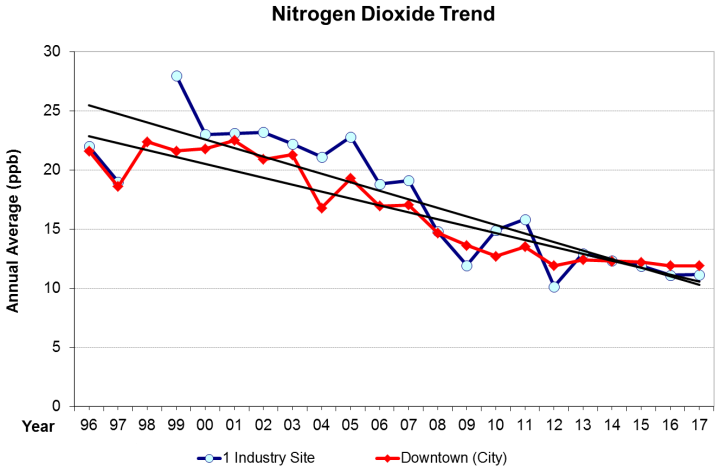
This chart displays the steadily decreasing trend of Nitrogen Oxides (NO_x) in seven cities in Ontario, including Hamilton. Since the 1990's both Toronto and London have seen reductions in NO_x levels of approximately 60%. Hamilton's NO_x levels have decreased by approximately 46% since 1990.



The slower decrease of NO_x levels in Hamilton is presumably due to the fact that Toronto and London do not have other sources (ex. industrial emissions) that contribute to overall NO_x levels that Hamilton has. The decrease in NO_x levels is a

Nitrogen Dioxide (NO_2)

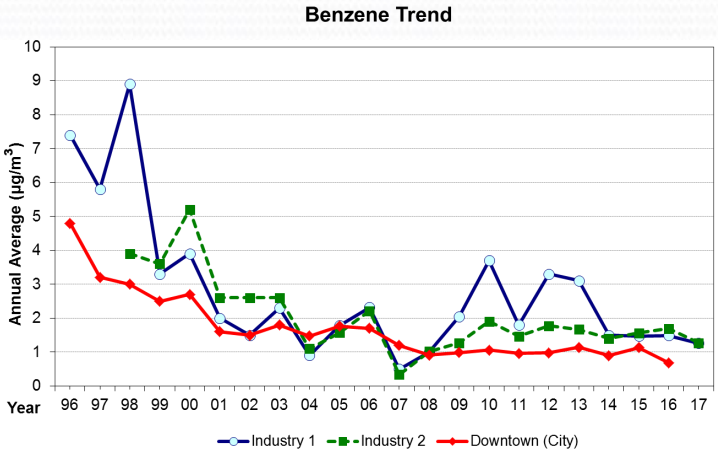
Nitrogen Dioxide (NO_2) is formed in the atmosphere from nitric oxide (NO) which is produced during combustion of fuels (i.e gasoline, diesel, coal, wood, oil and natural gas) and is responsible for a significant share of the air pollution-related health impacts in Hamilton. The leading sectors producing these emissions are the transportation and industrial sectors. The level of vehicle use across Hamilton has increased slightly during the past decade, however overall NO levels have decreased most likely due to improved engine technologies.



Both NO and NO_2 are routinely measured and their sum is reported as Nitrogen Oxides (NO_x) to reflect the presence of both species in urban areas. Ultimately all of the NO is converted to NO_2 which reacts with water in the atmosphere to produce nitric and nitrous acids (HNO_3 and HNO_2, respectively); these acids are converted into nitrate salts that constitute about 25% of the mass of fine particulate matter or $PM_{2.5}$.

Hamilton Air Monitoring Network Beach Strip Station 29102

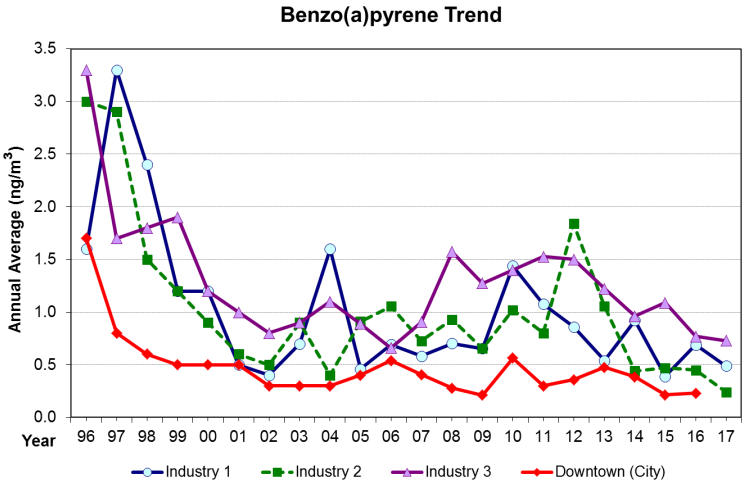
Benzene



Benzene is a carcinogenic (cancer causing agent) volatile organic compound (VOC) that is emitted from some operations within the steel industry, specifically coke ovens and coke oven by-product plant operations. Benzene is also a significant component of gasoline which can be up to 5% benzene. Vapours containing benzene are released during pumping at gasoline stations.

Air levels of benzene have been reduced dramatically since 1990's, due to significant upgrading of the coking plant operations, improved operating procedures and improved control of release of benzene vapours from the coke by-products. More work remains to be done to reduce low concentration exposures of benzene. Benzene concentrations for downtown for 2017 were not

Benzo[a]pyrene



Benzo[a]pyrene (BaP) is also a carcinogen and capable of causing cancer in both animals and humans. BaP is a member of a larger class of chemical compounds called polycyclic aromatic hydrocarbons (PAHs) which are emitted when carbon-based fuels such as coke, oil, wood, coal and diesel fuel are burned.

The principal sources of BaP in Hamilton are released from coke oven operations within the steel industry. There have been significant decreases in BaP levels since the late 1990s. BaP concentrations for downtown for 2017 were not available.

Conclusions

In 2017, the City of Hamilton provided a contribution of $56,000/year in support of Clean Air Hamilton and its activities. Descriptions of some of the programs supported by Clean Air Hamilton can be found on pages 5 - 7 in this report.

This annual funding is leveraged significantly in two ways: first, Clean Air Hamilton uses these funds in partnership with funds provided by other agencies and institutions to develop programs related to air quality; second, since all of the members of Clean Air Hamilton donate their time and expertise, there is a significant amount of in-kind support provided. It is estimated that Clean Air Hamilton's partners provide well over $200,000 in in-kind support.

