City of Hamilton
BOARD OF HEALTH

Meeting #: 19-007
Date: July 10, 2019
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 June 17, 2019

5. COMMUNICATIONS

5.1 Correspondence from Hastings Prince Edward Public Health respecting Concerns with Announces Expansion of the Sale of Alcohol Beverages in Ontario

Recommendation: Be received.

5.2 Correspondence from Peterborough Public Health respecting Changes to Provincial Autism Supports

Recommendation: Be received.

5.3 Correspondence from the Association of Local Public Health Agencies respecting Corrections to Resolution A19-9, Public Health Support for Accessible, Affordable, Quality Licensed Child Care

Recommendation: Be received.

5.4 Correspondence from Peterborough Public Health respecting the Association of Local Public Health Agencies response to their Financial Changes to Local Public Health resolution.

Recommendation: To be received.

5.5 Correspondence from Sudbury & Districts Public Health respecting Parity of Esteem Position Statement.

Recommendation: Be endorsed.

5.6 Correspondence from Peterborough Public Health respecting Support for Children Count Task Force Recommendations

Recommendation: Be endorsed.

5.7 Correspondence from the Windsor-Essex County Board of Health respecting Smoke-Free Multi-Unit Dwellings

Recommendation: To be endorsed, with staff to write a letter addressed to the Prime Minister, copied to the Minister of Health, Hamilton MPPs, the Association of Local Public Health Units, and Ontario Boards of Health

6. DELEGATION REQUESTS

7. CONSENT ITEMS

7.1 Food Strategy Priority Actions 2 (Food Skills & Employability) and 3 (Neighbourhood Food Infrastructure) (BOH13001(i)) (City Wide)

7.2 Managed Opioid Treatment Programs (BOH19023) (City Wide)

7.3 Feasibility of Providing Drug Checking (Fentanyl) Test Strips (BOH19024) (City Wide)

7.4 Seniors Oral Health (BOH19026) (City Wide)

8. PUBLIC HEARINGS / DELEGATIONS

9. STAFF PRESENTATIONS

10. DISCUSSION ITEMS

10.1 2018 Annual Ontario Public Health Standards (OPHS) Report and Attestation to the Province (BOH19027) (City Wide)

11. MOTIONS

12. NOTICES OF MOTION

13. GENERAL INFORMATION / OTHER BUSINESS

14. PRIVATE AND CONFIDENTIAL

15. ADJOURNMENT

BOARD OF HEALTH
MINUTES 19-006

1:30 p.m.
Monday, June 17, 2019
Council Chambers
Hamilton City Hall

Present:	Mayor F. Eisenberger (Chair), Councillor M. Wilson (Vice-Chair) Councillors J. Farr, N. Nann, S. Merulla C. Collins, E. Pauls, J.P. Danko, M. Pearson, L. Ferguson, A. VanderBeek, T. Whitehead
Absent with Regrets:	Councillor B. Clark, B. Johnson, J. Partridge – City Business; Councillor T. Jackson - Personal

THE FOLLOWING ITEMS WERE REFERRED TO COUNCIL FOR CONSIDERATION:

1. Correspondence from Kingston, Frontenac and Lennox & Addington Public Health respecting Health Promotion as a Core Function of Public Health (Item 5.1)

(Farr/VanderBeek)
That the Correspondence from Kingston, Frontenac and Lennox & Addington Public Health respecting Health Promotion as a Core Function of Public Health, be endorsed.

Result: Motion CARRIED by a vote of 12 to 0, as follows:

YES - Vice-Chair Maureen Wilson
YES - Councillor Jason Farr
YES - Councillor Nrinder Nann
YES - Councillor Sam Merulla
YES - Councillor Chad Collins
NOT PRESENT - Councillor Tom Jackson
YES - Councillor Esther Pauls
YES - Councillor John-Paul Danko
YES - Chair Fred Eisenberger
NOT PRESENT - Councillor Judi Partridge
YES - Councillor Terry Whitehead

YES - Councillor Arlene VanderBeek
YES - Councillor Lloyd Ferguson
NOT PRESENT - Councillor Brenda Johnson
YES - Councillor Maria Pearson
NOT PRESENT - Councillor Brad Clark

2. Correspondence from the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) respecting 2019-2020 Community Addictions Services Program Additional Base Funding (Added Item 5.9)

(Farr/Whitehead)
That the Board of Health authorize and direct the Medical Officer of Health to receive and utilize the funding from the Ministry of Health and Long-Term Care to support the Community Addictions Services Program, and report back to the Local Health Integration Network as required.

Result: Motion CARRIED by a vote of 12 to 0, as follows:

YES - Vice-Chair Maureen Wilson
YES - Councillor Jason Farr
YES - Councillor Nrinder Nann
YES - Councillor Sam Merulla
YES - Councillor Chad Collins
NOT PRESENT - Councillor Tom Jackson
YES - Councillor Esther Pauls
YES - Councillor John-Paul Danko
YES - Chair Fred Eisenberger
NOT PRESENT - Councillor Judi Partridge
YES - Councillor Terry Whitehead
YES - Councillor Arlene VanderBeek
YES - Councillor Lloyd Ferguson
NOT PRESENT - Councillor Brenda Johnson
YES - Councillor Maria Pearson
NOT PRESENT - Councillor Brad Clark

3. Correspondence from the Ministry of Health and Long-Term Care respecting 2019-2020 Low Income Seniors Dental Additional Base Funding (Added Item 5.10)

(Farr/Whitehead)
(a) That the Board of Health authorize and direct the Medical Officer of Health to receive, utilize and submit reports back to the Board on the funding from the Ministry of Health and Long-Term Care to support the delivery of a dental program for low income seniors; and,

(b) That staff report back to the Board of Health by October 2019 on the development of the program locally.

Result: Motion CARRIED by a vote of 12 to 0, as follows:

YES - Vice-Chair Maureen Wilson
YES - Councillor Jason Farr
YES - Councillor Nrinder Nann
YES - Councillor Sam Merulla
YES - Councillor Chad Collins
NOT PRESENT - Councillor Tom Jackson
YES - Councillor Esther Pauls
YES - Councillor John-Paul Danko
YES - Chair Fred Eisenberger
NOT PRESENT - Councillor Judi Partridge
YES - Councillor Terry Whitehead
YES - Councillor Arlene VanderBeek
YES - Councillor Lloyd Ferguson
NOT PRESENT - Councillor Brenda Johnson
YES - Councillor Maria Pearson
NOT PRESENT - Councillor Brad Clark

4. Corporate Climate Change Task Force Response to the Climate Change Emergency Declaration (BOH19022) (City Wide) (Item 9.1)

(Pauls/VanderBeek)
That Report BOH19022, respecting the Corporate Climate Change Task Force Response to the Climate Change, be received.

CARRIED

5. Arrell Youth Centre Secondment (BOH17008(a)) (City Wide) (Item 10.1)

(Pearson/VanderBeek)
That the Medical Officer of Health, or designate, be authorized and directed to execute any agreement and ancillary documents required to implement a contract between the City of Hamilton and Banyan Community Services Inc., operating as Arrell Youth Centre, that supports a 0.34 FTE Public Health Nurse secondment to Arrell Youth Centre for the term of July 1, 2019 to June 30, 2021 with an option to further renew the contract until June 30, 2023 in a form satisfactory to the City Solicitor.

Result: Motion CARRIED by a vote of 9 to 0, as follows:

YES - Vice-Chair Maureen Wilson
NOT PRESENT - Councillor Jason Farr
YES - Councillor Nrinder Nann
YES - Councillor Sam Merulla
NOT PRESENT - Councillor Chad Collins
NOT PRESENT - Councillor Tom Jackson
YES - Councillor Esther Pauls
YES - Councillor John-Paul Danko

YES - Chair Fred Eisenberger
NOT PRESENT - Councillor Judi Partridge
NOT PRESENT - Councillor Terry Whitehead
YES - Councillor Arlene VanderBeek
YES - Councillor Lloyd Ferguson
NOT PRESENT - Councillor Brenda Johnson
YES - Councillor Maria Pearson
NOT PRESENT - Councillor Brad Clark

6. By-law No. 11-080 To Prohibit Smoking Cannabis and Vaping Within City Parks and Recreation Properties (BOH07034(n)) (Item 10.2)

(Ferguson/VanderBeek)
That the by-law attached as Appendix "A" to Report BOH07034(n), being a bylaw to amend By-law No. 11-080 to Prohibit Smoking within City Parks and Recreation Properties (the "Amending By-law"), be approved.

Result: Motion CARRIED by a vote of 9 to 0, as follows:

YES - Vice-Chair Maureen Wilson
NOT PRESENT - Councillor Jason Farr
YES - Councillor Nrinder Nann
YES - Councillor Sam Merulla
NOT PRESENT - Councillor Chad Collins
NOT PRESENT - Councillor Tom Jackson
YES - Councillor Esther Pauls
YES - Councillor John-Paul Danko
YES - Chair Fred Eisenberger
NOT PRESENT - Councillor Judi Partridge
NOT PRESENT - Councillor Terry Whitehead
YES - Councillor Arlene VanderBeek
YES - Councillor Lloyd Ferguson
NOT PRESENT - Councillor Brenda Johnson
YES - Councillor Maria Pearson
NOT PRESENT - Councillor Brad Clark

7. Establishment of Departmental Climate Change Workplans within the City of Hamilton (Item 11.1)

(Eisenberger/Wilson)
WHEREAS; Public Health Services in its document, Corporate Climate Change Task Force Response to the Climate Change Emergency Declaration, has identified key strategic climate change adaptation and mitigation priority areas to be addressed by the City; and

WHEREAS; Public Health Services, in collaboration and cooperation with City departments, has made a compelling case continued action by the City of Hamilton in addressing the Climate Change Emergency Declaration;

THEREFORE, BE IT RESOLVED:

(a) That Staff develop a comprehensive, corporate-wide climate change adaptation and mitigation workplan, incorporative of all City departments, under the direction of the City Manager within six months;

(b) That the corporate-wide climate change adaptation and mitigation climate workplan be presented at the General Issues Committee meeting of November 20, 2019, and at subsequent General Issues Committee meetings on a quarterly basis; and,

(c) That Staff report annual updates on progress against the corporate-wide climate change adaptation and mitigation workplan to the General Issues Committee, commencing November 2020.

Result: Motion CARRIED by a vote of 9 to 0, as follows:

YES - Vice-Chair Maureen Wilson
NOT PRESENT - Councillor Jason Farr
YES - Councillor Nrinder Nann
YES - Councillor Sam Merulla
NOT PRESENT - Councillor Chad Collins
NOT PRESENT - Councillor Tom Jackson
YES - Councillor Esther Pauls
YES - Councillor John-Paul Danko
YES - Chair Fred Eisenberger
NOT PRESENT - Councillor Judi Partridge
NOT PRESENT - Councillor Terry Whitehead
YES - Councillor Arlene VanderBeek
YES - Councillor Lloyd Ferguson
NOT PRESENT - Councillor Brenda Johnson
YES - Councillor Maria Pearson
NOT PRESENT - Councillor Brad Clark

FOR INFORMATION:

Vice-Chair Wilson called the meeting to order.

(Pearson/Ferguson)
That the Board of Health recess at 1:31 p.m. in order to allow the meeting of the Public Works Committee to continue.

The Board of Health reconvened at 2:40 p.m.

(a) CERMONIAL ACTIVITIES (Item 1)

There were no ceremonial activities.

(b) CHANGES TO THE AGENDA (Item 2)

The Clerk advised the Board of the following changes to the agenda:

5. COMMUNICATIONS

5.7 Correspondence from the Association of Local Public Health Associations respecting Public Health Modernization

Recommendation: Be received.

5.8 Correspondence from Algoma Public Health respecting Proposed Change to Public Health in Ontario

Recommendation: Be received.

5.9 Correspondence from the Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) respecting 2019-2020 Community Addictions Services Program Additional Base Funding

Recommendation: That the Board of Health authorize and direct the Medical Officer of Health to receive and utilize the funding from the Ministry of Health and Long-Term Care to support the Community Addictions Services Program, and report back to the Local Health Integration Network as required.

5.10 Correspondence from the Ministry of Health and Long-Term Care respecting 2019-2020 Low Income Seniors Dental Additional Base Funding

(a) That the Board of Health authorize and direct the Medical Officer of Health to receive, utilize and submit reports back to the Board on the funding from the Ministry of Health and Long-Term Care to support the delivery of a dental program for low income seniors; and,

(b) That staff report back to the Board of Health by October 2019 on the development of the program locally.

5.11 Correspondence from the Association of Local Health Associations (alPHa) respecting 2019 alPHa Resolutions

Recommendation: Be received

6. DELEGATION REQUESTS

6.1 Ian Graham, respecting Climate Change consequences for Hamilton and the Greatlakes Basin (for today's meeting)

6.2 Kate Flynn, Centre for Climate Change Management, Mohawk College, respecting support for the Corporate Climate Change Task Force Response to Climate Change Emergency Declaration (for today's meeting)

6.3 Lynda Lukasik and Ian Borsuk, Environment Hamilton, respecting the Corporate Climate Change Task Force Response to Climate Change Emergency Declaration

7. CONSENT ITEMS

7.1 Food Advisory Committee Minutes - May 14, 2019

7.2 Physician Recruitment and Retention Steering Committee Clerk's Report - May 29, 2019

(Farr/Nann)
That the agenda for the June 17, 2019 Board of Health be approved, as amended.

Result: Motion CARRIED by a vote of 12 to 0, as follows:

YES - Vice-Chair Maureen Wilson
YES - Councillor Jason Farr
YES - Councillor Nrinder Nann
YES - Councillor Sam Merulla
YES - Councillor Chad Collins
NOT PRESENT - Councillor Tom Jackson
YES - Councillor Esther Pauls
YES - Councillor John-Paul Danko
YES - Chair Fred Eisenberger
NOT PRESENT - Councillor Judi Partridge
YES - Councillor Terry Whitehead
YES - Councillor Arlene VanderBeek
YES - Councillor Lloyd Ferguson

NOT PRESENT - Councillor Brenda Johnson
YES - Councillor Maria Pearson
NOT PRESENT - Councillor Brad Clark

(c) DECLARATIONS OF INTEREST (Item 3)

There were no declarations of interest.

(d) APPROVAL OF MINUTES OF PREVIOUS MEETING (Item 4)

(i) May 13, 2019 (Item 4.1)

(Merulla/Danko)
That the Minutes of the May 13, 2019 meeting of the Board of Health be approved, as presented.

Result: Motion CARRIED by a vote of 12 to 0, as follows:

YES - Vice-Chair Maureen Wilson
YES - Councillor Jason Farr
YES - Councillor Nrinder Nann
YES - Councillor Sam Merulla
YES - Councillor Chad Collins
NOT PRESENT - Councillor Tom Jackson
YES - Councillor Esther Pauls
YES - Councillor John-Paul Danko
YES - Chair Fred Eisenberger
NOT PRESENT - Councillor Judi Partridge
YES - Councillor Terry Whitehead
YES - Councillor Arlene VanderBeek
YES - Councillor Lloyd Ferguson
NOT PRESENT - Councillor Brenda Johnson
YES - Councillor Maria Pearson
NOT PRESENT - Councillor Brad Clark

(e) COMMUNICATIONS (Item 5)

(Whitehead/Pearson)
That the following Correspondence Items, be received:

(i) Correspondence from the Renfrew County and District Health Unit respecting a Review of Provincial Budget and Proposed Changes to Public Health (Item 5.2)

(ii) Correspondence from the Association of Local Public Health Agencies respecting an Update to Board of Health Members (Item 5.3)

(iii) Correspondence from the Brant County Health Unit respecting Concerns with the 2019 Provincial Budget (Item 5.4)

(iv) Correspondence from Public Health Sudbury & Districts respecting the North East Public Health Regional Boundaries - Modernization of the Ontario Public Health System (Item 5.5)

(v) Correspondence from Kingston, Frontenac and Lennox & Addington Public Health respecting the Provincial Government's Decision to Reverse Retroactive Funding Changes to Municipalities (Item 5.6)

(vi) Correspondence from the Association of Local Public Health Associations respecting Public Health Modernization (Added Item 5.7)

(vii) Correspondence from Algoma Public Health respecting Proposed Change to Public Health in Ontario (Added Item 5.8)

(viii) Correspondence from the Association of Local Health Associations (alPHa) respecting 2019 alPHa Resolutions (Added Item 5.11)

CARRIED

(f) DELEGATION REQUESTS (Item 6)

(Whitehead/Farr)
That the following delegation requests be approved for today’s meeting:

(i) Ian Graham, respecting Climate Change consequences for Hamilton and the Greatlakes Basin (for today's meeting) (Added Item 6.1)

(ii) Kate Flynn, Centre for Climate Change Management, Mohawk College, respecting support for the Corporate Climate Change Task Force Response to Climate Change Emergency Declaration (for today's meeting) (Added Item 6.2)

(iii) Lynda Lukasik and Ian Borsuk, Environment Hamilton, respecting the Corporate Climate Change Task Force Response to Climate Change Emergency Declaration (for today's meeting) (Added Item 6.3)

Result: Motion CARRIED by a vote of 12 to 0, as follows:

YES - Vice-Chair Maureen Wilson
YES - Councillor Jason Farr
YES - Councillor Nrinder Nann
YES - Councillor Sam Merulla
YES - Councillor Chad Collins
NOT PRESENT - Councillor Tom Jackson
YES - Councillor Esther Pauls
YES - Councillor John-Paul Danko
YES - Chair Fred Eisenberger
NOT PRESENT - Councillor Judi Partridge
YES - Councillor Terry Whitehead
YES - Councillor Arlene VanderBeek
YES - Councillor Lloyd Ferguson
NOT PRESENT - Councillor Brenda Johnson
YES - Councillor Maria Pearson
NOT PRESENT - Councillor Brad Clark

(g) CONSENT ITEMS (Item 7)

(i) Food Advisory Committee Minutes - May 14, 2019 (Added Item 7.1)

(VanderBeek/Ferguson)
That the Food Advisory Committee Minutes of May 14, 2019, be received.

CARRIED

(ii) Physician Recruitment and Retention Steering Committee Clerk's Report - May 29, 2019 (Added Item 7.2)

(Pearson/Wilson)
That the Clerk's Report for the Physician Recruitment and Retention Steering Committee of May 29, 2019, be received.

CARRIED

(h) PUBLIC HEARINGS / DELEGATIONS (Item 8)

(i) Ian Graham, respecting Climate Change Consequences for Hamilton and the Great Lakes Basin (Added Item 8.1)

Ian Graham addressed the Board respecting Climate Change Consequences for Hamilton and the Great Lakes Basin.

(Nann/Wilson)
That the delegation from Ian Graham respecting Climate Change Consequences for Hamilton and Great Lakes Basin, be received.

CARRIED

For further disposition, refer to Items 4 and 7.

(ii) Kate Flynn, Centre for Climate Change Management, Mohawk College, respecting support for the Corporate Climate Change Task Force Response to Climate Change Emergency Declaration (Added Item 8.2)

Kate Flynn, Centre for Climate Change Management, Mohawk College, addressed the Board respecting support for the Corporate Climate Change Task Force Response to Climate Change Emergency Declaration.

(Whitehead/Ferguson)
That the delegation from Kate Flynn, Centre for Climate Change Management, Mohawk College, respecting support for the Corporate Climate Change Task Force Response to Climate Change Emergency Declaration, be received.

CARRIED

For further disposition, refer to Items 4 and 7.

(iii) Lynda Lukasik and Ian Borsuk, Environment Hamilton, respecting the Corporate Climate Change Task Force Response to Climate Change Emergency Declaration (Added Item 8.3)

Lynda Lukasik and Ian Borsuk, Environment Hamilton, addressed the Board respecting the Corporate Climate Change Task Force Response to Climate Change Emergency Declaration.

(Pearson/Nann)
That the delegation from Lynda Lukasik and Ian Borsuk, Environment Hamilton, addressed the Board respecting the Corporate Climate Change Task Force Response to Climate Change Emergency Declaration, be received.

CARRIED

For further disposition, refer to Items 4 and 7.

(h) STAFF PRESENTATION (Item 9)

(i) Corporate Climate Change Task Force Response to the Climate Change Emergency Declaration (BOH19022) (City Wide) (Item 9.1)

Janette Smith, City Manager, addressed the Board with an introduction to the Corporate Climate Change Task Force Response to the Climate Change Emergency Declaration (BOH19022).

Trevor Imhoff, Senior Project Manager - Air Quality & Climate Change, addressed the Board with a presentation respecting the Corporate Climate Change Task Force Response to the Climate Change Emergency Declaration (BOH19022).

(Ferguson/Pearson)
That the presentation respecting Corporate Climate Change Task Force Response to the Climate Change Emergency Declaration (BOH19022), be received.

CARRIED

For disposition of this matter, refer to Item 4.

The presentation is available at www.hamilton.ca, and through the Office of the City Clerk.

(i) MOTION (Item 11)

(i) Establishment of Departmental Climate Change Workplans within the City of Hamilton (Item 11.1)

Mayor Eisenberger relinquished the Chair to Vice-Chair Wilson, to introduce the motion respecting the Establishment of Departmental Climate Change Workplans within the City of Hamilton.

For further disposition, refer to Item 7.

The Mayor assumed the Chair.

(j) ADJOURNMENT (Item 15)

(Ferguson/Pearson)
That, there being no further business, the Board of Health be adjourned at 4:10 p.m.

CARRIED

Respectfully submitted,

Mayor F. Eisenberger
Chair, Board of Health

Loren Kolar
Legislative Coordinator
Office of the City Clerk

HASTINGS PRINCE EDWARD
Public Health

Main Office – Belleville
179 North Park Street, Belleville, ON K8P 4P1
T: 613-966-5500 |1-800-267-2803 | **F:** 613-966-9418
TTY: 711 or 1-800-267-6511
www.hpePublicHealth.ca

June 06, 2019

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Room 281 Queen's Park
Toronto, ON M7A 1A1

Dear Premier Ford:

Re: Concerns with announced expansion of the sale of alcohol beverage in Ontario

At our May 1, 2019 Board of Health meeting for Hastings Prince Edward, our members expressed concern regarding the announced expansion of the sale of beverage alcohol in Ontario. This letter highlights the basis for our concerns and expresses recommendations to address them.

It is well known that increased alcohol consumption is related to numerous health and social consequences that can be broadly categorized into acute or short-term harms such as violence, alcohol-related motor vehicle collisions, injuries and suicides, as well as chronic long-term health effects such as cancers, heart and liver disease. The provincial government's announced changes to Ontario's beverage alcohol policy will increase alcohol availability, lower prices, and increase exposure to alcohol promotion. Research has proven that with increased physical availability, pricing and alcohol advertising comes increased harms, adding to the burden on Ontario's healthcare, social and justice systems.

Hastings and Prince Edward County (HPEC) residents are not immune to these alcohol harms. Our latest data shows that in 2014, 44.4% of Hastings Prince Edward (HPE) adults (age 19+) exceeded the Low-Risk Alcohol Drinking Guidelines. In Ontario, the proportion of adults who are binge drinkers (exceeded Guideline 2 on at least one occasion in the previous year) is also increasing over time. In HPE, 41.6% of adults are binge drinkers. HPEC has higher overall rates of injury-related hospitalizations attributable to alcohol which include self-inflicted harm, falls and motor vehicle collisions when compared to Ontario and peer public health units as defined by Statistics Canada.

We are particularly concerned about our vulnerable residents, including youth, individuals living on low income and those with substance use concerns. The harms of

increasing financial and physical access to alcohol tend to concentrate within these specific populations. It is well known that alcohol is the most commonly used substance among grade 7-12 students in Ontario. Research demonstrates that alcohol consumption by youth and other vulnerable populations is strongly influenced by the density of alcohol outlets. Higher availability also facilitates alcohol becoming a normative commodity and experience. There is evidence that exposing young people to alcohol marketing can encourage some to start drinking at an earlier age and increase consumption in those individuals who already drink.

Canadian and international case studies demonstrate that an absence of, or government decision to loosen alcohol policies has significant, measurable impacts on alcohol consumption and related harms. Full and partial privatization of alcohol sales in Alberta and British Columbia (respectively) has been followed by significant increases in alcohol-related traffic incidents, suicides, deaths and lower compliance with age of sale policies. The World Health Organization (WHO) European Region lacked a coordinated alcohol strategy until 2011. As of 2018, the European Region still has the highest alcohol consumption and burden of numerous alcohol-related harms, including alcohol-attributable deaths, alcohol use disorders, injuries, and cancers compared to all other regions.

