City of Hamilton

BOARD OF HEALTH REVISED

Meeting #: 19-010
Date: October 18, 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

---

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 August 14, 2019 (Deferred from the September 16, 2019 meeting, as quorum was not achieved)

4.2 Clerk's Report - September 16, 2019

5. COMMUNICATIONS

5.1 Correspondence from the Kingston, Frontenac and Lennox & Addington Board of Health respecting Principles and Criteria for the Restructuring Process (Deferred from the September 16, 2019 meeting, as quorum was not achieved)

Recommendation: Endorse the key principles and decision making criteria that should be used to guide public health restructuring, as outlined by Kingston, Frontenac and Lennox & Addington Board of Health.

5.2 Correspondence from the Middlesex-London Board of Health respecting Essential Components for Strong Local Public Health (Deferred from the September 16, 2019 meeting, as quorum was not achieved)

Recommendation: Endorse the essential components for strong local public health as outlined in Middlesex-London Board of Health Report No. 053-19.

5.3 Correspondence from the Ministry of Children, Community and Social Services respecting the Healthy Babies, Healthy Children Program Project Agreement (Deferred from the September 16, 2019 meeting, as quorum was not achieved)

Recommendation: Be received.

5.4 Correspondence from the Ministry of Health respecting a Ministry of Health Public Health Funding and Accountability Agreement with the Board of Health for the City of Hamilton (Deferred from the September 16, 2019 meeting, as quorum was not achieved)

Recommendation: Be received.

5.5 Correspondence from the Association of Local Public Health Units respecting their Fall Symposium and Meeting to be held on November 6 and 7, 2019 (Deferred from the September 16, 2019 meeting, as quorum was not achieved)

Recommendation: Be received.

5.6 Correspondence from the Association of Local Public Health Agencies respecting a Public Health Cost Sharing Funding Model (Deferred from the September 16, 2019 meeting, as quorum was not achieved)

Recommendation: Be received.

6. DELEGATION REQUESTS

6.1 Delegation Request from Noor Nizam, respecting the Ontario Seniors Dental Care Program (for a future meeting)

(Deferred from the September 16, 2019 meeting, as quorum was not achieved)

7. CONSENT ITEMS

7.1 IDEAS (Informed Decisions Empowering Adolescents) Program (BOH16059(b)) (City Wide) (Deferred from the September 16, 2019 meeting, as quorum was not achieved)

7.2 Semi-Annual Public Health Services Performance and Monitoring Report (Q1 & Q2 2019) (BOH19030) (City Wide) (Deferred from the September 16, 2019 meeting, as quorum was not achieved)

7.3 Physician Recruitment and Retention Steering Committee Report 19-001 - September 11, 2019 (Deferred from the September 16, 2019 meeting, as quorum was not achieved)

7.4 Annual Performance & Financial Report to the Public (BOH19033) (City Wide)

7.5 Associate Medical of Health (AMOH) Coverage Plan (BOH19035) (City Wide)

7.6 Organizational Risk Management Plan: 2019 Progress Report (BOH18032(a))

8. PUBLIC HEARINGS / DELEGATIONS

9. STAFF PRESENTATIONS

9.1 Immunization of School Pupils Act Overview (BOH19029) (City Wide) (Deferred from the September 16, 2019 meeting, as quorum was not achieved)

9.2 Seniors Oral Health (BOH19026(a)) (City Wide)

10. DISCUSSION ITEMS

11. MOTIONS

12. NOTICES OF MOTION

*12.1 Code Red Presentation to the Board of Health

13. GENERAL INFORMATION / OTHER BUSINESS

13.1 Amendments to the Outstanding Business List (Deferred from the September 16, 2019 meeting, as quorum was not achieved)

13.1.a Revised Due Dates Required

2015-A
Review of the City of Hamilton's Pest Control By-law
November 16, 2015
(Item 9.1)
Due Date: May 2019
Revised Due Date: TBD

2016-A
Hamilton Airshed Modelling System (BOH18016) (City Wide)
April 16, 2018
18-004
(Item 7.1)
Due Date: June 2019
Revised Due Date: TBD

2019-P
Pollution Surrounding the Parkview Community – Community Event
August 14, 2019
19-008
Items 6.1-6.13
Due Date: TBD

13.1.b Item to Be Removed

2016-C
Contaminated Sites Management Plan
December 5, 2016, 16-012 (Item 5.1)
Based on clarification and additional information provided by staff on the Historic Land Use inventory, Contaminated Sites Management Plan, Record of site condition requirements and mitigation measures, in consultation with the Councillor, this item can be marked as completed and removed

2019-Q
Correspondence from the Windsor-Essex County Health Unit respecting Immunization for School Children - Seamless Immunization Registry
August 14, 2019, 19-008 (Item 5.1)
Addressed as Item 9.1 on this agenda

14. PRIVATE AND CONFIDENTIAL

15. ADJOURNMENT

BOARD OF HEALTH
MINUTES 19-008

1:30 p.m.
Wednesday, August 14, 2019
Council Chambers
Hamilton City Hall

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

THE FOLLOWING ITEMS WERE REFERRED TO COUNCIL FOR CONSIDERATION:

1. COMMUNICATIONS (Item 5.2)

(Pearson/VanderBeek)
That the correspondence from Peterborough Public Health respecting Support for a National School Food Program (Item 5.2), be endorsed.

Result: Motion CARRIED by a vote of 11 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
YES - Councillor Tom Jackson
YES - Councillor Esther Pauls
NOT PRESENT - Councillor John-Paul Danko
NOT PRESENT - Chair Fred Eisenberger
NOT PRESENT - Councillor Judi Partridge
YES - Councillor Terry Whitehead
YES - Councillor Arlene VanderBeek
NOT PRESENT - Councillor Lloyd Ferguson
NOT PRESENT - Councillor Brenda Johnson

YES - Councillor Maria Pearson
YES - Councillor Brad Clark

2. Brody Robinmeyer, respecting Climate Change (for a future meeting) (Added Item 6.14)

(Whitehead/Merulla)
That the delegation request from Brody Robinmeyer, respecting Climate Change, be received and referred to the General Issues Committee.

Result: Motion CARRIED by a vote of 11 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
NOT PRESENT - Chair Fred Eisenberger
NOT PRESENT - Councillor Judi Partridge
YES - Councillor Terry Whitehead
YES - Councillor Arlene VanderBeek
NOT PRESENT - Councillor Lloyd Ferguson
NOT PRESENT - Councillor Brenda Johnson
YES - Councillor Maria Pearson
YES - Councillor Brad Clark

3. Ontario Health Teams Update (BOH19020(a)) (City Wide) (Item 9.1)

(Merulla/Clark)
That Report BOH19020(a), respecting Ontario Health Teams Update, be received.

CARRIED

4. Climate Change Delegation Requests (Added Item 11.1)

(Whitehead/Merulla)
That staff be directed to refer all delegation requests on Climate Change to the General Issues Committee.

Result: Motion CARRIED by a vote of 11 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
YES - Councillor Tom Jackson
YES - Councillor Esther Pauls
NOT PRESENT - Councillor John-Paul Danko
NOT PRESENT - Chair Fred Eisenberger
NOT PRESENT - Councillor Judi Partridge
YES - Councillor Terry Whitehead
YES - Councillor Arlene VanderBeek
NOT PRESENT - Councillor Lloyd Ferguson
NOT PRESENT - Councillor Brenda Johnson
YES - Councillor Maria Pearson
YES - Councillor Brad Clark

FOR INFORMATION:

(a) CERMONIAL ACTIVITIES (Item 1)

There were no ceremonial activities.

(b) CHANGES TO THE AGENDA (Item 2)

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

1. DELEGATION REQUESTS (Item 6)

6.3 Elsie Briggs, Parkview Community Association, respecting Pollution Surrounding the Parkview Community (for a future meeting)

6.4 Iveta Morin, respecting Pollution Surrounding the Parkview Community (for a future meeting)

6.5 George and Edie Bellamy, respecting Pollution Surrounding the Parkview Community (for a future meeting)

6.6 David Kebick, respecting Pollution Surrounding the Parkview Community (for a future meeting)

6.7 Brian Beck, respecting Pollution Surrounding the Parkview Community (for a future meeting)

6.8 Terry Morris, respecting Pollution Surrounding the Parkview Community (for a future meeting)

6.9 James MacDonald, respecting Pollution Surrounding the Parkview Community (for a future meeting)

6.10 Maureen White, respecting Pollution Surrounding the Parkview Community (for a future meeting)

6.11 Gabriel da Silva, respecting Pollution Surrounding the Parkview Community (for a future meeting)

6.12 Marius Madaras, respecting Pollution Surrounding the Parkview Community (for a future meeting)

6.13 Nolly Bayeng, respecting Pollution Surrounding the Parkview Community (for a future meeting)

6.14 Brody Robinmeyer, respecting Climate Change (for a future meeting)

(Clark/VanderBeek)
That the agenda for the August 14, 2019 Board of Health be approved, as amended.

Result: Motion CARRIED by a vote of 11 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
YES - Councillor Tom Jackson
YES - Councillor Esther Pauls
NOT PRESENT - Councillor John-Paul Danko
NOT PRESENT - Chair Fred Eisenberger
NOT PRESENT - Councillor Judi Partridge
YES - Councillor Terry Whitehead
YES - Councillor Arlene VanderBeek
NOT PRESENT - Councillor Lloyd Ferguson
NOT PRESENT - Councillor Brenda Johnson
YES - Councillor Maria Pearson
YES - 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) July 10, 2019 (Item 4.1)

(Pearson/Pauls)
That the Minutes of the July 10, 2019 meeting of the Board of Health be approved, as presented.

Result: Motion CARRIED by a vote of 11 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
YES - Councillor Tom Jackson
YES - Councillor Esther Pauls
NOT PRESENT - Councillor John-Paul Danko
NOT PRESENT - Chair Fred Eisenberger
NOT PRESENT - Councillor Judi Partridge
YES - Councillor Terry Whitehead
YES - Councillor Arlene VanderBeek
NOT PRESENT - Councillor Lloyd Ferguson
NOT PRESENT - Councillor Brenda Johnson
YES - Councillor Maria Pearson
YES - Councillor Brad Clark

(e) COMMUNICATIONS (Item 5)

(Clark/Jackson)
That the following Correspondence Items, be received:

(i) Correspondence from the Windsor-Essex County Health Unit respecting Immunization for School Children - Seamless Immunization Registry (Item 5.1)

Recommendation: Be received, and referred to Public Health Services staff for a report to the Board of Health in September 2019.

(ii) Correspondence from the Association of Local Public Health Agencies (alPHa) respecting the appointment of Councillor Wilson as the Board of Health Representative, Central West Region (Item 5.3)

(iii) Correspondence from the Simcoe Muskoka District Health Unit respecting Public Health Modernization (Item 5.4)

(iv) Correspondence from the Windsor-Essex County Health Unit respecting Smoke-Free-Smoke/Vape Free Outdoor Spaces (Item 5.5)

(v) Correspondence from the North Bay Parry Sound District Health Unit respecting a Public Health Transformation Initiative in Northeastern Ontario (Item 5.6)

CARRIED

(f) DELEGATION REQUESTS (Item 6)

(i) Delegation Requests respecting Pollution Surrounding the Parkview Community for a future meeting (Items 6.1 – 6.13)

(Merulla/Collins)
That the following Delegation Requests be received, and that Public Health staff be directed to host a community meeting, respecting pollution surrounding the Parkview Community, at the Museum of Steam and Technology inviting members of the Parkview Community, the Ministry of Environment, and local Ministers of Provincial Parliament:

(i) Daniel Morin, respecting Pollution Surrounding the Parkview Community (for future meeting) (Item 6.1)

(ii) Kathy Cook, respecting Pollution Surrounding the Parkview Community (for a future meeting) (Item 6.2)

(iii) Elsie Briggs, Parkview Community Association, respecting Pollution Surrounding the Parkview Community (for a future meeting) (Added Item 6.3)

(iv) Iveta Morin, respecting Pollution Surrounding the Parkview Community (for a future meeting) (Added Item 6.4)

(v) George and Edie Bellamy, respecting Pollution Surrounding the Parkview Community (for a future meeting) (Added Item 6.5)

(vi) David Kebick, respecting Pollution Surrounding the Parkview Community (for a future meeting) (Added Item 6.6)

(vii) Brian Beck, respecting Pollution Surrounding the Parkview Community (for a future meeting) (Added Item 6.7)

(viii) Terry Morris, respecting Pollution Surrounding the Parkview Community (for a future meeting) (Added Item 6.8)

(ix) James MacDonald, respecting Pollution Surrounding the Parkview Community (for a future meeting) (Added Item 6.9)

(x) Maureen White, respecting Pollution Surrounding the Parkview Community (for a future meeting) (Added Item 6.10)

(xi) Gabriel da Silva, respecting Pollution Surrounding the Parkview Community (for a future meeting) (Added Item 6.11)

(xii) Marius Madaras, respecting Pollution Surrounding the Parkview Community (for a future meeting) (Added Item 6.12)

(xiii) Nolly Bayeng, respecting Pollution Surrounding the Parkview Community (for a future meeting) (Added Item 6.13)

Result: Motion CARRIED by a vote of 11 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
NOT PRESENT - Chair Fred Eisenberger
NOT PRESENT - Councillor Judi Partridge
YES - Councillor Terry Whitehead
YES - Councillor Arlene VanderBeek
NOT PRESENT - Councillor Lloyd Ferguson
NOT PRESENT - Councillor Brenda Johnson
YES - Councillor Maria Pearson
YES - Councillor Brad Clark

(g) CONSENT ITEMS (Item 7)

(i) Food Advisory Committee Minutes - June 11, 2019 (Item 7.1)

(VanderBeek/Whitehead)
That the Food Advisory Committee Minutes for June 11, 2019, be received.

CARRIED

(h) STAFF PRESENTATION (Item 9)

(i) Ontario Health Teams Update (BOH19020(a)) (City Wide) (Item 9.1)

Paul Johnson, General Manager, Healthy and Safe Communities, accompanied by the following individuals, addressed the Board of Health with an overview of Report BOH19020(a), respecting an Ontario Health Teams Update, with the aid of a PowerPoint presentation:

- Dr. Elizabeth Richardson – Medical Officer of Health

- Dr. Tom Stewart – CEO, St. Joseph's Health System and Niagara Health
- Rob MacIsaac – President and CEO, Hamilton Health Sciences
- Terry McCarthy – Executive Director, Hamilton Family Health Team
- Dr. David Price – Professor and Chair, Department of Family Medicine, McMaster University
- Bernice King – Co-chair, Hamilton Health Team Partnership Council

(Ferguson/VanderBeek)
That the presentation respecting Ontario Health Teams Update (BOH19020(a)), be received.

CARRIED

For disposition of this matter, refer to Item 3.

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

(i) GENERAL INFORMATION AND OTHER BUSINESS (Item 13)

(i) Amendments to the Outstanding Business List:

(VanderBeek/Pauls)
That the following amendments to the Audit, Finance & Administration Committee's Outstanding Business List, be approved:

(a) Items to be Removed:

2015-B
Food Strategy BOH13001(d)
August 11, 2015 (Item 7.1)
Addressed as Item at the July 12, 2019 Board of Health meeting

2016-B
Food Strategy Priority Actions 2 & 3
August 11, 2016 (Item 7.1)
Addressed as Item 2 at the July 12, 2019 Board of Health meeting (Food Strategy Priority Actions 2 (Food Skills & Employability) and 3 (Neighbourhood Food Infrastructure) (BOH13001(i)))

2019-D
Accelerating and Prioritizing Climate Action in Response to the Climate Emergency
March 18, 2019, 19-003 (Added Item 8.3)

Addressed as Items 4 and 7 at the June 17, 2019 Board of Health meeting (Corporate Climate Change Task Force Response to the Climate Change Emergency Declaration (BOH19022) and Establishment of Departmental Climate Change Workplans within the City of Hamilton)

2019-E
Fentanyl Overdose Prevention Initiatives
March 18, 2019, 19-003 (Item 8.2)
Addressed as Item 4 at the July 12, 2019 Board of Health meeting (Report BOH19024, respecting the Feasibility of Providing Drug Checking (Fentanyl) Test Strips)

2019-G
Correspondence from the Toronto Board of Health Urging the Ministry of Health and Long-Term Care to Support Managed Opioid Programs
April 15, 2019, 19-004 (Item 5.2)
Addressed as Item 3 at the July 12, 2019 Board of Health meeting (Managed Opioid Treatment Programs (BOH19023) (City Wide))

2019-K
Establishment of Departmental Climate Change Workplans within the City of Hamilton
June 17, 2019, 19-006 (Item 11.1)
Referred to General Issues Committee for updates

Result: Motion CARRIED by a vote of 11 to 0, as follows:

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

(j) ADJOURNMENT (Item 15)

(Pearson/Ferguson)
That, there being no further business, the Board of Health be adjourned at 3:02 p.m.

CARRIED

Respectfully submitted,

Councillor Maureen Wilson
Vice-Chair, Board of Health

Angela McRae
Legislative Coordinator
Office of the City Clerk

BOARD OF HEALTH
CLERK'S REPORT 19-009

1:30 p.m.
Monday, September 16, 2019
Council Chambers
Hamilton City Hall

Pursuant to Section 5.4(4) of the City of Hamilton's Procedural By-law 18-270 at 2:01 p.m. the Chair advised those in attendance that quorum had not been achieved within 30 minutes after the time set for the Board of Health, therefore, the Clerk noted the names of those in attendance and the meeting stood adjourned.

Present:

Councillor M. Wilson (Vice-Chair)
Councillor J. Farr
Councillor C. Collins
Councillor T. Jackson
Councillor J.P. Danko
Councillor B. Clark
Councillor B. Johnson
Councillor A. VanderBeek

Respectfully submitted,

Loren Kolar
Legislative Coordinator
Office of the City Clerk

From:	Fernandes, Krislyn
To:	Kolar, Loren
Subject:	05.1 ENDORSE (2019-08-06) Kingston Frontenac Lennox Addington - Principles and Criteria to Guide PH Restructuring
Date:	September 4, 2019 3:04:42 PM
Attachments:	Board Letter - Principles and Criteria Aug 6, 2019.pdf

Krislyn Fernandes
Administrative Coordinator to Dr. Elizabeth Richardson, Medical Officer of Health

Office of the Medical Officer of Health | Public Health Services
Healthy and Safe Communities Dept. | City of Hamilton
100 Main Street West, 6th Floor | Hamilton, ON | L8P 1H6
t: 905.546.2424 x3502 | **e:** Krislyn.Fernandes@hamilton.ca

Mailing Address:
110 King Street West, 2nd Floor | Hamilton, ON | L8P 4S6

From: Moore, Wynando <Wynando.Moore@kflaph.ca>
Sent: August 6, 2019 2:25 PM
To: 'christine.elliott@pc.ola.org' <christine.elliott@pc.ola.org>
Cc: 'doug.ford@pc.ola.org' <doug.ford@pc.ola.org>; 'IArthur-QP@ndp.on.ca' <IArthur-QP@ndp.on.ca>; 'daryl.kramp@pc.ola.org' <daryl.kramp@pc.ola.org>; 'Dr.David.Williams@ontario.ca' <Dr.David.Williams@ontario.ca>; Loretta Ryan <loretta@alphaweb.org>; Ron.Higgins@FRONTENACCOUNTY.CA; ericsmith2015@hotmail.com; Kelly Pender <kpender@frontenaccounty.ca>; Brenda Orchard <borchard@lennox-addington.on.ca>; mayor@cityofkingston.ca; mturner@amo.on.ca; Helen.Angus@pc.ola.org; moh@hpeph.ca; Paula.Stewart@healthunit.org; Guan, Hugh <Hugh.Guan@kflaph.ca>; Buttemer, Samantha <Samantha.Buttemer@kflaph.ca>; allhealthunits@lists.alphaweb.org; Councillor Jeff McLaren <jmclaren@cityofkingston.ca>; Councillor Jim Neill <jneill@cityofkingston.ca>; Councillor John Wise <jfhwise@gmail.com>; Councillor Mary Rita Holland <mrholland@cityofkingston.ca>; Dr. David Pattenden <davidpattenden@kos.net>; Mayor Denis Doyle <denisdoyle@kos.net>; Ms. Conny Glenn <connyaglenn@gmail.com>; Wess Garrod (wessgarrod@gmail.com) <wessgarrod@gmail.com>
Subject: KFL&A Board of Health Letter - Principles and Criteria - Aug 6, 2019

Dear Minister Elliott:

The Kingston, Frontenac and Lennox & Addington (KFL&A) Board of Health passed the following motion at its July 24, 2019 meeting:

> *"THAT the KFL&A Board of Health share with the Government of Ontario key principles, and decision-making criteria that should be used to guide the restructuring process at the provincial level, and further that KFL&A Public Health looks forward to the opportunity to directly work with the Ministry on public health reorganization in the promised consultation process."*

Please find attached a letter from Denis Doyle, Chair, KFL&A Board of Health regarding the above.