Bruce Newbold, Ph.D.
Chair, Clean Air Hamilton

Air Quality - Additional Resources

To learn more about Clean Air Hamilton and our work visit www.cleanairhamilton.ca .

Air Quality and Health

To learn about how to protect your health visit: www.airhealth.ca

To learn about Hamilton Public Health Services and actions on air quality visit: http://preview.hamilton.ca/public-health/health-topics/air-quality-pollution-smog

Government Actions on Air Quality

To learn about the Province of Ontario's actions on air quality visit: www.airqualityontario.com/

To learn about the Government of Canada's actions on air quality visit: http://www.ec.gc.ca/Air/default.asp?lang=En&n=14F71451-1

Air Quality Monitoring

For a detailed model of hourly concentrations for a variety of pollutants across Hamilton visit: http://www.hamiltonaqhi.com

To check our air pollution levels in Hamilton and Ministry run air monitors visit: http://www.airqualityontario.com/

To check out the Hamilton Air Monitoring Network visit: http://www.hamnair.ca/

To check out Hamilton Air Quality Health Index website visit: http://www.hamiltonaqhi.com

Who we are...

"Clean Air Hamilton is an innovative, multi-stakeholder agent of change dedicated to improving air quality in our community. We are committed to improving the health and quality of life of citizens through

2017 MEMBERS

Bruce Newbold, *Chair (Incoming)* -*McMaster University*

Denis Corr, *Chair (Outgoing)* - *Corr Research*

Trevor Imhoff - *Air Quality Coordinator* - *Clean Air Hamilton*

ArcelorMittal Dofasco

Citizens

City of Hamilton - *Community Initiatives**

City of Hamilton Planning - *Community Planning*

City of Hamilton Public Works - *Office of Energy Initiatives*

City of Hamilton Public Works - *Transportation Demand Management**

Environment Canada*

Environment Hamilton

Green Venture

Hamilton Conservation Authority

Hamilton Industrial Environmental Association

Hamilton Public Health Services

Health Canada*

The Lung Association

McKibbon Wakefield Inc.

McMaster Institute for Healthier Environments

Ministry of Environment Conservation and Parks (MECP) - *Hamilton Regional Office*

Mohawk College*

Ontario Environmental Assessment Corporation (OEAC)

Stelco

** indicates "observing member"*

This report and the work of our members is dedicated to the memory of
Dr. Brian McCarry (1946—2013)
Chair of Clean Air Hamilton from 1997—2013

Clean Air Hamilton, November 2017

Production: Public Health Services
City of Hamilton

For further information, please contact:

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Coordinator Air Quality and Climate Change
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Healthy & Safe Communities Department
City of Hamilton
110 King St. W. 3rd Floor Hamilton, ON, L8P 4S6
Robert Thompson Building

Phone:905-546-2424 Ext. 1275
Email: cleanair@hamilton.ca
or visit our website:
www.cleanairhamilton.ca

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	December 10, 2018
SUBJECT/REPORT NO:	Clean Air Hamilton 2017 Progress Report (BOH18038) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Shelley Rogers (905) 546-2424, Ext. 1275 Trevor Imhoff (905) 546-2424, Ext. 1308
SUBMITTED BY & SIGNATURE:	Kevin McDonald Director, Healthy Environments Division Public Health Services

Council Direction:

Clean Air Hamilton reports annually to Board of Health on the trends of local air quality and the actions undertaken by members of Clean Air Hamilton to address local air quality in Hamilton.

Information:

Clean Air Hamilton is a community initiative to improve air quality in the City of Hamilton. It has a diverse membership with representation from environmental organizations, industry, businesses, academic institutions, citizens and different levels of government (federal, provincial and municipal). Initiated in 1998, Clean Air Hamilton works to improve air quality throughout the City of Hamilton and meet all ambient air quality criteria. The Board of Health supports the work of Clean Air Hamilton through an annual budget of $56,000.

Clean Air Hamilton hosted a strategic visioning workshop in 2016 and has identified five strategic themes related to air quality improvements to focus on for the following two to three years. These include:

- Governance & Structure;
- Air Zone Management;
- Transportation;
- Air Monitoring; and,
- Dust and Particulate Matter ($PM_{2.5}$) Mitigation.

Further details can be found in Appendix A, as well as summarized below.

Air Quality in Hamilton

Many air pollutants' annual percentages have decreased over time as measured at Ministry of the Environment, Conservation and Parks (MECP) (formally the Ministry of the Environment and Climate Change) downtown air monitoring station (Station 29000).

Total reductions in pollutant levels since the mid-1990's are:

- Total suspended particulate (TSP) – 57% total reduction over 20 years;
- Inhalable particulate matter (PM_{10}) – 37% total reduction over 20 years;
- Respirable particulate matter ($PM_{2.5}$) – 26% total reduction over 18 years;
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- Total reduced sulphur odours – 98% total reduction over 20 years;
- Benzene – 89% total reduction over 20 years; and,
- Polycyclic aromatic hydrocarbons (PAH) measured as benzo[a]pyrene – 78% total reduction over 20 years.

Prior to 2016, $PM_{2.5}$ concentrations monitored at MECP's Station 29000 were above the Canadian Ambient Air Quality Standards of 10 micrograms per cubic metre ($\mu g/m^3$). In 2016 and 2017 $PM_{2.5}$ concentrations were at 7.9 and 8.46 $\mu g/m^3$ respectively. The standards are scheduled to become more stringent in 2020 so continued effort to reduce particulate matter levels will be required.

Air Quality Health Index

The Ontario MECP replaced the Air Quality Index on June 24, 2015 with the Air Quality Health Index. Updates to the Board of Health (BOH10008) and (BOH10008(a)) were provided regarding the implementation of this new reporting structure in Hamilton. The Air Quality Health Index is a scale designed to assist citizens to develop an understanding of air quality and the impact on one's health. It is a health protection tool that will help limit one's short-term exposure by providing advice to citizens, including vulnerable individuals and recommended activity levels during all levels of air quality. The Air Quality Health Index scale is from 1 to 10+ with ranges and activity recommendations for at risk populations and the general population.

Table 1: Air Quality Health Index Categories and Health Messages[1]

Health Risk	Air Quality Health Index	Health Messages	
		At Risk Population*	General Population
Low	1 – 3	Enjoy your usual outdoor activity.	Ideal air quality for outdoor activities.
Moderate	4 – 6	Consider reducing or rescheduling strenuous activities outdoors, if you are experiencing symptoms.	No need to modify your usual outdoor activities unless you experience symptoms such as coughing and throat irritation.
High	7 – 10	Reduce or reschedule strenuous activities outdoors. Children and the elderly should also take it easy.	Consider reducing or rescheduling strenuous activities outdoors if you experience symptoms such as coughing and throat irritation.
Very High	Above 10	Avoid strenuous activities outdoors. Children and the elderly should also avoid outdoor physical exertion.	Reduce or reschedule strenuous activities outdoors, especially if you experience symptoms such as coughing and throat irritation.