Alcohol policy that aims to increase choice and convenience relies heavily on the assumption that individuals will make decisions about their alcohol consumption based on their knowledge of its health and social harms. Interventions involving individual education and awareness-raising strategies have limited effectiveness without supportive policy level interventions. Policy measures that raise minimum pricing, limit privatization, and control alcohol availability are some of the most effective policies for preventing alcohol-related harms at a population level. Such policies help to create environments that support individuals to make low-risk decisions for alcohol consumption.

The evidence is clear. Increased access to alcohol results in increased harms. As part of your government’s commitment to make evidence-informed decisions to improve the lives of Ontarians and end hallway medicine, we ask you to reconsider the extensive expansion of beverage alcohol sale.

We do note that the report, “Increasing Choice and Expanding Opportunity in Ontario’s Alcohol Sector”, released May 27 2019, states that your government will be working with public health experts to ensure that any changes do not lead to increased social costs. We also note that, as stated in Bill 100, “Protecting What Matters Most Act (Budget Measures), 2019”, municipalities will be empowered to maintain their role in local policy-making which can assist in addressing alcohol-related harms. While the details of these plans currently remain to be determined, we are encouraged by these

statements. We support your commitment to safe and responsible consumption of alcohol and urge your government that any actions undertaken to achieve this use evidence-based policies and are funded and monitored for effectiveness.

We look forward to working with you on this important issue.

Sincerely,

Dr. Piotr Oglaza MD, CPHI(C), CCFP, MPH, FRCPC
Medical Officer of Health

Jo-Anne Albert
Chair, Board of Health

Copied to:
The Honourable Christine Elliot, Minister of Health and Long-Term Care, Deputy Premier
The Honourable Lisa Thompson, Minister of Education
The Honourable Vic Fedeli, Minister of Finance, Chair of Cabinet
Todd Smith, MPP (Bay of Quinte)
Daryl Kramp, MPP (Hastings-Lennox and Addington)
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health and Long-Term Care
Ontario Boards of Health
Andrea Horwath, Leader, Official Opposition MPP Hamilton- Centre
John Fraser, MPP Ottawa South

Peterborough Public Health

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
P: **705-743-1000** or 1-877-743-0101
F: 705-743-2897
peterboroughpublichealth.ca

June 17, 2019

Received Jun 18 2019
MOH Office

The Honourable Lisa MacLeod
Ministry of Children, Community and Social Services
56 Wellesley Street West, 14th Floor
Toronto, ON M74 1E9
Sent via email: ***lisa.macleod@pc.ola.org***

Dear Minister MacLeod:

Re: Changes to Provincial Autism Supports

At its meeting on April 10, 2019, the Board of Health for Peterborough Public Health received a delegation from a local resident, Ms. Kristen Locklin regarding changes to provincial autism supports. Ms. Locklin provided a detailed presentation of the planned changes to the Ontario Autism Program. She also shared her personal story regarding her four-year-old autistic son who since starting Applied Behaviour Analysis therapy in late 2018 has been making incredible progress.

As you are aware, autism is a neurodevelopmental disorder, which affects 1/66 children. Autism affects a child's ability to communicate, and socially interact with their environment.

The Board of Health supports the province's plan to address the long waitlist, and to expand Ontario's five autism diagnostic hubs. However, we share Ms. Locklin's concern that funding will be provided directly to families rather than towards the provision of evidence-based programs. We also believe that the amount should be based upon the child's needs rather than their age. Children with autism need access to appropriate interventions by qualified practitioners at the right time and with the appropriate intensity. These are referred to as needs-based supports.

We are pleased that the province has struck an Autism Program Advisory Panel with experts in the field of needs-based supports and we look forward to hearing their recommendations regarding the future of the Ontario Autism Program.

Yours in health,

Original signed by

Councillor Kathryn Wilson
Chair, Board of Health

/ag

cc: Ms. Kristen Locklin
Hon. Lisa Thompson, Minister of Education
Hon. Christine Elliott, Minister of Health and Long-Term Care
Dr. Marie Bountrogianni, Co-Chair, Ontario Autism Program Advisory Panel
Margaret Spoelstra, Co-Chair, Ontario Autism Program Advisory Panel
Council, City of Peterborough
Council, County of Peterborough
Local MPPs
Association of Local Public Health Agencies
Ontario Boards of Health

From: Susan Lee
To: All Health Units
Subject: Corrections to alPHa Resolution A19-9 on Child Care
Date: June 19, 2019 12:36:13 PM
Attachments: A19-9 Quality Licensed Child Care CORRECTED.pdf

ATTENTION:

All Board of Health Members / Members of Health & Social Service Committees
All Senior Public Health Managers
****

Further to the June 14th email below, it has come to alPHa's attention that Resolution A19-9, *Public Health Support for Accessible, Affordable, Quality Licensed Child Care*, contained two errors, one each in the second last and last "And Further" clauses.

The second last clause included an amendment that did not pass (i.e., amendment in bolded italics as follows: "including establishing an early years and child care workforce strategy ***to maintain and***, to ensure child care professionals are adequately qualified and compensated") and the last clause incorrectly identified the College of Early Childhood ***Educators*** as the College of Early Childhood Education.

The corrected version of the resolution is attached and may also be found online in the Disposition of 2019 Resolutions document.

Regards,

Susan

Susan Lee
Manager, Administrative & Association Services
Association of Local Public Health Agencies (alPHa)
2 Carlton Street, Suite 1306
Toronto ON M5B 1J3
Tel. (416) 595-0006 ext. 25
Fax. (416) 595-0030
Please visit us at http://www.alphaweb.org

From: Susan Lee
Sent: June-14-19 10:00 AM
To: All Health Units <AllHealthUnits@lists.alphaweb.org>
Subject: Disposition of 2019 alPHa Resolutions

PLEASE ROUTE TO:

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

Senior Public Health Managers
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Below is a link to the disposition document regarding the June 2019 alPHa Resolutions, which were reviewed at this week's Annual General Meeting.

Disposition of 2019 alPHa Resolutions

Regards,

Susan

Susan Lee
Manager, Administrative & Association Services
Association of Local Public Health Agencies (alPHa)
2 Carlton Street, Suite 1306
Toronto ON M5B 1J3
Tel. (416) 595-0006 ext. 25
Fax. (416) 595-0030
Please visit us at http://www.alphaweb.org

alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa RESOLUTION A19-9 (Corrected)

TITLE: **Public Health Support for Accessible, Affordable, Quality Licensed Child Care**

SPONSOR: **Simcoe Muskoka District Health Unit**

WHEREAS the Ontario Public Health Standards indicate the child care sector is an important setting for Public Health interventions, related to the Standards for Health Equity, Healthy Growth and Development, Immunization, Institutional Outbreak Management, Infection Prevention, Food Safety and others; and

WHEREAS supporting families and healthy early childhood development is a core part of the mandate of public health; and

WHEREAS early childhood experiences and socioeconomic status (SES) are important social determinants of health, and are supported by affordable, accessible, quality child care; and

WHEREAS the positive effects of high quality child care and early learning programs can last a lifetime and are associated with immediate and long-term positive outcomes for children, particularly for children from lower socioeconomic backgrounds; and

WHEREAS the current number of licensed child care spaces across Ontario can accommodate less than 1 in 4 (23%) children from ages 0-4; and

WHEREAS Ontario has the highest child care costs provincially, with parents spending $750-$1700 per month for licensed child care, totalling between $9,000-$20,000+ per year for each child; and

WHEREAS public investment in child care demonstrates positive economic benefits; in Ontario, the return on investment is $2.27 for every dollar invested; and

WHEREAS the Ontario government's plan for a refundable tax credit for child care costs will not improve access to quality licensed child care spaces, requires initial out of pocket expenses by families, and may thereby increase health inequities; and

WHEREAS Ontario has the lowest rate of women's workforce participation nationally; recognizing income is a key social determinant of health for Canadian families; and

WHEREAS no provincial standard or definition for quality of child care exists; most of Ontario's municipalities have a quality assurance coordinator, however only half are using a measurement tool to assess quality of child care; and

WHEREAS there is a shortage of Registered Early Childhood Educators in Ontario, in part due to the low compensation they receive and burdensome workplace conditions;

NOW THEREFORE BE IT RESOLVED that alPHa will endorse the importance of an accessible, affordable, quality child care and early learning system, for improved health equity for families and enhanced child development outcomes;

AND FURTHER that alPHa will advocate to the provincial and federal governments to maintain their commitment to ensuring a more affordable child care system, and to expand access to quality, licensed child care services for all Ontario families, including access for families with diverse needs (eg. 24 hour care, weekend care, part time care);

AND FURTHER that alPHa will advocate to the province to maintain its commitment towards creating a provincial definition of quality, including establishing an early years and child care workforce strategy, to ensure child care professionals are adequately qualified and compensated;

AND FURTHER that alPHa will support local public health agencies to:

- enhance their knowledge and transfer knowledge to decision-makers and the general public about the health impacts of the current state of the child care system and the importance of progressing towards an increasingly accessible, affordable, quality child care system; this could be initiated at an upcoming alPHa forum.
- build capacity to support the child care sector, by sharing examples of best practices for public health programming in child care environments and useful approaches for creating and enhancing partnerships with child care providers; this could be initiated through professional development opportunities in collaboration with partner organizations, in particular the College of Early Childhood Educators.

ACTION FROM CONFERENCE: Carried as amended

Peterborough Public Health
1889-2019 LOCAL & STRONG

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
P: **705-743-1000** or 1-877-743-0101
F: 705-743-2897
peterboroughpublichealth.ca

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Received Jun 24 2019
MOH Office

June 24, 2019

Councillor Carmen McGregor
Board President
Association of Local Public Health Agencies
c/o Loretta Ryan, Executive Director
2 Carlton Street, Suite 1306
Toronto, ON M5B 1J3
Sent via e-mail: ***loretta@alphaweb.org***

Dear Councillor McGregor,

Thank you for your board's organization and hosting of the 2019 Association of Local Public Health Agencies (alPHa) Annual General Meeting (AGM). During this critical period of transition the opportunity to exchange information and hear different perspectives is very important.

As you are aware, Peterborough's late resolution was accepted for consideration. After a thorough discussion and debate, the resolution was approved with minor wording changes. The Peterborough Board appreciates the support of other boards of health and those who were in attendance.

With the adoption of the resolution at the AGM, the alPHa board is now bound by its content. In that respect I am inquiring about alPHa's plan to implement the approved actions. More specifically, could you please copy Peterborough Public Health on your follow-up to the province in respect of:

a. Calling upon the Ontario government to delay the implementation of any organizational and financial changes to local public health until April 1, 2021;
b. Calling upon the Ontario government to commit to engage in meaningful consultation over the next 18 months; and
c. Calling upon the Ontario government to phase in any changes to the cost shared funding formula over five years commencing in fiscal 2021-22;

In addition could you also provide us a copy of your request of the Association of Municipalities of Ontario and the City of Toronto to establish a joint task force mandated to undertake:

a. Establishing a set of principles that should guide any reorganization of public health in Ontario that include
b. Conducting public outreach to municipal, public health and other stake holders to validate and strengthen the comprehensive set of principles to shape future re-organization; and
c. Meeting with provincial politicians and officials to provide a municipal and public health perspective on any proposed changes and including the outcomes of consultation

My board is anxious to see progress on our resolution and would like to ensure a more robust response to our 2019 resolution than was provided to our 2018 resolution.

In response to our request, at our June 12th board meeting, your Executive Director, Loretta Ryan, provided us with the ultimate disposition of our 2018 resolution, entitled "Sustainable Funding for Local Public Health in Ontario". It is clear that not all of the recommended actions contained in that resolution were acted on and we are disappointed that commitments made at the 2018 AGM appear to have been ignored without accountability to the membership. We are sincerely hopeful that this will not be the case yet again.

I look forward to your timely reply.

Yours in health,

Original signed by

Councillor Kathryn Wilson
Chair, Board of Health

/ag

cc: Ontario Boards of Health

Public Health
Santé publique
SUDBURY & DISTRICTS

June 7, 2019

VIA EMAIL

The Honorable Christine Elliott
Minister of Health and Long-Term Care
Ministry of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Minister Elliott:

Re: Public Mental Health – Parity of Esteem Position Statement

I am very pleased to highlight for you the recent decision of the Board of Health for Public Health Sudbury & Districts to formally adopt the Parity of Esteem Position Statement. The Position Statement asserts that public health equally values mental and physical health.

The Parity of Esteem Position Statement is in direct alignment with Bill 116 in its recognition that mental health is an essential element of health. We are very enthusiastic about the provisions within Bill 116 to establish a Mental Health and Addictions Centre of Excellence and to implement a mental health and addictions strategy with sustained commitment from all sectors and levels of government. Please be assured that the Board of Health for Public Health Sudbury & Districts is a committed local partner in this important work.

At its meeting on May 16, 2019, the Board of Health carried the following resolution #15-19:

> *WHEREAS* the Board of Health for Public Health Sudbury & Districts recognizes that there is no health without mental health; and
>
> *WHEREAS* Public Health Sudbury & Districts intentionally adopts the term, public mental health, to redress the widespread misunderstanding that public health means public physical health;

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

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

Sudbury East / Sudbury-Est
1 rue King Street
Box / Boîte 58
St.-Charles ON P0M 2W0
t: 705.222.9201
f: 705.867.0474

Espanola
800 rue Centre Street
Unit / Unité 100 C
Espanola ON P5E 1J3
t: 705.222.9202
f: 705.869.5583

Île Manitoulin Island
6163 Highway / Route 542
Box / Boîte 87
Mindemoya ON P0P 1S0
t: 705.370.9200
f: 705.377.5580

Chapleau
101 rue Pine Street E
Box / Boîte 485
Chapleau ON P0M 1K0
t: 705.860.9200
f: 705.864.0820

Toll-free / Sans frais
1.866.522.9200

phsd.ca

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts endorse the Public Mental Health - Parity of Esteem Position Statement, May 16, 2019; and

FURTHER THAT copies of this motion and position statement be forwarded to local and provincial partners including all Ontario boards of health, Chief Medical Officer of Health, local MPPs, Ontario Public Health Association (OPHA), Association of Local Public Health Agencies (alPHa), local municipalities and Federation of Northern Ontario Municipalities (FONOM).

Officially adopting parity of esteem reinforces new, current and ongoing work which has been identified in our Public Mental Health Action Framework. The Framework is action-oriented and provides the roadmap for interventions, articulating our commitment to concepts and investments to improve mental health opportunities for all throughout the Public Health Sudbury & Districts service area.

Our local public health work in mental health will be more sustainable and effective if it is supported by organizational and provincial policies and structures that acknowledge mental health as an explicit goal along with physical health.

Yours sincerely,

Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health and Chief Executive Officer

Enclosure (1)

cc: All Ontario Boards of Health
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health and Long-Term Care
Mr. Jamie West, MPP, Sudbury
Ms. France Gelinas, MPP, Nickel Belt
Mr. Michael Mantha, MPP, Algoma-Manitoulin
Ms. Pageen Walsh, Executive Director, Ontario Public Health Association
Ms. Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Constituent Municipalities within Public Health Sudbury & Districts
Ms. Alison Stanley, Executive Director, Federation of Northern Ontario Municipalities

Position Statement
Parity of Esteem

Position Statement

The Board of Health for Public Health Sudbury & Districts actively supports the concept of parity of esteem, which is defined as equally valuing mental and physical health, for the wellbeing of all in our community. We will intentionally utilise the term public mental health to acknowledge mental health as an explicit goal in addition to the goal for physical health and well-being.
To advance mental health opportunities for all throughout the Public Health Sudbury & Districts service area, the Board further commits to:

- Ensuring that public mental health practice be relevant for everyone, regardless of mental illness diagnoses, with appropriate adaptations,
- Understanding mental health from a social determinants of health perspective and to working to improve equity in mental health,
- Understanding and shining a light on systemic and often hidden prejudice in support of opportunities for mental health for all,
- Privileging the voices of those with lived experiences and their families and carers, and
- Informing our public mental health practice with the aspiration to build hope, empowerment, and resilience in individuals and communities.

Background

Like physical health, mental health and well-being are influenced by the social, economic, and physical environments in which people work, live, and play. We also know that populations with socio-economic disadvantages are disproportionately affected by mental health problems and challenges.

People who experience mental illness and addictions are more likely to die prematurely than the general population. Mental illness can cut 10 to 20 years from a person's life expectancy. The disease burden of mental illness and addiction in Ontario is 1.5 times higher than all cancers put together and more than seven times that of all infectious diseases. This includes years lived with less than full function and years lost to early death. ,

The 2018 Ontario Public Health Standards (OPHS) identifies mental health in its mandate. Local public health must address mental health, focusing on mental health promotion, prevention, and early identification and referral. Within OPHS, the role of public health "is to support and protect the physical and mental health and well-being, resiliency and social connectedness of the health unit population . . . reaching all . . . with a special focus on those with greater risk of poor health outcomes".

Public Health Sudbury & Districts supports the concept of parity of esteem, or equally valuing mental and physical health. We support the assertion that our work in mental health will be more sustainable and effective if it is supported by organizational policies that acknowledge mental health as an explicit goal, while recognizing that it is also fundamental to physical health and well-being . There is no health without mental health.

The Public Mental Health Action Framework is Public Health Sudbury & Districts' roadmap that will assist us in putting into practice parity of esteem. The goals and outcomes for public mental health are and will be overarching and cross sectoral within our responsibilities. As outlined in the Framework, we will need to be intentional in our current work, in identifying how to further leverage what we are already doing and systematically identify new areas for public mental health initiatives. There is a role for everyone.

Commitments of Public Health

Our Public Mental Health Action Framework articulates our five commitments to concepts and investments to improve mental health opportunities for all throughout the Public Health Sudbury & Districts service area.

1. Mental Health for All: Public Health Sudbury & Districts is committed to ensuring that public mental health practice be relevant for everyone, regardless of mental illness diagnoses, with appropriate adaptations. Mental health and mental illness are distinct but related concepts. These concepts intersect and coexist in individuals and populations. Persons with serious mental illness or addiction can experience good mental health. Persons with no mental illness or addiction can experience poor mental health or difficulty coping.

2. Social Determinants of Mental Health: Public Health Sudbury & Districts is committed to understanding mental health from a social determinants of health perspective and to working to improve equity in mental health. The social determinants of mental health are understood to be the same as those determining physical health. They are the societal factors that underpin and drive individual-level risk and protective factors for disease.

3. Anti-stigma and Discrimination: Public Health Sudbury & Districts is committed to understanding and shining a light on systemic and often hidden prejudice in support of opportunities for mental health for all. Many who live with mental health and addictions problems have reported experiencing discrimination at work, from family and friends, within imagery found in the media, while attempting to secure housing, within health services or the justice system. Living with mental health problems or addictions can be accompanied by self-stigma and shame that is further reinforced by societal reactions. ,

4. Voices of People with Lived Experience: Public Health Sudbury & Districts is committed to privileging the voices of those with lived experiences and their families and carers. This will take place through collaboration with people with lived experience, connections with family and carers, transparency and accountability.

5. Hope, Belonging, Meaning and Purpose: Public Health Sudbury & Districts is committed to informing our public mental health practice with the aspiration to build hope, empowerment, and resilience in individuals and communities. This commitment draws us to understand and support mental health from a more holistic and community-based perspective. A perspective that considers mental wellness equally with physical, spiritual, and emotional wellness. We acknowledge the perspective of The First Nations Mental Wellness Continuum Framework.

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Peterborough Public Health
1889-2019 LOCAL & STRONG

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
P: **705-743-1000** or 1-877-743-0101
F: 705-743-2897
peterboroughpublichealth.ca

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June 25, 2019

The Honourable Todd Smith
Minister of Children, Community and Social Services
Sent via e-mail: ***todd.smith@pc.ola.org***

The Honourable Stephen Leece
Minister of Education
Sent via e-mail: ***minister.edu@ontario.ca***

The Honourable Christine Elliott
Minister of Health and Long-Term Care
Sent via e-mail: ***christine.elliott@pc.ola.org***

Dear Ministers,

Re: Support for Children Count Task Force Recommendations

On behalf of the Board of Health for Peterborough Public Health (PPH), I am writing in support of the recommendations of the Children Count Task Force. These recommendations support the health and wellbeing of Ontario's children and youth by streamlining and improving the systems that monitor and assess their health.

Peterborough Public Health is required as outlined in the Ontario Public Health Standards, 2018 (OPHS) to: "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".[1]

Unfortunately, measuring the status of child health is not a straight-forward task. Although the assessment and surveillance requirements outlined in the OPHS specify which aspects must be measured and reported, a comprehensive system for monitoring the status of child health in the province has yet to be developed, and there are gaps in indicator development and data collection.[2,3] The existing data only partially measure the health of children in the province, and in some cases even less information is available at the local public health agency level. The collection of relevant provincial and regional data on the full spectrum of child health indicators, with such data being made freely accessible to public health agencies, should be a future goal for Ontario.[4]

As such, we strongly support the Children Count Task Force's overarching recommendation to create a secretariat responsible for overseeing the implementation of the systems, tools, and resources required to improve the surveillance of child and youth health and well-being in Ontario.[5] Additionally, to further support this secretariat, we support the following five recommendations made by the task force:

- ***Recommendation 1:*** Create an interactive web-based registry of database profiles resulting from child and youth health and well-being data collection in Ontario schools.
- ***Recommendation 2:*** Mandate the use of a standardized School Climate Survey template in Ontario schools and a coordinated survey implementation process across Ontario.
- ***Recommendation 3:*** Develop and formalize knowledge exchange practice through the use of centrally coordinated data sharing agreements.
- ***Recommendation 4:*** Develop and implement a centralized research ethics review process to support research activities in Ontario school boards.
- ***Recommendation 5:*** Work with the Information and Privacy Commissioner (IPC) of Ontario to develop a guideline for the interpretation of privacy legislation related to student health and wellbeing data collection in schools.[6]

A strength of the Children Count Task Force and its recommendations is the broad range of perspectives, knowledge and expertise shared by leaders in federal and provincial government agencies and ministries, academics, local public health agencies, boards of education, and non-government organizations. We believe that implementing the recommendations will provide the information that all stakeholders need to properly assess the health status of our children and youth and the return on investment of related programs and services. Furthermore, implementation will result in a more efficient and improved data collection system.

We respectfully request that the Honourable Ministers seriously consider implementing these recommendations and welcome any opportunities to consult or engage in future actions that would support this work.

Thank you for your consideration.

Sincerely,

Original signed by

Councillor Kathryn Wilson
Chair, Board of Health

cc: Hon. Doug Ford, Premier of Ontario
Local MPPs
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Children Count Task Force (c/o Nicole Dupuis, Windsor Essex County Health Unit)
Ontario Boards of Health

References:
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6. Ibid

WINDSOR-ESSEX COUNTY HEALTH unit
Bureau de santé de Windsor-comté d'Essex

519-258-2146 | www.wechu.org

Windsor 1005 Ouellette Avenue, Windsor, ON N9A 4J8
Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

May 21, 2019

The Right Honorable Justin Trudeau
Prime Minister of Canada
House of Commons
Ottawa, ON K1A 0A6
Justin.trudeau@parl.gc.ca

Dear Prime Minister Trudeau:

On May 16, 2019, the Windsor-Essex County Board of Health passed the following Resolution regarding **Smoke-Free Multi-Unit Dwellings** to reduce the exposure of second-hand smoke in multi-unit housing:

Whereas, the federal government has passed the Cannabis Act, 2017 to legalize non-medical cannabis, coming into effect on October 17th, 2018, and

Whereas, cannabis smoke contains many of the same carcinogens, toxins, and irritants found in tobacco smoke with the added psychoactive properties of cannabinoids like THC, and

Whereas, Ontarians spend most of their time at home, and it is in this environment where exposure continues to be reported, and

Whereas, indoor air studies show that, depending on the age and construction of a building, up to 65% of the air in a private residence can come from elsewhere in the building and no one should be unwillingly exposed or forced to move due to unwanted second-hand smoke exposure,

Now therefore be it resolved that the Windsor-Essex County Board of Health endorse the following actions and policies to reduce the exposure of second-hand smoke in multi-unit housing:

1. Encourage all landlords and property owners of multi-unit housing to voluntarily adopt no-smoking policies in their rental units or properties and explicitly include cannabis smoke and vaping of any substance in the definition of smoking;

2. All future private sector rental properties and buildings developed in Ontario should be vape and smoke-free from the onset;

3. Encourage public/social housing providers to voluntarily adopt no-smoking and/or vaping policies in their units and/or properties;

4. All future public/social housing developments in Ontario should be smoke and vape-free from the onset.

5. Encourage the Ontario Ministry of Housing to develop government policy and programs to facilitate the provision of smoke-free housing.