Kind regards,

Wynando Moore

Wynando Moore
Executive Assistant to the Medical Officer of Health

Phone: 613-549-1232, Ext. 1237
Toll-Free: 1-800-267-7875
Fax: 613-549-1209
wynando.moore@kflaph.ca

KFL&A Public Health
221 Portsmouth Avenue
Kingston, Ontario K7M 1V5
www.kflaph.ca

Connect with us on Facebook | Twitter | YouTube

This e-mail may contain privileged and confidential information intended only for the individual or entity named in the message. If the reader of this message is not the intended recipient, or the agent responsible to deliver it to the intended recipient, you are hereby notified that any review, dissemination, distribution or copying of this communication is prohibited. If this communication was received in error, please notify us by reply e-mail and delete the original message.

Le présent message peut contenir des renseignements confidentiels réservés à l'usage exclusif du destinataire ou de l'organisme y figurant. Par conséquent, si vous n'êtes pas le destinataire de ce message ou la personne devant le lui remettre, nous vous avisons qu'il est strictement interdit de le passer en revue, de le diffuser, de le distribuer ou de le copier. Si vous avez reçu ce message par erreur, nous vous remercions de nous en aviser par retour de courriel et de détruire le message original.

KFL&A Public Health

August 6, 2019

The Honourable Christine Elliott, Deputy Premier
Minister of Health
Hepburn Block 10th Floor
80 Grosvenor Street
Toronto, ON M7A 1E9

Dear Minister Elliott:

In this time of public health restructuring in Ontario, it is crucial that we maintain a clear vision for the principles and criteria by which we can design and evaluate the amalgamation process. The Medical Officers of Health from across much of Eastern Ontario, all partners in the Eastern Ontario Wardens Caucus, along with CAOs from their counties, and myself came together on July 8, 2019, to develop a set of principles and criteria we believe should be used to guide the restructuring process at the provincial level. The Board of Health at KFL&A met on July 24, 2019 then to discuss the principles and criteria and agreed to unequivocally support the following below.

Key Principles for Restructuring Local Public Health in Ontario:

1. **Improve population health**: any modernization approaches and changes must protect and enhance population health.
2. **"Say for pay"** must be maintained for municipalities in a meaningful way, meaning the autonomous board must contain a majority of municipal representatives. It must allow for all "obligated municipalities", whether municipal or First Nation (Section 50, HPPA) to have meaningful decision-making to ensure public health remains responsive and accountable to the local communities it serves.
3. As a health unit composed of small urban, rural, and First Nations areas, the structure and delivery of services and programs must **meet the needs of these communities**. Local access and delivery must be maintained despite regionalization of back-office supports and efficiencies.
4. The **funding model and formula** for local public health must take factors into account such as equity, the older age of the population, the rural-urban mix, and must be sustainable.
5. The **best available evidence** should be considered as part of the policy decision making.
6. **Efficiencies will be identified and optimized** wherever possible, without sacrificing the quality and effectiveness of services provided.
7. Any new organizational structure will **build on the current strong collaborative relationships** among the current health units and local public health agencies in Eastern Ontario.
8. Any proposed infrastructure will **build on the assets** of the current local boards of health and respond to their challenges, looking for opportunities to improve public health services.

KFL&A Public Health

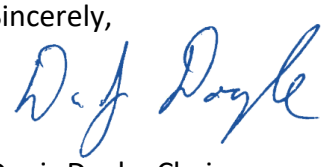
Decision-Making Criteria for Boundary Development:

1. **Alignment with Ministry of Health direction** - proposals must be evaluated considering the directions, vision and outcomes for Public Health as outlined by the Ministry.
2. **Maintenance of current partner alignment –** current relationships and partnerships with proposed Ontario Health Teams, Tertiary Care Centres, Universities/Colleges, neighbouring health units, school boards and other key partners should be maintained whenever possible.
3. **Meaningful governance by "obligated municipalities**" – consistent with the principle of "say for pay", decision-making must consider a meaningful governance model for obligated municipalities who are required to fund public health programs under the Health Protection and Promotion Act.
4. **Inclusion of Indigenous populations and Francophone populations**– amalgamation models need to ensure that Indigenous and Francophone populations are engaged at the governance level and in program planning and delivery.
5. **Efficiencies** – the potential for cost savings and efficiencies is paramount in the evaluation of models including evidence of economies of scale.
6. **Sufficient resources** – resources must be sufficient at the local level for regular programs and surge capacity, including resources to fill key positions including the Medical Officer of Health and other public health experts.

Our Board of Health feels that the current proposal by the Ministry would adversely affect KFL&A Public Health, and further, does not fulfill the key principles and criteria outlined above. Projections of the planned amalgamation estimate a costly process with potential impact on front-line services. A strength that will be lost is our strong working partnerships with both Hastings Prince Edward Public Health and Leeds Grenville Lanark District Health Unit formed through many years facing similar issues across our geography. If these partnerships are maintained, we would be able to achieve a solution that is beneficial for all stakeholders in our region.

We believe that this process should not be rushed to ensure decisions consider evidence and best practices to remove the risk of unintended negative consequences. To achieve our mutual goals, we look forward to the opportunity to directly work with the Ministry on public health reorganization in the promised consultation process and to consider these proposed principles and criteria.

Sincerely,



Denis Doyle, Chair
KFL&A Board of Health

KFL&A Public Health

Copy to: *Hon. D. Ford, Premier of Ontario*
Hon. H. Angus, Deputy Minister of Health
Ian Arthur, MPP Kingston and the Islands
Daryl Kramp, MPP Hastings-Lennox and Addington
Dr. David Williams, Chief Medical Officer of Health
Loretta Ryan, Association of Local Health Agencies
Ontario Boards of Health
KFL&A Board of Health members
Dr. Piotr Oglaza, MOH, HPEPH
Jo-Anne Albert, Board Chair, HPEPH
Dr. Paula Stewart, MOH, LGLDHU
Doug Malanka, Board Chair, LGLDHU
Warden R. Higgins, County of Frontenac
Warden E. Smith, County of Lennox and Addington
Kelly Pender, CAO, County of Frontenac
Brenda Orchard, CAO, County of Lennox and Addington
Mayor B. Paterson and City Councillors, City of Kingston
Monica Turner, Director of Policy, Association of Municipalities of Ontario

From:	Fernandes, Krislyn
To:	Kolar, Loren
Subject:	05.2 ENDORSE (2019-08-09) Middlesex London - Essential Components of Strong Public Health
Date:	September 4, 2019 2:55:39 PM
Attachments:	image001.jpg MLHU-Letter to CElliott re-Essential-components-for-local-public-health.pdf

Krislyn Fernandes
Administrative Coordinator to Dr. Elizabeth Richardson, Medical Officer of Health

Office of the Medical Officer of Health | Public Health Services
Healthy and Safe Communities Dept. | City of Hamilton
100 Main Street West, 6th Floor | Hamilton, ON | L8P 1H6
t: 905.546.2424 x3502 | **e:** Krislyn.Fernandes@hamilton.ca

Mailing Address:
110 King Street West, 2nd Floor | Hamilton, ON | L8P 4S6

From: Elizabeth Milne <Elizabeth.Milne@mlhu.on.ca>
Sent: August 9, 2019 3:32 PM
To: allhealthunits@lists.alphaweb.org
Subject: Middlesex-London Board of Health Letter & Response Paper: Essential Components for Strong Local Public Health

ATTENTION: BOARDS OF HEALTH

Please see the attached correspondence sent to Minister Christine Elliott on behalf of the Middlesex-London Board of Health.

From: Elizabeth Milne
Sent: Friday, August 9, 2019 10:15 AM
To: christine.elliott@ontario.ca
Cc: kbunting@middlesex.ca; Cathy Saunders <csaunder@london.ca>; allhealthunits@lists.alphaweb.org
Subject: Middlesex-London Board of Health Letter & Response Paper: Essential Components for Strong Local Public Health

Dear Minister Elliott,

Please find attached a letter from Ms. Trish Fulton, Chair of the Middlesex-London Board of Health regarding essential components for strong local public health.

A copy of Report No. 053-19 and a response paper titled *Keeping Middlesex-London Safe and Healthy: Essential components for a strong local public health sector through modernization* are

attached for your reference.

Sincerely,
Elizabeth Milne

Elizabeth Milne
Executive Assistant to the Board of Health and Communications Coordinator
Middlesex-London Health Unit | 50 King Street | London, ON | N6A 5L7
tel: 519-663-5317 ext. 2448
email: elizabeth.milne@mlhu.on.ca
www.healthunit.com | @MLHealthUnit

========= Middlesex-London Health Unit E-Mail Disclaimer ==========

Private and confidential, intended only for named recipient. If otherwise received, please destroy immediately. Health information in this email is only general information and is not intended to replace an in person consultation with a medical professional, nor is it intended to provide medical advice. Individual circumstances of which we are not aware may affect the information provided herein and as such, the Middlesex-London Health Unit assumes no liability or responsibility for your reliance thereon. The Middlesex-London Health Unit works under the authority of the Health Protection and Promotion Act and this correspondence may be used to assess your needs for public health services (519-663-5317).

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

July 19, 2019

The Honourable Christine Elliott
Minister of Health
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, Ontario
M7A 2C4

Dear Minister Elliott,

Re: Essential Components for Strong Local Public Health

At its meeting on July 18, 2019, the Middlesex-London Board of Health voted to endorse the following motion:

Moved by: Mr. Michael Clarke Seconded by: Mr. Ian Peer

That the Board of Health:

1) Receive Report No. 053-19 re: "Essential Components for Strong Local Public Health" for information; and

2) Direct staff to forward the Report in Appendix A to the Minister of Health, other boards of health, and relevant stakeholders.

The Board of Health also took time to hold a generative discussion concerning public health unit amalgamation. Members are looking forward to the opportunity to be involved in the consultation process. Members wanted to identify what is important about public health work that needs to continue, what input to and involvement in amalgamation plans going forward Board members are seeking.

In our discussion, we concluded that the current mission of the Middlesex-London Health Unit "to promote and protect the health of our community" remains appropriate but requires building a new understanding of the community to be served. Public health should remain a local focus however needs will necessarily arise across a larger more diverse catchment area, and with regionalization, the new public health entity will comprise a collection of very diverse communities.

Good governance for public health has so far reflected the local nature of public health delivery with a locally accountable governance structure. Members are concerned that the governance structure for a regional public health entity will struggle to maintain that important local accountability.

We hope that you will find this brief summary of our generative discussion helpful. We look forward to hearing details about the timelines and structure of the summer consultation process.

A copy of Report No. 053-19 and its Appendix re: *Keeping Middlesex-London Safe and Healthy: Essential components for a strong local public health sector through modernization* is enclosed for your reference.

Yours sincerely,

Trish Fulton
Chair, Middlesex-London Board of Health

c.c. Ontario Boards of Health
County of Middlesex
City of London

MIDDLESEX-LONDON HEALTH UNIT

REPORT NO. 053-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie, Medical Officer of Health / CEO

DATE: 2019 July 18

ESSENTIAL COMPONENTS FOR STRONG LOCAL PUBLIC HEALTH

Recommendation

It is recommended that that the Board of Health:

1) ***Receive Report No. 053-19 re: "Essential Components for Strong Local Public Health" for information; and***
2) ***Direct staff to forward the Report in Appendix A to the Minister of Health, other boards of health, and relevant stakeholders.***

Key Points

- Public Health Modernization will result in significant disruption to local public health.
- As the provincial government embarks on this modernization, it is important that key considerations, born out of decades of public health history, be contemplated.
- MLHU has prepared a response paper with key considerations and essential components for strong local public health.

Background

On April 11, 2019, the provincial budget introduced plans to significantly restructure Ontario's public health system, including the dissolution of its 35 health units and creation of 10 new regional public health entities. New boards of health under a common governance model would be established in line with the new regional entities, and substantial adjustments to provincial-municipal cost-sharing would occur over three budget years, as well as a reduction of the overall budget envelope for local public health. Since the announcement in April, the Health Unit has received further information regarding the proposed geographic boundaries and reviewed responses from stakeholders across the province. Please see: https://www.alphaweb.org/page/PHR_Responses.

Response to the 2019 Public Health Modernization

Given the magnitude of the impact that public health modernization will have on Middlesex-London, a response paper titled *Keeping Middlesex-London Safe and Healthy* (see Appendix A) has been prepared.

The paper outlines four essential components for a strong local public health sector:

1. Maintaining public health's unique upstream population health and disease prevention mandate;
2. Keeping public health at the community level to best serve residents and lead strategic community partnerships;
3. Ensuring public health funding and a strong workforce to fulfill its mandate; and
4. Governance structures that are transparent and locally accountable.

Next Steps

The response paper will be forwarded to the Minister of Health, local boards of health, and other relevant stakeholders. Additionally, MLHU will be participating in consultations regarding public health modernization throughout the summer and fall.

This report was prepared by the Healthy Organization Division.

Christopher Mackie, MD, MHSc, CCFP, FRCPC
Medical Officer of Health/CEO

Keeping Middlesex-London Safe and Healthy

Essential components for a strong local public health sector through modernization

July 2019

For information, please contact:

Middlesex-London Health Unit
50 King St.
London, Ontario
N6A 5L7
phone: 519-663-5317
fax: 519-663-8241
e-mail: health@mlhu.on.ca

© Copyright information
Middlesex-London Health Unit
50 King Street
London, Ontario
N6A 5L7

Content adapted with permission from, and thanks to, Peel Public Health

Cite reference as: Middlesex-London Health Unit. Keeping Middlesex-London safe and healthy: essential components for a strong local public health sector through modernization. London (ON): Middlesex-London Health Unit; 2019 Jul 18.

All rights reserved.

Contents

Executive Summary

Public health services provide high returns on investment. On average, one dollar invested in public health generates an eight dollar return through avoided health and social care costs (1). Despite this, public health only receives about two percent of all provincial health care spending in Ontario, with funding projected to decrease in future years.

The Provincial government recently announced plans to modernize the public health system by consolidating 35 public health units into ten new Regional Public Health Entities by 2020-2021. Also, there will be a progressive reduction in the funding cost-share formula with municipalities bearing a more significant portion of the costs. In Middlesex-London, this will mean shifting from a 75 percent provincial and 25 percent municipal share to 60 percent provincial and 40 percent municipal share by 2021-2022. Programs that were 100 percent provincially-funded will change to a cost-share structure in 2019-2020, except for the new Provincial Low-Income Seniors' Dental Program.

History has shown that when the public health system is weakened, serious consequences arise. After the Walkerton drinking water contamination in 2000 and the outbreak of Severe Acute Respiratory Syndrome (SARS) in 2003, major expert reports highlighted the need for a strong and autonomous public health sector to protect the health and safety of the public (2,3).

In this paper, we propose that modernization preserve the following components, which are essential for a strong local public health sector:

1. Maintaining public health's unique upstream mandate;
2. Keeping public health local;
3. Ensuring adequate funding and a strong workforce; and
4. Transparent and locally accountable governance.

The following summary illustrates how each component in a strong public health sector helps achieve our shared goal: healthy, productive, and thriving communities.

1. Maintaining public health's unique upstream population health and disease prevention mandate
    - Public health's unique mandate is to keep people healthy, prevent disease, and reduce health inequities.
    - We focus upstream – long before people need hospitals and health care. We collaborate with and complement other health care services to proactively reduce the impact of illness on "hallway medicine" and the acute care system.
    - To be successful leaders in prevention, we have five core public health functions:
        - population health assessment and surveillance – understanding who is sick and why
        - health promotion and policy development – creating supportive environments for healthy living by making the healthy choice the easy choice
        - health protection - identifying hazards to our health and taking action to stop or reduce their risk
        - disease prevention – working directly with clients to prevent and treat some illnesses, and working with community organizations, municipalities and the Province to create healthy public policies
        - emergency management – planning for and leading the response to public health emergencies
2. Keeping public health at the community level to best serve residents and lead strategic community partnerships

- A strong public health sector is responsive to local health priorities through collaborative engagement with local municipalities, schools, health care professionals, community organizations, and residents.
- Middlesex-London has a unique set of health issues that require tailored community responses and coordination.
- Local perspectives add value to provincial priority-setting and decision-making.

3. Ensuring public health has adequate funding and a strong workforce to fulfill its mandate
   - Overall funding for local public health should be sufficient to achieve the mandate and enable communities to thrive. Cost-sharing between the Province and municipalities should be achieved in a way that meets community needs and minimizes the burden on the local taxpayer.
   - The new Regional Public Health Entities should be empowered to identify the number, mix, and distribution of human resources necessary to meet local health needs.

4. Governance structures that are transparent, autonomous, and locally accountable
   - As boards of health are regionalized, it is vital that the role of the Medical Officer of Health and the Board of health, their autonomy, composition, and ability to promote healthy public policy be maintained.

Local public health has a unique mandate not fulfilled by any other organization at the local level. Only public health focuses on upstream population-level approaches to prevent injuries and illnesses before they occur. When the Provincial consultation begins, we strongly recommend the consideration of these essential components of a strong local public health sector to enable the achievement of our shared goal of healthy and thriving communities.

Purpose

The Middlesex-London Health Unit (MLHU) has prepared this report in response to recent provincial announcements regarding the modernization of Ontario's public health sector. The scale of the proposed changes to the governance, organization, and funding of local public health organizations in Ontario is unprecedented.

As the Province consults on modernization of public health there are important considerations, borne out of decades of public health experience, that support the Province's goals of enhancing municipal engagement, better integrating with health care to support more efficient service delivery, and preserving the essential components of a strong public health system in a new structure.