*People with heart or breathing problems are at greater risk. Follow your doctor's usual advice about exercising and managing your condition.

The MECP have three air quality monitoring stations in Hamilton which provide the data used to calculate the Air Quality Health Index. For approximate locations of air monitoring see Appendix A. Two different air quality alerts are issued during periods of poor air quality. A Special Air Quality Statement will be issued when the Air Quality Health Index is a high risk (>6) and is forecast to last for 1-2 hours. If the high risk Air Quality Health Index is forecast to be a persistent duration of at least 3 hours, then a Smog and Air Health Advisory will be issued.

In 2017 Hamilton experienced only two Special Air Quality Statements and no Smog and Air Health Advisory instances. Clean Air Hamilton does note that air quality can be variable at a local neighbourhood level and some areas of Hamilton can be impacted more than others by air pollutants.

Sulphur Dioxide and Benzene and Benzo[a]pyrene Air Quality Standards
In 2017, the Environmental Registry of Ontario released Environmental Bill of Rights

postings for sulphur dioxide, benzene and benzo[a]pyrene. The standards are based on health effects on humans and the environment.

The air quality standards for sulphur dioxide are decreasing to 100 µg/m^3 averaging over a one hour period (previously 690 µg/m^3) and the average annual standard will be 10 µg/m^3. The 24 hour standard for sulphur dioxide is being removed and replaced with the more stringent the one hour and annual standards. These new standards will be incorporated into Schedule 3 and take effect on July 1, 2023. See Table 2 below.

Table 2: Sulphur Dioxide Air Quality Standards and Upper Risk Thresholds

Time Period	Current Standard (µg/m^3)	Standard effective July 1, 2023 (µg/m^3)
Half Hour	830	830
One Hour	690	100
24 Hour Standard	275	None
Annual Average	None	10

Upper risk thresholds have will be introduced into Schedule 6, with a limit of 830 µg/m^3 in a half hour period and 690 µg/m^3 within a one hour period coming into effect on January 1, 2019.

The new benzene and benzo[a]pyrene standards consider the "cumulative impacts from multiple air pollution sources. The policy applies to air emissions of benzene and benzo[a]pyrene in the Hamilton/Burlington area and benzene in the Sarnia/Corunna area."[2] New and expanding facilities operating in the Hamilton/Burlington area will be required to provide emission models and certain actions, described in the policy, will be required for compliance, depending on existing ambient air quality concentrations. The new standards came into effect on October 1, 2018 for new facilities and current facility expansion applications. For more information please see the Government of Ontario's Environmental Registry website (https://ero.ontario.ca/notice/013-1680).

Clean Air Hamilton Programs 2017

A) Enhanced Fresh Air For Kids:

In 2017, Green Venture and Corr Research teamed up to provide the Enhanced Fresh Air for Kids program to five Hamilton elementary schools. The focus of the project is to educate students, teachers and the public about air quality around schools and the impact of engine idling. The program was delivered to St. Martin of Tours, Lawfield, Cathy Wever, Hillcrest and Adelaide Hoodless elementary schools, with classroom work, in-the–field air monitoring and at-school anti-idling awareness campaigns.

Students were educated on the importance of air quality, the Air Quality Health Index and gained an awareness of how their actions can impact and improve the air in their neighbourhoods. Students measured $PM_{2.5}$ and PM_{10} in their neighbourhoods. The MECP Mobile Air Monitoring van was also used to monitor air quality in the vicinity of the schools. These data were developed into air quality maps which students used to decide on their best ways to travel to and from their school.

The 2017 Enhanced Fresh Air for Kids program featured an enhanced anti-idling campaign. The program included anti-idling education where Green Venture led classrooms in the development of banners, pamphlets, key chains and other advertising material. Blitzes were included to set a measureable baseline for the success of the program. The initial blitzes took place at the beginning of the program in the fall and follow-up blitzes the following spring after the campaign was complete. Four of the five schools completed the secondary blitzes and collected data was used to form the conclusion of the success of the project. The schools found a 25% decrease in the number of cars idling between the blitzes with an increase to the total number of cars. Cathy Wever showed the largest decrease of 54%. The estimated reduction of greenhouse gas emissions equates to 7,858 kg CO_2 annually.

B) Building Community Awareness & Action Regarding Respirable Particulate Pollution in Hamilton:

Environment Hamilton is a Hamilton based not-for-profit organization that promotes environmental protection. In 2017, Clean Air Hamilton provided funding to Environment Hamilton to initiate their Building Community Awareness & Action Regarding Respirable Particulate Pollution in Hamilton program. The goal of the program was to educate citizens by assembling a group of volunteers to assist in building low cost particulate matter sensors to be deployed in stationary locations across the lower city.

Citizens were engaged through six community workshops and two youth workshops that were held to build and deploy the sensors. Volunteers were recruited through ten neighbourhoods in Hamilton. They were educated on air quality, behavioural change and the health effects of particulate matter. They were also informed on the reporting methods of problem sources of poor air quality and identification of priority locations for action. The youth workshops included walkabouts through the participants' neighbourhoods with particulate matter sensors. The collected data was then discussed with the participants increasing knowledge and awareness of the health impacts related to air quality.

Environment Hamilton used Arduino sensors to collect data. The sensors use infrared light and heat resistors to measure the amount of particulate matter in the air. Arduino is an open-source electronics platform that can be modified to perform interactive projects. The information collected can be viewed on Environment Hamilton's online air mapping system (www.inhalemap.com). The air mapping system can be used as an educational tool for citizens to increase knowledge and awareness of air quality in their neighbourhoods as well as the health impacts related to air quality.

2017 Clean Air Hamilton Website Update

City of Hamilton Staff are responsible for maintaining and updating the Clean Air Hamilton website. In 2017, City staff recruited 2Gen Interactive to redesign the Clean Air Hamilton Website (www.cleanairhamilton.ca). The Website contains Hamilton specific air quality information, health information, Clean Air Hamilton projects and programs, resources, meeting minutes and current events within Hamilton related to air quality.

Air Quality Programs in 2018

Clean Air Hamilton identified three programs to improve air quality in 2018, whose funding the Board of Health approved (BOH18020):

1. Cycle Hamilton Coalition Inc. Friendly Streets Hamilton ($12,000);
2. Green Venture and Corr Research Inc. Fresh Air for Kids ($10,700); and,
3. Green Venture for Bus Brains – School Bus Monitoring ($5,877).