AND FURTHER that this resolution be shared with the Honorable Prime Minister of Canada, local Members of Parliament, the Premier of Ontario, local Members of Provincial Parliament, Minister of Health and Long-term Care, Federal Minister of Health, the Attorney General, Chief Medical Officer of Health, Association of Local Public Health Agencies, Ontario Boards of Health, Ontario Public Health Association, the Centre for Addiction and Mental Health, and local community partners.

We would be pleased to discuss this resolution with you and thank you for your consideration.

Sincerely,

Gary McNamara
Chair, Board of Health

Theresa Marentette
Chief Executive Officer

c: Hon. Doug Ford, Premier of Ontario
Hon. Christine Elliott, Minister of Health & Long-Term Care
Hon. Ginette Petitpas Taylor, Minister of Health
Hon. David Lametti, Minister of Justice and Attorney General of Canada
Dr. David Williams, Chief Medical Officer of Health, Ministry of Health & Long Term Care
Pegeen Walsh, Executive Director, Ontario Public Health Association
Centre for Addiction and Mental Health
Association of Local Public Health Agencies – Loretta Ryan
Ontario Boards of Health
WECHU Board of Health
Corporation of the City of Windsor – Clerk's office
Corporation of the County of Essex – Clerk's office
Local MPP's – Percy Hatfield, Lisa Gretzky, Taras Natyshak, Rick Nicholls
Local MP's – Brian Masse, Cheryl Hardcastle, Tracy Ramsey

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	July 10, 2019
SUBJECT/REPORT NO:	Food Strategy Priority Actions 2 (Food Skills & Employability) and 3 (Neighbourhood Food Infrastructure) (BOH13001(i)) (City Wide) **(Outstanding Business List Item)**
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Sandy Skrzypczyk (905) 546-2424 Ext. 3523
SUBMITTED BY and SIGNATURE:	Kevin McDonald Director, Healthy Environments Division Public Health Services

COUNCIL DIRECTION

The Board of Health at its meeting of August 11, 2016 approved the Food Strategy (BOH13001(d)) Recommendation Report, including:

(b) That the Board of Health direct the Interdepartmental Food Strategy Steering Team, in collaboration with appropriate staff, to initiate the five Food Strategy Priority Actions, including:

(iii) Update the Board of Health regarding the progress on the feasibility of implementing Priority Actions 2 (Food Skills and Employability Program) and 3 (Community and Neighbourhood Infrastructure).

INFORMATION

In August 2012, the Board of Health requested that a comprehensive Food Strategy be developed. In 2013, the Interdepartmental Food Strategy Steering Team formed, with representation from Public Health Services, Planning and Economic Development, Community and Emergency Services, and Public Works. After an extensive review of

existing practices and evidence, a formal food strategy community engagement process was conducted in 2015 with over 2,700 citizens providing input. In August 2016, the Board of Health received the Food Strategy Recommendation Report BOH13001(d) and endorsed the Hamilton Food Strategy: Healthy, Sustainable, and Just Food for All.

From the Food Strategy's 46 Actions, five Food Strategy Priority Actions were identified as the focus for the first two to three years. Priority Action 1 (Funding Criteria and Process) was completed and endorsed by the Board of Health in June, 2017. Priority Actions 4 (Food Literacy Network) and 5 (Local Food Promotion) have been successfully implemented and staff continue to explore opportunities to expand these food initiatives. The following provides an update on the progress achieved on the two remaining Food Strategy Priority Actions.

Food Strategy Priority Action 2 — Food Skills and Employability:
Offer a food skills and employability program, particularly for vulnerable groups.

Since early 2018, Public Health has been working with various partners to plan a Food Skills and Employability Program to achieve the Food Strategy's Priority Action 2. Led by Indwell, a local non-profit housing organization, in partnership with Employment Services and Public Health Services' staff, as well as Brescia University College and Hamilton Health Sciences' Collaborative Dietetic Education Practical Training program — the Culinary Academy pilot program will be implemented in September 2019.

Students for the pilot will be Ontario Works and Ontario Disability Support Program (ODSP) recipients, giving these students the opportunity to gain pre-apprentice skills to enter the food sector workforce. Public Health Services will provide in-kind Safe Food Handling training, and in collaboration with dietetic interns, will provide four in-kind healthy eating and nutrition education sessions.

Indwell's Culinary Academy is a free and unique 12-week job training program for people living in poverty and those looking to enter or re-enter the workforce in the culinary arts. The program will be situated within one of Indwell's affordable housing complexes in one of Hamilton's economically challenged neighbourhoods. Graduates from this program will be equipped with the knowledge and skills to enter the food service sector prepared for paid employment. Currently, Hamilton does not offer this kind of tuition-free comprehensive food skills training that would meet the needs of vulnerable populations. Existing local chef training programs have either high tuition fees and/or lengthy programs that present barriers for some people.

Food skills training opportunities help build a strong local food economy and ensure the local food sector thrives and meets the increased demand for skilled workers. Similar food skills and employability programs, such as Fresh Starts Culinary Academy in

Marin, California and Toronto Public Health's Community Food Works Program address barriers for low income communities to access job training within the food sector. Both of these programs have proven track records, with the majority of students completing the courses and moving on to employment within the food sector, further education, and/or volunteer work within their communities.

While much of the costs to implement this pilot program are covered, funding gaps present a challenge to fully implement this intensive hands-on training program beyond the pilot phase. Hamilton is fortunate to have innovative non-profits such as Indwell that have access to a commercial kitchen, staff, and community partners to operate the Culinary Academy; however, the biggest challenge to any food skills and employability program is obtaining ongoing sustainable funding. Like other non-profit community programs, the lack of sustainable funding impacts running these programs long-term.

Food Strategy Priority Action 3 — Neighbourhood and Community Infrastructure:
Build, retro-fit, or repurpose infrastructure to support food initiatives, such as community kitchens, food markets, community gardens, etc.

Since 2016, Public Health Services' Registered Dietitians have engaged in the following actions to support Priority Action 3:

- Completed a kitchen scan assessing the availability of community facilities with kitchens that may be used by groups to run food skills programs. Results indicate there are limited community spaces with kitchen availability for food literacy programming by community groups, especially at no cost;
- Provided consultation for the Riverdale/Domenic Agostino Recreation Centre renovation to include a commercial teaching kitchen to enhance access to food literacy programs;
- Collaborating with Recreation staff to develop and implement a Healthy Food and Beverage Action Plan to increase healthy food choices within City Recreation centres;
- Initiated collaboration with Recreation staff to develop and implement comprehensive food literacy programming, utilizing the commercial kitchen at the new Bernie Morelli Centre;
- Advised and supported the installation of hydration stations within City facilities;
- Provided input into development plans to encourage access to healthy food via community gardens and food retail, while discouraging access to unhealthy food;
- Provided input on land-use planning documents highlighting the need to preserve agricultural land for growing nutritious food and improving access to local, healthy food;

- Initiated the evaluation of the benefits, barriers, and opportunities for expanding community gardening within Hamilton's public and private infrastructure realm;
- Worked with St. Jean de Brébeuf Catholic Secondary School to obtain a grant to install a salad bar within the cafeteria and renovate the school's greenhouse; and,
- Worked with the McMaster University's DeGroote School of Business — MBA Health Care and Marketing class (Winter 2019), focusing on a "healthy corner store" initiative in the McQuesten neighbourhood to increase healthy food options within a local convenience store.

Creating food friendly neighbourhoods increases Hamiltonians' physical access to healthy food and food literacy programs. Several challenges exist to build, retro-fit or repurpose infrastructure to support food friendly neighbourhoods. For example, the recent loss of some neighbourhood grocery stores decreases physical access to healthy food for those with limited mobility and/or lack of easy transportation options. The City and community stakeholders can encourage the private sector to implement and create infrastructure for healthy food access; however, within current policies and regulations, there is no requirement that food retailers must offer healthy food within their establishments. For the non-profit sector, ongoing challenges include limited resources and sustainable funding to build, retro-fit or repurpose infrastructure that supports food initiatives. An opportunity to address gaps is the continued inclusion of commercial teaching kitchens and community gardening within new builds and renovations of recreation centres and other City facilities to enhance community access to food initiatives.

Next Steps for Priority Actions 2 & 3

Public Health Services' Registered Dietitians will continue to provide healthy eating and nutrition education sessions beyond the pilot phase to Indwell's Culinary Academy Program.

Public Health Services' Registered Dietitians will continue to work with City staff and community partners to support and grow neighbourhood and community infrastructure to enhance access to nutritious food and food literacy initiatives.

APPENDICES AND SCHEDULES ATTACHED

Not Applicable.

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	July 10, 2019
SUBJECT/REPORT NO:	Managed Opioid Treatment Programs (BOH19023) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Shawna Scale (905) 546-2424 Ext. 7640 Brenda Marshall (905) 546-2424 Ext. 7161
SUBMITTED BY: **SIGNATURE:**	Michelle Baird Director, Epidemiology, Wellness and Communicable Disease Control Division Public Health Services

COUNCIL DIRECTION

The Board of Health at its meeting of April 15, 2019 received correspondence from the Toronto Board of Health regarding Managed Opioid Programs and approved the following:

> "The Correspondence from the Toronto Board of Health, Urging the Ministry of Health and Long-Term Care to Support Managed Opioid Programs, was received and referred to staff for a report back to the Board of Health."

INFORMATION

Opioid overdoses remain a top driver of preventable deaths in Ontario. Fentanyl or fentanyl analogues have been increasingly found in drugs seized by Ontario police services and tested by Health Canada's Drug Analysis Services.[1] Locally, the opioid-related death rate in Hamilton remains consistently higher than the provincial average. In 2018, there were 103 confirmed deaths related to an opioid-related emergency. There are another 19 probable deaths that are still under investigation by the Coroner's Office.

Preliminary data indicates the majority (82%) of accidental opioid overdose deaths were attributable to fentanyl or its analogues.

From January to April 2019, Hamilton Paramedic Services responded to 280 cases of suspected opioid overdoses, with monthly calls doubling compared to the same period in 2018. Overall, in 2019, the volume of monthly paramedic calls for overdoses continue to trend upward, with May being the highest volume to date. Most cases (73%) have been male, and the average age is 36 years. Calls to 911 for suspected opioid overdose have come from throughout Hamilton, with large concentrations in Ward 2 and Ward 3 (38.4% and 24.8%, respectively).

Tackling the harms associated with problematic substance use requires a multi-pronged approach. This includes prevention, treatment, harm reduction, and enforcement. In response to the increasing morbidity and mortality associated with opioid use, new treatment options, such as Managed Opioid Treatment, are emerging.

Opioid Agonist Therapy

Currently, opioid agonist therapy (OAT) is the first line, or standard treatment, for persons over 16 years of age with an opioid use disorder. The most common therapies are methadone (Methadose™) or buprenorphine/naloxone (Suboxone™). Individuals are prescribed one of these long-acting opioid drugs to help prevent withdrawal, provide long-term, stable, relief against opioid cravings and help stabilize their lives.[2,3] Medications are taken by mouth, under the direct supervision of trained health care professionals. Weekly urine tests are conducted to monitor treatment dose and screen for continued use of illicit drugs, where a subsequent positive test may result in treatment discharge.[2,4] To adhere to treatment, individuals are required to make daily, structured visits to their supervising health care professional to receive medication and be screened for illicit drug use.

Accessing and adhering to OAT can be difficult due to stigma and treatment requirements, especially for transient and rural or remote populations, with the schedule being demanding and restrictive for some patients.[2,5]

Managed Opioid Programs

Managed Opioid Programs (MOPs) provide alternative treatment options for people who have not benefited from standard OAT treatments or residential treatment programs[6] and are motivated to treat their opioid use disorder. MOPs are evidence-based programs offering treatments proven to curb use of street drugs and decrease crime while increasing adherence and retention in opioid use disorder treatment.[5,7,8] MOPs include the provision of a safe supply of prescribed injectable opioids, typically hydromorphone or pharmaceutical heroin (diacetylmorphine). This treatment has a history of successful use in various European countries for the treatment of chronic relapsing opioid dependence.[9]

The MOP model of supervised treatment involves careful patient screening and selection, structured induction and ongoing monitoring, and a high level of support and interaction with medical staff.[8] As MOPs are administered under direct medical supervision, they can provide the opportunity for additional case management, treatment, and facilitate access to other recovery supports such as housing, primary care services and trauma therapy.[10]

MOPs have been piloted and successfully implemented in other jurisdictions across Canada including: Surrey and Vancouver, British Columbia; Calgary, Alberta; and, a shelter-based program in Ottawa, Ontario. The uptake and subsequent demand for treatment in these jurisdictions is unable to keep pace with current availability, highlighting the opportunity for success with expansion.

Studies suggest improving adherence rates may reduce overall opioid-related deaths and reduce related causes of death from acute infections and HIV among incarcerated individuals and other similarly marginalized populations.[11]

Research of MOPs suggests that those in treatment:

- Fare better and remain longer in treatment when compared to using standard OAT medications alone;
- Have reduced risk for HIV and other infectious diseases;
- Engage in safer use practices;
- May be more prepared to transition to less intensive treatments;[9] and,
- Show gains in mental and physical health.[5,12]

Expansion of Managed Opioid Programs

The Federal Government has taken steps in recent years to expand availability of prescription injectable opioids in Canada. Since September 2016, physicians have been able to apply for special permission to prescribe injectable heroin under Health Canada.[13] In 2017, Health Canada approved the import of injectable heroin into Canada, in communities requesting it for urgent public health reasons.[9]

On May 1, 2019 Canada became the first country in the world to approve the use of injectable hydromorphone, as a treatment for adults with severe opioid use disorder. Pharmaceutical heroin (diacetylmorphine) was added to the list of Drugs for an Urgent Public Health Need under the direction and request of Canada's Chief Public Health Officer to assist with advancing action across the entire continuum of prevention, harm reduction, treatment, and recovery. These treatments are only to be administered by trained and qualified physicians with experience in the treatment of severe opioid use disorder and who have been trained in the provision of injectable opioid agonist therapy. This announcement makes it possible for all provinces and territories to import and use these drugs for the treatment of opioid use disorder, and to expand access to safer alternatives to Canada's illicit drug supply.

With the Federal Government expansion of available prescription injectable opioids, there is interest in expanding treatment options in Ontario for opioid use disorder.[9] Locally, addiction medicine physicians are exploring, in collaboration with the Drug Strategy, how a MOP could be implemented in Hamilton.

Conclusion

The opioid crisis continues to affect municipalities across Ontario. Innovative strategies are required to reduce accidental overdoses and related deaths caused by fentanyl. Expanding proven, evidence-based treatments, such as safe supply of injectable prescribed opioids through MOPs, will allow persons with opioid use disorders who have not benefited from traditional OATs to access comprehensive care to help stabilize their lives, improve their health and wellbeing, and reduce their use and dependence on illicit drugs. The Federal government recently announced changes that will facilitate expanded access of supervised injectable opioid treatment that, along with medical guidelines and informed practices, could be adopted and implemented across Ontario. Public Health Services is engaging with local partners on exploring opportunities related to this announcement. The Board of Health will receive information on these initiatives through the Drug Strategy updates.

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APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report BOH19023:	Expanding Opioid Substitution Treatment with Managed Opioid Programs

HL3.02

TORONTO

REPORT FOR ACTION

Expanding Opioid Substitution Treatment with Managed Opioid Programs

Date: February 12, 2019
To: Board of Health
From: Medical Officer of Health
Wards: All

SUMMARY

The opioid poisoning crisis continues unabated in Toronto in large part due to the illicit drug supply, which has become increasingly toxic with fentanyls and other potent drugs. There is a critical need to expand treatment options to include managed opioid programs. This strategy is part of the response to the overdose crisis in British Columbia and Alberta, and is urgently needed in Toronto and elsewhere in Ontario.

Methadone and Suboxone™ are the most commonly offered opioid substitution treatments. These need to be expanded to include managed opioid programs which provide patients with oral or injectable hydromorphone or diacetylmorphine (pharmaceutical heroin) under medical supervision. Managed opioid programs are evidence-based programs that have been shown to increase retention in treatment, reduce the use of street drugs, and decrease crime.

The Province of Ontario recently announced a $102 million funding agreement with the federal government for drug treatment. In the context of the current opioid poisoning crisis, the Ministry of Health and Long-Term Care should target some of this funding to rapidly scale up implementation of managed opioid programs in Toronto and elsewhere in Ontario to help save lives, and improve health outcomes for people who use drugs.

RECOMMENDATIONS

The Medical Officer of Health recommends that:

1. The Board of Health urge the Ministry of Health and Long-Term Care to:

    a. Immediately target operational and capital funding to support rapid scaled up implementation of managed opioid programs (including low barrier models) in Toronto and elsewhere in Ontario given the urgency of the opioid poisoning crisis.

    b. Take immediate action to ensure the required concentrations of managed opioid medications (i.e. 50 milligrams/milliliters and 100 milligrams/milliliters

hydromorphone) are accessible to treat people with opioid use disorder in Ontario. And further, to take the necessary steps to add these medications at the appropriate concentrations to the Ontario Drug Benefit Formulary for the treatment of opioid use disorder.

c. Seek authority from Health Canada to import diacetylmorphine (pharmaceutical heroin) for use as a managed opioid program medication in Ontario.

d. Work with Health Canada and other necessary federal bodies to address barriers to procuring, storing and transporting diacetylmorphine (pharmaceutical heroin) and/or mitigate their effects to facilitate use of this managed opioid program medication, and

e. Ensure that managed opioid medications are universally accessible to all Ontarians who could benefit from these kinds of programs, and that cost is not a barrier.

FINANCIAL IMPACT

There are no financial impacts associated with this report.

DECISION HISTORY

In June 2018, as part of a status report on implementation of the *Toronto Overdose Action Plan*, the Board of Health approved a recommendation supporting urgent implementation of managed opioid programs, including low barrier options.
http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2018.HL27.1

In March 2017, the Board of Health endorsed the *Toronto Overdose Action Plan*, which included recommendations for the provincial and federal governments to expand access to diacetylmorphine (pharmaceutical heroin) and/or hydromorphone as an opioid substitution treatment option.
http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2017.HL18.3

COMMENTS

Opioid deaths in Toronto

The opioid poisoning crisis continues unabated in Toronto as it is elsewhere in the country. In 2017, there were 308 opioid toxicity deaths in Toronto, which is a 66 percent increase from 2016, and a 125 percent increase from 2015[1]. Most of these deaths were accidental, and 71 percent were due to fentanyl as a contributing cause[2]. More detailed information from the Office of the Chief Coroner for Ontario about deaths caused by opioids (for the period of July 1, 2017 to June 30, 2018) found that fentanyl or its analogues were a contributing cause in over 77 percent of these deaths in Toronto, higher than in the rest of Ontario (69 percent)[1].

Preliminary data from the Office of the Chief Coroner for Ontario for the first six months of 2018 shows there were 111 opioid toxicity deaths in Toronto[1]. This number is expected to rise as the cause of death is confirmed for more cases.

Toxic illicit drug supply

The illicit drug supply in Toronto and elsewhere in the province has become increasingly toxic. In 2017, Health Canada's Drug Analysis Service[3] found fentanyl or its analogues 2469 times in drugs seized by Ontario police services, which is a 178% increase from 2016. In the first three months of 2018 (most recent data available), 59% of all heroin samples analyzed in Ontario also contained fentanyl or analogue(s).

Toronto Public Health (TPH) works with community partners to compile and share information about toxic substances, including issuing alerts when there are widespread reports of probable adulterated or particularly harmful drugs. Most recently, in January 2019, TPH issued an alert following many reports of concerning symptoms after use of a particular opioid in the illicit market. Toronto Overdose Prevention Society members worked with the laboratory at the Centre for Addiction and Mental Health to have post-use residue tested from this substance. The results found a toxic mix of different drugs, with a particularly toxic synthetic cannabinoid, AMB-FUBINACA, present along with opioids, cocaine, ketamine, methamphetamine, and other drugs.

Managed opioid programs

Comprehensive substance use treatment in Toronto needs to include a range of options to meet the diverse needs of people with substance use issues. Methadone and Suboxone™ are the most commonly offered opioid substitution treatments. Slow-release oral morphine has also emerged as a more recent opioid substitution medication[4]. These treatment options should be expanded to include managed opioid programs (MOP), which provide patients with oral or injectable hydromorphone (HDM) or diacetylmorphine (DAM or pharmaceutical heroin), along with methadone or slow release oral morphine for overnight relief.

Managed opioid programs have been shown in research and practice to be effective[4] and cost-saving[5]. In reviews of scientific evidence, MOP have demonstrated that they increase people's retention in treatment, reduce use of street drugs, and decrease crime[6]. Cost-effectiveness studies have shown that providing MOP to people for whom current treatment for opioid use disorder (such as methadone) has not worked is good value for the resources invested. Managed opioid programs that provide DAM to people with opioid use disorder who have not responded to other forms of treatment have been in place in several cities in Europe for decades[8]. Diacetylmorphine is available in The Netherlands and Switzerland, where it accounts for about 9 percent of all opioid substitution treatment, and is also available in Germany, England, and Denmark[9]. Managed opioid programs can be delivered in a variety of different models[10] including regulated low-barrier distribution programs[11].

Due to the unpredictability of the current illicit drug supply, there is an urgent need to expand treatment options, and implement managed opioid programs. This strategy is a

key aspect of the response to the overdose crisis in British Columbia and Alberta, and is urgently needed in Ontario.

The Ministry of Health and Long-Term Care (MOHLTC) has just negotiated a new treatment funding agreement ($102 million) with the federal government. Details of how this new funding will be allocated have not been announced, but ensuring some of the funds are targeted to MOP is critical. It is therefore recommended that the MOHLTC immediately target operational and capital funding to support a rapid scale up of MOP in Ontario (including low barrier models) given the urgency of the current opioid poisoning crisis.

Canadian managed opioid programs

In Canada, MOP began in 2005 as a research trial in Vancouver and Montreal[12], and have included the provision of both DAM, and/or HDM. These research trials demonstrated the effectiveness of this treatment option in decreasing both crime and improving retention in drug treatment[12, 13]. Programs based on this research have expanded and are now being delivered by several health care providers in Vancouver to respond to the overdose crisis[14]. New clinics in Surrey, British Columbia and Calgary, Alberta have recently opened, and more are planned. In Ottawa, there is one shelter-based MOP run by Ottawa Inner City Health, which has been successfully stabilizing a small group of people on HDM since late 2017[15]. New innovative programs that distribute HDM pills are being planned in British Columbia.[11]. In addition, clinical and other guidelines have been produced to guide practitioners in the effective delivery of these programs based on best practices[10, 16]. The foundations are therefore in place to scale up the implementation of these kind of programs in Ontario.

The stories from people participating in MOP in Vancouver demonstrate the kind of recovery that is possible with this form of treatment[17]:

"My life is starting to become more manageable… and I'm only two and a half months into it… I'm putting on weight, that's one thing. I'm eating better… It's stabilized my life…I don't wake up in the morning having to figure out what crime I'm going to do to pay for my drugs…and I'm actually looking for other things in my life, like even going swimming, leisure and stuff like that. …And this is only at the start."

"I don't get sick. I sleep all night. I don't do crimes. That's really good."

Barriers to implementation

Despite the evidence on the effectiveness of MOP, and the precedents of programs in other parts of Canada, there are a number of barriers to implementing MOP in Ontario, many of which could be addressed by the MOHLTC.

The current medications used in opioid substitution treatment (methadone and Suboxone™) are listed on the Ontario Drug Benefit Formulary. The costs for these medications are covered for people who are eligible for the Ontario Drug Benefit program (i.e. people aged 65 or older, and people enrolled in the Trillium Drug Program, Ontario Works, or the Ontario Disability Support Program). However, the concentrations of injectable HDM (50mg/ml and 100mg/ml) required as treatment for opioid use

disorder are not listed on the Ontario Drug Benefit Formulary. It is therefore recommended that the MOHLTC take immediate action to ensure the required concentrations of MOP medications (i.e. 50mg/ml and 100mg/ml hydromorphone) are accessible to treat people with opioid use disorder in Ontario. For example, the MOHLTC could provide funding to health care providers or other related organizations to cover the costs of these medications. Because many people who are treated for opioid use disorder are eligible for the Ontario Drug Benefit program, it is also important for the MOHLTC to take the necessary steps to add these medications at the appropriate concentrations to the Ontario Drug Benefit Formulary for the treatment of opioid use disorder.

Diacetylmorphine (pharmaceutical heroin) is currently not available in Ontario. Health Canada must authorize use and importation of this medication, and provinces must request special access. It is therefore recommended that the MOHLTC seek authority from Health Canada to import diacetylmorphine for use as a MOP medication in Ontario.