Our vision is: ***People Reaching Their Potential***

Our mission is: ***To protect and promote the health of our community***

To continue to achieve this vision and fulfill this mission, the future regional public health entity must:

1. Maintain public health's unique upstream population health and disease prevention mandate;
2. Keep public health at the community level to best serve residents and lead strategic community partnerships;
3. Ensure public health has adequate funding and a strong workforce to fulfill its mandate; and
4. Implement governance structures that are transparent and locally accountable.

Lessons from history show that when the public health system is weakened, serious consequences arise. After the Walkerton E. coli contamination in 2000 and SARS outbreak in 2003, many expert reports highlighted the need for a strong and autonomous public health sector (2,3).

Background

On April 11, 2019, the Ontario provincial budget introduced sweeping changes to the public health system. Objectives outlined in the provincial budget include replacing Ontario's 35 health units with 10 regional public health entities by April 1, 2020. This would dissolve all existing Boards of Health across the province.

The newly proposed boundaries (Figure 1) would see Middlesex-London Health Unit amalgamate with the Southwestern, Lambton, Chatham-Kent, and Windsor-Essex Health Units. The estimated population of this regional entity would be 1.3M.

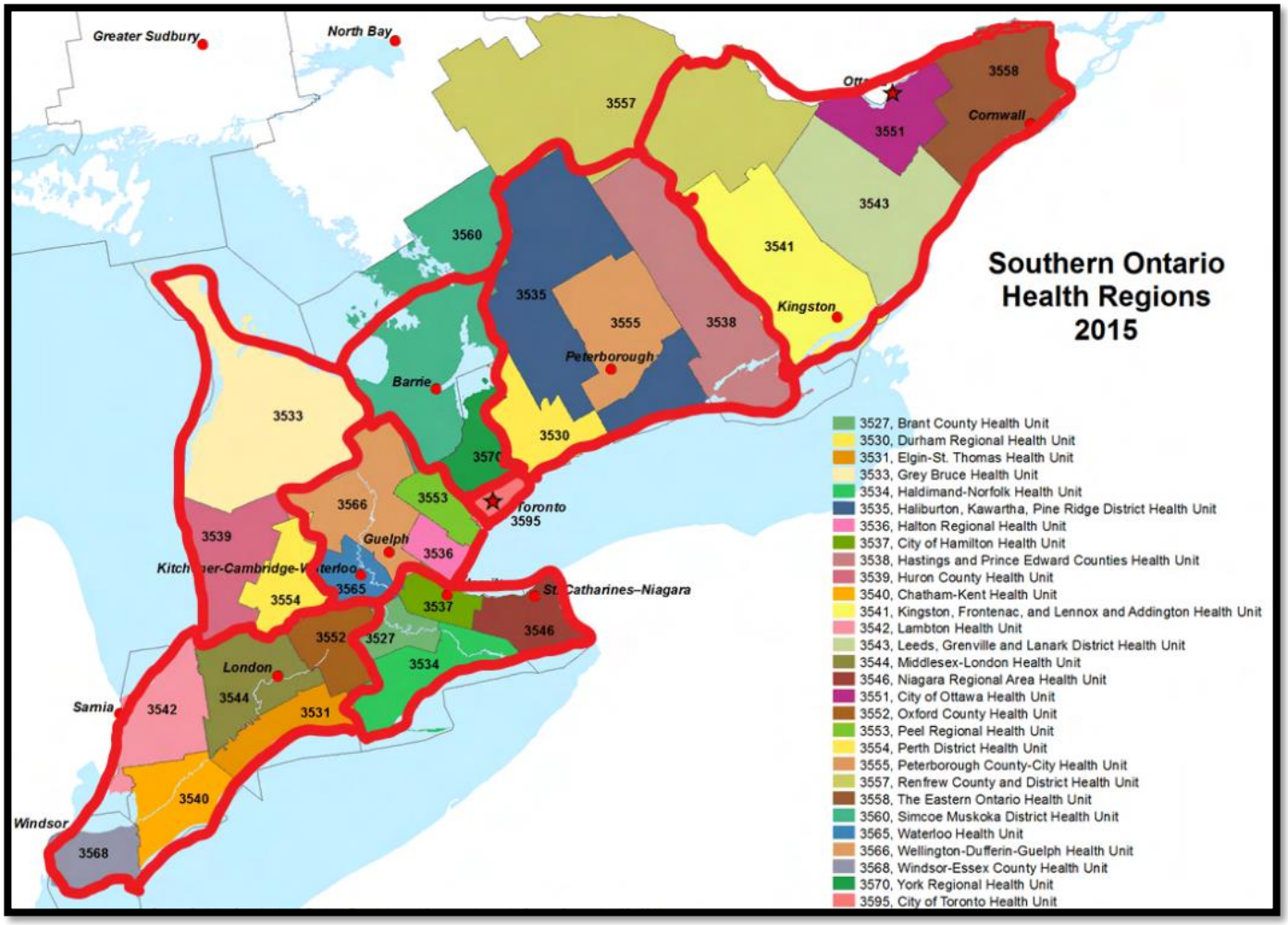
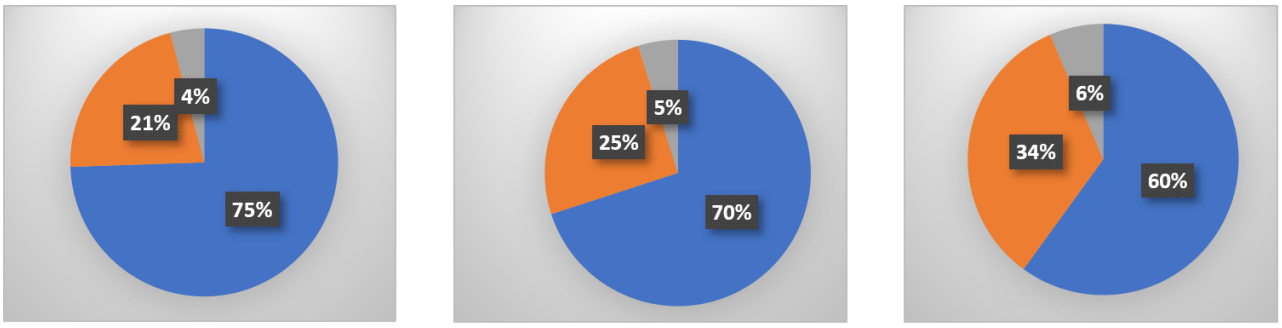


Figure 1 - Regional Public Health Entity Boundaries. Source: Statistics Canada, Health Regions, Boundaries and Correspondence with Census Geography, (82-402-x). Produced by the Statistical Registers and Geography Division for the Health Statistics Division, 2015.

The budget also proposes reducing total provincial funding for public health by $200 million over the next two to three years and amending the cost-sharing arrangements between the provincial government and the municipalities from 75% Provincial / 25% Municipal to 70% Provincial / 30% Municipal in the 2020-2021 fiscal year and then to a 60% Provincial / 40% Municipal in the 2021-2022 fiscal year.

A significant increase in contributions from municipalities would be necessary to accommodate the change to the cost-sharing formula if health units are expected to continue providing comprehensive public health programs and services to communities that are served. The potential changes to the municipal contributions are outlined in Figure 2.



Funding by Source	2019	%	2020	%	2021	%
MOHLTC	21,167,800	74.5%	19,896,674	70.0%	17,054,292	60.0%
City of London	6,095,059	21.4%	7,162,803	25.2%	9,550,404	33.6%
County of Middlesex	1,160,961	4.1%	1,364,343	4.8%	1,819,124	6.4%
Total Funding	**28,423,820**		**28,423,820**		**28,423,820**	
	TODAY		**70/30**		**60/40**	

Figure 2 – Potential Impact of the Proposed Cost-Sharing Arrangements of the City of London and County of Middlesex

The Ministry of Health and Long-Term Care (MOHLTC) expects to find the $200 million in savings from public health through the centralization of leadership, streamlining of back-office functions, IT services as well as the move to digital solutions at the regional level. These savings are expected to be achieved by 2021.

To lessen the immediate impact of these changes, the Province is considering one-time funding to offset costs as well as potential exceptions, or “waivers”, from some aspects of the Ontario Public Health Standards. Such funding and exceptions would be considered on a board-by-board basis.

The Province has also committed to consulting with public health units and municipalities on the phased implementation of the proposed changes.

Each of the following sections illustrates the vital elements of a strong local public health sector that will support the Province’s desired outcomes and ensure the public health needs of communities are met. These elements should be carried forward to a new structure.

Essential Considerations for Local Public Health

The essential components for local public health are drawn from the Ontario Public Health Standards, peer-reviewed literature and reports that have been previously prepared for the Middlesex-London Health Unit, and all levels of government in Canada.

1. *Maintaining public health's unique upstream population health and disease prevention mandate*

As outlined in the Ontario Public Health Standards:

> *The role of boards of health is to support and protect the physical and mental health and well-being, resiliency and social connectedness of the health unit population, with a focus on promoting the protective factors and addressing the risk factors associated with health outcomes (4).*

MLHU's focus on the health of the population stands in contrast to many of the other organizations and health service providers in the Middlesex-London region and it is imperative that its focus be maintained, if not strengthened.

What does this mean?

- Public health's unique mandate is to keep people healthy, prevent disease, and reduce health inequities.

- To be successful leaders in prevention, we have five core public health functions:

  - **Population Health Assessment and Surveillance** – understanding who is sick and why
  - **Health Promotion and Policy Development** – creating supportive environments for healthy living by making the healthy choice the easy choice
  - **Health Protection** - identifying hazards to our health and how to stop or reduce their risk
  - **Disease Prevention** – delivering comprehensive disease prevention services by working directly with clients to prevent and treat some illnesses, and working with community organizations, municipalities, and the Province to create healthy public policies
  - **Emergency Management** – planning for and leading the response to public health emergencies

- We focus upstream – long before people need hospitals and health care. We collaborate with and complement other health care services to proactively reduce the impact of illness on "hallway medicine" and the acute care system.

- The Medical Officer of Health and Chief Executive Officer (MOH / CEO) and the Board of Health use evidence and data to act in the interest of the health and safety of the community. The MOH / CEO leads a group of multi-disciplinary public health professionals to ensure public health crises are addressed quickly and effectively, ensure the public is aware of how to prevent disease and enhance health, and provide expert advice to decision-makers.

Why is this important?

Local public health's mandate is unique and considers everyone in the community, particularly those most vulnerable (e.g., low-income, newcomers, children, seniors).

Public health uses a population health approach, which means reducing the factors that cause disease, injury, and death in the community. While some actions should be taken across all communities, we also recognize that communities are diverse and the importance of building on strengths and reducing vulnerabilities in individual communities. Figure 3 provides examples of core public health activities that keep people healthy, productive, and out of the health care system.

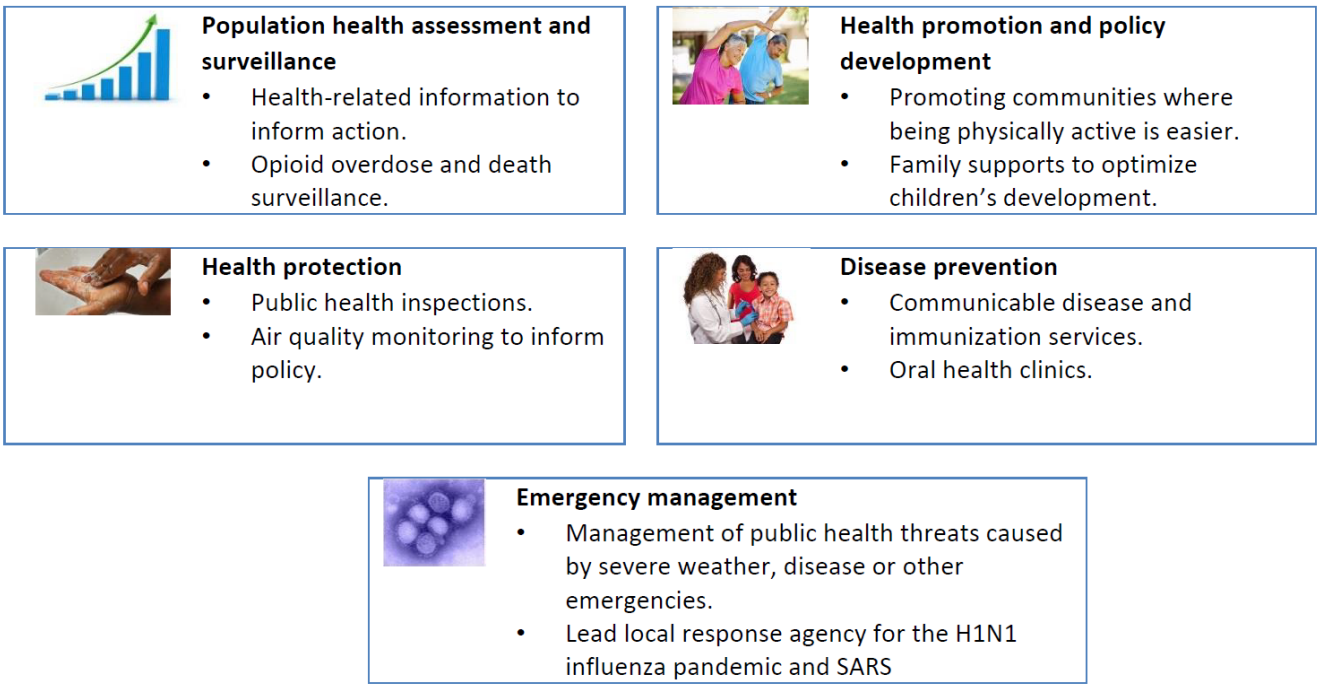


Figure 3 - Core Public Health Functions with Examples

While the success of prevention is mostly invisible, social and economic benefits are immense. When people avoid disease and injury, they are more likely to be productive and contribute to the economy. They require fewer hospital visits and rely less on health care throughout their lives (5). Figure 4 illustrates the loss in productivity due to communicable diseases.

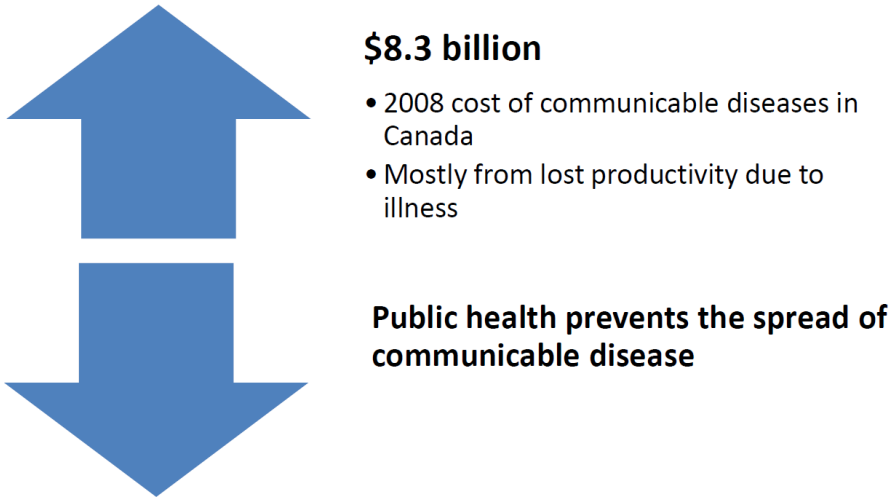


Figure 4 - Public Health Helps Decrease Lost Productivity due to Communicable Diseases (6)

The economic impact of SARS provides an example of the costs associated with outbreaks that are not prevented. Looking at the increase in provincial expenditures alone, and not considering the personal financial costs of those affected, there were $1.073 billion in unforeseen expenditures in the 2003-4 fiscal year (7).

A strong public health sector keeps people out of overcrowded hospitals.

The goal of public health is to keep people healthy, long before they become patients in the health care system. Public health programs focus on reducing risks to all residents. This ultimately drives down health care costs and makes the health care system more sustainable.

To achieve optimal health, both health care and public health are needed, and their roles are essential and complementary (Figure 5). Public health focuses on interventions with the greatest potential impact across a population and efforts to address the conditions where people live, work, play, grow and age to make healthy choices easier (8).

No other entity is primarily focused on upstream efforts to prevent illness before it arises. Investment in preventive strategies is an essential component to reduce “hallway medicine” and other strains on acute health care services.

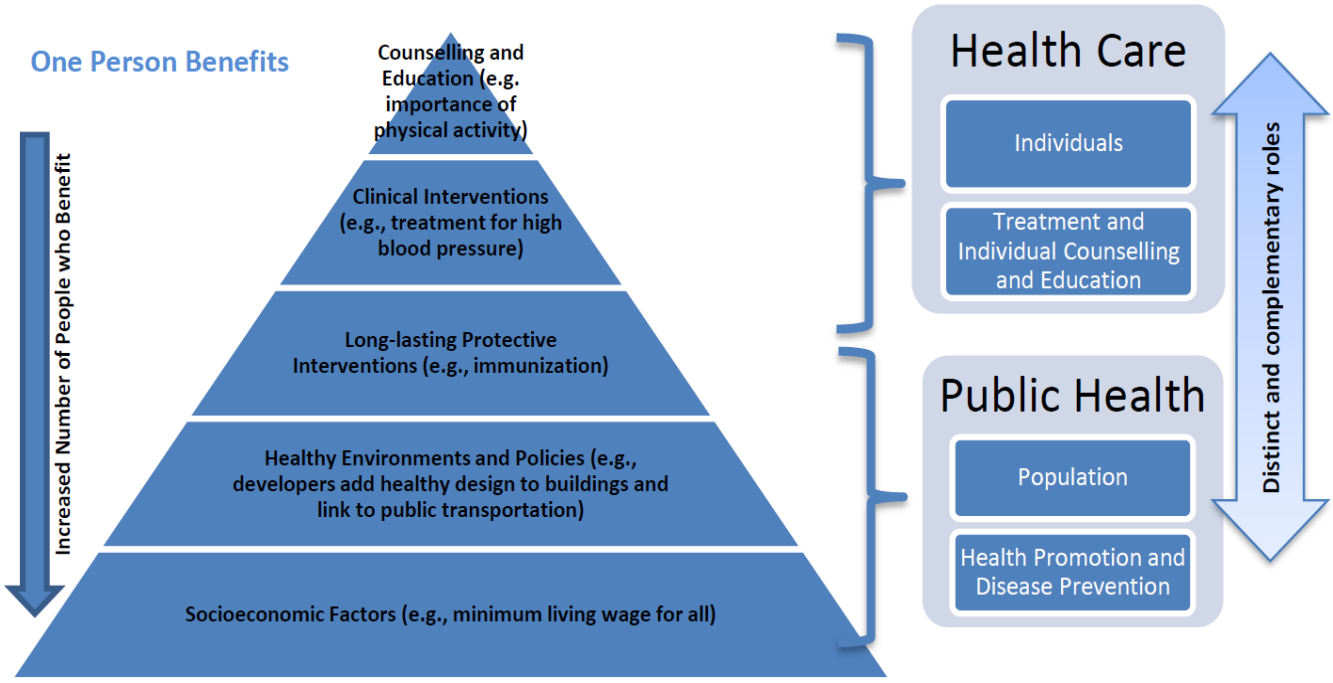


Figure 5 - How Public Health Complements Primary / Acute Care (Adapted from the Health Impact Pyramid)

A strong public health sector leads to multiple invisible benefits.