The results of these programs will be reported in the Clean Air Hamilton 2018 Air Quality Progress Report and presented to the Board of Health in 2019.

Future Actions

There has been substantial improvement in Hamilton's air quality since the 1970s; however air pollution continues to create adverse health impacts to Hamilton residents. Continued, concerted actions are imperative in the City of Hamilton. Collaboration from individuals, organizations, industries, the City of Hamilton and other levels of government are required to reach our goals.

- Continue to support and undertake all the recommendations of the Air Quality Task Force (BOH13029) and BOH report (BOH18016) in the areas of air modelling and monitoring, planning education and outreach, green infrastructure and updating of municipal policies that encourage and facilitates behavioural change to active and sustainable transportation and alternative forms of renewable and efficient energy for buildings;
- Continue to support and encourage Hamiltonians to reduce their transportation-based emissions through the use of transportation alternatives including: public

transit, bicycles, walking, hybrid or electric vehicles, etc. and support policies such as complete streets and transportation demand management; and,
- Encourage the continued efforts of the MECP and industry to reduce air borne contaminant in the City of Hamilton and the Province of Ontario.

Appendices and Schedules Attached

Appendix A to Report BOH18038 – Clean Air Hamilton 2017 Air Quality Progress Report

References

[1] Government of Ontario, Ministry of the Environment, Conservation and Parks (2017). What is the Air Quality Health Index? Retrieved from: (http://www.airqualityontario.com/science/aqhi_description.php).

[2] Government of Ontario. (2017). Environmental Registry. Retrieved from: (https://www.ebr.gov.on.ca/ERS-WEB-External/displaynoticecontent.do?noticeId=MTMzODAx&statusId=MjA1MDU4)

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 public health standards 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*.

Effective: January 1, 2018
Revised: July 1, 2018

Ontario

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Policy and Legislative Context

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Policy and Legislative Context

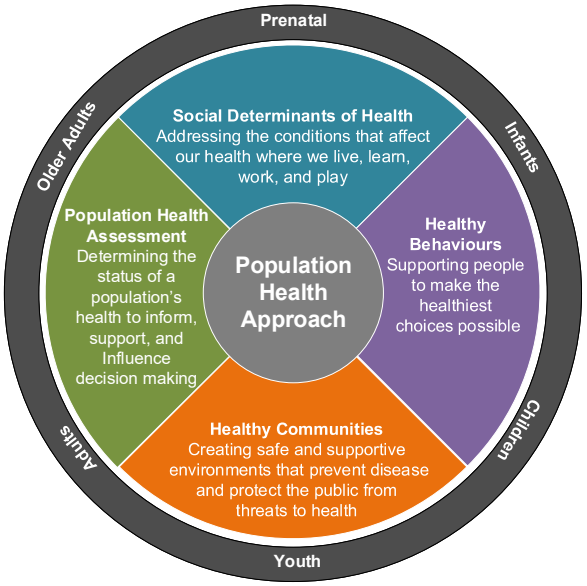
What is Public Health?

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 significance • 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 diseases of public health significance, 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 public health standards 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.

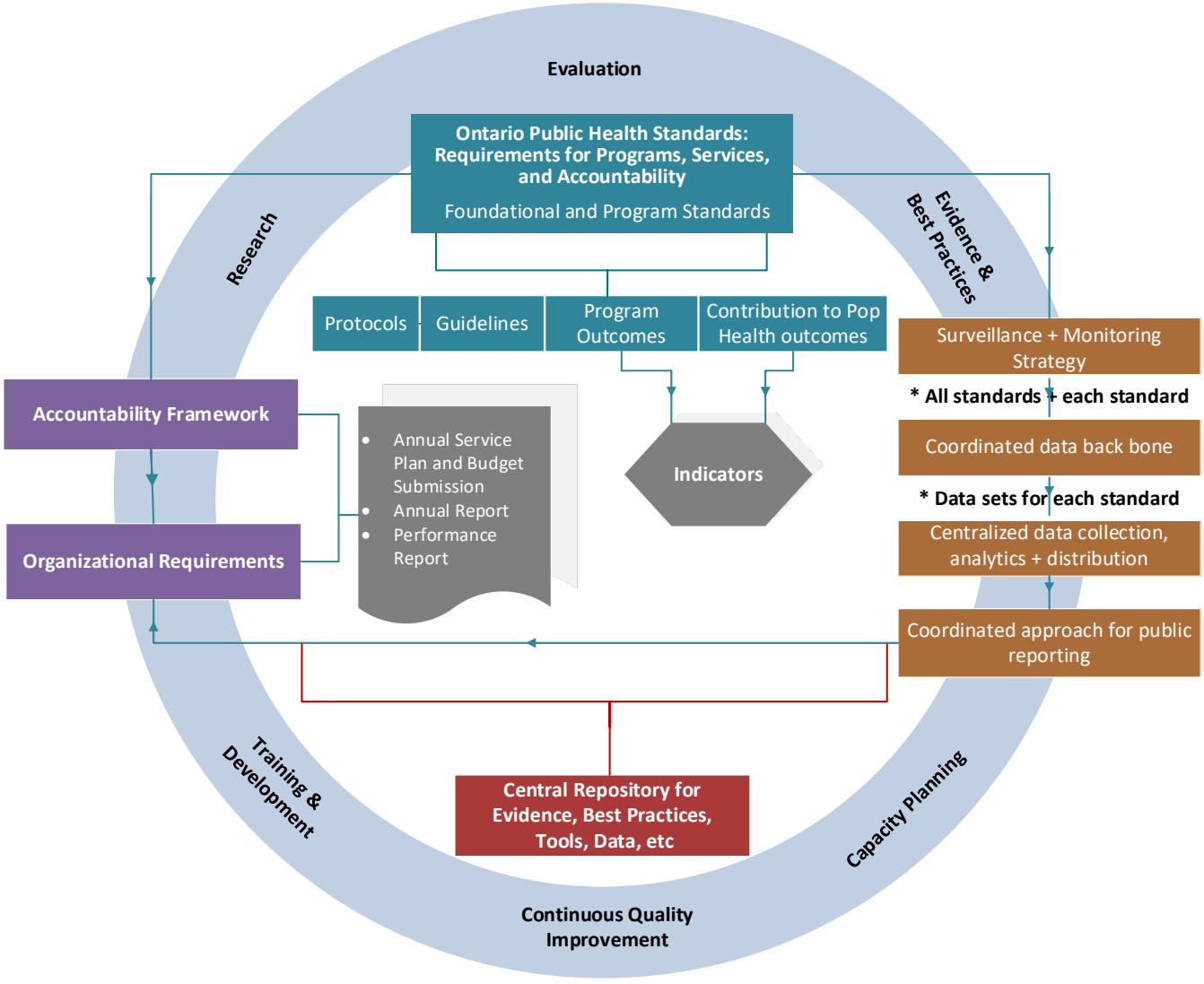
The Standards consist of the following sections:

- Defining the Work: What Public Health Does, which includes the Foundational and Program Standards;
- Strengthened Accountability, which includes the Public Health Accountability Framework and Organizational Requirements; and
- Transparency and Demonstrating Impact, which includes the Public Health Indicator Framework for Program Outcomes and Contributions to Population Health Outcomes and Transparency Framework: Disclosure and Reporting Requirements.