There are also considerable barriers to procuring, storing and transporting DAM, which make it inaccessible for most potential MOP providers. These regulations are federal as well as provincial, and there is a lack of information from the MOHLTC about who would pay for this medication even if the regulatory barriers to procuring, storing and transporting it were reduced or managed. It is therefore recommended that the MOHLTC work with Health Canada and other necessary federal bodies to address barriers to procuring, storing and transporting diacetylmorphine (pharmaceutical heroin) and/or mitigate their effects to facilitate use of this MOP medication. It is further recommended that the MOHLTC ensure that MOP medications are universally accessible to all Ontarians who could benefit from these kinds of programs, and that cost is not a barrier.

Treatment programs that offer opioid substitution therapies need to offer more than just medication. Supports for people in these programs should include case management, and other psychosocial supports. Health facilities may need to be renovated or expanded to accommodate the supervision of injectable medications. The MOHLTC often provides the funds to support these kind of services in community-based settings.

Conclusion

Managed opioid programs are an important part of a comprehensive response to the opioid crisis, which is associated with considerable preventable and premature deaths. Better treatment options and other services are urgently needed in Toronto to meet the needs of people who use substances and are at high risk of overdose. These treatment options help move people out of the illicit drug market, which is currently contaminated with very potent opioids (such as fentanyl and other analogs), and onto a safe supply of pharmaceutical opioids under medical supervision.

Urgent action and investment is needed from the MOHLTC to rapidly scale up the implementation of MOP in Toronto and elsewhere in Ontario to help save lives and improve health outcomes for people who use drugs.

CONTACT

Jann Houston, Director, Strategic Support, 416-338-2074, jann.houston@toronto.ca

SIGNATURE

Dr. Eileen de Villa
Medical Officer of Health

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INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	July 10, 2019
SUBJECT/REPORT NO:	Feasibility of Providing Drug Checking (Fentanyl) Test Strips (BOH19024) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Melissa Biksa (905) 546-2424 Ext. 3055
SUBMITTED BY: **SIGNATURE:**	Michelle Baird Director, Epidemiology, Wellness and Communicable Disease Control Division Public Health Services

COUNCIL DIRECTION

The Board of Health, at its meeting of March 18, 2019, received a delegation regarding fentanyl test strips and directed staff to investigate the feasibility of providing fentanyl test kits to people who use drugs in the City of Hamilton, to ensure safe consumption, with a report back to a future Board of Health meeting.

INFORMATION

Problematic substance use continues to be an area of significant public health concern within Hamilton. The opioid-related death rate in Hamilton has been consistently higher than the provincial rate and in 2018, there were 103 confirmed opioid-related deaths in Hamilton. There are an additional 19 probable deaths that are still under investigation by the Coroner's Office. In 2019, the trend continues upward as paramedic calls for opioid overdoses continue to rise throughout the city. May 2019 saw the highest number of calls per month, to-date, with 84 calls for opioid overdoses. To date, 2019 has seen three months of at least 80 calls for opioid overdoses (February, March and May). To compare, the previous highest was 75 calls, which occurred in September 2017. Overall, 2019 data shows a significant increase from an average of 38 calls per month in 2018, to 73 calls per month (as of the end of May 2019).

Addressing the complex issue of problematic substance use requires a comprehensive four pillar approach, with a focus on prevention, harm reduction, treatment and social justice (enforcement). This approach is being used by the Hamilton Drug Strategy, a city-wide collaborative to address the harms associated with substance use.

Background on Drug Checking

An emerging harm reduction intervention is providing people who use drugs (PWUD) with the opportunity to check their substance for content before use. While a relatively new intervention in Canada, drug checking services have been used in some areas in Europe since 1992.[1] In 2016, when it released recommendations on how to address the opioid crisis within Canada, the federal government included one recommendation for the Government of Canada to grant exemptions under the *Controlled Drugs and Substance Act* for the purpose of drug checking at supervised consumption sites as a harm reduction intervention.

Drug checking allows for analysis of the composition of the substance, indicating whether or not fentanyl is present in the substance. This provides the user with information they can consider in their decision of whether to alter their intent to use the substance, in order to prevent adverse impact. In addition, this intervention may assist with learning further information about a current drug supply that is circulating within a community when increases in adverse events are seen within a population. In Ontario, the Province currently only funds drug checking using test strips at Consumption and Treatment Services (CTS) sites. Testing is provided in conjunction with counselling with a harm reduction worker, who can provide information on drug use and overdose prevention.[1]

Research evidence on drug testing as an intervention is emerging, as its uptake has increased across Canada and throughout Europe. Studies completed to date on the use of drug checking strips do not indicate that individuals using these tests change their behaviour as a result (e.g. choose to not use the substance or use less substance as a harm reduction strategy). The findings of an evaluation done by InSite, a supervised consumption site in Vancouver, show that a small number of clients chose to discard their drug based upon the results of the drug checking. However, any findings on additional harm reduction interventions (e.g. using less drug) because of the drug checking were not reported.[1]

Commercially available drug checking strips can be used with minimal training and are suitable for use in a community setting as they provide quick and actionable results. Advantages of drug checking are that it provides a tool for engagement and harm reduction education for individuals using substances on ways to decrease harms associated with substance use. However, there are limitations, as testing strips only detect a limited number of chemicals. Fentanyl analogues are not always included in these tests and can be difficult to detect.[2] Drug checking strips also only provide an

indication of whether a chemical (fentanyl) is present, not the concentration, which makes it difficult to understand the overall composition and effects of the drug.

Feasibility of Drug Checking

Within Ontario, fentanyl testing kits from the company BTNX were provided to interested Overdose Prevention Sites (OPS) as requested by the Ministry of Health & Long-Term Care (MOHLTC) for drug checking purposes.[3] Within Ontario, the OPS model has been replaced by CTS sites. Fentanyl test strips were and continue to be provided free of charge to interested OPS and now CTS sites via the MOHLTC. Testing strips provided by the MOHLTC are for on-site use, and not for community distribution.

Local Implementation of Drug Checking

Hamilton currently has one OPS transitioning to a CTS site at Hamilton Urban Core Community Health Centre (HUCCHC). While operating as an OPS, HUCCHC did not choose to offer drug checking services on-site. At present there continues to be no plan to offer drug checking strips at this site.

Public Health Services (PHS) is currently completing an application for a CTS site. The range of services offered by PHS at a potential CTS site would be discussed with the MOHLTC during the application process. The provision of drug checking services will be considered through this process.

Further implementation of drug checking services in other harm reduction services provided by PHS is not recommended at this time. Limitations on the accuracy of the drug checking and the impact on substance use does not support implementation of such a service. PHS currently provides harm reduction services through a mobile service, the Van, and it is not feasible for clients to bring their supply to a mobile service such as this. Continued focus of the harm reduction program will be on careful use of substances including not using substances alone, using substances at a CTS site, having naloxone on hand, and using a small amount of substances to prevent overdose. PHS will explore any opportunities that exist for drug checking as a surveillance measure of the local drug supply.

In summary, drug checking is a promising harm reduction intervention that is being implemented in some jurisdictions across Ontario. Drug checking provides further opportunity for engagement at CTS sites with harm reduction workers on safer use of substances. However, current testing strips are unable to detect concentrations and potency of drugs and are often unable to test for all chemicals included in the drug. Further exploration on drug checking to inform surveillance of the local drug supply and provision at a CTS site operated by PHS will continue to be explored.

References

1. Public Health Ontario (2017). Evidence Brief: Drug checking services as a harm reduction intervention.

2. McGowan, C., Harris, M, Platt, L., Hope, V. & Rhodes, T. (2016). Fentanyl self-testing outside supervised injection settings to prevent opioid overdose: do we know enough to promote it? International Journal of Drug Policy, 58, 31-36.

3. Ontario Harm Reduction Network. (2019). The Outreach Network Symposium: Drug Checking Discussion. February 2019.

APPENDICES AND SCHEDULES ATTACHED

Not Applicable.

CITY OF HAMILTON
PUBLIC HEALTH SERVICES
Healthy Families Division

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	July 10, 2019
SUBJECT/REPORT NO:	Seniors Oral Health (BOH19026) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Pat Armstrong (905) 546-2424 Ext. 7158
SUBMITTED BY: **SIGNATURE:**	Jennifer Vickers-Manzin, CNO Director, Healthy Environments Division Public Health Services

RECOMMENDATION(S)

That the Board of Health authorize and direct the Medical Officer of Health to receive, utilize and submit reports back on the funding from the Ministry of Health and Long-Term Care to support the delivery of a dental program for low-income seniors, and that staff report back to the Board of Health by end of Q3 2019 on the development of the program locally.

EXECUTIVE SUMMARY

Oral health impacts overall health and wellbeing. Population health and program data show that poor oral health is common in Hamilton and unequally affects the city's most vulnerable populations. Within our vulnerable populations, seniors experience significant challenges accessing dental care due to low dental insurance coverage and low percentage who visit the dentist regularly.

Many Hamilton seniors who need dental care do not have dental insurance coverage and cannot afford to pay out-of-pocket. As a result, seniors are increasingly seeking dental care from hospital emergency departments rather than seeking treatment early and regularly.

As recently announced in Ontario's 2019 budget, the Ministry of Health and Long-Term Care (MOHLTC) recognizes the importance of the public health sector's role in supporting and addressing the needs of vulnerable populations to help prevent disease, complications and hospitalizations. The goal is that the Ontario Seniors Dental Care Program will help reduce unnecessary trips to the hospital, prevent chronic disease and increase quality of life for seniors.

Public Health Units (PHUs) will be the entities receiving operating base funding from the MOHLTC to implement the program in their local jurisdiction.

Hamilton Public Health Services (PHS) will receive up to $2,248,100 in additional base funding to support a new dental program for low-income seniors (Appendix "A" to BOH19026). This program is being funded at 100% provincial funding (i.e. not cost-shared with municipalities).

As a funding requirement, the Board of Health must enter into discussion with all local Community Health Centers (CHCs) and Aboriginal Health Access Centers (AHACs) to ascertain the feasibility of a service delivery partnership.

Forthcoming amendments to the Ontario Public Health Standards (OPHS) and related protocols from the MOHLTC will outline PHU requirements and operational roles and responsibilities (e.g. service delivery; oral health navigation; data collection and analysis; and reporting). Eligibility criteria, the application process, enrolment and the service schedule will also be available.

The Ministry has advised that the program will have a staged implementation. The first phase is to begin late summer 2019 and will include leveraging existing infrastructure to provide dental care to eligible low-income seniors at PHUs, CHCs, and AHACs.

The second phase will be implemented this coming Winter (2019). The Program will be expanded by investing in new dental services in underserviced areas, including through mobile dental buses and an increased number of dental suites in PHUs.

Staff will report back to the Board of Health by end of Q3 2019 on the development of the Seniors Dental Care Program locally, following consultation with CHCs and AHACs, and clearer direction from the Ministry.

Alternatives for Consideration – Not Applicable.

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: Up to $2,248,100 in additional base funding from the MOHLTC to support the new dental program for low-income seniors.

Staffing: Dental program staffing will increase based on the model of care and hours of operations that are developed to support the new low-income seniors program in the downtown dental clinic and dental health bus.

Legal: All partnerships must be governed by a Service Level Agreement (SLA) between the Board of Health (BOH) and CHC or AHAC, outlining performance expectations, funding and reporting requirements, and accountability mechanisms. SLAs will be developed once PHS has ascertained the feasibility of a service delivery partnership with local CHCs and AHACs.

It is anticipated that the Public Health Funding and Accountability Agreement will be updated to reflect amendments to the Ontario Public Health Standards (OPHS) and related protocols that will outline PHU requirements and operational roles and responsibilities.

HISTORICAL BACKGROUND

Currently, the City of Hamilton provides dental services to low-income seniors through the Public Health Dental Clinic and the dental health bus for those unable to access financial support for dental care. Additionally, City of Hamilton residents who require dental care can apply for funding for treatment through Ontario Work's Special Support Program. In 2018, staff collaborated with Hamilton Community Foundation (HCF) to develop and implement Oral Health Enhancements including enhancing supplemental denture coverage for eligible low-income seniors.

Staff will report back on the implications for these programs once we have further details from the MOHLTC.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

Forthcoming amendments to the Ontario Public Health Standards (OPHS) and related protocols from the MOHLTC will outline PHU requirements and operational roles and responsibilities (e.g. service delivery; oral health navigation; data collection and analysis; and reporting).

RELEVANT CONSULTATION

PHS is currently consulting with relevant internal programs, CHCs, and AHACs in Hamilton. After engagement internally and with community groups, and collective planning concludes, PHS will report back to the Board of Health by the end of Q3 2019 on the local development of the Seniors' Oral Health Program.

ANALYSIS AND RATIONALE FOR RECOMMENDATION(S)

Oral health is linked to overall health and is an important health issue for seniors. As people age, their oral health may become worse due to medications, medical conditions as well as limited mobility issues that make good oral hygiene difficult to maintain. In addition, seniors may face further barriers to accessing dental care due to cost, limited physical and cognitive abilities and transportation.

Many Hamiltonian seniors who need dental care do not have dental insurance coverage and cannot afford to pay out-of-pocket. As a result, seniors are increasingly seeking dental care from hospital emergency departments rather than seeking treatment early and regularly (Appendix "B" to BOH19026). Untreated health issues, such as infection, pain and abscesses, can lead to chronic disease and lower quality of life.

The senior population in Hamilton is projected to increase by 71,500 by the year 2039. In 2018 there were 102,500 seniors living in Hamilton, and 60% of seniors do not have dental insurance coverage. Moreover, there has been a steady increase in seniors visiting local emergency departments for dental care with double the number of visits from seniors living in low-income areas compared to those living in high-income areas (Appendix "B" to BOH19026).

In 2018, the dental clinic and dental health bus provided 1014 appointments for 490 seniors. The dental health bus turned away 587 clients of all ages. It is anticipated that with population growth there will be an increase in demand for services over the next 20 years.

With the April 2019 provincial budget, the MOHLTC recently announced a new publicly-funded dental care program for low-income seniors that will begin in late summer 2019. The Ministry has issued operational funding letters listing allocations to support program planning and development. There is a commitment of an annual investment of up to $2,248,100.00 in 100% provincial dollars for a new Ontario Seniors' Oral Health Program in the City of Hamilton.

As a funding requirement, the Board of Health must enter into discussion with all local CHCs and AHACs to ascertain the feasibility of a service delivery partnership.

Income eligibility for single seniors is $19,300 and for a couple less than $32,300. Population data indicates that there are 10,230 seniors in Hamilton who may be eligible for this program. The Ministry is utilizing an expert panel to finalize its schedule of services.

The program will be accessed by an application process through the Ministry like the Healthy Smiles Ontario Program. The program will provide direct dental preventive and treatment services to eligible seniors through Public Health Clinics, CHCs and AHACs.

The Ministry has indicated that implementation will be staged. The first phase is to be implemented by late summer 2019 and will deliver dental services to low-income seniors by leveraging existing infrastructure. The second phase is to be implemented by Winter 2019 and will expand the program by investing in new dental infrastructure.

Staff will report back to the Board of Health by end of Q3 2019 on the development of the Seniors Dental Care Program locally, following consultation with CHCs and AHACs, and clearer direction from the Ministry.

ALTERNATIVES FOR CONSIDERATION

Not Applicable.

ALIGNMENT TO THE 2016 – 2025 STRATEGIC PLAN

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

APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report BOH19026:	City of Hamilton, Public Health Services: 2019-20 Funding for the New Dental Program for Low-income Seniors
Appendix “B” to Report BOH19026:	Hamilton Seniors Oral Health Report 2018-2019

Ministry of Health and Long-Term Care

Office of the Deputy Premier and Minister of Health and Long-Term Care

777 Bay Street, 5th Floor
Toronto ON M7A 1N3
Telephone: 416 327-4300
Facsimile: 416 326-1571
https://www.ontario.ca/health

Ministère de la Santé et des Soins de longue durée

Bureau du vice-premier ministre et du ministre de la Santé et des Soins de longue durée

777, rue Bay, 5e étage
Toronto ON M7A 1N3
Téléphone : 416 327-4300
Télécopieur : 416 326-1571
https://www.ontario.ca/sante

Ontario

JUN 0 7 2019

Mayor Fred Eisenberger
Chair, Board of Health
City of Hamilton, Public Health Services
71 Main Street West, 2nd Floor
Hamilton ON L8P 4Y5

Dear Mayor Eisenberger:

I am pleased to advise you that the Ministry of Health and Long-Term Care will provide the Board of Health for the City of Hamilton, Public Health Services up to $2,248,100 in additional base funding for the 2019-20 funding year to support the new dental program for low income seniors. This program aims to prevent chronic disease, reduce infections and improve quality of life, while reducing burden on the health care system.

Dr. David Williams, Chief Medical Officer of Health, will write to the City of Hamilton, Public Health Services shortly concerning the terms and conditions governing this funding.

A dental program for low-income seniors is a key example of the public health sector's important role in supporting and addressing the needs of vulnerable populations to help prevent disease, complications and hospitalizations.

We will be working closely with our key delivery partners in the public health sector over the coming weeks and months ahead to support implementation of this program.

Thank you for your dedication and commitment to public health in this province.

Sincerely,

Christine J. Elliott

Christine Elliott
Deputy Premier and Minister of Health and Long-Term Care

c: Dr. Elizabeth Richardson, Medical Officer of Health, City of Hamilton, Public Health

SENIOR'S ORAL HEALTH 2018-2019

Hamilton

Seniors (age 65+) in Hamilton [1-4]

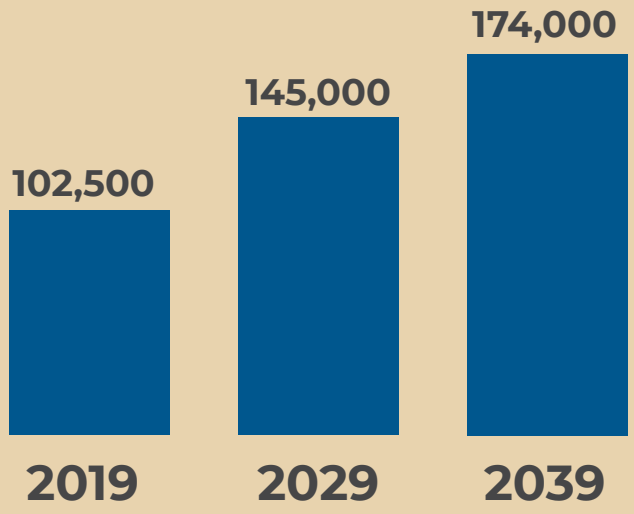
Hamilton's senior population is growing quickly, but many seniors do not have dental insurance coverage. Income status is a major determinant of oral health and seniors with lower income are more likely to have unmet dental care needs.

102,500 Number of seniors living in Hamilton

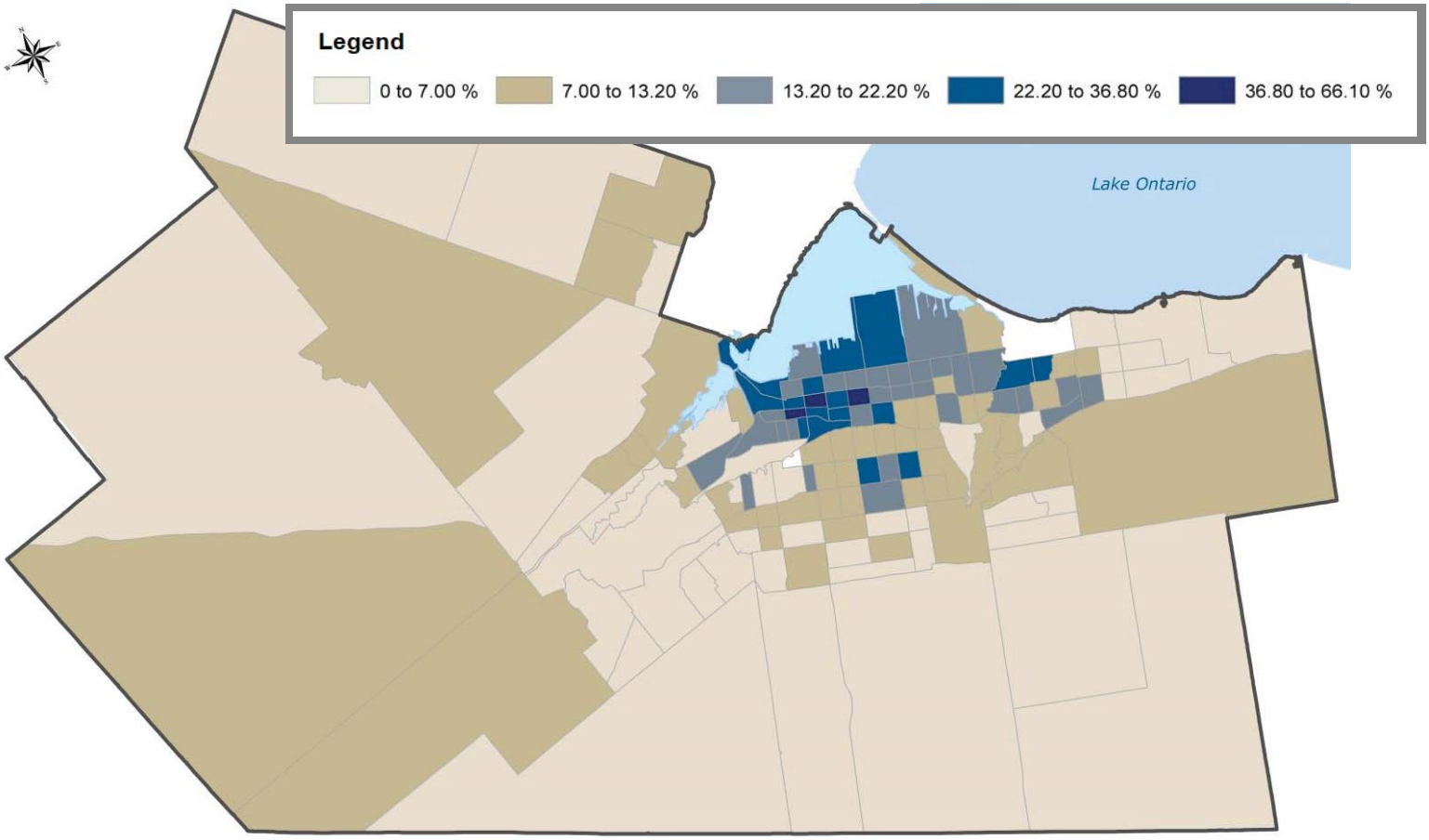
61,000 Estimated number of seniors with no dental insurance in Hamilton

10,230 Estimated number of seniors eligible for low income dental coverage in Hamilton

Projected growth of senior population in the City of Hamilton (2019-2039)



Percentage (%) of seniors living in low income households, City of Hamilton (2016)



Oral Health Status of Hamilton Seniors [4]

Poor oral health is linked to:

Psycho-social well-being

Heart disease

Respiratory disease

Malnutrition

Oral health is vital to overall health and well-being. Hamilton seniors commonly report experiencing oral pain or discomfort. Many skip routine visits to the dentist due to perceptions regarding need (e.g., not needed if wearing dentures) and the out-of-pocket cost (lack of insurance).

In Hamilton...

74% of people with very good or excellent oral health say they have very good or excellent mental health

In comparison, only...

43% of people with fair or poor oral health say they have very good or excellent mental health

47% Hamilton seniors wear partial or full dentures.

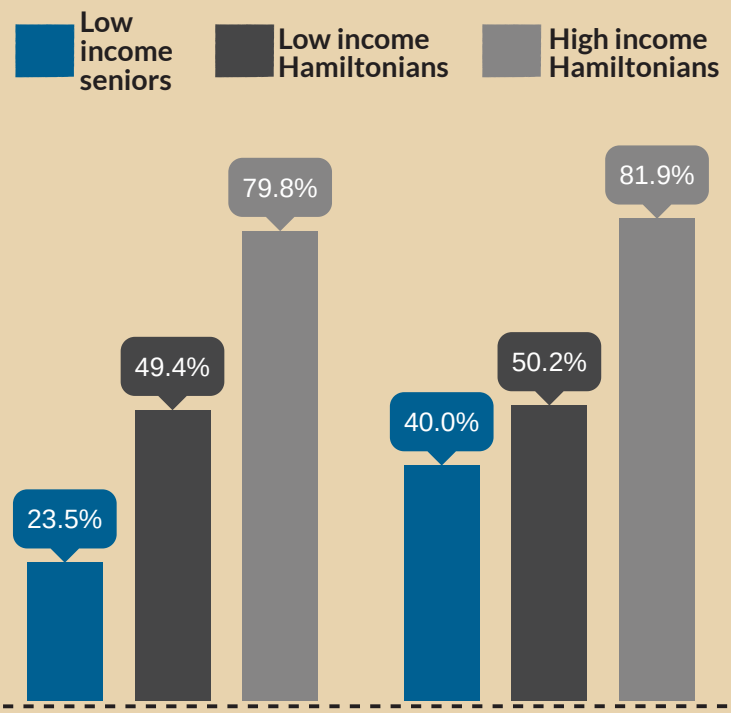
39% Hamilton seniors experienced oral/facial pain or discomfort in the past year.