Some of public health's key successes, such as safe food and water or the control of communicable, vaccine-preventable diseases, have paradoxically reduced its perceived value among voters and decision-makers, making it vulnerable to budget cuts and weakened governance structures (9). The average lifespan of Canadians has increased by almost 25 years since 1920, with public health advances being among the main reasons for improvement (10).

Public health has a unique role in helping everyone have a fair chance to live a healthy life.

All Middlesex-London residents should have the opportunity to make healthy choices regardless of their income, education or ethnic background. It is known that the poorest people in Ontario are nearly twice as likely as the richest people to report multiple chronic conditions (11). This impacts municipalities through health service utilization, lower productivity, and other social costs.

Public health collaborates with municipalities and other stakeholders to decrease health inequities in their communities. Health inequities are differences in health that groups of people experience because of unfair and modifiable social advantage or disadvantage. Public health addresses health inequities through programs that benefit everyone and some that help those most in need. For instance, mothers who give birth in the Middlesex-London region are screened for a referral to the Healthy Babies, Healthy Children or Nurse Family Partnership home visiting program. Mothers at highest risk for poor infant and maternal outcomes (e.g., postpartum depression, lack of social or financial support) are prioritized for at home support from a Public Health Nurse and/or Family Visitor.

In addition, we offer free services to all residents of Middlesex-London in our dental, immunization, and sexual health clinics, regardless of health insurance (OHIP)-coverage or immigration status.

In sum, local public health has a unique mandate not fulfilled by any other organization at the local level. It keeps people healthy and out of overcrowded hospitals. It has multiple invisible benefits, including a great return on investment and it has a special role in helping everyone have a fair chance to live a healthy life.

2. *Keeping public health at the community level to best serve residents and lead strategic community partnerships*

Middlesex-London Health Unit is located in Southwestern Ontario. These are the traditional lands of the Attawandaran (Neutral) peoples who once settled this region alongside the Algonquin and Haudenosaunee peoples. The three First Nations communities with longstanding ties to this geographic area are Chippewa of the Thames First Nation (Anishinaabe), Oneida Nation of the Thames (Haudenosaunee); and Munsee-Delaware Nation (Leni-Lunaape) (12).

Middlesex-London covers 3,317 square kilometers; a relatively small land area compared to other health units with a relatively large population of 455,526 people in 2016. Nine out of 10 people in Middlesex-London live in urban areas, predominately London, and Strathroy (12).

What does this mean?

- A strong public health sector is responsive to local health priorities through collaborative engagement with local municipalities, schools, health care professionals, community organizations and residents.
- Middlesex-London has a unique set of health issues that require tailored community responses and coordination.
- Local perspectives add value to provincial priority-setting and decision-making.

Why is this important?

Unique public health issues in Middlesex-London.

There are many health issues to consider locally. The community health status resource details the health status of Middlesex-London and highlights several issues that demand attention (12):

1. The projected growth rate between 2016 and 2041 for Middlesex-London is 26.1% (with those aged 65 years and older doubling in this period). This translates to increased demand for public health services (e.g., immunizations, clinic visits, dental screening, and inspections).
2. In Middlesex-London, approximately 1 in 5 people are immigrants and over one in ten immigrants are recent immigrants (12.9%).
3. Injuries represent an area of substantial burden in the Middlesex-London, particularly in the rural population. Falls are the leading cause of injury-related deaths and visits to the emergency department and disproportionately those who are elderly.
4. Middlesex-London has multiple overlapping drug-related crises: opioid-related overdoses, invasive Group A Streptococcal (iGAS) disease, endocarditis, hepatitis C, HIV, and hepatitis A.
5. The proportion of women reporting a mental health concern during their pregnancy is significantly higher in Middlesex-London compared to Ontario and increased over time from 2013 to 2017.

“Moving the needle” on complex health issues like these requires keen local insight, solid knowledge of health behaviour and illness prevention, combined with strong local partnerships.

Engaged and empowered communities and stakeholders are essential for public health.

Public health emergencies, such as SARS and pandemic influenza H1N1, demonstrate that local investments are needed to ensure clear coordination among hospitals, health care providers, and government. Beyond emergencies, strong collaboration is essential to tackle complex health issues, such as substance use.

An example of the latter is MLHU's work on the Community Drug and Alcohol Strategy. This brought a collaborative focus to addressing the multiple and overlapping challenges gripping the community, including opioids, crystal meth, alcohol, and other substances. The partnership leading the development of this strategy included representatives from the health, education and social services sectors, as well as from law enforcement, the private sector, municipal government, and people with lived experience. Extensive community input was vital in helping to shape the Strategy. The Strategy consists of 23 recommendations with 98 associated actions and sets a long-term comprehensive plan to prevent and address local substance-related harms. Work to implement the recommendations is underway and will continue through 2019 and beyond (13).

In sum, engagement with municipal partners and community members improves the health outcomes of whole population groups, including those involved, and saves money. Public health governance is an opportunity to increase community involvement, reflect the diversity of residents, and maintain local priorities.

Additionally, research has shown that public health engagement and empowerment of local communities leads to better health outcomes:

- Higher performing public health units were found to have greater community interaction (14).
- Public health departments that prioritize the community's needs and who partner with the community will see differences in health outcomes (15).
- Partnerships not only with academia but also with hospitals, community organizations, social services, private businesses, and law enforcement are important (16).
- Engaging outside agencies in planning of program and service delivery is significantly related to public health performance (17).
- The longer that public health agencies have been engaging in partnerships, the better their performance metrics related to partnership development (18).

3. *Ensuring public health funding and a strong workforce to fulfill its mandate*

Public health is the responsibility of all levels of government. In Ontario, Provincial policy has typically cost-shared public health funding with municipalities being legally obligated to pay their cost-share as per the Health Protection and Promotion Act.

In addition to having the appropriate resources, all health units in Ontario should be fully staffed with enough people and the right mix of people and competencies. There must be strong and effective leadership at all levels.

What does this mean?

- Overall funding for local public health should be adequate to achieve the mandate and enable communities to thrive. Cost-sharing between the Province and municipalities should be achieved in a way that meets community needs and minimizes the burden on the local taxpayer.

- The new Regional Public Health Entities should have the capacity to identify the optimal number, mix and distribution of public health skills, and workers to meet local health needs.

Why is this important?

Imagine you are raising a child. If you feed, clothe, and give the child a roof over their head, they will live. But to thrive, the child also needs social interaction, love, interesting experiences, and so much more.

Public health is in the business of helping community health to thrive. If public health funding is not increased or protected, and if human resource capacity is compromised, there will be significant implications, such as:

- Challenges meeting current and future community health needs;
- Inability to detect and respond to future public health emergencies;
- Difficulties delivering mandated public health programs and services; and
- Needing to divert resources from some programs to others or stop completely.

Adequate funding is required to meet community health needs.

Provincial contributions to public health spending have fluctuated since the mid-1990s, as illustrated in Figure 6.

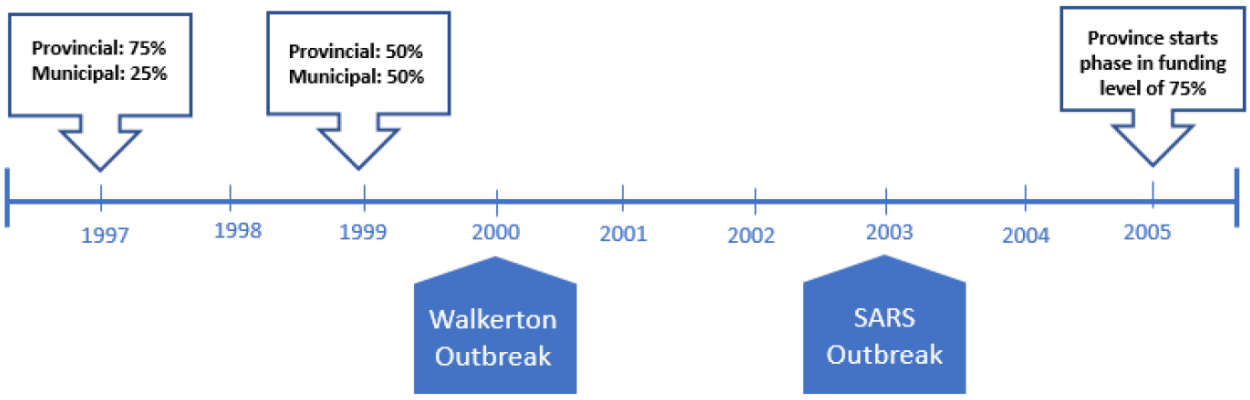


Figure 6 - Timeline of Provincial and Municipal Funding Share for Public Health Services in Ontario (19, 20)

The increase in provincial funding in 2005 was in response to the two public health emergencies – the outbreak in Walkerton in 2000 and the SARS epidemic in 2003. The purpose of the increased contribution was to enhance the capacity of the public health system, which had been weakened by reduced investment in public health in the years prior.

The Province intended to reach the 75/25 funding split within three years, but this did not occur. For example, in 2011, only 17 of the 36 health units had reached the 75/25 funding split for mandatory programs (21).

In 2015, the Ministry of Health and Long-Term Care Funding Review Working reviewed the funding formula and made recommendations. The recommended funding allocations for public health units were based on population and equity measures and identified MLHU as one of the lowest provincially funded public health units on a per capita basis. Middlesex-London benefited from a needs-adjusted funding model and saw an increase in mandatory program funding in 2016 and 2017.

The Middlesex-London Health Unit has already identified program efficiencies given historical provincial underfunding.

Since 2005, MLHU has been able to maintain municipal funding increases at 0%. This has been accomplished through responsible financial governance and stewardship and using a Program Budgeting Marginal Analysis (PBMA) process. Every health organization has limited resources and the need to make choices about how to allocate these resources. The PBMA process aims to align resources with the mandate and strategic priorities of the organization, improve decision-making transparency and rigor, and provide staff and public ownership of the decision-making process.

Over the past five budget cycles, MLHU has been able to find savings of $3.9 million and approve ongoing investments of $3 million and $1.6 one-time investments to maximize the impact our services have on the community. Examples of these investments include:

- Increased public health nursing capacity for outreach work with people who use injection drugs and who have HIV, Hepatitis C, or other blood-borne diseases to prevent the spread of these diseases and improve health outcomes. This program has essentially ended an HIV outbreak in people who inject drugs.

- The Nurse-Family Partnership home visiting program for young, low-income, and first-time mothers. This program helps teenage mothers meet their education and employment related objectives, and set their children up for success in life.
- An innovative needle-syringe recovery partnership program where a team sweeps high-risk urban areas to reduce waste related to discarded harm reduction equipment

Investment in public health saves money and improves health.

The public health sector receives a small portion (about two percent) of the provincial health care budget, yet it provides a high return on investment. Under proposed modernization plans, this already small portion of the provincial health care budget will be reduced even further over the next three years.

This is counterintuitive, given that public health programs offer such a high return on investment. For example, every dollar invested in public health programming saves eight dollars of avoided health and social care costs (1). The return on investment, illustrated in Figure 7, is even more favorable for interventions that changed public policies such as limiting tobacco marketing or using infrastructure to make active transportation easier (1).

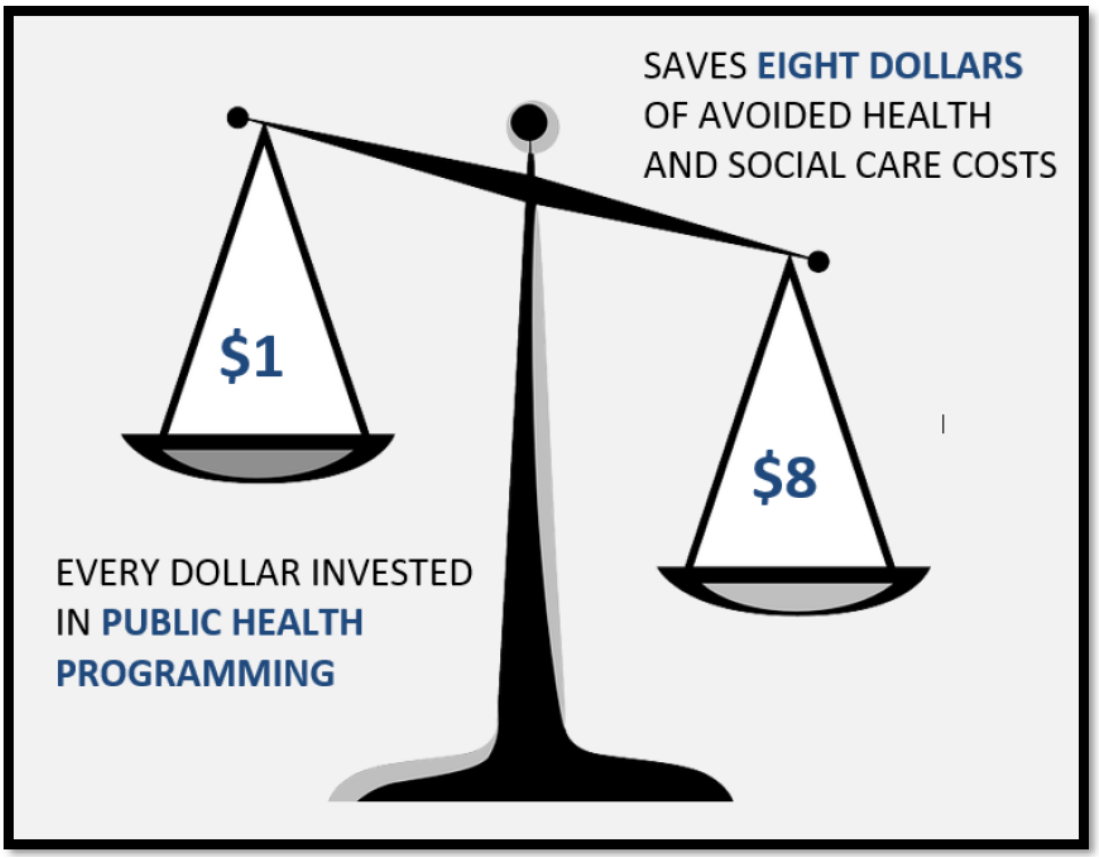


Figure 7 – Public Health Return on Investment

Some additional examples of the extent to which public health is a good return on investment include:

• $1 invested in immunizing children saves $14 in health and social costs (22).
• $1 invested in heart disease prevention pays back $11 in health and social benefits (23).
• $1 invested for improved walkability pays back $2 in health benefits (24).

Public health investments are a crucial way to improve the “social determinants of health” within a population. As seen in Figure 8 below, the most important factors in health or illness are socially determined, such as income, early childhood experiences, education, and housing. In contrast, only 25 percent of what influences our health is related to health care.

Despite this, nearly all funding goes to the health care system. In fact, only about two percent of health care funding goes to public health initiatives, even though these focus on improving the environment and social determinants of health.

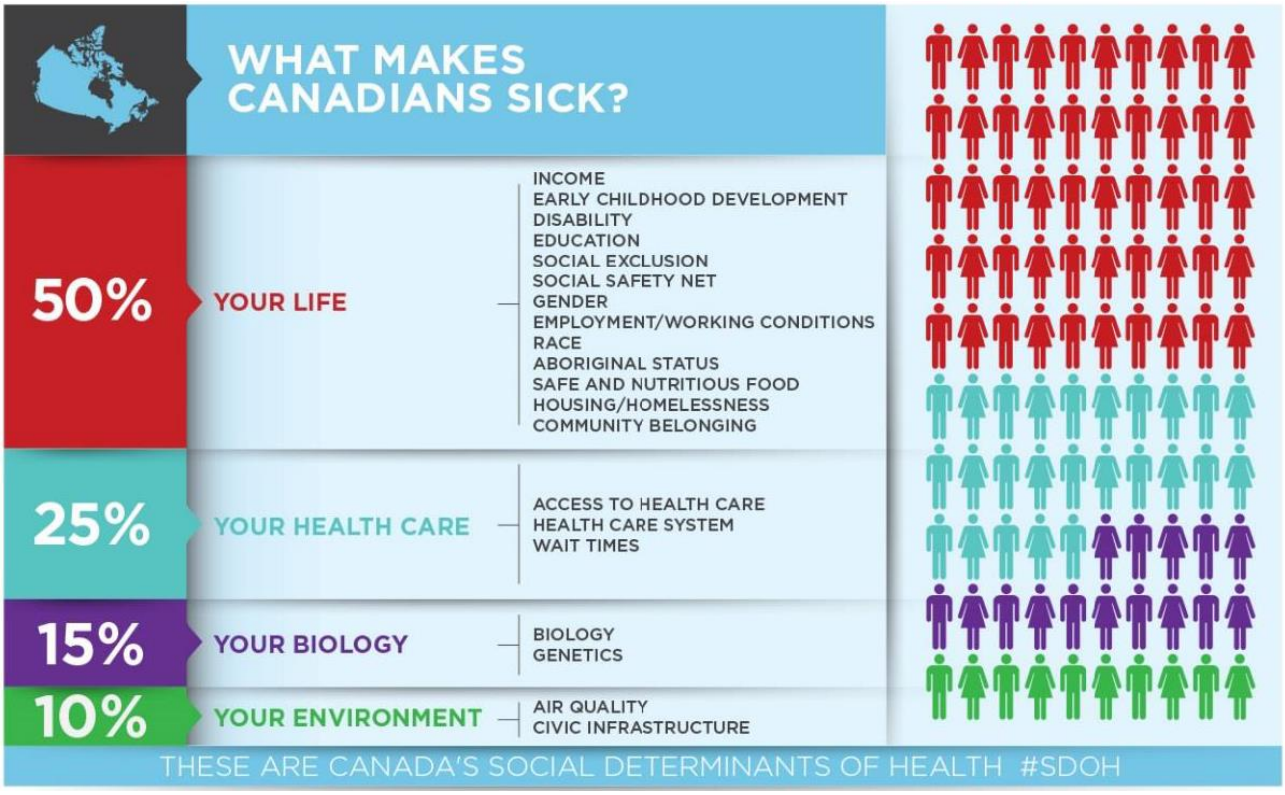


Figure 8 – What Makes Canadians Sick (25)

The new Regional Public Health Entities should have the capacity to identify the optimal number, mix and distribution of public health skills, and staff to meet local health needs.

One of the most important strengths of our public health system lies in its dedicated workforce. Public health expertise spans several health disciplines, including nutritionists, nurses, health promoters, inspectors, epidemiologists, and many more. The distribution of public health expertise, resources and services should be tailored to meet current and future local needs and priorities (26).

Reduced available funding would impact the critical mass of staff required to deliver quality programs and services and reduce our capacity to respond to public health emergencies or

periods of increased need. In addition, the application of cost-cutting initiatives that limit staffing (e.g., hiring freezes) compromise efforts to attract and keep qualified individuals in the public health workforce (27).

4. *Governance structures that are transparent and locally accountable*

Transparency and local accountability are essential for health units to maintain the trust of the public and to be able to respond effectively in the event of a public health emergency. Governance structures contribute significantly to the ability of a regional health entity's ability to act in this way.

What does this mean?

- As boards of health are regionalized, it is important that the role of the Medical Officer of Health and the Board of health, their autonomy, composition, and ability to promote healthy public policy be maintained.

Why is this important?

Weakening the roles of the Medical Officer of Health and Board of Health can compromise key parts of the public health sector and negatively impact the community.