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 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 for Program Outcomes and Contributions to Population Health Outcomes 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: Disclosure and Reporting Requirements 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.

[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).

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 disease 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 behaviour;
            - 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 has or 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 in accordance with the *Healthy Environments and Climate Change Guideline, 2018* (or as current).
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 in accordance with the *Healthy Environments and Climate Change Guideline, 2018* (or as current).
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

in accordance with the *Healthy Environments and Climate Change Guideline, 2018* (or as current).

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 Program 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 significance.[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 significance, including diseases of public health significance, 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 significance include, but are not limited to; those specified as diseases of public health significance as set out by regulation under the *Health Protection and Promotion Act* and include zoonotic and vector-borne diseases. Emerging infectious diseases may be considered of public health significance 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 communicable diseases defined in the legislation as set out by regulation under the *Health Protection and Promotion Act*.

- The public, community partners, and health care providers report all potential rabies exposures.
- Veterinarians report all animal cases of avian chlamydiosis, avian influenza, novel influenza, and Echinococcus multilocularis infection for appropriate follow up of human contacts of infected animals.
- 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 diseases of public health importance and other emerging infectious diseases.
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 significance;

   b) Infection prevention and control practices; and

   c) Reporting requirements for diseases of public health significance, 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 significance.

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 *Management of Potential Rabies Exposures Guideline, 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 *Tuberculosis Program Guideline, 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*; the *Management of Potential Rabies Exposures Guideline, 2018* (or as current); 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

[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.

agencies[15] and orders of government, in accordance with the *Management of Potential Rabies Exposures Guideline, 2018* (or as current) and the *Rabies Prevention and Control Protocol, 2018* (or as current).

15. The board of health shall receive and respond to all reported animal cases of avian chlamydiosis (infection of birds with the causative agent of psittacosis in humans), avian influenza, novel influenza, and *Echinococcus multilocularis* infection, in accordance with the *Health Protection and Promotion Act*; the *Management of Avian Chlamydiosis in Birds Guideline, 2018* (or as current); the *Management of Avian Influenza or Novel Influenza in Birds or Animals Guideline, 2018* (or as current); and the *Management of Echinococcus Multilocularis Infections in Animals Guideline, 2018* (or as current).
16. 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).
17. 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).
18. 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); the *Infection Prevention and Control Disclosure Protocol, 2018* (or as current); and the *Personal Service Settings Guideline, 2018* (or as current).
19. The board of health shall inspect and evaluate infection prevention and control practices in personal service settings in accordance with the *Infection Prevention and Control Complaint Protocol, 2018* (or as current); the *Infection Prevention and Control Disclosure Protocol, 2018* (or as current); and the *Personal Service Settings Guideline, 2018* (or as current).
20. The board of health shall inspect settings associated with risk of infectious diseases of public health significance in accordance with the *Healthy Environments and Climate Change Guideline, 2018* (or as current); the *Infection*

[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]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 18, 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*.

Prevention and Control Complaint Protocol, 2018 (or as current); the *Infection Prevention and Control Protocol, 2018* (or as current); and the *Personal Service Settings Guideline, 2018* (or as current).

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

    a) Infectious diseases of public health significance 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);

    b) Potential rabies exposures in accordance with the *Health Protection and Promotion Act*; the *Management of Potential Rabies Exposures Guideline, 2018* (or as current); and the *Rabies Prevention and Control Protocol, 2018* (or as current); and

    c) Animal cases of avian chlamydiosis, avian influenza, novel influenza, or *Echinococcus multilocularis* infection, in accordance with the *Health Protection and Promotion Act*, the *Management of Avian Chlamydiosis in Birds Guideline, 2018* (or as current); the *Management of Avian Influenza or Novel Influenza in Birds or Animals Guideline, 2018* (or as current); and the *Management of Echinococcus Multilocularis Infections in Animals Guideline, 2018* (or as current).

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 Guideline, 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); the *School Health 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, in accordance with the *School Health Guideline, 2018* (or as current), 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 behaviours 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).

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

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:
   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.

[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.

- 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.
- 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]
- Concussions;
- Falls;
- Life promotion, suicide risk and prevention;
- Mental health promotion;
- Off-road safety;
- Road safety;
- Substance use; 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).

[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.

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.

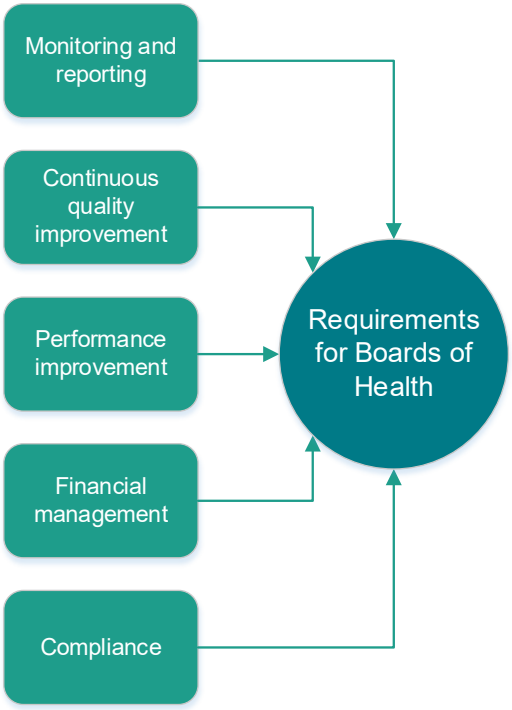
The Organizational Requirements specify the requirements where monitoring and/or reporting are required of boards of health to demonstrate accountability to the ministry. They are organized according to the following four domains of the accountability framework:

- 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 for Program Outcomes and Contributions to Population Health Outcomes** (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 behaviours 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 for Program Outcomes and Contributions to Population Health Outcomes** (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 Environments, 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: Public Health Indicator Framework for Program Outcomes and Contributions to Population Health Outcomes

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
 	
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
 	
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
	Chronic Disease Prevention and Well-Being; Healthy Environments; 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
	Immunization	• % of doses wasted annually by publicly funded vaccine • % of 7 and 17 year olds whose vaccinations are up-to-date for all ISPA designated diseases • % of students with a valid religious or conscience exemption for ISPA designated diseases • % of immunization providers of publicly funded vaccines indicating they have adequate information to support optimal immunization practices, including AEFI reporting • % of inspected vaccine storage locations that meet storage and handling requirements • % of health units that meet the provincial reporting rate for adverse events following immunization (AEFI) for the three vaccines administered through school-based programs (HPV, Meningococcal, and Hepatitis B)
	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

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: Disclosure and Reporting Requirements** (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: Transparency Framework: Disclosure and Reporting Requirements

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

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Ontario

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	December 10, 2018
SUBJECT/REPORT NO:	Board of Health Orientation (BOH18037) (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

Council Direction:

Not applicable.