34% Hamilton seniors with partial or full dental insurance coverage.

57% Hamilton seniors who make routine dentist visits (at least annually).

Access to Dental Care among Seniors in Hamilton [4-5]

Who has the poorest access to dental care?



Seniors accessing the City of Hamilton's dental services

Year	Dental Clinic Appointments (Clients)	Dental Health Bus Appointments (Clients)
2015	538 (154)	274 (n/a)
2016	709 (250)	299 (n/a)
2017	648 (258)	287 (206)
2018	681 (246)	333 (244)

The Hamilton Community Foundation has invested more than $150,000 over 3-years to supplement denture expenses for up to 325 low income seniors in Hamilton.

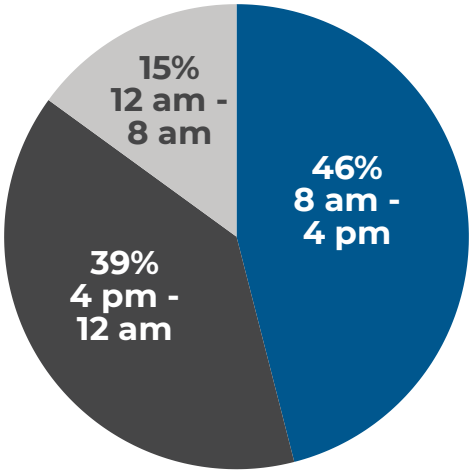
Emergency Dental Care among Seniors in Hamilton[6-7]

How many seniors are seeking dental care from local emergency departments?

Year	Number of Emergency Department Visits
2004	57 visits
2017	152 visits

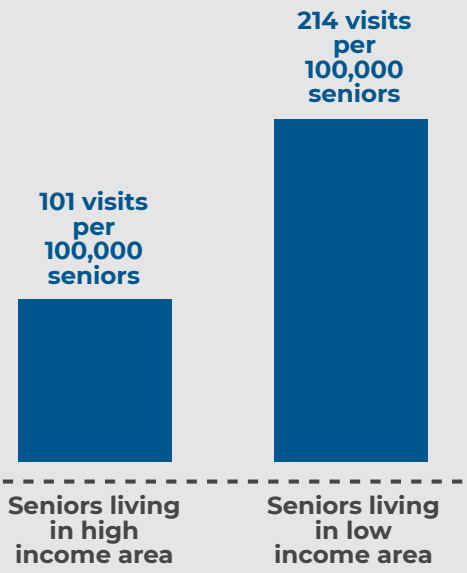
Hamilton seniors are increasingly seeking dental care from local hospital emergency departments. About 20% of this increase is explained by population growth, but most of the increase may be explained other factors.

When do people seek dental care from local emergency departments?



Mornings are the most common time when Hamilton seniors are seeking emergency dental care, with diminishing visits over the rest of the day. Saturday, Sunday, and Monday are the most popular days for dental-related emergency vists.

Which seniors are more likely to seek dental care from local emergency departments?



Seniors living in low income neighbourhoods in Hamilton are twice as likely to go to the emergency department for dental care. This is likely driven by very low rates of dental insurance coverage among low income seniors.

References

1. Ontario Ministry of Finance. Ontario Population Projections Update, 2017–2041. [June 25, 2018].
2. Statistics Canada. 2016 Census of Population.
3. Canadian Institute for Health Information. Ontario Drug Benefit Program. [June 10, 2019].
4. Statistics Canada. Canadian Community Health Survey, 2013-2014. Share File, Ontario MOHLTC.
5. City of Hamilton. Dental Program Administrative Data. [May 26, 2019].
6. Ambulatory Emergency External Cause 2004-2017, Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [May 13, 2019].
7. IDS: National Ambulatory Care Reporting System (NACRS).

Questions about the information in this report can be directed to epiandeval@hamilton.ca

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	July 10, 2019
SUBJECT/REPORT NO:	2018 Annual OPHS Report and Attestation to the Province (BOH19027) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Carolyn Hureau (905) 546-2424 Ext. 6004
SUBMITTED BY: **SIGNATURE:**	Dr. Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services

COUNCIL DIRECTION

Not Applicable.

INFORMATION

Background

As outlined in Report BOH17010(b), in addition to the new Ontario Public Health Standards (OPHS), the Ministry of Health and Long-Term Care (Ministry) has developed a Public Health Accountability Framework and organizational requirements to ensure boards of health have the necessary foundations in place to successfully carry out public health work and achieve population health outcomes. The Public Health Accountability Framework and organizational requirements are included within Chapter 3: Strengthened Accountability of the OPHS (Appendix “A” to Report BOH19027).

The Public Health Accountability Framework requires boards of health to provide a year-end summary to report on program achievements and finances, identify major changes in planned program activities, and demonstrate compliance with programmatic and financial requirements. A new template, the Annual OPHS Report and Attestation, was recently released by the Ministry. The Annual OPHS Report and Attestation

replaces program specific annual reports and the Program-Based Grants Annual Settlement that were previously submitted separately to the Ministry.

The new report is comprised of four sections, including:

- Narrative descriptions of the delivery of public health programs and services;
- Financial year-end actuals and annual report reconciliation;
- Program outcome indicator results; and,
- Attestation on each of the organizational requirements.

On June 28, 2019, the Annual OPHS Report and Attestation for 2018 was submitted to the Ministry under delegated authority by Council (Report FCS18009(a)). As per the Ministry's instructions, the submission also included audited financial statements and an Auditor's Attestation Report. The full 2018 Annual OPHS Report and Attestation is provided in Appendix "B" to Report BOH19027. Going forward, the expectation is that boards of health will submit an Annual OPHS Report and Attestation by April 30th of the following year.

As specified in the organizational requirements, boards of health are also required to publicly post an annual performance and financial report. This enables boards of health to demonstrate to the public how they are responding to local community needs, thereby increasing transparency and building trust and confidence among residents. Staff are currently preparing the 2018 Performance and Financial Report to the Community, which will come to the Board of Health and then be posted on the City of Hamilton website.

Organizational Requirements Compliance Assessment

As part of the 2018 Annual OPHS Report and Attestation, an assessment was conducted by staff to determine Hamilton Public Health Services' (PHS) compliance with the organizational requirements (Appendix "A" to Report BOH19027). Assessing compliance with these requirements allows boards of health to demonstrate accountability to the Ministry for the work they do, how they do it, and the results achieved. The organizational requirements fall within the four domains of:

1. Delivery of Programs and Services;
2. Fiduciary Requirements;
3. Good Governance and Management Practices; and,
4. Public Health Practice.

In 2018, Hamilton PHS implemented the action plans outlined in BOH17010(c) to further increase compliance with the organizational requirements. As a result, Hamilton PHS achieved full compliance with 54 out of the 57 organizational requirements. This demonstrates significant progress from 2017 where there were 17 areas of partial

compliance and 1 area of non-compliance. Action plans for the remaining 3 areas of partial compliance are outlined below.

Table 1: Action Plans for the Remaining Three Areas of Partial Compliance

Requirement	Action for Compliance
Human resource policies and procedures are regularly reviewed and revised, and include the date of the last review / revision.	Review and revision of these policies will be completed by Corporate Human Resources in accordance with their timelines.
Engage in relationships with Indigenous communities in a way that is meaningful for them.	PHS participated in the development of the City-led Hamilton Urban Indigenous Strategy in 2018. This Strategy will be used to guide meaningful engagement, a key component in shaping and developing the PHS Indigenous Health Strategy.
Ensure by-laws and policies and procedures are reviewed and revised at least every two years.	Department policies will be reviewed every two years and will be up to date by the end of 2019. Finance & Administration, Information Technology, and Human Resource policies will be reviewed by the respective departments in accordance with their timelines.

APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report BOH19027:	Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (Chapter 3)
Appendix “B” to Report BOH19027:	2018 Annual OPHS Report and Attestation

Ministry of Health and Long-Term Care

Protecting and Promoting the Health of Ontarians

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

The Ontario Public Health Standards: Requirements for Programs, Services, and Accountability are published as the 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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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.

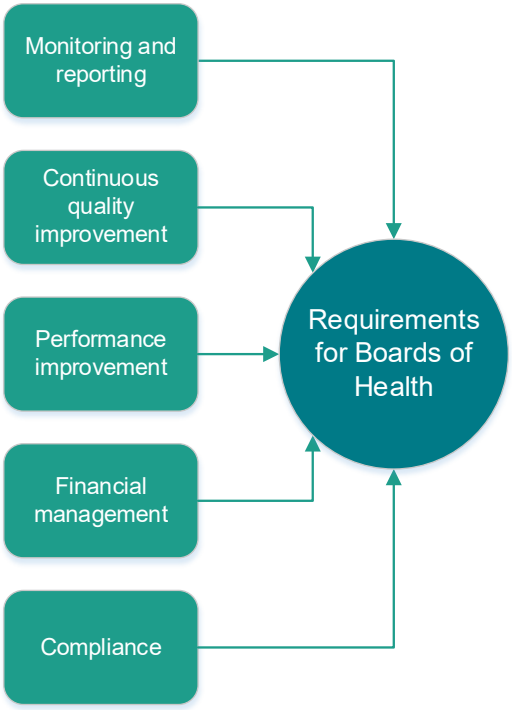
The Organizational Requirements specify the requirements where monitoring and/or reporting are required of boards of health to demonstrate accountability to the ministry. They are organized according to the following four domains of the accountability framework:

- 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.

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Ontario

Ministry of Health and Long-Term Care

2018 Annual Report and Attestation

(as of December 31, 2018)

To be completed by

Board of Health for the City of Hamilton, Public Health Services

2018 Annual Report and Attestation

Instructions

The Annual Report and Attestation, which replaces separate program specific annual reports and the Program-Based Grants Annual Settlement Report, is a new reporting tool that boards of health are required to submit annually as per the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (the "Standards") and Public Health Funding and Accountability Agreement (the "Accountability Agreement").

The Annual Report and Attestation requires boards of health to provide a year-end summary report on program achievements and finances, identify any major changes in planned program activities due to local events, and demonstrate compliance with programmatic and financial requirements.

As per the Accountability Agreement, the Ministry of Health and Long-Term Care (the "ministry") requires that the 2018 Annual Report and Attestation be completed and returned to the ministry on April 30, 2019. However, the due date for submitting the 2018 Annual Report and Attestation to the ministry has been **extended to June 28, 2019**.

The Annual Report and Attestation worksheets have been organized as follows:

1. Cover

This page has been customized to include the name of the board of health for which this report is to be completed.

2. Instructions

Provides an overview of the intent of the template and instructions on how to complete the worksheets.

Narrative Report Worksheets

Includes a set of worksheets to report on key achievements related to the delivery of public health programs and services. Yellow cells in the following two worksheets indicate where narrative input is required.

3.1 Narrative – Base

The purpose of this worksheet is for boards of health to describe key activities and program achievements for 2018 for specific Foundational Standards and Program Standards. Required narrative information will differ for each Standard included in this worksheet.

3.2 Narrative – One-Time

The purpose of this worksheet is for boards of health to describe the activities they undertook for one-time projects/initiatives funded by the ministry in 2018-19 and any outcomes achieved. This worksheet has been customized to include 2018-19 one-time projects/initiatives approved by the ministry for the board of health, and as listed in the board of health's most recent Schedule A of the Accountability Agreement. Boards of health are also required to confirm whether a project was completed or started, and if not, why it was not completed or started.

4. Financial Worksheets

Financial Year-End Actuals by Program

This section includes a set of worksheets that requires boards of health to provide financial year-end actuals for each program delivered by the board of health for the period of January 1, 2018 to December 31, 2018 and for each one-time project approved by the ministry for the 2017-18 and 2018-19 fiscal years. Expenditures and offset revenues reported in these worksheets should only reflect funding approved by the ministry as per the programs/sources of funding listed in Schedule A of the Accountability Agreement, and should not include any funding approved through separate processes/transfer payment agreements (e.g. Healthy Babies Healthy Children).

Please note that yellow cells in the financial worksheets indicate where data input is required by the board of health.

4.1 Base Funding

The purpose of this worksheet is for boards of health to report financial year-end actuals at 100% (both provincial and municipal portions) for each program delivered by the board of health under the Foundational and Program Standards, as well as indirect administrative costs, for the period of January 1, 2018 to December 31, 2018. This worksheet has been customized to include program names submitted by boards of health in their 2018 Annual Service Plan and Budget Submissions and reported expenditures in their 2018 4th quarter Standards Activity Reports.

Similar to the 2018 Annual Service Plan and Budget Submissions, boards of health are required to report the financial data within specified expenditure categories – salaries and wages, benefits, travel, professional services, expenditure recoveries and offset revenues, other program expenditures, and any inadmissible adjustments (specifically capital fund reserves, depreciation of capital assets/amortization, and sick time and vacation accruals). Variances are calculated against reported expenditures from the 2018 Q4 Standards Activity Reports submitted by boards of health.

2018 Annual Report and Attestation

Instructions

For the purposes of the 2018 annual reconciliation process, boards of health must report financial year-end actuals related to the Medical Officer of Health (MOH) / Associate Medical Officer of Health (AMOH) Compensation Initiative in the Indirect Costs section of this worksheet. Expenditures related to salaries, benefits and other program expenditures (eligible stipends funded by the ministry under the initiative) are **not** to include any portion of the cost-shared base salaries/benefits for the MOH and AMOH positions and should only reflect the 2018 "top-up"/eligible funding approved for the board of health by the ministry.

Data entered in this worksheet will populate the Expenditures by Account and Offset Revenues worksheet ("4.4 Expend by Acct & Offset Rev") and the Annual Reconciliation by Sources of Funding worksheet ("4.6 AR by Sources of Funding").

4.2 One-Time Funding

The purpose of this worksheet is for boards of health to report financial year-end actuals for each one-time project approved by the ministry for the 2017-18 (April 1, 2017 to March 31, 2018) and 2018-19 (April 1, 2018 to March 31, 2019) fiscal years, and within specified expenditure categories (see above, "4.1 Base Funding"). Variances are calculated against reported expenditures from the 2018 4th quarter Standards Activity Report for the 2018-19 one-time funding.

2018-19 one-time projects/initiatives **will not** be settled as part of the 2018 annual reconciliation process; however, expenses incurred from April 1, 2018 to December 31, 2018 must be reported in this worksheet.

Boards of health must also report actual expenditures for one-time projects/initiatives approved for the 2017-18 fiscal year in this worksheet. 2017-18 funding for these projects will be settled as part of the 2018 annual reconciliation process.

Data entered in this worksheet will populate the Expenditures by Account and Offset Revenues worksheet ("4.4 Expend by Acct & Offset Rev") and the Annual Reconciliation by Sources of Funding worksheet ("4.6 AR by Sources of Funding").

4.3 Variance Explanation

Similar to the quarterly Standards Activity Reports, boards of health are required to provide an explanation for variances greater than 3% (negative or positive) in this worksheet.

Annual Reconciliation Report

This section refers to worksheets 4.4 (Expend by Acct & Offset Rev), 4.5 (Funding from Ministry), and 4.6 (AR by Sources of Funding).

The purpose of this section is to reconcile the expenditures incurred by the board of health for the period of January 1, 2018 to December 31, 2018 and for each one-time project approved by the ministry for the 2017-18 and 2018-19 funding years against the funding received from the ministry for the same periods.

Expenditures are populated from the base funding and one-time funding worksheets and funding received from the ministry is to be entered in worksheet "4.5 Funding from Ministry". Boards of health are also required to provide details about the expenditure recoveries and offset revenues for mandatory programs (cost-shared) and other sources of funding in worksheet "4.4 Expend by Acct & Offset Rev".

4.4 Expend by Acct & Offset Rev

Actual Expenditures by Account
This table summarizes the total base and one-time financial year-end actuals by expenditure account/category. Total expenditures in this table must align with the board of health's Audited Financial Statements.

There is no data entry required in this table. It has been populated with data entered in the previous base and one-time worksheets.

Expenditure Recoveries & Offset Revenues Reconciliation
Boards of health are required to enter the details of the total expenditure recoveries and offset revenues reported under the base funding and one-time funding worksheets. Totals calculated in this table have to match the information entered in the base funding and one-time funding worksheets.

4.5 Funding from Ministry

2018 Annual Report and Attestation

Instructions

This worksheet calculates the funding the board of health received from the ministry for ministry funded public health programs/ sources of funding. The funding calculated in this worksheet will populate the funding received from the ministry column in the Annual Reconciliation by Sources of Funding worksheet ("4.6 AR by Sources of Funding").

Funding adjustments processed between January 1, 2018 and March 31, 2018, which pertain to the 2017 calendar year (e.g., cash flow adjustments related to the 4th quarter financial reporting), must be reported under the Prior Year Adjustments Processed in 2018 section (Column C). Clawbacks should be inputted as **positive** amounts and reflows should be inputted as **negative** amounts.

Funding adjustments processed between January 1, 2019 and March 31, 2019, which pertain to the 2018 calendar year (e.g., cash flow adjustments related to the 4th quarter financial reporting), must be reported under the 2018 Adjustments Processed in 2019 section (Column D). Clawbacks should be inputted as **negative** amounts and reflows should be inputted as **positive** amounts.

Boards of health can find these funding details in the IFIS TPAS payment reports provided by the ministry, for the relevant time periods.

4.6 AR by Sources of Funding

This worksheet reconciles the financial year-end actuals by program/source of funding against the ministry's approval and funding received from the ministry, and calculates any amount due to (from) the ministry. Please note that any surplus related to 2018-19 one-time funding can be carried over to March 31, 2019.

Please note that the amount reflected as the “Approved Allocation” for the MOH/AMOH Compensation Initiative is based on 2018 eligible funding/cash flow for the purposes of calculating any potential variance for the period of January 1, 2018 to December 31, 2018.

There is no data entry required in this worksheet. It has been populated with data entered in the previous base and one-time worksheets.
Along with the financial worksheets included in the Annual Report and Attestation, boards of health are also required to submit the following **by June 28, 2019**:

- *Audited Financial Statements* that have been audited by a licensed public accountant and include a Statement of Financial Position (Balance Sheet), a Statement of Revenues and Expenditures (Statement of Operations), and an Auditor's Report. The Audited Financial Statements must align with the reported total expenditures in the Annual Reconciliation Report worksheets.
- *Auditor's Attestation Report* signed by their auditor(s) in the prescribed format with all sections included. The auditor(s) is only required to audit the Annual Reconciliation Report worksheets 4.4 (Expend by Acct & Offset Rev), 4.5 (Funding from Ministry), and 4.6 (AR by Sources of Funding) in the Annual Report and Attestation. Boards of health must ensure that this requirement is met.

5. Program Outcome Indicators

The purpose of this worksheet is for boards of health to report on the program outcome and locally developed indicators as outlined in the accompanying Program Outcome Indicators Reporting Instructions. Program outcome indicators included in the Annual Report and Attestation are provincially defined indicators to help monitor success of program outcomes as referenced in the Ontario Public Health Standards, while locally developed indicators refer to measures used at the local level to help monitor success of programs that vary across boards of health due to differences in population needs.

6. Board of Health Attestation

The purpose of this worksheet is for boards of health to complete a certificate of attestation to demonstrate compliance with the organizational requirements outlined in the Standards, as well as some program specific requirements. The worksheet is organized according to each Domain of the Organizational Requirements in the Standards.

To complete these worksheets, review each attestation question/item (Column A) to assess whether the board of health has fully met a requirement and select one of the following responses (Column B) from a drop-down list as follows: "Yes" – indicates that the board of health has fully met this requirement; "No" – indicates that the board of health has not fully met this requirement; and, "Not Applicable" (N/A) – this requirement does not apply to the board of health.

If the response is "Yes", the board of health is **not** required to provide further explanation, and can proceed to the next attestation question/item.

If the response is “No”, the board of health is required to provide a high level explanation (Column C) describing the circumstances under which the requirement(s) was not fully met and any impacts, and what actions the board of health has undertaken or will undertake to fully meet the requirement, including timelines for meeting the requirement (Column D).

If the response is “N/A”, the board of health is required to provide a high level explanation (Column C) describing why the item is not applicable to the board of health.

7. Certification by the Board of Health

This worksheet provides certification of the submission by the Chair of the Board of Health, Medical Officer of Health/Chief Executive Officer, and the Chief Financial Officer/Business Administrator.

Board of Health for the City of Hamilton, Public Health Services

2018 Annual Report and Attestation

Narrative - Base Funding
(for the period of January 1, 2018 to December 31, 2018)

Foundational Standards

Population Health Assessment Foundational Standard

1. Describe the engagement mechanism that existed between the board of health medical officer of health (MOH) and the Local Health Integration Network (LHIN) Chief Executive Officer (CEO), and planning activities to support this engagement.

There was a LHIN / PHS Steering Committee that met on a regular basis. This committee had formal terms of reference and strategic areas of focus for the coming year. The goal of this committee was to capitalize on the range of skills, roles, mandates and relationships of the respective agencies to improve population health.

In addition, the MOH and LHIN CEO both sat on the Hamilton Sub-Region Anchor Table (formerly known as the Hamilton Community Health Workgroup). They brought health status and health equity information to the group and shared in collaborative planning. Hamilton PHS also supported system planning through the Data Integration Sub-group that in 2018 focused on chronic obstructive pulmonary disease. Other working groups, including Mental Health & Addictions and Vanier Towers, were also struck as a result of the Hamilton Sub-Region Anchor Table collaboration, and PHS staff brought population health assessment and content expertise to these groups.

2. Describe how the board of health was consulted on the LHINs' 2018-19 Integrated Health Service Plan.

The LHIN CEO shared the 2018-2019 Integrated Health Service Plan for comments. Feedback was discussed and addressed at one of the LHIN / PHS Steering Committee meetings.

3. Describe how population health assessments were used to influence program planning in order to meet the needs of priority populations.

Population Health Assessment & Surveillance (PHAS) Strategy
A focus area for 2018 was the implementation of the PHAS Strategy. The objectives of this Strategy were to:
1. Better understand the health of Hamiltonians;
2. Share intelligence with community and system partners; and,
3. Ensure focused investment by facilitating the use of intelligence to inform action.

Health Check
The Health Check project was conducted to measure and prioritize the burden of health outcomes as well as risk factors, the drivers of disease, in the City of Hamilton. This assessment has been used to inform priority setting exercises and provide local context as a component of evidence-informed decision making. For example, in 2018, the Health Check project helped to inform program reviews related to three priority areas, including: Health Equity; Healthy Weights; and, Mental Health and Addictions.

Child & Youth Health Atlas
The Child & Youth Health Atlas was developed to identify, measure, track, prioritize, and take action on health issues affecting children and youth in Hamilton. The Atlas provides an overview of the health and well-being of the school-age population using key indicators such as social determinants of health (e.g., employment, income, education), mental health, oral health, sexual health, visual health, immunization, early childhood development, and health behaviours, such as healthy eating and physical activity. Over the past year, the Atlas was used by Hamilton Public Health and school board partners to develop shared priorities and actions to achieve a collective impact.

4. Describe how the board of health monitored food affordability.

Hamilton PHS has continued to monitor food affordability using the Nutritious Food Basket survey. In 2018, food pricing was conducted in seven grocery stores by Registered Dietitians. Food affordability analysis was carried out using the Income Scenarios Spreadsheet and Backgrounder developed by Ontario Dietitians in Public Health. Results of the food affordability analysis were made available to the public and shared with relevant community partners and stakeholders.

Health Equity Foundational Standard

1. Describe the engagement mechanisms that existed between the board of health, the LHIN(s), municipalities, and other relevant stakeholders working with Indigenous communities to decrease health inequities.

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Hamilton PHS engaged with the Hamilton Executive Directors Aboriginal Coalition (HEDAC) and the Hamilton Urban Indigenous Strategy leaders to identify opportunities for partnership and collaboration to advance goals of Truth and Reconciliation and Indigenous health equity.

The focus of the City-led Hamilton Urban Indigenous Strategy in 2018 was to "cultivate the strategy". This involved engaging Indigenous and non-Indigenous residents in a variety of ways about the needs and priorities for the strategy. PHS participated on the Internal Staff Circle on Indigenous Relations. This workgroup was established to champion relationship building, share information and best practices, and identify opportunities for improved engagement with Indigenous peoples. Together, the workgroup:

- Developed a plan for the Cultural Competency Training for the City of Hamilton workforce; and,
- Recommended City initiatives that would meet community needs identified through several engagement activities.