- Public health and safety. The Medical Officer of Health and Board of Health must act quickly and effectively during public health crises. This includes the ability to rapidly deploy a skilled team of public health professionals to work with municipalities, health care, and others, and have the continuing legal authority to put the public's health first.

- Public trust. All residents have the right to know about the health of the community and what can be done to improve it. As the doctor for the community, the Medical Officer of Health should never be prevented from being honest and transparent about the community's health. Additionally, the Board of Health should have the ability to act on the independent advice provided by the Medical Officer of Health to ensure public health and safety.

The independence to allocate resources to local public health needs and engage in the promotion of healthy public policy ensures that community health needs are addressed.

Allocation and expenditure of resources are some of the most important predictors of health unit performance (16). Additionally, the presence of a local board of health with policymaking authority is associated with positive performance of essential public health standards (16, 28).

The strongest predictor of public health agency performance is the size of the population served (16, 28). Specifically, the larger the jurisdiction size, up to a maximum of 500,000 people, was found to be a positive predictor of performance (29).

The socioeconomic status of a community is a strong predictor of health status in a community (28, 30, 31). Addressing the social determinants of health in a community may be one of the most successful methods of elevating health status in the community.

Conclusion

Public health plays a distinct role in protecting the health of residents. Only public health focuses on upstream population-level approaches to prevent injuries and illnesses before they occur. Investments in public health should be viewed as a cost-effective way to improve the sustainability of our health care system by relieving the strain on primary and acute care.

Investments in public health have proven to generate high returns on investment. We know, for example, that for every dollar invested in public health, communities benefit from an $8 return on investment (1). Despite this, public health receives just about two percent of all provincial health care spending.

As the Ontario Government considers its approach to public health modernization, it is critical the core components of a strong public health system are maintained or strengthened. Positive public health outcomes require:

- Maintaining public health's unique upstream population health and disease prevention mandate;
- Keeping public health at the community level to best serve residents and lead strategic community partnerships;
- Ensuring public health has adequate funding and a strong workforce to fulfill its mandate; and
- Governance structures that are transparent and locally accountable.

Analyses of historical public health crises clearly show that, without these components in place, our communities are less protected and at higher risk for avoidable illness and death.

References

1. Masters R, Anwar E, Collins B, Cookson R, Capewell S. Return on investment of public health interventions: a systematic review. J Epidemiol Community Health [Internet]. 2017 Aug [cited 2019 July 3]; 71:827-34. Available from: https://jech.bmj.com/content/71/8/827

2. O'Connor D. Report of the Walkerton Inquiry: the events of May 2000 and related issues [Internet]. Toronto (ON): Ontario Ministry of the Attorney General; 2002 Jan [cited 2019 July 3]. 504 p. Available from: http://www.archives.gov.on.ca/en/e_records/walkerton/index.html

3. National Advisory Committee on SARS and Public Health. Learning from SARS: renewal of public health in Canada [Internet]. Ottawa (ON): Health Canada; 2003 Oct [cited 2019 July 3]. 234 p. Available from: http://www.phac-aspc.gc.ca/publicat/sars-sras/pdf/sars-e.pdf

4. Ministry of Health and Long-Term Care. Ontario public health standards: requirements for programs, services, and accountability [Internet]. Toronto (ON): Ministry of Health and Long-Term Care; 2018 Jan [revised 2018 Jul 1; cited 2019 July 3]. 75 p. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/

5. Senate, Standing Committee on Social Affairs, Science and Technology, Subcommittee on Population Health. A healthy, productive Canada: a determinant of health approach [Internet]. Ottawa (ON): Senate; 2009 Jun [cited 2019 July 3]. 59 p. Available from: https://sencanada.ca/content/sen/Committee/402/popu/rep/rephealth1jun09-e.pdf

6. Diener A, Dugas J. Inequality-related economic burden of communicable diseases in Canada. Can Commun Dis Rep. 2016 Feb 18;42(Suppl 1):S18-113.

7. Ontario Ministry of Finance. Quarterly Ontario finances: first quarter 2003-2004 [Internet]. Toronto (ON): Ontario Ministry of Finance; 2003 Jun 30 [cited 2019 July 3]. [about 19 screens]. Available from: https://www.fin.gov.on.ca/en/budget/finances/2003/ofin031.html

8. Frieden TR. A framework for public health action: the health impact pyramid. Am J Public Health. 2010 Apr;100(4):590–5.

9. Martin-Moreno JM, Harris M, Jakubowski E, Kluge H. Defining and assessing public health functions: a global analysis. Annu Rev Public Health. 2016 Mar 18;37:335-55.

10. Decady Y, Greenberg L. Ninety years of change in life expectancy [Internet]. Ottawa (ON): Statistics Canada; 2014 Jul [cited 2019 July 3]. 10 p. Available from: https://www150.statcan.gc.ca/n1/pub/82-624-x/2014001/article/14009-eng.htm

11. Chief Medical Officer of Health. Improving the odds: championing health equity in Ontario – 2016 annual report of the Chief Medical Officer of Health of Ontario [Internet]. Toronto (ON): Ontario Ministry of Health and Long-Term Care; 2018 Feb [cited 2019 July 3]. 27 p. Available from: http://www.health.gov.on.ca/en/common/ministry/publications/reports/cmoh_18/cmoh_18.pdf

12. Middlesex-London Health Unit. Middlesex-London Community Health Status Resource [Internet]. London (ON): Middlesex London Health Unit; 2019 January 25 [cited 2019 July 3]. Available from: http://communityhealthstats.healthunit.com

13. Middlesex-London Health Unit. MLHU annual report 2018 [Internet]. London (ON): Middlesex-London Health Unit; 2019 April 23 [cited 2019 July 3]. 22 p. Available from: https://www.healthunit.com/annual-reports by selecting and downloading the PDF.

14. Erwin PC. The performance of local health departments: a review of the literature. J Public Health Manag Pract. 2008 Mar;14(2):E9-18.

15. Kanarek N, Stanley J, Bialek R. Local public health agency performance and community health status. J Public Health Manag Pract. 2006 Nov;12(6):522-7.

16. Brownson R, Allen P, Duggan K, Stamatakis K, Erwin P. Fostering more-effective public health by identifying administrative evidence-based practices: a review of the literature. Am J Prev Med. 2012 Sep;43(3):309-19.

17. Halverson P, Miller C, Kaluzny A, Fried B, Schenck S, Richards T. Performing public health functions: the perceived contribution of public health and other community agencies. J Health Hum Serv Adm. 1996;18(3):288-303.

18. Downey LH, Thomas WA, Gaddam R, Scutchfield FD. The relationship between local public health agency characteristics and performance of partnership-related essential public health services. Health Promot Pract. 2013 Mar;14(2):284-92.

19. Pasut G. An overview of the public health system in Ontario [Internet]. 2007. [cited 2019 July 3]. Available from: <www.durham.ca/departments/health/pub/hssc/publicHealthSystemOverview.pdf>.

20. Campbell A. SARS and public health in Ontario: first interim report. Vol. 4, The SARS commission. Toronto(ON): Queen's Printer for Ontario; 2004 Apr 15. 271 p.

21. Middlesex-London Health Unit. Survey of public health unit funding for programs funded by obligated municipalities. London (ON): Middlesex-London Health Unit; 2012.

22. White CC, Koplan JP, Orenstein WA. Benefits, risks and costs of immunization for measles, mumps and rubella. Am J Public Health [Internet]. 1985 Jul [2019 July 3]75(7):739–44. Available from: https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.75.7.739

23. Abelson P, Taylor R, Butler J, Gadiel D, Clements M, Mui S-L. Returns on investment in public health [Internet]. Canberra (AT): Department of Health and Ageing; 2003 [cited 2019 July 4]. 198 p. Available from: http://web.archive.org/web/20070330131255/http://www.health.gov.au/internet/wcms/publishing.nsf/content/19B2B27E06797B79CA256F190004503C/$File/roi_eea.pdf

24. Guo JY, Gandavarapu S. An economic evaluation of health-promotive built environment changes. Prev Med. 2010 Jan;50(Suppl 1):S44–9.

25. Canadian Medical Association. Health care in Canada: what makes us sick? Canadian Medical Association town hall report. Ottawa (ON): Canadian Medical Association; 2013 Jul. 16 p.

26. Drehobl PA, Roush SW, Stover BH, Koo D. Public health surveillance workforce of the future. MMWR Suppl [Internet]. 2012 Jul [cited 2019 July 3];61(3):25-9. Available from: https://www.cdc.gov/Mmwr/preview/mmwrhtml/su6103a6.htm

27. Capacity Review Committee. Revitalizing Ontario's public health capacity: the final report of the Capacity Review Committee [Internet]. Toronto (ON): Queen's Printer for Ontario; 2006 May [cited ???]. 70 p. Available from:http://neltoolkit.rnao.ca/sites/default/files/1._Capacity_Review_Committee_Full_Report_2006%20(1).pdf

28. Hyde J, Shortell S. The structure and organization of local and state public health agencies in the U.S.: a systematic review. Am J Prev Med. 2012 May;42(5 Suppl 1):S29-41.

29. Mays GP, McHugh M, Shim K, Perry N, Lenaway D, Halverson PK, Moonesinghe R. Institutional and economic determinants of public health system performance. Am J Public Health. 2006;96(3):523-31.

30. Hajat A, Cilenti D, Harrison L, MacDonald P, Pavletic D, Mays G, Baker E. What predicts local public health agency performance improvement? A pilot study in North Carolina. J Public Health Manag Pract. 2009;15(2):E22-33.

31. Harris AL, Scutchfield F, Heise G, Ingram RC. The relationship between local public health agency administrative variables and county health status rankings in Kentucky. J Public Health Manag Pract. 2014;20(4):378-83.

From:	Fernandes, Krislyn
To:	Kolar, Loren
Subject:	05.3 RECEIVE (2019-08-20) 2019-20 Transfer Payment HBHC (City of Hamilton Public Health Services)
Date:	September 4, 2019 3:06:35 PM
Attachments:	2019-20 HBHC Amending_City of Hamilton.pdf 2019-20 HBHC Hamilton Amendment.pdf
Importance:	High

Krislyn Fernandes
Administrative Coordinator to Dr. Elizabeth Richardson, Medical Officer of Health

Office of the Medical Officer of Health | Public Health Services
Healthy and Safe Communities Dept. | City of Hamilton
100 Main Street West, 6th Floor | Hamilton, ON | L8P 1H6
t: 905.546.2424 x3502 | **e:** Krislyn.Fernandes@hamilton.ca

Mailing Address:
110 King Street West, 2nd Floor | Hamilton, ON | L8P 4S6

From: Lenz-Billard, Sandra (MCCSS) <Sandra.Lenz-Billard@ontario.ca>
Sent: August 20, 2019 9:41 AM
To: Richardson, Dr. Elizabeth <Elizabeth.Richardson@hamilton.ca>
Cc: Vickers-Manzin, Jennifer <Jennifer.Vickers-Manzin@hamilton.ca>; Weber, Stacey (MCCSS) <Stacey.Weber@ontario.ca>
Subject: 2019-20 Transfer Payment HBHC (City of Hamilton, Public Health Services)
Importance: High

On behalf of Stacey Weber,

Please see information attached regarding your 2019-20 Transfer Payment Agreement.

Thank you.

Ministry of Children, Community and Social Services

Early Child Development Branch

Children with Special Needs Division

3rd Floor
101 Bloor St. W.
Toronto ON M5S 2Z7

Tel: 416-327-7386

Ministère des Services à l'enfance et des Services sociaux et communautaires

Direction du développement de la petite enfance

Division des services aux enfants ayant des besoins particuliers

3e étage
101, rue Bloor Ouest
Toronto ON M5S 2Z7

Tél. : 416-327-7386

Ontario

August 19, 2019

Dr. Elizabeth Richardson
Medical Officer of Health
City of Hamilton, Public Health Services
1 Hughson Street North, 4th Floor
Hamilton, ON L8R 3L5

elizabeth.richardson@hamilton.ca

Dear Dr. Richardson:

Re: Agreement between Her Majesty the Queen in right of Ontario as represented by the Minister of Children, Community and Social Services ("Province") and City of Hamilton, Public Health Services effective as of January 1, 2018 for the delivery of the Healthy Babies Healthy Children Program Project (the "Agreement").

Attached is an amending agreement which amends key portions of the Agreement. Amended Sections include:

- A1.2 Funding Year;
- A11.1 Termination on Notice
- A17.1, A17.2, A17.3 Notice; and
- Schedules "B" through "F".

The maximum annual funding allocation for the Healthy Babies Healthy Children Program is $3,533,913. Effective as of this Amendment, the Funding Year for Healthy Babies Healthy Children will now shift to align with the fiscal year of the Province (April 1 – March 31). Please refer to A1.2 (a) and (b) for information.

The 2019-20 Healthy Babies Healthy Children Program Transfer Payment Budget Package is available on the Healthy Child Development SharePoint website. Program staff in your organization have been provided with the necessary information to access the site.

The package contains the following documents:

- 2019-20 Funding Guidelines
- 2019 Q1 Calendar and 2019-20 Fiscal Request for Funding Templates

- 2019-20 Financial Quarterly Reporting Template
- 2019-20 Reporting Schedule
- 2018 Settlement Package Certification
- 2018 Settlement Form
- 2018 Settlement Package Auditor's Questionnaire
- Retainable and Non-Retainable Revenue Policy

Please complete all sections of each form as accurately as possible and ensure that your Request for Funding submission has the appropriate signatures before submitting.

Please print two copies of the Amending Agreement, complete schedule "B", sign the signature page and complete and sign the 2019 Q1 Calendar and 2019-20 Fiscal Request for Funding templates. Two copies of the signed Amending Agreement along with the Request for Funding templates and a copy of the current certificate of insurance must be returned to the address below by Friday September 13, 2019.

Marta Stanczyk, Administrative Assistant
Early Child Development Branch
Ministry of Children, Community and Social Services
3rd Floor, 101 Bloor Street West
Toronto, ON M5S 2Z7
416-327-7378

Electronic copies of the Request for Funding (excel) should also be emailed to ECDBFinanceTeam@ontario.ca. The Province will countersign Amendment No. 1 and return a copy to you.

Your ongoing support of programs for Ontario's children and families is appreciated.

Sincerely,

Stacey Weber
Director

Attachments

c. Jennifer Vickers-Manzin, Director, Family Health Division, City of Hamilton

Ministry of Children, Community and Social Services
Early Child Development Branch

2019-20 TRANSFER PAYMENT CHECKLIST

Please include this checklist with your submission.

- ☐ Two (2) copies of the TP Agreement or Amending Agreement with original signatures
- ☐ Completed & signed 2019 Q1 Calendar and 2019-20 Fiscal Request for Funding Excel Spreadsheets
- ☐ Copy of current insurance certificate (Section A10.0)

Complete packages should be sent to:
Marta Stanczyk, Administrative Assistant
Ministry of Children, Community and Social Services
101 Bloor St. W. 3rd Fl.
Toronto, ON M5S 2Z7

Due Date: September 13, 2019

Please provide a person for us to contact directly with questions regarding your submission.

Name: _____

Title: _____

Telephone: _____

Email: _____

REMINDER:

2019-20 reporting documents and templates and the 2018 Year-End Reconciliation Package are available for download through the Healthy Child Development SharePoint site. Program Leads within your organization have the information to access this site.

This Amending Agreement No. 1 effective as of the 1st day of August 2019.

BETWEEN:

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO
as represented by the Minister of Children, Community and Social Services

(the "**Province**")

- and -

CITY OF HAMILTON, PUBLIC HEALTH SERVICES

(the "**Recipient**")

BACKGROUND

1. Her Majesty the Queen in right of Ontario as represented by the Minister of Children and Youth Services and the Recipient entered into an agreement effective as of the 1st day of January 2018 (the "**Agreement**").

2. The Minister of Children, Community and Social Services has been assigned the authority to exercise the powers and duties of the Minister of Children and Youth Services;

3. The Parties wish to amend the Agreement in the manner set out in this amending agreement (the "**Amending Agreement No. 1**").

In CONSIDERATION of the mutual covenants and agreements contained herein, and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereto agree as follows:

1. Capitalized terms used but not defined in Amending Agreement No. 1 have the same meanings ascribed to them in the Agreement.

2. Section A1.2 of the Agreement is amended by deleting the definition of "Funding Year" and replacing it with:

"Funding Year" means:

in the case of the first Funding Year, the period commencing on the Effective Date and ending on the following March 31; and

in the case of Funding Years subsequent to the first Funding Year, the period commencing on April 1 following the end of the previous Funding Year and ending on the following March 31.

3. Section A11.1 of the Agreement is deleted and replaced with the following:

   A11.1 Termination on Notice. The Province, in its sole discretion, without liability, cost or penalty, and without prejudice to any other rights or remedies under this Agreement or at law or in equity, may terminate this Agreement at any time, for any reason, upon giving at least sixty (60) days' written notice to the Recipient.

4. Section A17.1 of the Agreement is deleted and replaced with the following:

   A17.1 Notice in Writing and Addressed. Notice will be in writing and will be delivered by email, postage-prepaid mail, or personal delivery, and will be addressed to the Province and the Recipient respectively as provided for Schedule "B", or as either Party later designates to the other by Notice.

5. Sub-section A17.2 (b) is deleted and replaced with the following:

   (b) in the case of email, or personal delivery, one Business Day after the Notice is delivered.

6. Sub-section A17.3(b) is deleted and replaced with the following:

   (b) Notice will be by email or personal delivery.

7. Schedule "B" of the Agreement is deleted and replaced with Schedule "B", attached to Amending Agreement No. 1 as Appendix "1".

8. Schedule "C" of the Agreement is deleted and replaced with Schedule "C", attached to Amending Agreement No. 1 as Appendix "2".

9. Schedule "D" of the Agreement is deleted and replaced with Schedule "D", attached to Amending Agreement No. 1 as Appendix "3".

10. Schedule "E" of the Agreement is deleted and replaced with Schedule "E", attached to Amending Agreement No. 1 as Appendix "4".

11. Schedule "F" of the Agreement is deleted and replaced with Schedule "F", attached to Amending Agreement No. 1 as Appendix "5".

12. This Amending Agreement No. 1 shall be effective as of the first date written above.

13. Except for the amendments provided for in Amending Agreement No. 1, all provisions in the Agreement shall remain in full force and effect.

-SIGNATURE PAGE FOLLOWS-

The Parties have executed this Amending Agreement No. 1 on the date set out below.

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO as represented by the Minister of Children, Community and Social Services

_____ _____

Date Stacey Weber, Director
Early Child Development Branch

CITY OF HAMILTON, PUBLIC HEALTH SERVICES

_____ _____

Date Name
Title

I have authority to bind the Recipient

_____ _____

Date Name
Title

I have authority to bind the Recipient

Appendix 1

SCHEDULE "B"
PROJECT SPECIFIC INFORMATION AND ADDITIONAL PROVISIONS

Maximum Annual Funds	$ 3,533,913 for the purpose of completing the HBHC Project
Amount for the purposes of section A5.2 (Disposal) of Schedule "A"	$ 5,000
Insurance	$ 2,000,000 per occurrence
Contact information for the purposes of Notice to the Province	Stacey Weber, Director Early Child Development Branch 3rd Floor, 101 Bloor Street West Toronto, ON M5S 2Z7 stacey.weber@ontario.ca 416-327-7386
Contact information for the purposes of Notice to the Recipient	Dr. Elizabeth Richardson, Medical Officer of Health 1 Hughson Street North, 4th Floor Hamilton, ON L8R 3L5 elizabeth.richardson@hamilton.ca **Phone:**
Contact information for the senior financial person in the Recipient organization (e.g., CFO, CAO) – to respond as required to requests from the Province related to the Agreement	**Name/Position:** **Address:** **Email:** **Phone:**

Additional Provisions:

Open Data
The Province reserves the right to publish contract information as open data. This includes Recipient contact information, financial terms, key dates, and outcomes or outputs.