Information:

In keeping with the Ontario Public Health Standards (Appendix A), it is an organizational requirement that members of boards of health are aware of their roles and responsibilities, and emerging issues and trends in public health, through the development and implementation of a comprehensive orientation plan for new board members, and a continuing education program for all board members.

The following orientation will be provided to all members of Hamilton's Board of Health:

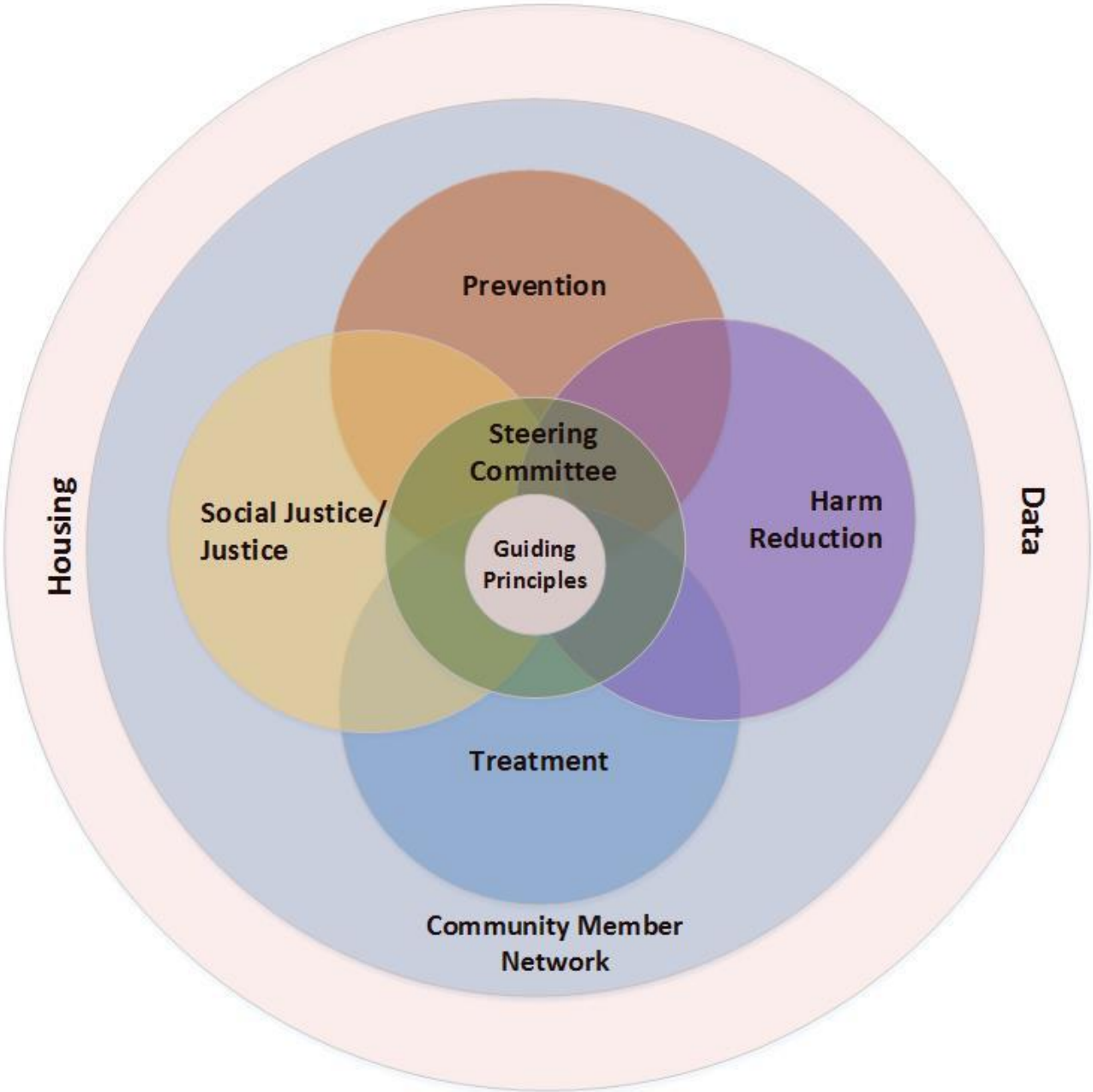
- Introductory presentation on board of health governance and accountability at the Board of Health meeting December 10, 2018;
- Presentation of population health data and health equity concepts at the Board of Health meeting January 14, 2018;
- Showcase of public health programs and services in City Hall following the Board of Health meeting January 14, 2018; and,
- Availability of online resources related to the public health mandate and governance.

In addition to orientation for all board members, all individuals in support roles in Councillors' Offices will be invited to participate in the showcase of public health programs and services on January 14, 2018. This will provide an opportunity to learn more about the work of public health and how to contact public health for future support.

Appendices and Schedules Attached

Appendix A to Report BOH18037 – Ontario Public Health Standards

Hamilton Drug Strategy Structure



INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	December 10, 2018
SUBJECT/REPORT NO:	Hamilton Drug Strategy (BOH18015) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Robin Dozet, (905) 546-2424 Ext. 7460 Brenda Marshall (905) 546-2424 Ext. 7161
SUBMITTED BY: **SIGNATURE:**	Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services

Council Direction:

The Board of Health has received and approved several reports relevant to the Drug Strategy:

- Sept 19, 2016: An information report on A Comprehensive Public Health Approach to Drug and Substance Misuse (BOH16035);
- March 20, 2017: An information report on the Opioid Response Summit (BOH17006);
- April 20, 2017: A recommendation report on the Hamilton Opioid Response Provincial and Federal Funding Request (BOH17013), which included a request to support a Drug Strategy for Hamilton; and,
- July 13, 2017: A recommendation report on the Provincial Opioid Response Initiative Funding (BOH17028), which approved the use of funds to hire a Drug Strategy Coordinator.