In 2018, PHS decided to recruit for an Indigenous Health Strategy Specialist to lead the development of a strategy that addresses Indigenous health issues in Hamilton. The successful candidate will lead consultation and engagement with Indigenous and non-Indigenous community partners to identify existing health issues / gaps and actions to address them.

2. Describe how health equity strategies and approaches were embedded into programs and services to reduce health inequities in the following areas:

- 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
- Substance Use and Injury Prevention

In 2018, Hamilton PHS continued to apply a health equity approach and sought out opportunities to address population diversity. An example of this was the Families First Pilot. This program offered integrated support between home visiting, child care, Ontario Works, employment services, and recreation in order to reduce barriers and empower lone parents to meet their basic needs, improve health, and increase economic stability.

PHS also engaged with community stakeholders on a number of initiatives in order to develop and implement action strategies that addressed health inequities.

- **Vanier Towers** – Results from a population health assessment showed that this community was unfairly burdened by significant social disparities that contributed to negative health outcomes. As a result, partners from multiple sectors (including Primary Care, Emergency Medical Services, City Housing Hamilton and other service providers) collaborated to implement a community-integrated service model that offered free access to over 20 on-site services to support residents and improve their overall health and well-being.
- **Transgender Coalition** – Through participation in the Hamilton Transgender Health Coalition, PHS worked with community partners to advocate for increased access to health services to address unique healthcare needs.
- **Financial Empowerment Initiative** – In partnership with the United Way and the Social Planning and Research Council, PHS supported tax filing clinics that targeted individuals who had lapses in or had never filed federal income tax returns.
- **Indigenous strategy** – please see narrative for Indigenous engagement.

Several interventions within PHS use a proportionate universalism approach that balance targeted and universal population perspectives. Please see the School Health narrative for an example.

A standardized method for identifying health inequities, priority populations and local public health priorities was also developed. This included the development of a new tool, ***Equity Counts*** , to facilitate the prioritization process using population health assessment. In 2019, each program will identify priority populations using this standardized method.

3. Confirm the number of staff at the board of health that completed Indigenous cultural competency training.

Three staff members have completed the formal Indigenous Cultural Competency Training (ICCT).
In 2018, the focus was to develop an ICCT module for staff that would increase knowledge of the customs and traditions of Indigenous communities. To ensure the training was evidence-based, a review of best practices was conducted including curriculum content, effective learning spaces, training methods, etc. The ICCT will be made available to staff in 2019.

Effective Public Health Practice

1. Describe how evaluation and research activities were embedded into board of health processes to inform improved outcomes and evidence-informed decision making.

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Narrative - Base Funding
(for the period of January 1, 2018 to December 31, 2018)

In 2018, several research and evaluation activities were conducted to inform decision making and improve outcomes for Hamiltonians.

Opioid Early Warning Qualitative Survey and Stakeholder Situation Pilot

As a result of this pilot evaluation project, the decision was made to continue the weekly enhanced opioid early warning data collection and reporting. This included expanding the invitation to new stakeholders to encourage participation. Results from this evaluation also helped to identify new preferred communication formats (e.g. newsletter). As a result, our current enhanced opioid surveillance system includes both quantitative and qualitative information reported directly from frontline community service providers, allowing public health planners to better identify current local opioid-related trends and implement timely public health response.

Farm to Cafeteria Evaluation

The objective of the Farm to Cafeteria evaluation was to measure the impact of implementing a salad bar on students' fruit and vegetable consumption. By understanding the current eating behaviours of students, Public Health Nurses are able to collaborate with Hamilton school boards and develop a targeted health promotion campaign to encourage salad bar use and consumption of local fruits and vegetables.

Result-Based Accountability (RBA)

In 2018, all PHS program areas used the RBA framework for program planning and evidence-informed decision making. In addition, the RBA framework was used to guide the work related to three priority areas: 1) mental health and addictions; 2) healthy weights; and 3) health equity. This involved identifying strategic goals, population indicators, performance measures, and identifying evidence-informed interventions. To build capacity within PHS, the Epidemiology & Evaluation Team also conducted several RBA workshops for various program areas.

Emergency Management Foundational Standard

Emergency Management Planning Activities

1. Provide a short description of emergency management integrated* planning activities conducted this year, including key community stakeholders and levels of government engaged, processes in place for recovering public health services identified as time-critical (similar to those identified in the Continuity of Operations Plans), key responses you coordinated, and changes implemented to your emergency management planning, practice and plans that resulted from recommendations included in your debriefs and/or after action reports. *(*Developed in collaboration with community stakeholders, other levels of government and other health system partners)*

Hamilton PHS worked closely with the City's Emergency Management Coordinators (CEMC), first responders and other community partners throughout the year to increase the overall preparedness in the community. Two of these initiatives included emergency exercises: a cyber security incident and vehicle ramming. The exercises resulted in several corrective actions that were implemented by applicable program areas. Staff also worked with the CEMCs to develop and complete a Business Impact Analysis for various service profiles in the City including infectious diseases and healthy environments.

Inclement Weather Plans were utilized in the winter months during a City-wide closure to ensure all critical public health services continued without interruption. This was the first closure in several years and was a great test of the plan. Lessons learned from the closure were used to further improve and update the plans.

PHS continued integral drug strategy development, building on previous opioid response work with local government, health system partners and community organizations. Staff provided expertise to support this ongoing work by coordinating the response and providing detailed surveillance data to inform planning and response actions.

Health Assessment, Awareness, and Surveillance Activities

2. Provide a short description of activities/processes the board of health conducted to (1) identify public health risks, hazards and impacts; potential disruptions to public health service delivery; and, threats to continuity of operations; and, (2) provide a public health perspective to other hazard awareness and risk assessment processes conducted in your area/region.

(1) Hamilton PHS constantly monitors for public health hazards and keeps community partners and the public informed of risks. Many reports were generated and communicated to local health system partners on a regular basis including: daily and monthly surveillance reports; outbreak bulletins; weekly cluster reports; and semi-annual performance monitoring reports. In addition to these scheduled reports, community partners were alerted about emerging risks or issues through medical advisories using the mass notification system (ERMS). In 2018 medical advisories were sent for Listerioisis, Acute Flaccid Myelitis, Lyme disease, Cyclosporiasis and for several other potential threats. Risks to the public were communicated through media releases and through the City's social media accounts with additional communication as needed (e.g. media interviews). General awareness campaigns at the individual program level occurred on an ongoing basis to educate the public to various risks (e.g. radon, smoking, rabies, Lyme disease).

(2) Hamilton PHS staff provided a public health perspective to a variety of community hazard and risk assessment processes including:

- Distribution of heat and cold alerts with resource information;
- Cannabis and drug use reports;
- Ongoing opioid monitoring webpage;
- Hamilton's Airshed Modelling System;
- Annual review of the City's Hazard Identification and Risk Assessment; and,
- Infectious disease activity.

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Narrative - Base Funding
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Communication and Notification

3. Provide a short description of (1) 24/7 notification protocols available for communication with board of health staff, community partners, and governmental bodies, developed and maintained by the board of health, including main modes of contact available for the medical officer of health; and, (2) communication modes used to disseminate information regarding hazards to the board of health, staff and other relevant community partners (e.g., Emergency Management Communications Tool, social media, news, media).

An on-call schedule for after-hours calls to the City's Customer Contact Centre is maintained to ensure someone is always available to respond to an emergency. On-call staff have access to a call sheet with key after-hours contacts for other organizations they may need to liaise with including local response agencies (water treatment plan, first responders, hospitals, laboratories) as well as provincial government contacts (MOHLTC Population and Public Health Division, Spills Acton Centre, EMO Duty Officer). On-call staff also have access to the 24/7 notification procedure and contact information for the Public Health Emergency Control Group in the event an after-hours situation warrants activation of the Incident Management System.

During an emergency or emerging health threat, PHS leverages all available communication channels to reach impacted community members. These include the media, social media, City of Hamilton websites, existing program networks, the Emergency Management Communication Tool and the ERMS mass notification system to push out public health information. A public health inquiry line is also set up during emergencies to answer health related questions from the public as was done during IPAC lapse situations in 2018.

4. Does the board of health's 24/7 notification process include the availability of the medical officer of health?

The board of health has a 24/7 notification process set up to respond to threats to public health at all times. The Medical Officer of Health (MOH) or an Associate Medical Officer of Health (AMOH) is always available as part of the on-call process along with two managers (infectious disease and environmental health), one public health nurse (infectious disease) and at least one public health inspector (environmental health). The City's Customer Contact Centre keeps a list of the on-call staff and contact numbers with scripts detailing who to call and when.

Learning and Practice

5. Provide a short description of emergency management learning opportunities delivered to board of health staff, including the activities you conducted to practice emergency planning and 24/7 notification procedures (e.g., general response plans, etc.) either as part of training, an exercise, a response or recovery.

In addition to participating in multiple City emergency exercises, PHS staff also took part in two public health specific emergency exercises. These were developed in 2018 solely for PHS staff to test their emergency plan and notification systems. These exercises included a Hepatitis A outbreak from a food handler at a local festival, and a musical concert that resulted in multiple opioid overdoses. In addition, the Emergency Response Coordinator frequently met with new members of the Emergency Control Group for 1:1 or small group training sessions. Over the course of the year, all Emergency Control Group members participated in an exercise or training session.

Staff who are not part of the Emergency Control Group were encouraged to review the Public Health Ontario emergency management training modules to acquire basic knowledge of emergency management. Staff were also asked to review the emergency guidelines that were created for all staff members advising what to do in the event of a specific emergency (e.g. fire, active shooter, flood, etc.).

Program Standards

Chronic Disease Prevention and Well-Being Program Standard

1. Describe the program of public health interventions that was implemented and how mental health promotion strategies and approaches were embedded into the program of public health interventions

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A holistic approach that promotes both physical and mental health is essential to improving health and reducing the burden of illness from chronic diseases. As such, each of the interventions implemented as part of this program aimed to enhance protective factors and reduce risk factors related to physical and mental health.

Creating a built environment that encourages physical activity continued to be an area of focus. In 2018, staff advocated for heath in all policies and provided regular input on development, zoning, and planning applications. The program also implemented the *"Power Off and Play"* theme of the Healthy Kids Community Challenge aimed at reducing screen time and increasing physical activity among children with a focus on those living in high needs neighbourhoods.

Initiatives related to food literacy and food infrastructure were implemented as part of the City of Hamilton's Food Strategy. For example, a free 12-week food skills and employability program was developed for recipients of OW and ODSP who were interested in working in the culinary industry. To support local food and help grow the agri-food sector, an interactive online farm map was created and input was provided on land use planning documents.

A comprehensive strategy that combined a balance of inspection, education and progressive enforcement was implemented to prevent and control tobacco use. Specific interventions included:

- enforcement of the Smoke Free Ontario Act at all tobacco and vapor product retail locations;
- implementation of control actions through the Central West Tobacco Control Area Network;
- intensive cessation counselling and workshops;
- development of a cessation care pathway to integrate related health services and supports; and,
- development of smoke-free policies for multi-unit (social) housing in Hamilton.

Interventions specifically focused on mental health were also implemented. For example, PHS provided consultation and support to several workplaces implementing the *National Standard for Psychological Health & Safety in the Workplace* .

Food Safety Program Standard

1. What actions were taken by the board of health to shift a food premise from high to moderate risk based on the annual risk categorization assessment?

Hamilton PHS utilized the ***Ontario Risk Categorization of Food Premises*** tool to conduct annual risk assessments. Following careful assessment of both profile and performance factors, each premise was assigned a risk category of high, moderate, or low. If a food premise was deemed high risk, inspections were conducted at least once every four months until the next annual risk assessment. Several actions were taken during the initial risk assessment and subsequent inspections to assist high risk premises reduce their risk and shift to moderate or low risk. More specifically, Public Health Inspectors:

- Ensured there was at least one food handler or supervisor on the premise who had completed food handler training;
- Provided on site food handler education to owners / operators;
- Worked with owners / operators to identify improvements to current safe food handling practices; and,
- Ensured critical infractions were resolved in a timely manner through routine and re-inspections.

Results and detailed notes from each annual risk assessment as well as subsequent inspections were entered into the Hedgehog database. While conducting inspections, Public Health Inspectors reviewed past records to monitor progress and assist premises in reducing their risk level.

Healthy Environments Program Standard

1. Describe the program of public health interventions that was implemented and how environmental strategies and approaches in accordance with the *Healthy Environments and Climate Change Guideline, 2018* (or as current), were embedded into the program to promote healthy built and natural environments.

In 2018, Health Hazards program staff implemented several interventions and strategies in accordance with the Healthy Environments and Climate Change Guidelines. To reduce environmental health risks, investigations were conducted following reports of various hazards in the public domain (i.e., poor air quality, contaminated land, rental housing conditions, etc). Development of a 'heat vulnerability map' of the Hamilton community was also initiated as a population-based preventive strategy to identify areas at high risk for adverse outcomes associated with extreme prolonged heat events. PHS collaborated with City of Hamilton Emergency Medical Services to add 911 call data for heat-related illnesses to the map. Once high risk areas for heat-related illnesses have been identified, PHS will implement appropriate interventions to reduce risk (i.e., working with landlords in impacted areas to promote 'cool places' and increasing awareness among residents about heat-related illnesses).

To increase public awareness of environmental health risks, staff developed and implemented two educational campaigns: one on heat-related illness and one on risks of radon exposure. A project plan was also developed to conduct a local radon research study that is expected to further increase public awareness.

The program continued to work collaboratively with key stakeholders on a number of healthy environment strategies. For example:

- A by-law to address "Airborne Particulate Matter" in Hamilton was drafted in collaboration with municipal staff and community members; and,
- A regional governance model for Climate Change mitigation and adaptation was developed in collaboration with Mohawk College and the City of Burlington.

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Healthy Growth and Development Program Standard

1. Describe the program of public health interventions that was implemented and how mental health promotion strategies and approaches were embedded into the program of public health interventions

A priority in 2018 was to build capacity across the community to enhance system planning and integration through development of shared tools/policies, screening, assessment, and cross-sector education. Examples of interventions included:

- The development of a ***Safe Transitions*** strategy through intersectoral collaboration to enhance services offered to new parents and newborns that were integrated, high quality and comprehensive. Outcomes from this collaboration included shared key messages, care pathway development with streamlined criteria, universal prenatal screening, and a reduction in the duplication of services.
- Implementation of the ***Families First Pilot*** that offered lone parent families 0-6 year of age integrated supports between home visiting, child care, Ontario Works, employment and recreation in order to improve timely access to service.

The program also offered tailored education to meet individual and group needs for families with children 0-6, including:

- ***Nurse-Family Partnership*** , an intensive home-visiting program for at risk parents aged 21 and under;
- ***Breastfeeding*** home visits and telephone support;
- ***Check It Out Drop-In Sessions*** that provided access to many professionals (i.e., PHNs, speech and language pathologists, mental health workers, etc.) who screened, assessed and referred children at risk for poor growth and developmental outcomes.

Mental health promotion strategies were embedded in these program interventions as each one aimed to reduce the potential for adverse childhood experiences and promote protective factors. The program also contributed to system planning by participating on the Infant and Early Years Mental Health System Support Committee. This was a community collaborative organized to facilitate a coordinated and integrated cross-sector planning approach for infant and early years mental health service delivery in the City of Hamilton. In 2018, the Committee set strategic priorities with short and long-term objectives. These were informed by the results of a scan conducted by the Hospital of Sick Children that identified strengths and gaps among current infant and early years mental health services and programs within Hamilton.

School Health Program Standard

1. Describe the program of public health interventions that was implemented and how the board of health offered support to school boards and schools to assist with the implementation of health related curricula and health needs in schools, as outlined in the *School Health Guideline, 2018* (or as current).

The School Program used a proportionate universalism approach to provide equitable services to areas with greater need. In total, 48 high priority schools received intensive public health nursing support. This included school-level consultation to assist with the identification of health needs and development of evidence-informed Annual School Plans to address those needs. Universal services were provided to all publicly funded Hamilton schools including dental screening, vision screening, school-based immunization, curriculum support, consultation on emerging health priorities and sharing of population health data.

To support school boards, the School Program established a leadership committee with senior leadership from local boards. Together this committee identified mutual health priorities, goals, and indicators of success. These decisions were informed by the Child and Youth Health Atlas, a tool that provides an overview of the health and well-being of school-age children using population health and education data.

2. Describe how mental health promotion strategies and approaches were embedded into School Health programs and services.

Within the School Program, mental health and well-being was promoted through school board partnerships to enact School Mental Health ASSIST. In addition, Public Health Nurses from the School Program worked directly with school communities to develop action plans related to mental health promotion. Action plans were tailored to the needs of individual schools and focused on areas such as fostering resilience among students, creating a supportive environment, and assisting in referral to appropriate services. This included the development of resource guides for teachers to support implementation of curriculum related to mental health and well-being.

Evidence-based programming for bullying prevention (PrevNet, Fun with Friends) was also implemented in conjunction with individual schools. Further work was initiated in 2018 around mental health promotion and revising health promotion content to ensure it was inclusive of the Indigenous community.

Substance Use and Injury Prevention Program Standard

1. Describe the program of public health interventions that was implemented related to Substance Use and how mental health promotion strategies and approaches were embedded into the program of public health interventions.

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A comprehensive health promotion approach was used to implement a program of interventions related to substance use prevention, harm reduction, and mental health promotion.

The following initiatives were carried out as part of the local opioid response: naloxone distribution and training; implementation of the awareness campaigns (i.e., 4 C's Opioid Overdose Awareness, Careful Use Campaign); and, ongoing monitoring and surveillance of opioid activity in the community to inform action plans. To ensure the local opioid response was coordinated, PHS continued to engage with community partners across the health sector. One outcome from this was the development of a city-wide Drug Strategy and action plans related to the four pillars of prevention, treatment, harm reduction and enforcement. Following the legalization of cannabis in Fall 2018, a denormalization campaign targeted towards youth was implemented to increase awareness of the harms associated with cannabis use.

The program also offered several harm reduction services, including: the provision of needles and safe injection supplies; safe disposal of needle litter through the Community Points Program; and, testing through street health and outreach clinics. These programs aimed to increase testing for STI/BBIs, provide access to harm reduction supplies, ensure access to vaccinations, and link clients to mental health and community services.

Initiatives to promote mental health and well-being were integrated into the substance use program of interventions. In addition, planning for a departmental wide *Mental Health and Addictions Strategy* was initiated to inform further mental health promotion initiatives based on local need. The program also began updating mental well-being programming to ensure it was inclusive for Indigenous populations.

2. Describe the program of public health interventions related to Injury Prevention and how mental health promotion strategies and approaches were embedded into the program of public health interventions.

Interventions within this program aimed to prevent or reduce the occurrence of injuries across the lifespan. To prevent injury among children, the program continued to run Car Seat Clinics to inspect and install car seats and educate parents / caregivers about car seat safety. A Car Seat Disposal Drive was also run in collaboration with City of Hamilton Emergency Medical Services and Public Works to get rid of car seats that were unfit for use (broken or expired).

Increasing concussion awareness among community partners was another program goal. For example, the program worked in partnership with local schools and amateur sports organizations to develop consistent implementation plans related to the *Return to Learn* and *Return to Play* policies. Through collaboration with community partners, subsidized helmets were also distributed to children and families in need.

Another program priority was self-harm and suicide prevention, particularly among youth and young adults. PHS continued to participate on the Suicide Prevention Community Council of Hamilton and regularly provided population health data to inform the ongoing implementation of the Hamilton Suicide Prevention Strategy.

Several initiatives to prevent and reduce falls among Hamilton's senior population were carried out, including:

- Advocacy for improved injury prevention codes for Canadian homes;
- Support with policy development related to the Canadian National Building Codes; and,
- Collaboration with Hamilton Pharmacists Partnership to promote Medscheck and the use of a falls risk screening tool with residents 65 and older.

Board of Health for the City of Hamilton

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Narrative - One-Time Funding
(for the period of April 1, 2018 to March 31, 2019)

Project / Initiative	Description *(Provide a brief description of the project/initiative that was undertaken. If the project was not completed, describe why)*	Outcomes *(Provide a brief description of the achievements of the project/ initiative)*
One-Time Funding		
Raccoon Rabies Business Case	Two full-time Public Health Inspectors were hired to meet the increased service levels resulting from the raccoon rabies outbreak. The Inspectors carried out the following initiatives aimed at reducing the incidence and spread of rabies: • Supported and coordinated the local collection of wild animal specimens for raccoon rabies surveillance and testing by the Ministry of Natural Resources and Forestry; • Liaised with key stakeholders regarding animal to animal and human exposure events; • Conducted an evaluation of the Rabies Program; • Provided 10 presentations to high-risk animal care providers to increase awareness; and, • Ran two low cost rabies vaccination clinics. One of the recommendations from the evaluation was to provide targeted communication to pet owners to increase awareness of rabies in domestic pets and promote vaccination. To increase uptake among individuals who were unable to afford to have their pets vaccinated, PHS collaborated with local veterinarians to provide low cost rabies vaccination vouchers and PHS also offered the two low-cost rabies vaccination clinics.	This work continues to be essential in combatting the raccoon rabies outbreak and preventing human cases. In 2018, a total of 120 dogs and 40 cats were vaccinated through the low-cost rabies vaccination clinics. Since expanding the raccoon rabies awareness campaign in 2018, fewer residents have needed post exposure prophylaxis (PEP); only 83 residents received rabies PEP in 2018 compared to 145 in 2017. There were also fewer reports of rabid wildlife in 2018; 36 rabid animals were identified by the Ministry of Natural Resources and Forestry compared to 204 in 2016. In addition, results from the Rabies Program Evaluation were used to improve education / awareness strategies, key messages, and service delivery. These results were presented at a rabies intra-agency meeting where many key stakeholders were present.

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Narrative - One-Time Funding
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Project / Initiative	Description *(Provide a brief description of the project/initiative that was undertaken. If the project was not completed, describe why)*	Outcomes *(Provide a brief description of the achievements of the project/ initiative)*
Public Health Inspector Practicum	Four students working towards their certificate in public health inspection joined Hamilton PHS for 3 months in 2018 to complete a practicum. To learn about environmental health programming in public health, the students spent time with staff in the following programs: Food Safety; Safe Water; Health Hazards; Vector Borne Disease; and, Infectious Disease. The main focus of the students' work was to monitor and sample water from all of the public beaches in the City of Hamilton. This involved water testing, documenting and interpreting results, posting facilities and beaches with negative results, and ensuring the results were publicly disclosed in a timely manner via the City of Hamilton website.	During the term of the practicum, students: • Inspected 490 food premises (including high, moderate, and low-risk); • Inspected 221 recreational water facilities; and, • Collected 850 water samples from the 7 public beaches in Hamilton. While at PHS, students also gained experience carrying out: • Confinement and releases for rabies control; • Pest complaint investigations; and, • Low-risk consultations related to environmental hazards.