Appendix 2

Schedule "C"
PROJECT

Project Purpose and Goals
Healthy Babies Healthy Children (HBHC) Project services are provided during the prenatal period and to families with children from birth up to their transition to school, using targeted project approaches with a universal screening opportunity at time of birth. The goal of HBHC is to optimize newborn and child healthy growth and development and reduce health inequities for families receiving services.

Project Scope
The Recipient will manage the HBHC Project, in accordance to the "Healthy Babies Healthy Children Protocol, 2018" (or as current) as described in the Ontario Public Health Standards: Requirements for Programs, Services and Accountability, pursuant to Section 7 of the *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, to deliver the required components of the provincial HBHC project. The Recipient will complete the HBHC project targets listed below by the end of March for each year the project is provided. Performance towards these activities will establish baselines that will be used to inform ongoing continuous quality improvement for the project.

Project Components and Service Targets
1. Service and System Integration.
2. Access to Information and Resources.
3. Early Identification and Intervention Screening.
    a. Prenatal - targeted screening that supports early identification of the following key populations that would benefit most from prenatal interventions:
        i. Young (e.g., teen) mothers.
        ii. Families experiencing isolation or poor access to prenatal services.
    b. Postpartum – a minimum of 80% of births screened is required to achieve universal screening reach.
    c. Early Childhood – in light of existing measures that identify up to 30% of children 0-6 years old have compromised child development, targeted screening of the following key populations that would benefit most from early childhood interventions.
        i. Families with an exposure to adverse childhood events.
        ii. Families with a child(ren) having an existing developmental delay with no or limited service supports.
        iii. Priority populations experiencing inequities in health status related to the social determinants of health.

4. Assessment.
        i. Families identified with risk are more likely to accept follow-up services when they receive contact within 48 hours of being discharged from birth admission.
        ii. Universal contact may be achieved with a minimum of 80% total reach.

5. Blended Home Visiting Services.
    a. A minimum of 50% of families confirmed with risk continue to receive home visiting services which include:
        i. Accepting Blended Home Visiting services during the period of service.
        ii. Establishing and maintaining a Family Service Plan.
        iii. Participating in quality intensive home visiting services.
6. Service Coordination.
7. Referral to/from Community Services.
8. Research.
9. Evaluation.

Additionally, project outcomes and population outcomes, as identified in the HBHC Guidance Document,[1] will be monitored through project reports and datamarts in the *Healthy Child Development Integrated Services for Children Information System (HCD-ISCIS) Reporting Sub-system (IRSS)*. Project delivery will be monitored through the use of these reports and ad-hoc queries to verify and validate data to the Province, and to support the annually identified Continuous Quality Improvement (CQI) initiatives.

[1] The Public Health Unit is expected to be guided by the HBHC Guidance Document 2012 which is to be used with the HBHC Protocol 2018 until such time that the HBHC Reference Document becomes operationalized or other guiding documents to support operationalization are developed.

Appendix 3

Schedule "D"
BUDGET

Recipient to complete and submit "2019 Q1 Calendar and 2019-20 Fiscal Request for Funding" to the Province for approval.

Appendix 4

Schedule "E"
PAYMENT PLAN

The Province shall provide the funding identified in Schedule “B” in accordance to the following schedule:

The transfer amount will be paid in instalments at the mid and end of each month over the corresponding Funding Year.

Appendix 5

Schedule "F"
REPORTS

Within one (1) month of completing the second (Q2) and third (Q3) three (3) month period from the time the HBHC Project commences, the Recipient shall provide an interim progress report to the Province:

(a) including a quarterly (Q2 and Q3) unaudited financial statement which accounts for HBHC Project revenue and expenditures;

(b) including a quarterly (Q2 and Q3) HBHC Project progress report generated by the *Healthy Child Development Integrated Services for Children Information System (HCD-ISCIS) Reporting Sub-system (IRSS)* or other Province approved Information System indicating whether the activities and outcomes of the HBHC Project were met;

(c) providing any other details requested by the Province.

Within 45 days of completing the fourth (Q4) three (3) month period from the time the HBHC Project commences, the Recipient shall provide an interim progress report to the Province:

(a) including a quarterly (Q4) unaudited financial statement which accounts for HBHC Project revenue and expenditures;

(b) including a quarterly (Q4) HBHC Project progress report generated by the *Healthy Child Development Integrated Services for Children Information System (HCD-ISCIS) Reporting Sub-system (IRSS)* or other Province approved Information System indicating whether the activities and outcomes of the HBHC Project were met;

(c) providing any other details requested by the Province.

Within four (4) months after March 31 in any Funding Year of the HBHC Project, the Recipient shall submit a final report to the Province:

(a) including a final audited financial statement, auditors questionnaire and certification form which accounts for HBHC Project revenue and expenditures.

(b) including an annual HBHC Project report generated by the *Healthy Child Development Integrated Services for Children Information System (HCD-ISCIS) Reporting Sub-system (IRSS)* or other Province approved Information System indicating whether the outcomes of the HBHC Project were met. The information generated by the Province will be in an anonymized form;

(c) providing any other details requested by the Province.

At the request of the Province, the Recipient shall submit ad hoc reports generated by the *Healthy Child Development Integrated Services for Children Information System (HCD-ISCIS) Reporting Sub-system (IRSS)* or other Province approved Information System. The information generated for the Province will be in an anonymized form.

From:	Fernandes, Krislyn
To:	Kolar, Loren
Subject:	05.4 RECEIVE (2019-08-20) 2019-20 Public Health Funding for the City of Hamilton Public Health Services
Date:	September 4, 2019 2:54:57 PM
Attachments:	Hamilton_Minister"s Letter.pdf Hamilton_CMOH Letter.pdf Hamilton_Amending Agreement.pdf
Importance:	High

Krislyn Fernandes
Administrative Coordinator to Dr. Elizabeth Richardson, Medical Officer of Health

Office of the Medical Officer of Health | Public Health Services
Healthy and Safe Communities Dept. | City of Hamilton
100 Main Street West, 6th Floor | Hamilton, ON | L8P 1H6
t: 905.546.2424 x3502 | **e:** Krislyn.Fernandes@hamilton.ca

Mailing Address:
110 King Street West, 2nd Floor | Hamilton, ON | L8P 4S6

From: Olivera, Janette (MOHLTC) <Janette.Olivera@ontario.ca> **On Behalf Of** Walker, Elizabeth S. (MOHLTC)
Sent: August 20, 2019 10:32 AM
To: Office of the Mayor <mayor@hamilton.ca>; Richardson, Dr. Elizabeth <Elizabeth.Richardson@hamilton.ca>
Cc: MacDonald, Gillian (MOHLTC) <Gillian.MacDonald2@ontario.ca>; Williams, Dr. David (MOHLTC) <Dr.David.Williams@ontario.ca>; Feeney, Brent (MOHLTC) <Brent.Feeney@ontario.ca>; Yuill, Jim (MOHLTC) <Jim.Yuill@ontario.ca>; Buchanan, Teresa (MOHLTC) <Teresa.Buchanan@ontario.ca>; Trevisani, David <David.Trevisani@hamilton.ca>; Han, Sandra (MOHLTC) <Sandra.Han@ontario.ca>
Subject: 2019-20 Public Health Funding for the City of Hamilton, Public Health Services
Importance: High

Please find attached the 2019-20 public health funding approval letters for your public health unit, as signed by the Honourable Christine Elliott, Deputy Premier and Minister of Health, and Dr. David Williams, Chief Medical Officer of Health.

Also attached to this email are new Schedules to the Public Health Funding and Accountability Agreement that outline the terms and conditions governing the funding.

If you have any questions, please don't hesitate to contact me or Sandra Han, Acting Manager, Accountability and Liaison Branch, at 416-314-1050 or via email at Sandra.Han@ontario.ca.

Thank you.

Liz

Liz Walker
Director, Accountability and Liaison Branch
Office of Chief Medical Officer of Health, Public Health
Ministry of Health
393 University Ave., 21st Floor
Toronto ON M7A 2S1

Desk: (416) 212-6359
Cell: (416) 528-7448

Ministry of Health

Office of the Deputy Premier
and Minister of Health

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

Ministère de la Santé

Bureau du vice-premier ministre
et du ministre de la Santé

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

iApprove-2019-01185

AUG 2 0 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:

The Ontario government is taking a comprehensive approach to modernize Ontario's health care system which includes a coordinated public health sector that is nimble, resilient, efficient, and responsive to the province's evolving health needs and priorities. While the broader health care system undergoes transformation, a clear opportunity has emerged for us to transform and strengthen the role of public health and its connectedness to communities.

As you are aware, the government made the decision to maintain the current cost-sharing arrangements for boards of health for 2019, to provide municipalities with additional time to find efficiencies that will ensure the sustainability of these critical shared public health services.

As a result, the Board of Health for the City of Hamilton, Public Health Services will be provided up to $31,460,300 in base funding and up to $10,000 in one-time funding for the 2019-20 funding year, to support the provision of public health programs and services in your public health unit. 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 the funding.

While the way in which we are implementing our plan to strengthen public health has changed, the need to do so has not. The current public health structure requires modernization – having 35 independent entities, all with varying capacity, does not facilitate consistent implementation of the core elements of a strong public health system.

Our government has heard that the scale and pace of change is of concern to the public health and municipal sectors. While the modernization of the public health sector remains a priority, the Ministry of Health intends to consult with public health and municipal partners throughout the fall of 2019 to inform the development of Regional Public Health Entities and to ensure that adequate time is provided for thoughtful dialogue and implementation planning.

.../2

Mayor Fred Eisenberger

In order to support public health unit planning for 2020, municipalities can use a planned funding change to bring the municipal share to 30% for public health programs and services effective as of January 1, 2020. However, to help provide additional stability as municipalities begin to adapt to shifting funding models, our government will also provide one-time mitigation funding to assist all public health units and municipalities to manage this increase while we work to transform the public health system across the province over the next couple of years. While final confirmation of 2020 funding will be provided through the 2020 Budget process, we expect that all municipalities will be protected from any cost increases resulting from this cost-sharing change that exceed 10% of their existing costs.

We continue to rely on your strong leadership to build a modern and sustainable public health sector. Thank you for the important service that your public health unit provides to Ontarians, and your ongoing dedication and commitment to addressing the public health needs of Ontarians.

Sincerely,

Christine Elliott
Deputy Premier and Minister of Health

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

Ontario

Ministry of Health

Office of Chief Medical Officer of Health,
Public Health
393 University Avenue, 21st Floor
Toronto ON M5G 2M2

Telephone: (416) 212-3831
Facsimile: (416) 325-8412

Ministère de la Santé

Bureau du médecin hygiéniste en chef,
santé publique
393 avenue University, 21e étage
Toronto ON M5G 2M2

Téléphone: (416) 212-3831
Télécopieur: (416) 325-8412

iApprove-2019-01185

AUG 2 0 2019

Dr. Elizabeth Richardson
Medical Officer of Health
City of Hamilton, Public Health Services
110 King Street West, 2nd Floor
Hamilton ON L8P 4S6

Dear Dr. Richardson:

Re: Ministry of Health Public Health Funding and Accountability Agreement with the Board of Health for the City of Hamilton, Public Health Services (the "Board of Health") dated January 1, 2014, as amended (the "Agreement")

Further to the recent letter from the Honourable Christine Elliott, Deputy Premier and Minister of Health, I am writing to inform you that the Board of Health will be provided up to $31,460,300 in base funding and up to $10,000 in one-time funding for the 2019-20 funding year, to support the provision of public health programs and services in your community.

Please find attached to this letter a new Schedule A (Grants and Budget), Schedule B (Related Program Policies and Guidelines), Schedule C (Reporting Requirements), and Schedule D (Board of Health Financial Controls) that, pursuant to section 3.4 of the Agreement shall replace the existing schedules. All terms and conditions contained in the Agreement remain in full force and effect.

We appreciate your cooperation with the Ministry of Health in managing your funding as effectively as possible. You are expected to adhere to our reporting requirements, particularly for in-year service and financial reporting, which is expected to be timely and accurate. Based on our monitoring and assessment of your in-year service and financial reporting, your cash flow may be adjusted appropriately to match actual services provided.

It is also essential that you manage costs within your approved budget.

.../2

Dr. Elizabeth Richardson

Please review the new Schedules carefully. Should you require any further information and/or clarification, please contact Elizabeth Walker, Director, Accountability and Liaison Branch, Office of Chief Medical Officer of Health, Public Health, at 416-212-6359 or by e-mail at Elizabeth.Walker@ontario.ca.

There is a significant role for public health to play within the larger health care system and it will continue to be a valued partner. I look forward to your input and collaboration as we work to modernize the public health sector.

Thank you for your ongoing support as the Ministry of Health continues to build a modern, sustainable public health sector that meets the needs of Ontarians.

Yours truly,

David C. Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health

Attachments

c: Mayor Fred Eisenberger, Chair, Board of Health for the City of Hamilton
David Trevisani, Manager, City of Hamilton Public Health Services
Jim Yuill, Director, Financial Management Branch, MOH
Teresa Buchanan, Director (A), Fiscal Oversight & Performance Branch, MOH

New Schedules to the Public Health Funding and Accountability Agreement

BETWEEN THE PROVINCE AND THE BOARD OF HEALTH

(BOARD OF HEALTH FOR THE CITY OF HAMILTON, PUBLIC HEALTH SERVICES)

EFFECTIVE AS OF THE 1ST DAY OF JANUARY 2019

SCHEDULE "A"
GRANTS AND BUDGET

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

DETAILED BUDGET - MAXIMUM BASE FUNDS (FOR THE PERIOD OF JANUARY 1, 2019 TO DECEMBER 31, 2019, UNLESS OTHERWISE NOTED)					
Programs/Sources of Funding			**2018 Approved Allocation ($)**	**Increase / (Decrease) ($)**	**2019 Approved Allocation ($)**
Mandatory Programs (Cost-Shared)			24,126,300	-	24,126,300
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%)			1,560,300	-	1,560,300
Infectious Diseases Control Initiative (100%)	# of FTEs	10.00	1,111,200	-	1,111,200
MOH / AMOH Compensation Initiative (100%)[1]			271,000	-	271,000
Needle Exchange Program Initiative (100%)			202,000	-	202,000
Nursing Initiatives (100%)			392,100	-	392,100
Ontario Seniors Dental Care Program (100%)[2]			-	2,248,100	2,248,100
Smoke-Free Ontario Strategy (100%)			1,178,700	-	1,178,700
Total Maximum Base Funds[3]			**29,212,200**	**2,248,100**	**31,460,300**

DETAILED BUDGET - MAXIMUM ONE-TIME FUNDS (FOR THE PERIOD OF APRIL 1, 2019 TO MARCH 31, 2020, UNLESS OTHERWISE NOTED)	
Projects / Initiatives	**2019-20 Approved Allocation ($)**
Public Health Inspector Practicum Program (100%)	10,000
Total Maximum One-Time Funds[3]	**10,000**

(1) Cash flow will be adjusted to reflect the actual status of current MOH and AMOH positions.

(2) Base funding for the Ontario Seniors Dental Care Program is pro-rated at $1,686,075 for the period of April 1, 2019 to December 31, 2019.

(3) Maximum base and one-time funding is flowed on a mid and end of month basis. Cash flow will be adjusted when the Province provides a new Schedule "A".

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

Enhanced Food Safety – Haines Initiative (100%)

The Enhanced Food Safety – Haines Initiative was established to augment the Board of Health's capacity to deliver the Food Safety Program as a result of the provincial government's response to Justice Haines' recommendations in his report "Farm to Fork: A Strategy for Meat Safety in Ontario".

Base funding for this initiative must be used for the sole purpose of implementing the Food Safety Program Standard under the Ontario Public Health Standards. Eligible expenses include such activities as: hiring staff, delivering additional food-handler training courses, providing public education materials, and program evaluation.

Funded projects/activities must be over and above the level of activities underway or planned based on existing mandatory programs base funding.

Enhanced Safe Water Initiative (100%)

Base funding for this initiative must be used for the sole purpose of increasing the Board of Health's capacity to meet the requirements of the Safe Water Program Standard under the Ontario Public Health Standards.

Funded projects/activities must be over and above the level of activities underway or planned based on existing mandatory programs base funding.

Harm Reduction Program Enhancement (100%)

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

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

<u>Local Opioid Response</u>

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

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

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

- Conduct a population health/situational assessment, including the identification of opioid-related community challenges and issues, which are informed by local data, community engagement, early warning systems, etc.
- Lead/support the development, implementation, and evaluation of a local overdose response plan (or drug strategy). Any plan or initiative should be based on the needs identified (and/or gaps) in your local assessment. This may include building community outreach and response capacity, enhanced harm reduction services and/or education/prevention programs and services.
- Engage stakeholders - identify and leverage community partners to support the population health/situational assessment and implementation of local overdose response plans or initiatives. This should include First Nations, Métis and Inuit communities where appropriate.
- Adopt and ensure timely data entry into the Ontario Harm Reduction Database, including the Transition to the Ontario Harm Reduction Database and ensure timely collection and entry of minimum data set as per direction from the Province (to be provided).

<u>Naloxone Kit Distribution and Training</u>

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

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

- Ordering of naloxone kits as outlined by the Province; this includes naloxone required by eligible community organizations distributing naloxone.
- Coordinate and supervise naloxone inventory, including managing supply, storage, maintaining inventory records, and distribution of naloxone to eligible community organizations, and ensuring community organizations distribute naloxone in accordance with eligibility criteria established by the ministry.
- With the exception of entities (organizations, individuals, etc.) as specified by the Province:
  - Train community organization staff on naloxone administration, including how to administer naloxone in cases of opioid overdose, recognizing the signs of overdose and ways to reduce the risk of overdose. Board of Health staff would also instruct agency

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

staff on how to provide training to end-users (people who use drugs, their friends and family).
- Train community organization staff on naloxone eligibility criteria, including providing advice to agency staff on who is eligible to receive naloxone and the recommended quantity to dispense.
- Support policy development at community organizations, including providing consultation on naloxone-related policy and procedures that are being developed or amended within the eligible community organizations.
- Promote naloxone availability and engage in community organization outreach, including encouraging eligible community organizations to acquire naloxone kits for distribution to their clients.