Information:

The Hamilton Drug Strategy (HDS) is a city-wide collaboration to address the harms associated with substance use experienced by individuals, families and the community. HDS involves key stakeholders and members of the community to identify and address systems-level gaps, and to implement evidence-based practices to ensure all individuals can live their best quality of life. The City of Hamilton is a partner in this

community driven strategy and provides administrative and community engagement support through a Senior Project Manager and Health Promotion Specialist.

The purpose of this report is to provide an overview of the HDS, a status update on progress to date, and to provide an overview of the areas of focus for future action.

History of the Hamilton Drug Strategy

The HDS evolved in response to the Mayor's 2017 call to action regarding the rising number of opioid-related deaths in Hamilton. A stakeholder group quickly formed to take action in reducing opioid mortality and morbidity, and was a catalyst for a more comprehensive approach to addressing multiple substances and related harms in Hamilton. In 2017, Public Health Services (PHS) received funding from the Ministry of Health and Long Term Care (MOHLTC) to address the opioid crisis in Hamilton and part of this funding was used to coordinate a city-wide drug strategy (BOH17028). Consistent with other drug strategies across the province, the HDS used the four pillar framework of the 2016 Canadian Drugs and Substances Strategy[1] as an overarching approach to guide the strategy formation. The four pillar approach focuses on:

1. Prevention;
2. Treatment;
3. Enforcement/social justice; and,
4. Harm reduction (BOH16035).

In addition, the HDS is focusing on the importance of accessible, affordable, and safe housing and data driven actions.

Overview of the Hamilton Drug Strategy

The HDS kicked off at the Hamilton Drug Strategy Summit in March 2018 which highlighted the need for a comprehensive drug strategy including building collaboration among community partners. The goal of the HDS is to ensure that residents of Hamilton are free of harm due to substance use and can enjoy the best quality of life. To realize this goal the strategy aims to:

- Prevent and reduce alcohol/drug use among youth;
- Reduce deaths and poisonings due to alcohol/drugs;
- Divert people who use alcohol/drugs from entering the criminal justice system to receive appropriate care; and,
- Provide supports for people who use alcohol/ drugs in the criminal justice system for harm reduction, treatment and rehabilitation.

The HDS capitalizes on the existing strengths of Hamilton's mental health and addictions system and the assets already present in our community. The HDS will strive to provide an integrated and comprehensive approach, and to connect community agencies, strategies and programs to reduce the impact of substance use in the community.

The HDS is comprised of a community member network including with a steering committee and four working groups focused on action in the areas of:

- Prevention;
- Harm reduction;
- Social justice/justice; and,
- Treatment.

See Appendix A for a diagram of the HDS structure.

Overview of the Hamilton Drug Strategy Working Groups

Each working group has identified priority areas of focus and draft actions plans. The draft action plan is currently undergoing community consultations which include:

- A survey with 250 members of community with lived experience;
- Key informant reviews; and,
- Presentations to, and feedback from, key stakeholder groups.

Feedback from the consultations will be incorporated into the action plans and priority activities will be identified for 2019. See Appendix B for a diagram highlighting the HDS development and implementation timelines.

Prevention

The Prevention Work Group is focused on preventing high-risk youth aged 12-24 years old from ever using substances and preventing harmful use of substances among youth who do use. The aims are to:

- Educate youth and provide a culture of moderation;
- Promote low-cost or free extracurricular opportunities;
- Create awareness of youth mental health and addictions support;
- Create opportunities for youth to hear from their peers;
- Enhance parenting skills and educate families on the risk and protective factors for substance use; and,
- Collaborate with educators and service providers to promote resources, training and other initiatives to prevent problematic substance use among high-risk youth.

Harm Reduction

The Harm Reduction Work Group is focused on reducing the harms caused by alcohol and drug use in the community. The aims are to:

- Increase access to harm reduction programs and services;
- Improving coordinated care for individuals moving between institutions (hospitals and correctional facilities), and the community and for those receiving opioid agonist therapies;
- Enhance training for service providers and health care professionals;
- Increase access to addictions specialists in temporary housing; and,
- Provide stigma education to the general community.

Social Justice/Justice

The Social Justice/Justice Work Group is focused on the continuum of prevention, harm reduction and treatment for individuals who are at-risk for or who are involved in the justice system. The aims are to:

- Support individuals engaged in the justice system by initiating the treatment process during incarceration;
- Increase awareness of, and connecting individuals to community services prior to, and at release from incarceration;
- Investigate opportunities for temporary housing with 24 hour addiction support; and,
- Advocate for funding and expansion of diversion programs.

Treatment

The Treatment Work Group is focused on improving accessibility and quality of care within addiction treatment and rehabilitation services. The aims are to:

- Collaborate with key partners to develop an integrated care pathway to support those dealing with a substance use disorder;
- Train and educate allied health care professionals on a variety of topics such as stigma and continuum of care, including harm reduction, screening, substance use disorder treatment, etc.; and,
- Reinforce family and caregiver supports and skill building opportunities.

Next Steps

Action plans and 2019 priority activities will be finalized by the end of December 2018 for implementation in Q1 2019.

Appendices and Schedules Attached

Appendix A to Report BOH18015 – Hamilton Drug Strategy Structure
Appendix B to Report BOH18015 – Hamilton Drug Strategy Plan and Deliverables

References

1. Health Canada. (2016). Canadian Drugs and Substances Strategy. Ottawa, ON.

Hamilton Drug Strategy Development and Implementation Timelines

11.1

CITY OF HAMILTON
M O T I O N

Board of Health: December 10, 2018

MOVED BY COUNCILLOR ……..……..…….……..……..……..…….