Board of Health for the City of Hamilton, Public Health Services

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Standard - Section / Program	Sources of Funding	Q4 Expenditures (at 100%)	Salaries and Wages	Benefits	Travel	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Adjustments	Actual Expenditures (at 100%)	Variance Under / (Over)	
A	B	C	D	E	F	G	H	I	J	K =SUM (D : J)	L = C - K	M =L / C
Direct Costs												
Foundational Standards												
Emergency Management	Mandatory Programs (Cost-Shared)	141,619	94,602	21,160	594	1,362	(7,308)	33,525	-	143,935	(2,316)	-1.6%
Other Foundational Standards	Chief Nursing Officer Initiative (100%)	121,500	97,180	24,320	-	-		-	-	121,500	-	0.0%
Other Foundational Standards	Mandatory Programs (Cost-Shared)	1,864,755	1,177,007	313,655	299	5,880	(1,999)	372,229	-	1,867,071	(2,316)	-0.1%
Other Foundational Standards	Social Determinants of Health Nurses Initiative (100%)	180,500	143,530	36,970	-	-		-	-	180,500	-	0.0%
Foundational Standards Total		**2,308,374**	**1,512,319**	**396,105**	**893**	**7,242**	**(9,307)**	**405,754**	**-**	**2,313,006**	**(4,632)**	**-0.2%**
Chronic Disease Prevention and Well-Being												
Built Environment	Mandatory Programs (Cost-Shared)	877,767	554,151	144,028	323	826	(49)	178,488	-	877,767	-	0.0%
Cancer Prevention	Mandatory Programs (Cost-Shared)	889,244	559,318	140,618	291	956	(51)	188,112	-	889,244	-	0.0%
Harm Reduction	Mandatory Programs (Cost-Shared)	29,784	16,415	4,021	3	15	(46)	9,376	-	29,784	-	0.0%
Healthy Food Systems	Mandatory Programs (Cost-Shared)	1,210,907	762,461	200,549	456	951	(67)	246,557	-	1,210,907	-	0.0%
Mental Health Promotion	Mandatory Programs (Cost-Shared)	165,009	109,433	25,973	50	69	(11)	29,495	-	165,009	-	0.0%
Smoke Free Ontario - Prosecution	Smoke-Free Ontario Strategy: Prosecution (100%)	10,005	1,432	168	-	7,905		500	-	10,005	-	0.0%
Smoke Free Ontario - Protection and Enforcement	Smoke-Free Ontario Strategy: Protection and Enforcement (100%)	403,075	278,292	68,478	5,763	27		50,515	-	403,075	-	0.0%
Smoke Free Ontario - Tobacco Control Area Network - Coordination	Smoke-Free Ontario Strategy: Tobacco Control Area Network - Coordination (100%)	308,568	164,843	44,207	1,042	4,397		94,079	-	308,568	-	0.0%
Smoke Free Ontario - Tobacco Control Area Network - Prevention	Smoke-Free Ontario Strategy: Tobacco Control Area Network - Prevention (100%)	278,911	-	-	1,080	509		277,322	-	278,911	-	0.0%
Smoke Free Ontario - Tobacco Control Coordination	Smoke-Free Ontario Strategy: Tobacco Control Coordination (100%)	100,000	80,310	19,690	-	-		-	-	100,000	-	0.0%
Smoke Free Ontario - Youth Tobacco Use Prevention	Smoke-Free Ontario Strategy: Youth Tobacco Use Prevention (100%)	81,305	3,556	776	1,234	-		75,739	-	81,305	-	0.0%
Substance Use Prevention	Mandatory Programs (Cost-Shared)	61,801	33,119	10,196	10	95	(13)	18,394	-	61,801	-	0.0%
Tobacco Control, Prevention and Cessation	Mandatory Programs (Cost-Shared)	633,844	456,422	121,582	2,839	1,210	(82,921)	134,712	-	633,844	-	0.0%
Chronic Disease Prevention and Well-Being Total		**5,050,220**	**3,019,752**	**780,286**	**13,091**	**16,960**	**(83,158)**	**1,303,289**	**-**	**5,050,220**	**-**	**0.0%**
Food Safety												
Enhanced Food Safety Initiative	Enhanced Food Safety - Haines Initiative (100%)	78,559	41,022	6,780	-	-		30,757	-	78,559	-	0.0%
Food Safety	Mandatory Programs (Cost-Shared)	1,677,417	1,269,545	322,721	28,201	1,965	(381,508)	436,493	-	1,677,417	-	0.0%
Food Safety Total		**1,755,976**	**1,310,567**	**329,501**	**28,201**	**1,965**	**(381,508)**	**467,250**	**-**	**1,755,976**	**-**	**0.0%**
Healthy Environments												
Air Quality and Climate Change	Mandatory Programs (Cost-Shared)	114,646	77,590	14,828	248	481	(48)	21,547	-	114,646	-	0.0%
Health Hazards	Mandatory Programs (Cost-Shared)	1,219,984	741,329	185,846	9,335	5,010	(5,546)	284,010	-	1,219,984	-	0.0%
Healthy Environments Total		**1,334,630**	**818,919**	**200,674**	**9,583**	**5,491**	**(5,594)**	**305,557**	**-**	**1,334,630**	**-**	**0.0%**
Healthy Growth and Development												
Child Health	Mandatory Programs (Cost-Shared)	3,725,003	2,459,186	641,990	16,964	2,170	(931)	607,940	-	3,727,319	(2,316)	-0.1%
Reproductive Health	Mandatory Programs (Cost-Shared)	1,386,561	911,600	246,313	3,958	4,607	(12,283)	234,682	-	1,388,877	(2,316)	-0.2%
Healthy Growth and Development Total		**5,111,564**	**3,370,786**	**888,303**	**20,922**	**6,777**	**(13,214)**	**842,622**	**-**	**5,116,196**	**(4,632)**	**-0.1%**
Immunization												
Vaccine Inventory Management	Mandatory Programs (Cost-Shared)	973,124	603,793	163,656	3,970	264	(1,877)	203,318	-	973,124	-	0.0%
Immunization Total		**973,124**	**603,793**	**163,656**	**3,970**	**264**	**(1,877)**	**203,318**	**-**	**973,124**	**-**	**0.0%**
Infectious and Communicable Diseases Prevention and Control												
Harm Reduction	Mandatory Programs (Cost-Shared)	167,133	104,905	28,081	285	1,979	(156)	34,355	-	169,449	(2,316)	-1.4%
Infection Prevention and Control Nurses Initiative	Infection Prevention and Control Nurses Initiative (100%)	90,100	72,470	17,630	-	-		-	-	90,100	-	0.0%
Infectious Disease Program	Mandatory Programs (Cost-Shared)	4,317,347	2,836,668	754,032	38,114	53,581	(117,374)	761,592	-	4,326,613	(9,266)	-0.2%
Infectious Diseases Control Initiative	Infectious Diseases Control Initiative (100%)	1,174,970	852,926	221,032	701	8,998		91,313	-	1,174,970	-	0.0%
Mental Health Promotion	Mandatory Programs (Cost-Shared)	140,287	79,767	22,896	149	703	(114)	36,886	-	140,287	-	0.0%
Sexual Health	Mandatory Programs (Cost-Shared)	2,362,810	1,434,608	397,559	13,623	136,414	(103,886)	491,443	-	2,369,761	(6,951)	-0.3%
Substance Use Prevention	Mandatory Programs (Cost-Shared)	122,482	78,511	20,548	19	887	(14)	24,847	-	124,798	(2,316)	-1.9%

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Standard - Section / Program	Sources of Funding	Q4 Expenditures (at 100%)	Salaries and Wages	Benefits	Travel	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Adjustments	Actual Expenditures (at 100%)	Variance Under / (Over)	
A	B	C	D	E	F	G	H	I	J	K =SUM (D : J)	L = C - K	M =L / C
Vector Borne Diseases	Vector-Borne Diseases Program (Cost-Shared)	1,017,497	611,269	160,422	21,352	109,259		115,195	-	1,017,497	-	0.0%
Infectious and Communicable Diseases Prevention and Control Total		**9,392,626**	**6,071,124**	**1,622,200**	**74,243**	**311,821**	**(221,544)**	**1,555,631**	**-**	**9,413,475**	**(20,849)**	**-0.2%**
Safe Water												
Enhanced Safe Water Initiative	Enhanced Safe Water Initiative (100%)	42,856	22,942	1,420	-	209		18,285	-	42,856	-	0.0%
Safe Water	Mandatory Programs (Cost-Shared)	1,092,424	712,836	174,738	16,588	1,769	(9,828)	196,321	-	1,092,424	-	0.0%
Small Drinking Water Systems	Small Drinking Water Systems Program (Cost-Shared)	60,122	41,168	11,101	1,200	-		6,653	-	60,122	-	0.0%
Safe Water Total		**1,195,402**	**776,946**	**187,259**	**17,788**	**1,978**	**(9,828)**	**221,259**	**-**	**1,195,402**	**-**	**0.0%**
School Health - Oral Health												
Healthy Smiles Ontario	Healthy Smiles Ontario Program (100%)	1,560,301	902,770	243,583	8,978	909		404,061	-	1,560,301	-	0.0%
Oral Health Assessment	Mandatory Programs (Cost-Shared)	360,834	211,779	52,141	2,985	3,106	(691)	91,514	-	360,834	-	0.0%
School Health - Oral Health Total		**1,921,135**	**1,114,549**	**295,724**	**11,963**	**4,015**	**(691)**	**495,575**	**-**	**1,921,135**	**-**	**0.0%**
School Health - Vision												
Child Visual Health and Vision Screening	Mandatory Programs (Cost-Shared)	23,186	17,802	3,526	2	794	(1)	3,379	-	25,502	(2,316)	-10.0%
School Health - Vision Total		**23,186**	**17,802**	**3,526**	**2**	**794**	**(1)**	**3,379**	**-**	**25,502**	**(2,316)**	**-10.0%**
School Health - Immunization												
Immunization of School Pupils	Mandatory Programs (Cost-Shared)	1,856,848	1,298,968	330,789	7,689	2,079	(177,593)	399,548	-	1,861,480	(4,632)	-0.2%
School Health - Immunization Total		**1,856,848**	**1,298,968**	**330,789**	**7,689**	**2,079**	**(177,593)**	**399,548**	**-**	**1,861,480**	**(4,632)**	**-0.2%**
School Health - Other												
Chronic Disease Prevention	Mandatory Programs (Cost-Shared)	300,663	190,370	52,892	1,646	130	(3,205)	58,830	-	300,663	-	0.0%
Harm Reduction	Mandatory Programs (Cost-Shared)	41,908	30,735	3,944	258	1,084	(14)	5,901	-	41,908	-	0.0%
Injury Prevention	Mandatory Programs (Cost-Shared)	150,342	91,186	26,424	502	119	(972)	33,083	-	150,342	-	0.0%
Mental Health Promotion	Mandatory Programs (Cost-Shared)	786,435	510,575	135,128	2,947	1,020	(5,460)	144,541	-	788,751	(2,316)	-0.3%
School Health	Mandatory Programs (Cost-Shared)	1,853,071	1,181,748	326,090	10,198	1,433	(19,855)	355,773	-	1,855,387	(2,316)	-0.1%
Sexual Health	Mandatory Programs (Cost-Shared)	270,637	174,782	47,039	1,640	78	(3,199)	50,297	-	270,637	-	0.0%
Substance Use Prevention	Mandatory Programs (Cost-Shared)	240,077	160,701	38,089	825	1,124	(979)	40,317	-	240,077	-	0.0%
Tobacco Control, Prevention and Cessation	Mandatory Programs (Cost-Shared)	82,605	50,118	13,171	12	117	(15)	19,202	-	82,605	-	0.0%
School Health - Other Total		**3,725,738**	**2,390,215**	**642,777**	**18,028**	**5,105**	**(33,699)**	**707,944**	**-**	**3,730,370**	**(4,632)**	**-0.1%**
Substance Use and Injury Prevention												
Injury Prevention	Mandatory Programs (Cost-Shared)	375,360	204,428	66,669	1,988	2,146	(390)	102,835	-	377,676	(2,316)	-0.6%
Electronic Cigarettes Act - Protection and Enforcement	Electronic Cigarettes Act: Protection and Enforcement (100%)	52,236	17,111	3,920	5	-		31,200	-	52,236	-	0.0%
Harm Reduction	Mandatory Programs (Cost-Shared)	412,262	261,011	58,573	2,095	9,830	(227)	83,296	-	414,578	(2,316)	-0.6%
Harm Reduction Program Enhancement	Harm Reduction Program Enhancement (100%)	250,002	192,457	54,972	-	-		2,573	-	250,002	-	0.0%
Needle Exchange Program Initiative	Needle Exchange Program Initiative (100%)	204,504	-	-	-	-		204,504	-	204,504	-	0.0%
Substance Use Prevention	Mandatory Programs (Cost-Shared)	276,019	183,566	37,739	1,829	7,626	(101)	45,360	-	276,019	-	0.0%
Substance Use and Injury Prevention Total		**1,570,383**	**858,573**	**221,873**	**5,917**	**19,602**	**(718)**	**469,768**	**-**	**1,575,015**	**(4,632)**	**-0.3%**
Direct Costs Total		**36,219,206**	**23,164,313**	**6,062,673**	**212,290**	**384,093**	**(938,732)**	**7,380,894**	**-**	**36,265,531**	**(46,325)**	**-0.1%**
Indirect Costs												
[illegible]	Mandatory Programs (Cost-Shared)	1,959,819	1,311,263	282,715	17,079	30,261	(49,542)	321,718	-	1,913,494	46,325	2.4%
MOH / AMOH Compensation Initiative	MOH / AMOH Compensation Initiative (100%)		56,591	29,789						86,380	(86,380)	0.0%
Indirect Costs Total		**1,959,819**	**1,367,854**	**312,504**	**17,079**	**30,261**	**(49,542)**	**321,718**	**-**	**1,999,874**	**(40,055)**	**-2.0%**
Total Expenditures related to 2018		**38,179,025**	**24,532,167**	**6,375,177**	**229,369**	**414,354**	**(988,274)**	**7,702,612**	**-**	**38,265,405**	**(86,380)**	**-0.2%**

Board of Health for the City of Hamilton, Public Health Services

2018 Annual Report and Attestation

One-Time Funding

Project / Initiative	Source of Funding	Q4 Expenditures (at 100%)	Salaries and Wages	Benefits	Travel	Professional Services	Expenditure Recoveries & Offset Revenues	Other Program Expenditures	Adjustments	Actual Expenditures (at 100%)	Variance Under / (Over)	
A	B	C	D	E	F	G	H	I	J	J =SUM (C : I)	K = C - J	L = K / C
2017-18 One-Time Funding												
April 1, 2017 to December 31, 2017												
Operating Funding												
Expanded Smoking Cessation Programming for Priority Populations	Smoke-Free Ontario Expanded Smoking Cessation Programming for Priority Populations (100%)		-	-	-	-		24,693	-	24,693		
Needle Exchange	Needle Exchange Program Initiative (100%)		-	-	-	-		4,138	-	4,138		
Panorama	Panorama - Immunization Solution (100%)		108,840	31,260	-	-		-	-	140,100		
Public Health Inspector Practicum Program	Public Health Inspector Practicum Program (100%)		9,268	1,333	2,682	-		(3,283)	-	10,000		
Raccoon Rabies - Low Cost Clinics and Promotion Campaign Evaluation	Outbreaks of Diseases: Clinic and Promotion Campaign Evaluation (100%)		-	-	-	153		15,009	-	15,162		
Smoke-Free Ontario Enforcement Tablet Upgrade 2017	Smoke-Free Ontario Strategy: Enforcement Tablet Upgrade (100%)		-	-	-	-		3,467	-	3,467		
Staffing request for Raccoon Rabies Strain in Hamilton	Outbreaks of Diseases: Racoon Rabies Strain (100%)		163,566	40,877	4,037	-		920	-	209,400		
Vaccine Records Screening and Suspension	Immunization of School Pupils Act - Regulatory Amendments Implementation (100%)		37,981	12,019	-	-		-	-	50,000		
April 1, 2017 to December 31, 2017 Total			**319,655**	**85,489**	**6,719**	**153**	**-**	**44,944**	**-**	**456,960**		
January 1, 2018 to March 31, 2018												
Operating Funding												
Expanded Smoking Cessation Programming for Priority Populations	Smoke-Free Ontario Expanded Smoking Cessation Programming for Priority Populations (100%)		-	-	-	-		(116)	-	(116)		
Needle Exchange	Needle Exchange Program Initiative (100%)		-	-	-	-		124,635		124,635		
Panorama	Panorama - Immunization Solution (100%)		-	-	-	-		-	-	-		
Public Health Inspector Practicum Program	Public Health Inspector Practicum Program (100%)		-	-	-	-		-	-	-		
Raccoon Rabies - Low Cost Clinics and Promotion Campaign Evaluation	Outbreaks of Diseases: Clinic and Promotion Campaign Evaluation (100%)		-	-	-	-		42,588	-	42,588		
Smoke-Free Ontario Enforcement Tablet Upgrade 2017	Smoke-Free Ontario Strategy: Enforcement Tablet Upgrade (100%)		-	-	-	-		357	-	357		
Staffing request for Raccoon Rabies Strain in Hamilton	Outbreaks of Diseases: Racoon Rabies Strain (100%)		-	-	-	-		-	-	-		
Vaccine Records Screening and Suspension	Immunization of School Pupils Act - Regulatory Amendments Implementation (100%)		-	-	-	-		-	-	-		
January 1, 2018 to March 31, 2018 Total			**-**	**-**	**-**	**-**	**-**	**167,464**	**-**	**167,464**		
2017-18 One-Time Funding Total			**319,655**	**85,489**	**6,719**	**153**	**-**	**212,408**	**-**	**624,424**		
2018-19 One-Time Funding												
April 1, 2018 to December 31, 2018												
Operating Funding												
Raccoon Rabies Business Case	Immunization/Infectious Diseases: Raccoon Rabies Strain (100%)	327,201	218,408	55,986	4,619	1,716		46,472	-	327,201	-	0.0%
Public Health Inspector Practicum	Public Health Inspector Practicum Program (100%)	10,000	9,220	1,006	809	-		(1,035)	-	10,000	-	0.0%
April 1, 2018 to December 31, 2018 Total		**337,201**	**227,628**	**56,992**	**5,428**	**1,716**	**-**	**45,437**	**-**	**337,201**	**-**	**0.0%**
2018-19 One-Time Funding Total		**337,201**	**227,628**	**56,992**	**5,428**	**1,716**	**-**	**45,437**	**-**	**337,201**	**-**	**0.0%**
Total Expenditures related to 2018		**337,201**	**227,628**	**56,992**	**5,428**	**1,716**	**-**	**212,901**	**-**	**504,665**		

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Variance Explanation

**** Please provide variance explanations for variances that are greater than 3% (negative or positive).***

Program / Project / Initiative	Source of Funding	Variance Under / (Over)	
		$	%
A	B	C	D
Child Visual Health and Vision Screening	**Mandatory Programs (Cost-Shared)**	**(2,316)**	**-10.0%**
Variance due to correction to classification of AMOH revenue under MOH Compensation Initiative funding.			
[Program / Project / Initiative Name]	**[Sources of Funding]**	**[$]**	**[%]**
Variance Explanation			
[Program / Project / Initiative Name]	**[Sources of Funding]**	**[$]**	**[%]**
Variance Explanation			
[Program / Project / Initiative Name]	**[Sources of Funding]**	**[$]**	**[%]**
Variance Explanation			

Board of Health for the City of Hamilton, Public Health Services

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Actual Expenditures by Account
January 1, 2018 to December 31, 2018

Account	Budget (at 100%)	Actual (at 100%)	Variance Under / (Over)	
A	B	C	D = B - C	E = D / B
Salaries and Wages	24,753,810	24,759,795	(5,985)	-0.0%
Benefits	6,567,250	6,432,169	135,081	2.1%
Travel	246,070	234,797	11,273	4.6%
Professional Services	470,670	416,070	54,600	11.6%
Expenditure Recoveries & Offset Revenues	(978,260)	(988,274)	10,014	-1.0%
Other Program Expenditures	7,315,550	7,915,513	(599,963)	-8.2%
Total Expenditures	**38,375,090**	**38,770,070**	**(394,980)**	**-1.0%**
Adjustments	-	-	-	0.0%
Total Adjusted Expenditures	**38,375,090**	**38,770,070**	**(394,980)**	**-1.0%**

Board of Health for the City of Hamilton, Public Health Services

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Expenditure Recoveries & Offset Revenues Reconciliation
January 1, 2018 to December 31, 2018

Mandatory Programs	Actual (at 100%)
Interest Income	
Universal Influenza Immunization Program clinic reimbursement	(1,790)
Meningococcal C Program clinic reimbursement	(97,402)
Human Papilloma Virus Program reimbursement	(76,755)
OHIP Billings	(112,672)
Sexually Transmitted Diseases Revenue - Sale of contraceptives	(19,145)
User Fees	(570,138)
Sale of Equipment	(285)
Sale of Service & secondments	(90,583)
Work orders, fines & other revenue	(19,505)
Sub-total Mandatory Programs Expenditure Recoveries & Offset Revenues (A)	**(988,274)**
Reported in Base Funding and One-Time Funding Worksheets	(988,274)
Difference	-
Other Sources of Funding	
Interest Income	
Other (Specify):	
Sub-total Other Programs Offset Revenues (B)	**-**
Reported in Base Funding and One-Time Funding Worksheets	-
Difference	-
Total Expenditure Recoveries & Offset Revenues (C = A+B)	**(988,274)**
Difference	-

Board of Health for the City of Hamilton, Public Health Services

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As of December 31, 2018

Funding Received from the Ministry

Programs/Sources of Funding	Cashflow Received in 2018	Prior Year Adjustments Processed in 2018	2018 Adjustments Processed in 2019	Other		Funding Received from the Ministry
				$	Please Specify	
A	B	C	D	E	F	G = SUM (B:E)
2017-18 One-Time Funding (April 1, 2017 to March 31, 2018)						
Operating Funding						
Smoke-Free Ontario Expanded Smoking Cessation Programming for Priority Populations (100%)	21,137	3,863	-			25,000
Needle Exchange Program Initiative (100%)	128,851	-				128,851
Panorama - Immunization Solution (100%)	138,890	1,210				140,100
Public Health Inspector Practicum Program (100%)	10,000	-				10,000
Outbreaks of Diseases: Clinic and Promotion Campaign Evaluation (100%)	59,024	976				60,000
Smoke-Free Ontario Strategy: Enforcement Tablet Upgrade (100%)	(4,845)	10,845				6,000
Outbreaks of Diseases: Racoon Rabies Strain (100%)	209,711	(311)				209,400
Immunization of School Pupils Act - Regulatory Amendments Implementation (100%)	50,010	(10)				50,000
2017-18 One-Time Funding Total (A)	**612,778**	**16,573**	**-**	**-**		**629,351**
Base Funding (January 1, 2018 to December 31, 2018)						
Mandatory Programs (Cost-Shared)	23,330,300					23,330,300
Chief Nursing Officer Initiative (100%)	121,500					121,500
Electronic Cigarettes Act: Protection and Enforcement (100%)	51,453	447				51,900
Enhanced Food Safety - Haines Initiative (100%)	78,300					78,300
Enhanced Safe Water Initiative (100%)	42,300					42,300
Harm Reduction Program Enhancement (100%)	250,000					250,000
Healthy Smiles Ontario Program (100%)	1,612,529	(52,229)				1,560,300
Infection Prevention and Control Nurses Initiative (100%)	90,100					90,100
Infectious Diseases Control Initiative (100%)	1,111,200					1,111,200
MOH / AMOH Compensation Initiative (100%)	80,648		6,364			87,012
Needle Exchange Program Initiative (100%)	217,375	(15,375)				202,000
Small Drinking Water Systems Program (Cost-Shared)	41,100					41,100
Smoke-Free Ontario Strategy: Prosecution (100%)	10,000					10,000
Smoke-Free Ontario Strategy: Protection and Enforcement (100%)	374,200					374,200
Smoke-Free Ontario Strategy: Tobacco Control Area Network - Coordination (100%)	285,800					285,800
Smoke-Free Ontario Strategy: Tobacco Control Area Network - Prevention (100%)	268,949	7,851				276,800
Smoke-Free Ontario Strategy: Tobacco Control Coordination (100%)	100,000					100,000
Smoke-Free Ontario Strategy: Youth Tobacco Use Prevention (100%)	80,357	(357)				80,000
Social Determinants of Health Nurses Initiative (100%)	180,500					180,500
Vector-Borne Diseases Program (Cost-Shared)	776,500	(21,600)				754,900
Base Funding Total (B)	**29,103,111**	**(81,263)**	**6,364**	**-**		**29,028,212**
2018-19 One-Time Funding (April 1, 2018 to March 31, 2019)						
Operating Funding						

2018 Annual Reconciliation
As of December 31, 2018

Funding Received from the Ministry

Programs/Sources of Funding	Cashflow Received in 2018	Prior Year Adjustments Processed in 2018	2018 Adjustments Processed in 2019	Other		Funding Received from the Ministry
				$	Please Specify	
A	B	C	D	E	F	G = SUM (B:E)
Immunization/Infectious Diseases: Raccoon Rabies Strain (100%)	245,400		81,800			327,200
Public Health Inspector Practicum Program (100%)	7,500		2,500			10,000
2018-19 One-Time Funding Total (C)	**252,900**	**-**	**84,300**	**-**		**337,200**