Use of NARCAN® Nasalspray

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

- Its use of the Narcan is entirely at its own risk. There is no representation, warranty, condition or other promise of any kind, express, implied, statutory or otherwise, given by her Majesty the Queen in Right of Ontario as represented by the Ministry of Health, including Ontario Government Pharmaceutical and Medical Supply Service in connection with the Narcan.
- The Province takes no responsibility for any unauthorized use of the Narcan by the Board of Health or by its clients.
- The Board of Health also agrees:
  - To not assign or subcontract the distribution, supply or obligation to comply with any of these terms and conditions to any other person or organization without the prior written consent of the Province.
  - To comply with the terms and conditions as it relates to the use and administration of Narcan as specified in all applicable federal and provincial laws.
  - To provide training to persons who will be administering Narcan. The training shall consist of the following: opioid overdose prevention; signs and symptoms of an opioid overdose; and, the necessary steps to respond to an opioid overdose, including the proper and effective administration of Narcan.
  - To follow all provincial written instructions relating to the proper use, administration, training and/or distribution of Narcan.
  - To immediately return any Narcan in its custody or control at the written request of the Province at the Board of Health's own cost or expense.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

- That the Province does not guarantee supply of Narcan, nor that Narcan will be provided to the Board of Health in a timely manner.

Opioid Overdose Early Warning and Surveillance

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

- Surveillance systems should include a set of "real-time" qualitative and quantitative indicators and complementary information on local illicit synthetic opioid risk. Partners should include, but are not limited to: emergency departments, first responders (police, fire and ambulance) and harm reduction services.
- Early warning systems should include the communication mechanisms and structures required to share information in a timely manner among health system and community partners, including people who use drugs, about changes in the acute, local risk level, to inform action. They should also include reporting to the province through a mechanism currently under development.

Healthy Smiles Ontario Program (100%)

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

HSO builds upon and links with existing public health dental infrastructure to provide access to dental services for eligible children and youth.

The HSO Program has the following three (3) streams (age of ≤ 17 years of age and Ontario residency are common eligibility requirements for all streams):

1. **Preventive Services Only Stream (HSO-PSO):**
   - Eligibility comprised of clinical need and attestation of financial hardship.
   - Eligibility assessment and enrolment undertaken by boards of health.
   - Clinical preventive service delivery in publicly-funded dental clinics and through fee-for-service providers in areas where publicly-funded dental clinics do not exist.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

2. Core Stream (HSO-Core):

- Eligibility correlates to the level at which a family/youth's Adjusted Net Family Income (AFNI) is at, or below, the level at which they are/would be eligible for 90% of the Ontario Child Benefit (OCB), OR family/youth is in receipt of benefits through Ontario Works, Ontario Disability Support Program, or Assistance for Children with Severe Disabilities Program.
- Eligibility assessment undertaken by the Ministry of Finance and Ministry of Community and Social Services; enrolment undertaken by the program administrator, with client support provided by boards of health as needed.
- Clinical service delivery takes place in publicly-funded dental clinics and through fee-for-service providers.

3. Emergency and Essential Services Stream (HSO-EESS):

- Eligibility comprised of clinical need and attestation of financial hardship.
- Eligibility assessment undertaken by boards of health and fee-for-service providers, with enrolment undertaken by the program administrator.
- Clinical service delivery takes place in publicly-funded dental clinics and through fee-for-service providers.

Base funding for this program must be used for the ongoing, day-to-day requirements associated with delivering services under the HSO Program to eligible children and youth in low-income families. It is within the purview of the Board of Health to allocate funding from the overall base funding amount across the program expense categories.

HSO Program expense categories include:

- Clinical service delivery costs, which are comprised of:
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff that provide clinical dental services for HSO;
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff that undertake the following ancillary/support activities for HSO: management of the clinic(s); financial and programmatic reporting for the clinic(s); and, general administration (i.e., receptionist) at the clinic(s); and,
  - Overhead costs associated with HSO clinical service delivery services such as: clinical materials and supplies; building occupancy costs; maintenance of clinic infrastructure; staff travel associated with portable and mobile clinics; staff training and professional development associated with clinical staff and ancillary/support staff, if applicable; office equipment, communication, and I & IT.

- Oral health navigation costs, which are comprised of:

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

- Salaries, wages, and benefits of full-time, part-time, or contracted staff that are engaged in:
  - Client enrolment for all streams of the program;
  - Promotion of the HSO Program (i.e., local level efforts at promoting and advertising the HSO Program to the target population);
  - Referral to services (i.e., referring HSO clients to fee-for-service providers for service delivery where needed);
  - Case management of HSO clients; and,
  - Oral health promotion and education for HSO clients.
- Salaries, wages, and benefits of full-time, part-time, or contracted staff that undertake the following ancillary/support activities related to oral health navigation: management, financial and programmatic reporting, and general administration (if applicable).
- Overhead costs associated with oral health navigation such as: materials and supplies; building occupancy costs incurred for components of oral health navigation; staff travel associated with oral health navigation, where applicable; staff training and professional development associated with oral health navigation staff and ancillary/support staff, if applicable; office equipment, communication, and I & IT costs associated with oral health navigation.

The Board of Health is responsible for ensuring promotional/marketing activities have a direct and positive impact on meeting the objectives of the HSO Program.

The Board of Health is reminded that HSO promotional/marketing materials approved by the Province and developed provincially are available for use by the Board of Health in promoting the HSO Program.

The overarching HSO brand and provincial marketing materials were developed by the Province to promote consistency of messaging, and "look and feel" across the province. When promoting the HSO Program locally, the Board of Health is requested to align local promotional products with the provincial HSO brand. When the Board of Health uses the HSO brand, it is required to liaise with the Ministry of Health's Communications and Marketing Division to ensure use of the brand aligns with provincial standards.

Operational expenses not covered within this program include: staff recruitment incentives, billing incentives, and client transportation. Other expenses not included within this program include other oral health activities required under the Ontario Public Health Standards, including the *Oral Health Protocol, 2018*.

Other requirements of the HSO Program include:

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

- The Board of Health is required to bill back relevant programs for services provided to non-HSO clients using HSO resources. All revenues collected under the HSO Program, including revenues collected for the provision of services to non-HSO clients such as Ontario Works adults, Ontario Disability Support Program adults, municipal clients, etc., with HSO resources must be reported as income in the Standards Activity Reports, Annual Reports, and Annual Service Plan and Budget Submission. Revenues must be used to offset expenditures of the HSO Program.
- For the purposes of reporting and monitoring for the HSO Program, the Board of Health must use the following provincial approved systems or mechanisms, or other as specified by the Province.
  - Aggregate screening, enrolment, and utilization data for any given month must be submitted by the 15th of the following month to the ministry in the ministry-issued template titled Dental Clinic Services Monthly Reporting Template.
  - Client-specific clinical data must be recorded in either dental management software (e.g., ClearDent, AbelDent, etc.) or in the template titled HSO Clinic Treatment Workbook that has been issued by the ministry for the purposes of recording such data.
- The Board of Health must enter into Service Level Agreements with any partner organization (e.g., Community Health Centre, Aboriginal Health Access Centre, etc.) delivering services as part of the HSO Program. The Service Level Agreement must set out clear performance expectations, clearly state funding and reporting requirements between the Board of Health and local partner, and ensure accountability for public funds.
- Any significant change to previously approved HSO business models, including changes to plans, partnerships, or processes, must be approved by the Province before being implemented.
- Any contract or subcontract entered into by the Board of Health for the purposes of implementing the HSO Program must be conducted according to relevant municipal procurement guidelines.
- The Board of Health is responsible for ensuring value-for-money and accountability for public funds.
- The Board of Health must ensure that funds are used to meet the objectives of the HSO Program with a priority to deliver clinical dental services to HSO clients.

Infectious Diseases Control Initiative (100%)

Base funding for this initiative must be used solely for the purpose of hiring infectious diseases control positions and supporting these staff (e.g., recruitment, salaries/benefits, accommodations, program management, supplies and equipment, other directly related costs) to monitor and control infectious diseases, and enhance the Board of Health's ability to handle and coordinate increased activities related to outbreak management, including providing support to other boards of health during infectious disease outbreaks. Positions eligible for

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

base funding under this initiative include physicians, inspectors, nurses, epidemiologists, and support staff.

The Board of Health is required to remain within both the funding levels and the number of FTE positions approved by the Province.

Staff funded through this initiative are required to be available for redeployment when requested by the Province, to assist other boards of health with managing outbreaks and to increase the system's surge capacity.

MOH / AMOH Compensation Initiative (100%)

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

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

The maximum base allocation approved for the Board of Health includes criteria for potential MOH and AMOH positions such as: additional salary and benefits for 1.0 FTE MOH position and 1.0 FTE or more AMOH positions where applicable, potential placement at the top of the MOH/AMOH Salary Grid, and inclusion of stipends. Some exceptions will apply to these criteria.

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

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

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

Needle Exchange Program Initiative (100%)

Base funding for this initiative must be used for the purchase of needles and syringes, and their associated disposal costs, for the Board of Health's Needle Exchange Program.

Nursing Initiatives (100%)

The Province provides base funding to the Board of Health for the following nursing initiatives and positions:

1. Chief Nursing Officer;
2. Infection Prevention and Control Nurses; and,
3. Social Determinants of Health Nurses.

Chief Nursing Officer Initiative

Base funding must be must to support up to or greater than one full-time equivalent (FTE) Chief Nursing Officer and/or nurse practice lead to enhance the health outcomes of the community at individual, group, and population levels through contributions to organizational strategic planning and decision making; by facilitating recruitment and retention of qualified, competent public health nursing staff; by enabling quality public health nursing practice; and, by articulating, modeling, and promoting a vision of excellence in public health nursing practice, which facilitates evidence-based services and quality health outcomes in the public health context.

The following qualifications are required for designation as a Chief Nursing Officer:

- Registered Nurse in good standing with the College of Nurses of Ontario;
- Baccalaureate degree in nursing;
- Graduate degree in nursing, community health, public health, health promotion, health administration or other relevant equivalent OR be committed to obtaining such qualification within three (3) years of designation;
- Minimum of 10 years nursing experience with progressive leadership responsibilities, including a significant level of experience in public health; and,
- Member of appropriate professional organizations (e.g., Registered Nurses' Association of Ontario, Association of Nursing Directors and Supervisors in Official Health Agencies in Ontario-Public Health Nursing Management, etc.).

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

Infection Prevention and Control Nurses

Base funding must be used to support up to or greater than one FTE infection prevention and control nursing services at the Board of Health.

The position(s) is required to have a nursing designation (Registered Nurse, Registered Practical Nurse, or Registered Nurse in the Extended Class); and, Certification in Infection Control (CIC), or a commitment to obtaining CIC within three (3) years of beginning of employment.

Social Determinants of Health Nurses

Base funding must be used to support nursing activities of up to or greater than two FTE public health nurses with specific knowledge and expertise in social determinants of health and health inequities issues, and to provide enhanced supports internally and externally to the Board of Health to address the needs of priority populations impacted most negatively by the social determinants of health.

These positions are required to be to be a registered nurse; and, to have or be committed to obtaining the qualifications of a public health nurse as specified in section 71(3) of the *Health Protection and Promotion Act* (HPPA) and section 6 of Ontario Regulation 566 under the HPPA.

Ontario Seniors Dental Care Program (100%)

The Ontario Seniors Dental Care Program (OSDCP) provides comprehensive dental care to eligible low-income seniors to help reduce unnecessary trips to the hospital, prevent chronic disease and increase quality of life for seniors. The program will be implemented through a staged implementation approach as follows:

STAGE 1: Late Summer 2019 – Dental care provided to eligible low-income seniors through public health units, Community Health Centres, and Aboriginal Health Access Centres based on increasing public health unit operational funding and leveraging existing infrastructure.

STAGE 2: This coming Winter (i.e., Winter 2019-20) – Program expanded by investing in new dental services in underserviced areas, including through mobile dental buses and an increased number of dental suites in Public Health Units, Community Health Centres, and Aboriginal Health Access Centres.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

Eligibility

Clients will be eligible for the OSDCP if they:

- Are 65 years of age or older;
- Are residents of Ontario;
- Meet the Ministry of Health-specified income eligibility thresholds i.e., single seniors with annual incomes of $19,300 or less after taxes, or senior couples (one or both people aged 65 or older), with a combined annual income of $32,300 or less after taxes; and,
- Have no access to any other form of dental benefits, including through government programs such as the Ontario Disability Support Program, Ontario Works, or the Non-Insured Health Benefits Program.

Eligible clients will be enrolled for up to one benefit year at a time with eligibility re-determined on an annual basis. The benefit year for the OSDCP will align with the benefit year for the Healthy Smiles Ontario Program (i.e., from August 1st until July 31st of the following calendar year).

Basket of Services

The basket of dental services under this Program will be consistent with the Ministry of Children, Community, and Social Services Schedule of Dental Services and Fees, but with the inclusion of certain essential prosthodontics (e.g., dentures) in the basket of services. Eligible clients will be required to pay a 10% co-payment on the total cost of the prosthodontic to the Board of Health.

In addition to prosthodontics, key examples of services included are as follows:

- Examinations/assessments: new patient exam; check-up exam; specific exam; emergency exam.
- Preventive services: polishing; fluoride; sealants; scaling.
- Restorative services: services to repair cavities or broken teeth such as temporary fillings, permanent fillings, crowns.
- Radiographs.
- Oral surgery services to remove teeth or abnormal tissue.
- Anaesthesia.
- Endodontic services: services to treat infections and pain with root canals being the most common service.
- Periodontal services to treat gum disease and other conditions.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

Program Enrolment

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

Program Delivery

The OSDCP will be delivered through Public Health Units, Community Health Centres, and Aboriginal Health Access Centres across the province with care provided by salaried dental providers. These service delivery partners are well positioned to understand the needs of priority populations and provide high quality dental care to low-income seniors in their communities.

With respect to Public Health Unit service delivery under the OSDCP, Public Health Units may enter into partnership contracts on a salaried basis with other entities / organizations or providers/specialists as needed (e.g., to address potential access issues) to provide services to enrolled clients in accordance with the OSDCP schedule of services on behalf of the Public Health Unit.

Base funding for the OSDCP must be used by the Board of Health in accordance with the OSDCP-related requirements of the Oral Health Protocol, 2018 (or as current) for the ongoing, day-to-day requirements associated with oral health navigation and delivering eligible dental services to enrolled clients through public health unit service delivery and/or through local service delivery partners. The Board of Health can allocate base funding for this Program across the program expense categories, with every effort to be made to **maximize clinical service delivery and minimize administrative costs**.

The official start of the Program (i.e., Stage 1 program launch with the commencement of clinical service delivery to clients) is anticipated for late Summer 2019. Beginning April 1, 2019, the Board of Health can begin ramp-up activities in preparation for the late summer 2019 launch of the Program. Eligible ramp-up expenses (staff and/or overhead) effective April 1, 2019 are:

- Costs associated with program outreach for the purpose of identifying clients in the community;
- Costs associated with community outreach for the purpose of identifying and liaising with potential service delivery partners;
- Costs associated with project management to ensure readiness by late summer 2019;
- Information and information technology in accordance with Ministry of Health direction;
- Clinical and office equipment, materials, and supplies; and,

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

- Planning costs associated with Ministry of Health-approved capital projects in support of the OSDCP, in accordance with any terms and conditions identified through the capital approval process.

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

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

- *Oral health navigation costs*, which are comprised of:
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff engaged in: client enrolment assistance for the Program's clients (i.e., assisting clients with enrolment forms); program outreach (i.e., local-level efforts for identifying potential clients); and, oral health education and promotion to the Program's clients.
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff that undertake the following ancillary/support activities related to oral health navigation: management, financial and programmatic reporting, and general administration (if applicable); and,
  - Overhead costs associated with oral health navigation such as: materials and supplies; building occupancy costs incurred for components of oral health navigation; staff travel associated with oral health navigation, where applicable; staff training and professional development associated with oral health navigation and ancillary/support staff, if applicable; office equipment, communication, and information and information technology costs associated with oral health navigation.

Operational expenses that are **not** eligible under this Program include:

- Staff recruitment incentives;
- Billing incentives;

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

- Client transportation unless otherwise approved by the Ministry of Health; and,
- Costs associated with any activities required under the Ontario Public Health Standards, including the Oral Health Protocol, 2018 (or as current), which are not related to the OSDCP.

Other Requirements

Marketing

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

Revenue

- The Board of Health is required to bill-back relevant programs for services provided to non-OSDCP clients using resources under this Program. All revenues collected under the OSDCP, including revenues collected for the provision of services to non-Program clients such as Ontario Works adults, Ontario Disability Support Program adults, Non-Insured Benefits clients, municipal clients, Healthy Smiles Ontario clients, etc., with resources under this Program must be reported as an offset revenue to the Province. Priority must always be given to clients eligible under this Program. The Board of Health is required to closely monitor and track revenue from bill-back for reporting purposes to the Province.
- The Board of Health is required to collect a 10% co-payment from clients receiving prosthodontics. The client is responsible for reimbursing the Board of Health for 10% of the total cost of the prosthodontic with the Board of Health paying for the remainder (90%) through base funding under this Program. The revenue received from the co-payment is to be used to offset the expenditures of the Program. The Board of Health must report the aggregate amount of the co-payment to the Province. The Board of Health is required to closely monitor and track revenue from co-payments for reporting purposes to the Province.

Community Partners

- The Board of Health must enter into discussions with all Community Health Centres and Aboriginal Health Access Centres in their catchment area to ascertain the feasibility of a partnership for the purpose of delivering this Program.
- The Board of Health must enter into Service Level Agreements with any partner organization (i.e., Community Health Centres, Aboriginal Health Access Centres) delivering services under this Program. The Service Level Agreement must set out clear performance expectations, clearly state funding and reporting requirements between the Board of Health and the local partner, and ensure accountability for public funds.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Base***
Source	***Public Health***

The Board of Health must ensure that base funding is used to meet the objectives of the Program, with a priority to deliver clinical dental services to clients, while staying within the base funding allocation.

Smoke-Free Ontario Strategy (100%)

The Smoke-Free Ontario Strategy is a multi-level comprehensive tobacco control strategy aiming to eliminate tobacco-related illness and death by: preventing experimentation and escalation of tobacco use among children, youth and young adults; increasing and supporting cessation by motivating and assisting people to quit tobacco use; and, protecting the health of Ontarians by eliminating involuntary exposure to second-hand smoke. These objectives are supported by crosscutting health promotion approaches, capacity building, collaboration, systemic monitoring and evaluation.

The Province provides base funding to the Board of Health to implement tobacco control activities that are based in evidence and best practices, contributing to reductions in tobacco use rates.

Base funding for the Smoke-Free Ontario Strategy must be used in the planning and implementation of comprehensive tobacco control activities across prevention, cessation, prosecution, and protection and enforcement at the local and regional levels.

The Board of Health must comply and adhere to the Smoke-Free Ontario Strategy: Public Health Unit Tobacco Control Program Guidelines and the Directives: Enforcement of the *Smoke-Free Ontario Act*. Operational expenses not covered within this program include information and information technology equipment.

SCHEDULE “B”

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***One-Time***
Source	***Public Health***

Public Health Inspector Practicum Program (100%)

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

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

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***Other***
Source	***Public Health***

Vaccine Programs

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

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

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

Influenza

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

Meningococcal

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

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

Human Papillomavirus (HPV)

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

SCHEDULE "C"

REPORTING REQUIREMENTS

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

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

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

Definitions

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

"Q1" means the period commencing on January 1st and ending on the following March 31st.

"Q2" means the period commencing on April 1st and ending on the following June 30th.

"Q3" means the period commencing on July 1st and ending on the following September 30th.

"Q4" means the period commencing on October1st and ending on the following December 31st.