SECONDED BY COUNCILLOR ……..……..…….……

Interview Sub-committee to the Board of Health

That the following five (5) Councillors be appointed to the Interview Sub-Committee to the Board of Health for the balance of the 2018-2022 term of Council:

(i) _____

(ii) _____

(iii) _____

(iv) _____ (alternate member)

(v) _____ (alternate member)

Review of Board of Health Outstanding Business List – September 17, 2018

	Issue	Date Action Initiated	Lead Dept/Div	Direction	Due date
G	Review of the City of Hamilton's Pest Control By-law	November 16, 2015 (Item 9.1)	Public Health Healthy Enviro	(a)That Public Health staff review Hamilton's pest control bylaw, currently part of the Property Standards Bylaw, with the goal of establishing an independent Bed Bug and/or pest control bylaw; and (b)That the review include an investigation of other jurisdictions who have implemented a minimum standard guideline for the treatment of bed bugs and other pests.	**ON HOLD – with Legal** **Feb 2019**
J	Food Strategy BOH13001(d)	August 11, 2015 (Item 7.1)	Public Health Healthy Enviro	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 If new requests for City resources (e.g. staff, financial) are received by Council prior to approval of Priority Action 1, Council direct these requests to the Interdepartmental Food Strategy Steering Team **for review and to report back with recommendations to Board of Health**;	**See below**
L	Food Strategy Priority Actions 2 & 3	August 11, 2016 (Item 7.1)	Public Health Healthy Enviro	To explore the feasibility of implementing Priority Actions 2 (Food Skills and Employability Program) and 3 (Community and Neighbourhood Infrastructure) and report back to the Board of Health **by the end of 2018;**	**Q4 2018;** **Mar 2019**
P	Contaminated Sites Management Plan	December 5, 2016 Item 5.1	PED	(a) That Planning staff be directed to update the Contaminated Sites Management Plan (CSMP) and expand upon the 2008 Historic Land Use Inventory (HLUI) inventory to include city-wide contaminated lands; and (b)That Planning staff provide a consolidated list of contaminated lands from the Ministry of the Environment be submitted to the Board of Health.	**Q4 2018** **Waiting on PED report**
W	Ground Water Extraction for Commercial Water Bottling (BOH17011) (City Wide)	April 20, 2017 (Item 8.2)		(c) That staff report back to the Board of Health on the outcome of the Province of Ontario's review of the regulation of water-taking by commercial water-bottling facilities under Ontario Water Resources Act,	**Q4 2018** **Ask to Remove** **or Q1 2020**

Review of Board of Health Outstanding Business List
September 17, 2018
Page 2 of 4

	Issue	Date Action Initiated	Lead Dept/Div	Direction	Due date
				expected to be completed before the Ministry of the Environment and Climate Change's two year moratorium on water-taking permits for these facilities expires on January 1, 2019.	
GG	Physician Recruitment and Retention Steering Committee Report 17-001 - Annual Report / Key Performance Indicators and Current Statistics	September 18, 2017 BOH 17-007 (Item 8.1) and (Item 8.1(i))		(b) That the Director, Physician Recruitment, schedule a meeting with Mayor Eisenberger, Dr. Eric Hoskins, Minister of Health and Long-Term Care, Donna Cripps, CEO of the Hamilton Niagara Haldimand Brant Local Health Integration Network, and Councillor T. Whitehead, Chair of the Physician Recruitment and Retention Steering Committee, to discuss the issue detailed in the letters to the Ministry of Health and Long-Term Care.	**Director of Physician Recruitment to inform BOH when meeting scheduled**
NN	Mental Health Court - Expanded Use of Naloxone on Hamilton Fire Vehiclles (BOH18012)	March 19, 2018 18-003 Item 8.2 **amended at Council**		That the Medical Officer of Health, or her designate, be directed to petition the provincial government to look at the feasibility of providing a special Mental Health Court, to be situated in the City of Hamilton.	**Due Date *& Documentation Required** **Remove - Completed**
OO	Hamilton Airshed Modelling System (BOH18016) (City Wide)	April 16, 2018 18-004 (Item 7.1)	PHS/PED	(a) That staff work with Golder Associates to undertake sub-region analyses using the Hamilton Airshed Modelling System, and in consultation with key stakeholders and affected residents; (b)That staff examine the feasibility of using Hamilton Airshed Modelling System to estimate morbidity and mortality outcomes associated with air pollution **and report back to Board of Health, if applicable**; (d) **That the Board of Health request the Ministry** of Environment and Climate Change to work with the City of Hamilton, other Ontario municipalities and levels of government regarding traffic-related air pollutants to address transboundary transportation contributions impacting the City of Hamilton;	**Due Date Required** **June 2019**

Review of Board of Health Outstanding Business List
September 17, 2018
Page 3 of 4

	Issue	Date Action Initiated	Lead Dept/Div	Direction	Due date
				(e)**That the Board of Health advocate that the province** of Ontario adopt the 24-hour Canadian Ambient Air Quality Standard for fine particulate matter (PM 2.5) of 28 micrograms per cubic metre of air (28 µg/m3) as air quality benchmarks for the maximum desirable concentration of particulate matter in the City of Hamilton; and (f)Support the Ministry of the Environment and Climate Change in their proposal for a new policy focusing on Cumulative Effects Assessment in air approvals: "to more effectively consider cumulative impacts from multiple air pollution sources - both industrial and non-industrial" to address air quality issues in the City of Hamilton.	
PP	Feasibility of Workspace for the Physician Recruitment Specialist	April 16, 2018 18-004 (Added Item 9.1)		Staff were directed to investigate the feasibility of providing an office space for the Physician Recruitment Specialist, within their offices.	**Due Date Required** **Remove - Completed**
QQ	Request for Hospital Space to Address the Current Opioid (and other drug) Overdose Crisis in Hamilton	Council 18-009 May 9, 2018 Item 7.4		That the appropriate staff from Public Health be requested as a priority to engage with both Hamilton Health Sciences and St. Joseph's Hospital on the feasibility of housing a supervised consumption site in their hospital(s), as a means of addressing the opioid (and other drug) overdose crisis in Hamilton.	**Due Date Required** **Remove - Completed**
RR	Board of Health Self-Evaluation Results (BOH18011(a)) (City Wide)	September 17, 2018 18-007 (Item 5.5)		That Report BOH 18011(a), Board of Health Self-Evaluation Results, be received and referred to the Governance Review Sub-committee to consider the appointment of a Vice-Chair for the Board of Health for a 1 year period, on an on-going basis.	**Sent to Governance**

Review of Board of Health Outstanding Business List
September 17, 2018
Page 4 of 4

	Issue	Date Action Initiated	Lead Dept/Div	Direction	Due date
SS	Supervised Consumption Sites	September 17, 2018 18-007 (Added Item 6.1)		(b)That a letter be sent to the Christine Elliot, Minister of Health, expressing both the Board of Health's support for Supervised Consumption Sites and the business case for Supervised Consumption Sites, signed by each of the Councillors; and (c)That a letter be sent to the Federal Minister of Health, reaffirming our support of Supervised Consumption Sites and any associated applications for a permanent Supervised Consumption Sites facility in the City of Hamilton.	**Remove - completed**
TT	Correspondence from the City of Toronto, Board of Health, respecting "A Public Approach to Drug Policy" (Item HL28.2)	September 17, 2018 18-007 (Added Item 11.2)		That the Correspondence from the City of Toronto, Board of Health, respecting "A Public Approach to Drug Policy" (Item HL28.2) be received, **with a report back from staff in Q1 2019.**	**Due Date Required** **March 2019**