Board of Health for the City of Hamilton, Public Health Services

2018 Annual Reconciliation
As of December 31, 2018

Annual Reconciliation by Sources of Funding

Programs/Sources of Funding	Q4 Expenditures (at 100%)	Actual Expenditures (at 100%)	Variance Under / (Over)		Actual Expenditures (at provincial share)	Approved Allocation	Eligible Expenditures	Funding Received from the Ministry	Due to / (From) Province
			$	(%)					$
A	B	C	D = B -C	E = D / B	F = C * Prov. Share	G	H = MIN(F,G)	I	J = I - H
2017-18 One-Time Funding (April 1, 2017 to March 31, 2018)									
Operating Funding									
Smoke-Free Ontario Expanded Smoking Cessation Programming for Priority Populations (100%)		24,577			24,577	25,000	24,577	25,000	423
Needle Exchange Program Initiative (100%)		128,773			128,773	128,851	128,773	128,851	78
Panorama - Immunization Solution (100%)		140,100			140,100	140,100	140,100	140,100	-
Public Health Inspector Practicum Program (100%)		10,000			10,000	10,000	10,000	10,000	-
Outbreaks of Diseases: Clinic and Promotion Campaign Evaluation (100%)		57,750			57,750	60,000	57,750	60,000	2,250
Smoke-Free Ontario Strategy: Enforcement Tablet Upgrade (100%)		3,824			3,824	6,000	3,824	6,000	2,176
Outbreaks of Diseases: Racoon Rabies Strain (100%)		209,400			209,400	209,400	209,400	209,400	-
Immunization of School Pupils Act - Regulatory Amendments Implementation (100%)		50,000			50,000	50,000	50,000	50,000	-
2017-18 One-Time Funding Total (A)		**624,424**			**624,424**	**629,351**	**624,424**	**629,351**	**4,927**
Base Funding (January 1, 2018 to December 31, 2018)									
Mandatory Programs (Cost-Shared)	32,164,014	32,164,014	-	0.0%	24,123,011	23,330,300	23,330,300	23,330,300	-
Chief Nursing Officer Initiative (100%)	121,500	121,500	-	0.0%	121,500	121,500	121,500	121,500	-
Electronic Cigarettes Act: Protection and Enforcement (100%)	52,236	52,236	-	0.0%	52,236	51,900	51,900	51,900	-
Enhanced Food Safety - Haines Initiative (100%)	78,559	78,559	-	0.0%	78,559	78,300	78,300	78,300	-
Enhanced Safe Water Initiative (100%)	42,856	42,856	-	0.0%	42,856	42,300	42,300	42,300	-
Harm Reduction Program Enhancement (100%)	250,002	250,002	-	0.0%	250,002	250,000	250,000	250,000	-
Healthy Smiles Ontario Program (100%)	1,560,301	1,560,301	-	0.0%	1,560,301	1,560,300	1,560,300	1,560,300	-
Infection Prevention and Control Nurses Initiative (100%)	90,100	90,100	-	0.0%	90,100	90,100	90,100	90,100	-
Infectious Diseases Control Initiative (100%)	1,174,970	1,174,970	-	0.0%	1,174,970	1,111,200	1,111,200	1,111,200	-
MOH / AMOH Compensation Initiative (100%)		86,380			86,380	87,012	86,380	87,012	632
Needle Exchange Program Initiative (100%)	204,504	204,504	-	0.0%	204,504	202,000	202,000	202,000	-
Small Drinking Water Systems Program (Cost-Shared)	60,122	60,122	-	0.0%	45,092	41,100	41,100	41,100	-
Smoke-Free Ontario Strategy: Prosecution (100%)	10,005	10,005	-	0.0%	10,005	10,000	10,000	10,000	-
Smoke-Free Ontario Strategy: Protection and Enforcement (100%)	403,075	403,075	-	0.0%	403,075	374,200	374,200	374,200	-
Smoke-Free Ontario Strategy: Tobacco Control Area Network - Coordination (100%)	308,568	308,568	-	0.0%	308,568	285,800	285,800	285,800	-
Smoke-Free Ontario Strategy: Tobacco Control Area Network - Prevention (100%)	278,911	278,911	-	0.0%	278,911	276,800	276,800	276,800	-
Smoke-Free Ontario Strategy: Tobacco Control Coordination (100%)	100,000	100,000	-	0.0%	100,000	100,000	100,000	100,000	-
Smoke-Free Ontario Strategy: Youth Tobacco Use Prevention (100%)	81,305	81,305	-	0.0%	81,305	80,000	80,000	80,000	-
Social Determinants of Health Nurses Initiative (100%)	180,500	180,500	-	0.0%	180,500	180,500	180,500	180,500	-
Vector-Borne Diseases Program (Cost-Shared)	1,017,497	1,017,497	-	0.0%	763,123	754,900	754,900	754,900	-
Base Funding Total (B)	**38,179,025**	**38,265,405**	**(86,380)**	**-0.2%**	**29,954,998**	**29,028,212**	**29,027,580**	**29,028,212**	**632**
Total 2018 Annual Reconciliation (A+B)		**38,889,829**			**30,579,422**	**29,657,563**	**29,652,004**	**29,657,563**	**5,559**
2018-19 One-Time Funding (April 1, 2018 to March 31, 2019)							**Surpluses to be Carried Forward to March 31,2019**		
Operating Funding									

2018 Annual Reconciliation
As of December 31, 2018

Annual Reconciliation by Sources of Funding

Programs/Sources of Funding	Q4 Expenditures (at 100%)	Actual Expenditures (at 100%)	Variance Under / (Over)		Actual Expenditures (at provincial share)	Approved Allocation	Eligible Expenditures	Funding Received from the Ministry	Due to / (From) Province
			$	(%)					$
A	B	C	D = B -C	E = D / B	F = C * Prov. Share	G	H = MIN(F,G)	I	J = I - H
Immunization/Infectious Diseases: Raccoon Rabies Strain (100%)	327,201	327,201	-	0.0%	327,201	327,200	327,200	327,200	-
Public Health Inspector Practicum Program (100%)	10,000	10,000	-	0.0%	10,000	10,000	10,000	10,000	-
2018-19 One-Time Funding Total	**337,201**	**337,201**	**-**	**0.0%**	**337,201**	**337,200**	**337,200**	**337,200**	**-**

Board of Health for the City of Hamilton, Public Health Services

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Program Outcome Indicators

Please refer to the technical instructions provided with the Annual Report and Attestation template to enable the board of health to report on program outcome indicator results. Section numbers in this worksheet refer to section numbers in the technical instructions.

1.0. CHRONIC DISEASE PREVENTION AND WELL-BEING

1.1 Provide locally developed indicators and associated results, where possible, to monitor the success of chronic disease prevention and well-being programs.

- % of elementary and secondary schools with a School Travel Plan – Result: 50.9% (80/157)
- % of targeted immigration service providers who reported using the information disseminated in the e-health communique for action – Result: 88.1% (37/42)
- % of tobacco retailers with tobacco sales convictions – Result: 16% (57/356)
- % of complaints related to tobacco control and sales that were responded to within 24 hours – Result: 100% (253/253)
- % of tobacco retailers in compliance with display, handling and promotion sections of the SFOA at time of last inspection – Result: 98.3% (350/356)
- % of electronic cigarette retailers in compliance with the Electronic Cigarette Act – Result: 94.7% (180/190)
- % of tobacco vendors in compliance with youth access legislation at the time of last inspection – Result: 84.3% (300/356)
- % of tobacco retailers inspected once per year for compliance with display, handling, and promotion sections of the Smoke-Free Ontario Act – Result: 100% (356/356)
- % of smokers that have attended a Tobacco Cessation Clinic at least once after registering – Result: 65.9% (1,704/2,585)

Data collection for the following indicators commenced in January 2019. Results will be available for the 2019 Outcome Indicators Report.

- % of targeted community partners with increased knowledge, skills and/or confidence following chronic disease prevention education
- % of elementary and secondary schools that have active transportation policies
- % of key partner agencies that reported using Nutritious Food Basket information for action or decision-making

2.0. FOOD SAFETY

2.1. Proportion of food premises that shift between moderate and high risk based on annual risk categorization assessment

Number of food premises that shift from high to moderate risk	140
Total number of food premises that shift from moderate to high risk	38

Board of Health Comments (as needed)

2.2. Percentage and number of Salmonella and E. Coli foodborne outbreaks investigated for which a probable source was identified

Number of locally acquired Salmonella and E. Coli foodborne outbreak(s) where a probable source was identified	1
Total number of Salmonella and E. Coli outbreak(s)	1
Number of locally acquired Salmonella and E. Coli foodborne outbreak(s) where a probable source was identified/Total number of Salmonella and E. Coli outbreak(s)*100	100.00%

In addition, note the type of setting where the outbreak occurred (e.g., hospital, long-term care home, day care, restaurant, home).

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Program Outcome Indicators

This Salmonella outbreak occurred at a local restaurant.

Board of Health Comments (as needed)

2.3. Incidence of reportable Salmonella, Campylobacter and E. Coli foodborne illness cases

As per the technical instructions, the ministry will be collecting the data for this section.

3.0. HEALTHY ENVIRONMENTS

3.1 Provide locally developed indicators, where possible, to monitor the success of healthy environments programs.

Data collection for the following indicators commenced in January 2019. Results will be available for the 2019 Outcome Indicators Report.

- % of assigned milestones completed from the Bay Area Climate Change Partnership project
- % of assigned milestones completed from the Air Quality Task Force Action Plan 2019

4.0. HEALTHY GROWTH AND DEVELOPMENT

4.1 Provide locally developed indicators, where possible, to monitor the success of healthy growth and development programs.

- % of pregnancies in Hamilton screened by Healthy Babies Healthy Children – Result: 12.9% (706/5,489)
- % of first time, pregnant youth (≤ 21 years of age) who accessed the Nurse Family Partnership program – Result: 97.1% (136/140)
- % of pregnant women who reported being more confident in their ability to breastfeed after attending prenatal classes – Result: 71.1% (138/194)
- % of pregnant women in Hamilton who registered for Hamilton Public Health Services prenatal classes – Result: 9.8% (537/5,489)

5.0. IMMUNIZATION

As per the technical instructions, the ministry and Public Health Ontario will be collecting the data for this section.

6.0. INFECTIOUS AND COMMUNICABLE DISEASES PREVENTION AND CONTROL

As per the technical instructions, the ministry will be collecting the data for this section.

7.0. SAFE WATER

7.1. Recreational Water: Percentage of re-inspections of spas per year

Number of re-inspections of spas	11
Total number of re-inspections and inspections of spas	90

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Program Outcome Indicators

(Number of re-inspections of spas/Total number of re-inspections and inspections of spas)*100%	12.22%

Board of Health Comments (as needed)

7.2. Recreational Water: Percentage of recreational water premises with no critical infractions in the last year (pools, spas, wading pools, splash pads, and receiving basins for water slides)

Number of Class A pools with no critical infractions	18
Total number of Class A pools	49
(Number of Class A pools with no critical infractions/Total number of Class A pools)*100%	36.73%
Number of Class B pools with no critical infractions	50
Total number of Class B pools	77
(Number of Class B pools with no critical infractions/Total number of Class B pools)*100%	64.94%
Number of spas with no critical infractions	14
Total number of spas	21
(Number of spas with no critical infractions/Total number of spas)*100%	66.67%
Number of wading pools with no critical infractions	1
Total number of wading pools	11
(Number of wading pools with no critical infractions/Total number of wading pools)*100%	9.09%
Number of splash pads and receiving basins with no critical infractions	5
Total number of splash pads and receiving basins	63
(Number of splash pads and receiving basins with no critical infractions/Total number of splash pads and receiving basins)*100%	7.94%

Additional Reporting Information:
- Include inspections conducted during the reporting year
- Include total number of each recreational water facility as per the inventory in the reporting year

Board of Health Comments (as needed)

8.0. SCHOOL HEALTH

8.1 Provide locally developed indicators, where possible, to monitor the success of school health programs.

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Program Outcome Indicators

- % of all JK, SK and Grade 2 students who received an oral health screening in all publicly funded schools – Result: 92.1% (14,608/15,867)
- % of all JK, SK, Grade 2, 4, 6, 8 students who received an oral health screening from high intensity schools – Result: 87.1% (1,721/1,977)

Data collection for the following indicators commenced in 2019. Results will be available for the 2019 Outcome Indicators Report.
- % of targeted schools with completed annual action plan activities per school year
- % of eligible children enrolled in Healthy Smiles Ontario who accessed the service

Data collection for the following indicators will commence in September 2019. Results will be available for the 2019 Outcome Indicators Report.
- % of SK students who received a vision screening from all schools in Hamilton
- % of SK students who screened positive who received a comprehensive eye exam by last notification

9.0. SUBSTANCE USE AND INJURY PREVENTION

9.1 Provide locally developed indicators, where possible, to monitor the success of substance use and injury prevention programs.

- % of needles distributed that are returned to the harm reduction program – Result: 56% (672,771/1,200,937)
- % of eligible external stakeholders providing naloxone through the Ontario Naloxone Program – Result: 19.4% (6/31)
- % of Needle Exchange Van service requests that were responded to – Result: 93.1% (3,354/3,603)
- % of naloxone kits distributed that were used by clients – Result: 18.0% (568/3158)

Data collection for the following indicators commenced in 2019. Results will be available for the 2019 Outcome Indicators Report.
- % of planned activities in relation to public health that are implemented for the harm reduction, prevention, treatment and social justice work groups of the Hamilton Drug Strategy
- % of partner organizations who are satisfied with the Hamilton Drug Strategy

Board of Health for the City of Hamilton, Public Health Services

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Attestation by Domain of the Public Health Accountability Framework

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1.0 Delivery of Programs and Services			
1.1 Did the board of health deliver programs and services in accordance with the Ontario Public Health Standards?	Yes		
1.2 Did the board of health comply with programs provided for in the *Health Protection and Promotion Act* ?	Yes		
1.3 Did the board of health undertake population health assessments that included the identification of priority populations, social determinants of health and health inequities, and measure and report on them?	Yes		
1.4 Did the board of health publicly disclose results of all inspections or other required information in accordance with the Ontario Public Health Standards?	Yes		
1.5 Did the board of health 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?	Yes		
1.6 Did the board of health 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 Ontario Public Health Standards?	Yes		
1.7 Does the board of health have a strategic plan that establishes strategic priorities over 3 to 5 years? Did the plan include input from staff, clients, and community partners, and is a process in place to review the plan at least every other year?	Yes		
1.8 Did the board of health develop and implement a program of public health interventions in accordance with the Chronic Disease Prevention and Well-Being Program Standard, using a comprehensive health promotion approach as outlined in the *Chronic Disease Prevention Guideline, 2018* (or as current), that addressed chronic disease risk and protective factors to reduce the burden of illness from chronic diseases in the public health unit population?	Yes		

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1.9 Did the board of health enforce the *Skin Cancer Prevention Act (Tanning Beds), 2013* in accordance with the *Tanning Beds Protocol, 2019* (or as current)?	Yes		
1.10 Did the board of health conduct routine inspections of all high and moderate risk fixed food premises as per the *Food Safety Protocol, 2019* (or as current)?	Yes		
1.11 Did the board of health develop and implement a program of public health interventions that promoted healthy built and natural environments in accordance with the Healthy Environments Program Standard?	Yes		
1.12 Did the board of health develop and implement a program of public health interventions in accordance with the Healthy Growth and Development Program Standard, using a comprehensive health promotion approach as outlined in the *Healthy Growth and Development Guideline, 2018* (or as current), that supported healthy growth and development in the public health unit population?	Yes		
1.13 Did the board of health complete inventory counts as specified in the *Vaccine Storage and Handling Protocol, 2018* (or as current)?	Yes		
1.14 Did the board of health conduct routine inspections of small drinking water systems and recreational water facilities as per the *Recreational Water Protocol, 2019* (or as current) and *Safe Drinking Water and Fluoride Monitoring Protocol, 2019* (or as current)?	Yes		
1.15 Did the board of health develop and implement a program of public health interventions in accordance with the School Health Program Standard, using a comprehensive health promotion approach as outlined in the *School Health Guideline, 2018* (or as current) to improve the health of school-aged children and youth?	Yes		
1.16 Did the board of health develop and implement a program of public health interventions using a comprehensive health promotion approach, as outlined in the *Substance Use Prevention and Harm Reduction Guideline, 2018* (or as current) and the *Tobacco, Vapour and Smoke Guideline, 2018* (or as current), that addresses risk and protective factors to reduce the burden of substance use in the public health unit population?	Yes		

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1.17 Did the board of health develop and implement a program of public health interventions using a comprehensive health promotion approach, as outlined in the *Injury Prevention Guideline, 2018* (or as current), that addressed risk and protective factors to reduce the burden of preventable injuries in the public health unit population?	Yes		
2.0 Fiduciary Requirements			
2.1 Did the board of health comply with the terms and conditions of the Public Health Funding and Accountability Agreement?	Yes		
2.2 Did the board of health place the grant provided by the ministry in an interest bearing account at a Canadian financial institution and report interest earned to the ministry?	Yes		
2.3 Did the board of health report all revenues it collected for programs or services in accordance with the direction provided in writing by the ministry?	Yes		
2.4 Did the board of health report any part of the grant that was not used or accounted for in a manner requested by the ministry?	Yes		
2.5 Did the board of health repay ministry funding as requested by the ministry?	Yes		
2.6 Did the board of health ensure that expenditure forecasts were as accurate as possible?	Yes		
2.7 Did the board of health keep a record of financial affairs, invoices, receipts and other documents, and prepare annual statements of their financial affairs?	Yes		
2.8 Did the board of health 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?	Yes		
2.9 Did the board of health use the grant only for the purposes of the *Health Protection and Promotion Act* and provide or ensure the provision of programs and services in accordance with the *Health Protection and Promotion Act* , Ontario Public Health Standards, and the Public Health Funding and Accountability Agreement?	Yes		

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2.10 Did the board of health spend the grant only on admissible expenditures?	Yes		
2.11 Did the board of health comply with the *Municipal Act, 2001,* and ensured that the administration adopted policies with respect to its procurement of goods and services?	Yes		
2.12 Did the board of health conduct an open and competitive process to procure goods and services?	Yes		
2.13 Did the board of health ensure that the administration implemented appropriate financial management and oversight to ensure the following were in place? a) A plan for the management of physical and financial resources; b) A process for internal financial controls based on generally accepted accounting principles; c) A process to ensure that areas of variance were addressed and corrected; d) A procedure to ensure that the procurement policy was 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.	Yes		
2.14 Did the board of health have financial controls in place that met the specified attributes and objectives as per *Schedule D* of the Public Health Funding and Accountability Agreement?	Yes		
2.15 Did the board of health negotiate and have in place service level agreements for corporately provided services?	Yes		
2.16 Did the board of health have and maintain insurance?	Yes		
2.17 Did the board of health 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?	Yes		
2.18 Did the board of health dispose of an asset which exceeded $100,000 in value, and with the ministry's prior written confirmation?	N/A	No assets exceeding $100,000 in value were disposed of in 2018.	

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2.19 Did the board of health ensure that the grant was not carried over from one year to the next, unless pre-authorized in writing from the ministry?	Yes		
2.20 Did the board of health maintain a capital funding plan which included policies and procedures to ensure that funding for capital projects was appropriately managed and reported?	Yes		
2.21 Did the board of health comply with the Community Health Capital Programs policy?	Yes		
3.0 Good Governance and Management Practices			
3.1 Did the board of health operate in a transparent and accountable manner, and provide accurate and complete information to the ministry?	Yes		
3.2 Did the board of health ensure that members were 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?	Yes		
3.3 Did the board of health carry out its obligations without a conflict of interest and disclose to the ministry an actual, potential, or perceived conflict of interest?	Yes		
3.4 Did the board of health 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?	Yes		

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3.5 Did the board of health comply with medical officer of health appointment and reporting requirements of the *Health Protection and Promotion Act* , and the ministry's *Policy Framework on Medical Officer of Health Appointments, Reporting, and Compensation* ? This includes, but is not limited to, having or ensuring: a) The appointment and approval of a full-time Medical Officer of Health at a minimum of a 0.8 full-time equivalent (28 to 32 hours or 4 days per business week on-site at the public health unit); b) The appointment of a physician as Acting Medical Officer of Health at a minimum of a 0.8 full-time equivalent (28 to 32 hours or 4 days per business week on-site at the public health unit), where there was no Medical Officer of Health or Associate Medical Officer of Health in place; c) The Medical Officer of Health reported directly to the board of health (solid line relationship) on matters of public health significance/importance; d) The Medical Officer of Health was part of the senior management team; e) Staff resopnsible for the delivery of public health programs and services reported directly to the Medcial Officer of health without any need to report to intermediaries (solid line relationship); and, f) Compliance with eligibility criteria under the Medical Officer of Health and Associate Medical Officer of Health Compensation Initiative.	Yes		
3.6 Did the board of health ensure that the administration established a human resources strategy which considered the competencies, composition and size of the workforce, as well as community composition, and included initiatives for the recruitment, retention, professional development, and leadership development of the public health unit workforce?	Yes		
3.7 Did the board of health ensure that the administration established and implemented written human resource policies and procedures which were made available to staff, students, and volunteers?	Yes		
3.8 Did the board of health ensure all policies and procedures were regularly reviewed and revised, and included the date of the last review/revision?	No	Human Resource policies and procedures are maintained by the City of Hamilton Human Resources division and may or may not be regularly reviewed and revised.	Review and revision of these policies will be completed by the City of Hamilton Human Resources Division in accordance with their timelines.

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3.9 Did the board of health engage in community and multi-sectoral collaboration with LHINs and other relevant stakeholders in decreasing health inequities?	Yes		
3.10 Did the board of health engage in relationships with Indigenous communities in a way that was meaningful for them?	No	PHS has partially met this requirement by participating in the development of the City-led Hamilton Urban Indigenous Strategy in 2018. This involved taking part in working circles that focused on Indigenous relations. This City-led Strategy will be used to guide the development of a PHS Indigenous Health Strategy - please see action plan.	An Indigenous Health Strategy Specialist was hired in 2019 to lead the development of a PHS strategy to address Indigenous health issues in Hamilton. A key component of shaping and developing the PHS Indigenous Health Strategy will be consultation and meaningful engagement with Indigenous communities to identify existing health issues / gaps and actions to address them.
3.11 Did the board of health 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?	Yes		
3.12 Did the board of health 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 were 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.	Yes		

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3.13 Did the board of health ensure that by-laws, policies and procedures were reviewed and revised as necessary, and are reviewed at least every two years?	No	PHS has partially met this requirement. Council Procedures (By-law No. 14-300) and Council Code of Conduct (By-law No. 16-290) were updated within the last two years. In addition, PHS department policies have a review schedule of every two years and will be up to date by the end of 2019. Policies and procedures that are reviewed and revised by other City of Hamilton departments will be done in accordance with their timelines.	Finance & Administration, Information Technology, and Human Resource policies will be reviewed by the respective City of Hamilton departments in accordance with their timelines.
3.14 Did the board of health provide governance direction to the administration and ensure that the board of health remained informed about the activities of the organization regarding 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.	Yes		
3.15 Did the board of health have a self-evaluation process of its governance practices and outcomes that are completed at least every other year?	Yes		
3.16 Did the board of health ensure that the administration developed and implemented a set of client service standards?	Yes		
3.17 Did the board of health ensure that the medical officer of health, as the designated health information custodian, maintained information systems and implemented policies/ procedures for privacy and security, data collection and records management?	Yes		
4.0 Public Health Practice			
4.1 Did the board of heath ensure that the administration established, maintained, and implemented policies and procedures related to research ethics?	Yes		

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4.2 Did the board of health designate a Chief Nursing Officer and meet specific requirements under Schedule B of the Public Health Funding and Accountability Agreement? This includes but is not limited to: a) The Chief Nursing Officer role was implemented at the management level or participated in senior management meetings; b) The Chief Nursing Officer reported directly to the medical officer of health or Chief Executive Officer; and, c) The Chief Nursing Officer articulated, modelled, and promoted a vision of excellence in public health nursing practice, which facilitated evidence-based services and quality health outcomes in the public health context	Yes		
4.3 Did the board of health use 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?	Yes		
4.4 Did the board of health employ qualified public health professionals in accordance with the *Qualifications for Public Health Professionals Protocol, 2018* (or as current)?	Yes		
4.5 Did the board of health support a culture of excellence in professional practice, ensuring a culture of quality and continuous organizational self-improvement?	Yes		
5.0 Other			
5.1 Did the board of health have a formal risk management framework in place that identified, assessed, and addressed risks?	Yes		
5.2 Did the board of health produce an annual financial and performance report to the general public, as well as its Strategic Plan?	Yes		

Board of Health for the City of Hamilton, Public Health Services

2018 Annual Report and Attestation

Certification by the Board of Health

Chair, Board of Health	
Name	
(Signature) (Date)	

Medical Officer of Health / Chief Executive Officer	
Name	
(Signature) (Date)	

Chief Financial Officer / Business Administrator	
Name	
(Signature) (Date)	

Medical Officer of Health / Chief Executive Officer and Chief Financial Officer / Business Administrator:

- certify that the Annual Reconciliation worsheets with all the supporting documents are accurate financial statements attributable to the public health programs for the period specified and that the supporting documents are available for audit.
- certify that the attached Audited Financial Statements have been reviewed and approved by the Board and are in accordance with GAAP reporting standards.