Report Details

Annual Service Plan and Budget Submission

- The Board of Health shall provide its Annual Service Plan and Budget Submission by March 1st of the current Board of Health Funding Year.
- The Annual Service Plan and Budget Submission Template sets the context for reporting required of the Board of Health to demonstrate its accountability to the Province.
- When completed by the Board of Health, it will: describe the complete picture of programs and services the Boards of Health will be delivering within the context of the Ontario Public Health Standards; demonstrate that Board of Health programs and services align with the priorities of its communities, as identified in its population health assessment; demonstrate accountability for planning – ensure the Board of Health is planning to meet all program requirements in accordance with the Ontario Public Health Standards, and ensure there is a link between demonstrated needs and local priorities for program delivery; demonstrate the use of funding per program and service.

Quarterly Standards Activity Reports

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

Annual Report and Attestation

- The Annual Report and Attestation will provide a year-end summary report on achievements on all programs governed under the Agreement, in all accountability domains under the Organizational Requirements, and identification of any major

changes in planned activities due to local events.
- The Annual Report will include a narrative report on the delivery of programs and services, fiduciary requirements, good governance and management, public health practice, and other issues, year-end report on indicators, and a board of health attestation on required items.

Annual Reconciliation Report
- The Board of Health shall provide to the Province an Annual Reconciliation Report (as part of the Annual Report and Attestation) for funding provided for public health programs governed under the Accountability Agreement.
- The Annual Reconciliation Report must contain: Audited Financial Statements; and, Auditor's Attestation Report in the Province's prescribed format.

MOH/AMOH Compensation Initiative Application
- The Board of Health shall complete, sign, and submit an annual application in order to participate in this Initiative and be considered for funding.
- Application form templates and eligibility criteria/guidelines shall be provided by the Province.

SCHEDULE "D"

BOARD OF HEALTH FINANCIAL CONTROLS

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

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

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

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

   Examples of potential controls to support this objective include, but are not limited to:
   - Documented policies and procedures to provide a sense of the organization's direction and address its objectives.
   - Define approval limits to authorize appropriate individuals to perform appropriate activities.
   - Segregation of duties (e.g., ensure the same person is not responsible for ordering, recording, and paying for purchases).
   - An authorized chart of accounts.
   - All accounts reconciled on a regular and timely basis.
   - Access to accounts is appropriately restricted.
   - Regular comparison of budgeted versus actual dollar spending and variance analysis.
   - Exception reports and the timeliness to clear transactions.
   - Electronic system controls, such as access authorization, valid date range test, dollar value limits, and batch totals, are in place to ensure data integrity.

- Use of a capital asset ledger.
- Delegate appropriate staff with authority to approve journal entries and credits.
- Trial balances including all asset accounts that are prepared and reviewed by supervisors on a monthly basis.

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

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

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

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

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

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

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

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

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

From: Fernandes, Krislyn
To: Kolar, Loren
Subject: (2019-09-05) alPHA - Save the date - alPHa Fall Symposium & Section Meetings
Date: September 5, 2019 11:24:23 AM
Attachments: Fall 2019 Flyer.pdf

Hi Loren,

Can we add this BOH Correspondence as "To Be Received" for the Sept BOH?

Thank you,

Krislyn Fernandes
Administrative Coordinator to Dr. Elizabeth Richardson, Medical Officer of Health

Office of the Medical Officer of Health | Public Health Services
Healthy and Safe Communities Dept. | City of Hamilton
100 Main Street West, 6th Floor | Hamilton, ON | L8P 1H6
t: 905.546.2424 x3502 | **e:** Krislyn.Fernandes@hamilton.ca

Mailing Address:
110 King Street West, 2nd Floor | Hamilton, ON | L8P 4S6

From: Susan Lee <susan@alphaweb.org>
Sent: September 5, 2019 9:50 AM
To: All Health Units <AllHealthUnits@lists.alphaweb.org>
Subject: Save the date - alPHa Fall Symposium & Section Meetings

ATTENTION:
All Board of Health Members
All Senior Public Health Directors & Managers
****

Please see the attached Save the Date flyer regarding alPHa's upcoming Fall 2019 Symposium and Section Meetings. The flyer may also be accessed by clicking here.

The Fall 2019 Symposium will be held on November 6 from 8:30 am to 5:00 pm at the Dalla Lana School of Public Health (DLSPH), University of Toronto. In the late afternoon and early evening, there will be a special reception and guest lecture sponsored by the DLSPH.

On November 7, half-day Section meetings for board of health members and COMOH members will take place in the morning at the Chestnut Conference Centre in Toronto.

Registration and program details will be available shortly, so please stay tuned. In the meantime, attendees are advised to begin reserving their accommodations (see attached flyer for more information).

We hope to see you in November!

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

SAVE THE DATE!

Fall 2019 Symposium

Wednesday, November 6
Dalla Lana School of Public Health
Health Sciences Building, 6th Floor
University of Toronto
155 College Street, Toronto
(main intersection: University & College)

- Plenary: 8:30 AM – 4:30 PM
  (lunch on your own)
- Reception & Guest Lecture: 5 – 7 PM

Section Meetings

Thursday, November 7
Chestnut Conference Centre
3rd Floor
89 Chestnut Street, Toronto
(main intersection: University & Dundas)

- 8:30 AM – 12 Noon
- Separate meetings for board of health members and COMOH members

alPHa
Association of Local PUBLIC HEALTH Agencies

Fall 2019 Symposium: November 6
Section Meetings: November 7

IMPORTANT NOTES:

- The November 6 Symposium and November 7 Section meetings will be held at *different* locations (see above).
- Attendees are advised to start booking their guest accommodations. Nearby hotels include the Chelsea Hotel, DoubleTree by Hilton Hotel, and Courtyard by Marriott Toronto Downtown. Guestroom blocks have *not* been arranged with these hotels; reservations at these and other lodgings must be made individually by conference attendees.

From: Fernandes, Krislyn
To: Kolar, Loren
Subject: 05.6 RECEIVE (2019-08-21) alPHa - Public Health Cost Sharing Funding Model Update
Date: September 4, 2019 2:54:27 PM

Krislyn Fernandes
Administrative Coordinator to Dr. Elizabeth Richardson, Medical Officer of Health

Office of the Medical Officer of Health | Public Health Services
Healthy and Safe Communities Dept. | City of Hamilton
100 Main Street West, 6th Floor | Hamilton, ON | L8P 1H6
t: 905.546.2424 x3502 | **e:** Krislyn.Fernandes@hamilton.ca

Mailing Address:
110 King Street West, 2nd Floor | Hamilton, ON | L8P 4S6

From: Info <info@alphaweb.org>
Sent: August 21, 2019 9:09 AM
To: All Health Units <AllHealthUnits@lists.alphaweb.org>
Subject: Public Health cost sharing funding model update

ATTENTION:
CHAIRS, BOARDS OF HEALTH
MEDICAL OFFICERS OF HEALTH
SENIOR MANAGERS, ALL PROGRAMS
****

Dear alPHa members,

Following this week's 2020 public health cost share announcements, we have received clarification from the Ministry of Health regarding the 30% cost share:

Effective January 1,2020, it will include all of the current 100% ministry of health funded programs except:

*** Senior's dental**
*** MOH/AMOH compensation**
*** unorganized territories grants**

We await further details as to the promised one-time funding for 2020 to offset the extra cost to the municipalities. We will share additional information as soon as it is available.

Take Care,

Loretta Ryan
Executive Director
Association of Local Public Health Agencies (alPHa)
647-325-9594

Form: Request to Speak to Committee of Council
Submitted on Wednesday, September 4, 2019 - 12:28 pm

==Committee Requested==
Committee: Board of Health

==Requestor Information==
Name of Individual: Noor Nizam

Name of Organization: Individual Senior Citizen of Hamilton/Dundas

Contact Number: [redacted]

Email Address: [redacted]

Mailing Address: [redacted]

Reason(s) for delegation request: I wish to address the BOH committee ONLY as an individual senior citizen concerning the need for incorporating Amendments/suggestions to the Ontario Seniors Dental Care Program which has been proposed by the Public Health Services - City Hamilton in accordance with the $. 2.248 million "free" additional base funding for 2019 - 20 funding year, provided by the Provincial Ministry of Health and Long-Term Care to support the new dental program for low-income seniors, which is aimed to prevent chronic disease, reduce infections and improve quality of life, while reducing the burden on health care System. The proposal lacks attention to the need for Awareness and information disbursement and the inclusion of diverse community languages, disparity regarding the number of Low-income Seniors Eligible for the programe, the possibility to include Dentists and Endodontists practicing in main cities/rural cities in Hamilton to support the program who can be remunerated under this program temporarily until

discussions with the CHC's and AHACS's in their local jurisdiction to ascertain their feasibility of a service partnership is concluded, the lack of attention concerning the isolated low-income seniors and homeless low-income seniors to be included in the program, and the need to extend the Dental Health Bus facility to include service schedules in Dundas, Flamborough and Greensville.

Will you be requesting funds from the City? No

Will you be submitting a formal presentation? Yes

Hamilton

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	September 16, 2019
SUBJECT/REPORT NO:	IDEAS (Informed Decisions Empowering Adolescents) Program (BOH16059(b)) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Chris Pickersgill (905) 546-2424 Ext. 3787
SUBMITTED BY: **SIGNATURE:**	Kevin McDonald on behalf of Jennifer Vickers-Manzin, CNO Director, Healthy Environments Division Public Health Services

COUNCIL DIRECTION

Not Applicable.

INFORMATION

The Informed Decisions Empowering Adolescents (IDEAs) Program has been funded since 1998 as one of the initiatives to promote the healthy sexuality of youth in Hamilton. Impact Education Consulting produces and organizes the IDEAs Program within selected schools. The IDEAs program trains secondary school aged students to deliver peer to peer curriculum to Grade 8 students. IDEAs is comprised of three topic sessions focused on: (1) high school culture; (2) substance misuse; and, (3) sexuality.

On June 22, 2017, the Hamilton Wentworth District School Board (HWDSB) provided Public Health Services written notice to discontinue the IDEAs program in their schools. At the HWDSB's request, the decision to cease IDEAs programming took effect in July 2017.

On December 4, 2017, the Board of Health received the Information Report (BOH16059(a)), Informed Decisions Empowering Adolescents (IDEAs) – Update. The BOH endorsed the extension of the contract with Impact Education Consulting to allow for continued service delivery in the French Public School Board, Conseil Scolaire Viamonde (CSViamonde), and the French Catholic School Board, Conseil Scolaire Catholique MonAvenir (CSC MonAvenir). Impact Education Consulting had approached the Hamilton Wentworth Catholic District School Board (HWCDSB) to consider initiating IDEAs within their school board. At the time of the report, Public Health Services had not received direction from the HWCDSB of their decision to pursue IDEAs programming within their school board.

Public Health Staff met with representatives from the CSViamonde and CSC MonAvenir to review the IDEAs program. Both CSViamonde and CSC MonAvenir expressed a desire to continue offering IDEAs within their boards. As a result, Public Health Services continued to contract with Impact Education Consulting to deliver IDEAs solely within the French language school boards for the 2018-2019 school year.

On July 8, 2019, the HWCDSB confirmed that after a thorough review of the IDEAs program, they would not be adopting the IDEAs program within their board.

Public Health Services plans to contract with Impact Education Consulting based on current service requests and levels. This will maintain service delivery to Grade 8 students in the four CSViamonde and CSC MonAvenir schools through the 2019-2020 school year.

APPENDICES AND SCHEDULES ATTACHED

Not Applicable.

Hamilton

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	September 16, 2019
SUBJECT/REPORT NO:	Semi-Annual Public Health Services Performance and Monitoring Report (Q1 & Q2 2019) (BOH19030) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Ashley Vanderlaan (905) 546-2424 Ext. 4718 Carolyn Hureau (905) 546-2424 Ext. 6004
SUBMITTED BY: **SIGNATURE:**	Dr. Ninh Tran on behalf of Dr. Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services

COUNCIL DIRECTION

During the last Board of Health evaluation completed in 2018 (see report BOH18011(a)), staff committed to providing regular updates on progress with the Annual Service Plan & Budget (ASP&B) as well as the Multi-Year Business Plan (MYBP). This report fulfils that commitment for Q1 & Q2 of 2019.

INFORMATION

Three priority areas for action were identified in the 2019 ASP&B, based on population health assessment data and knowledge of our community:

- Mental Health & Addictions;
- Healthy Weights; and,
- Health Equity.

During the first half of 2019, staff from across the department have reviewed the needs, evidence, resources, and mandate in each of these priority areas and developed plans

for renewed action in these areas. These will be presented to the Board of Health at its November meeting.
The ASP&B, MYBP, and related documents also outline goals and objectives for the full breadth of programs delivered by Public Health Services (PHS). These are aligned with the mandates set out by the Province and its agencies, to whom the Board is accountable. In this report, relevant indicators are presented to show progress across these program objectives. Future reports will also track progress on the priority area action plans.

Staff have been working to maximize the efficiency, transparency, and usefulness of the Performance Management and Monitoring System used to track progress on PHS priorities, program objectives, and targets. The information generated by the system is used by staff and management for program planning and continuous quality improvement. System indicators described in this report reflect the indicators chosen prior to the 2019 ASP&B submission in March 2019. In some areas, there is a rich availability of data to use for these purposes, while in other areas staff are working to develop new ways to gather meaningful information. The system continues to be improved to provide the breadth and depth of information needed to ensure performance on Public Health priorities and program objectives, and strengthen the precision of targets.

Much of the monitoring data that is tracked reflects the demand work carried out within the environmental health and infectious disease areas, as mandated by the Ontario Public Health Standards. Monitoring trends over time strengthens the quality of evidence available for program planning and continuous quality improvement.

Previously, the Board of Health received two separate reports that contained this performance and monitoring data (for 2018 year-end, see the Semi-Annual Public Health Performance report BOH19008 and the Semi-Annual Infectious Disease and Environmental Health Report BOH19007). As outlined in the latter, these reports have now been combined to provide more streamlined and comprehensive reporting on progress in one report.

2019 Priorities
As noted above, staff have been working to identify further efforts needed to address the three priority areas. New action plans will be outlined in a report to the Board in November. Staff have already begun implementation actions in several areas, and there is substantial ongoing work in existing programs related to these priorities. Reporting on progress in these action areas will begin in the Performance Report for the second half of 2019.

2019 Program Performance and Monitoring Data
A summary of the 2019 Q1-Q2 performance and monitoring results are presented in Appendix “A” to Report BOH19030.

As the PHS' Performance Management and Monitoring System improves, the goal is to integrate existing performance measurement and monitoring strategies into an overarching system to:

- Demonstrate accountability;
- Increase transparency;
- Provide staff and management with timely evidence on which to base decisions and program planning;
- Monitor program efficiency and effectiveness for continuous quality improvement; and,
- Fulfil internal and Ministry reporting requirements.

Further development of PHS' Performance Management and Monitoring System will also result in improvements to future Semi-Annual PHS Performance and Monitoring reports. The next semi-annual report will be provided to the Board of Health in Q1 2020.

APPENDICES AND SCHEDULES ATTACHED

Appendix "A" to Report BOH19030:	Q1-Q2 2019 Semi-Annual PHS Performance and Monitoring Measure Results

ALL PUBLIC HEALTH SERVICES DIVISIONS				
#	**Measure**	**Target**	**Q1-Q2 Results 2019**	**Comments**
OBJECTIVE: Increase Partner & Community Engagement				
P1	% of program managers who report collecting client feedback as regular practice	N/A	61.1% (11/18)	This result will be used to set the target for the 2019 Q3-Q4 Report.
P2	% of program managers who report having 2 or more partnerships with community groups/organizations	N/A	100% (17/17)	This result will be used to set the target for the 2019 Q3-Q4 Report.
OBJECTIVE: Increase Opportunities to Improve Practice and Service Delivery				
P3	% of program managers who report identifying targeted health interventions for priority populations	N/A	86.7% (13/15)	This result will be used to set target for the 2019 Q3-Q4 Report.
P4	% of program managers who report Evidence Informed Practice principles have been adopted	N/A	88.2% (15/17)	This result will be used to set target for the 2019 Q3-Q4 Report.
P5	% of programs managers who report undertaking at least one Continuous Quality Improvement (CQI) initiative	N/A	94.4% (17/18)	This result will be used to set target for the 2019 Q3-Q4 Report.
P6	% of vacancies that remain vacant after 3 months of recruitment (by Division)	N/A	EWCDC: 45.5% (15/33) HE: 60% (18/30) HF: 40.5% (17/42)	Due to the April 11, 2019 budget announcement by the Province, select positions were initially held vacant while awaiting further details of the Province’s restructuring plans for local public health.
OBJECTIVE: Improve Client Satisfaction with Public Health Services				
P7	% of Our Citizen Survey respondents who rated Public Health Services as "Good", "Very Good", or "Excellent"*	80%	N/A	In 2018, the result for this measure was 75%. 2019 survey underway, data will be available for the 2019 Q3-Q4 Report.

#	Measure	Target	Q1-Q2 Results 2019	Comments
OBJECTIVE: Improve Workplace Culture				
P8	% of Our People Survey (OPS) action plan items completed by Division	100% by Q4 2019	EWCDC[1]: 17.6% (6/34) HE[2]: 31.8% (7/22) HF[3]: 15.6% (7/45)	Many OPS action plan items are ‘in-progress’ and will be completed by end of Q4 2019.
OBJECTIVE: Improve Employee Training in Public Health Practice				
P9	Cumulative % of staff who completed PHS specific training (OnCore)	100% by Q4 2019	78.1% (346/443)	On schedule to reach target by end of year.
OBJECTIVE: Improve Employee Development				
P10	% of employees who "meet or exceed" PAD goals	N/A	N/A	Data will be generated during the end-of-year PAD review meetings, and available in the 2019 Q3-Q4 report.
OBJECTIVE: Increase Preparedness in the Event of a Public Health Emergency				
P11	% of Public Health Emergency Control Group personnel who have participated in either an exercise, actual emergency activation or training within the past year	100% by the end of Q4	37.8% (14/37)	On schedule to reach target by end of year. A greater number of emergency exercises are planned for Q4 to allow for increased participation.
P12	% of corrective actions completed after an exercise or emergency activation within 12 months of identification	100% by the end of Q4	66.7% (12/18)	Outstanding corrective actions to be completed by end of year. On schedule to reach target.
OBJECTIVE: Increase the use of Population Health Assessment to Inform Planning and Decision-Making				
P13	% of requests for Population Health Assessment products resulting in a public health action or program decision	90%	93.3% (14/15)	N/A
OBJECTIVE: Increase Collaboration with Indigenous Communities				
P14	% of the Indigenous Workplan Initiatives completed	N/A	N/A	The Indigenous Workplan is currently being developed.

#	Measure	Target	Q1-Q2 Results 2019		Comments
OBJECTIVE: Increase Transparency to Protect Community Health					
P15	% of completed inspections with publicly disclosed inspection results	100%	100%	(2645/2645)	Inspection/convictions include: • Smoke-Free Ontario Act convictions • Food premises – routine and complaint-based inspections; • Public pools and spas – routine and complaint-based inspections; • Recreational camps (overnight camps only) – routine and complaint-based inspections; • Personal service settings – routine and complaint-based inspections; • Licensed child care centres – routine and complaint-based inspections; • Tanning facilities – complaint-based inspections; • Infection prevention and control (IPAC) lapse investigation reports; and, • Beach water quality during the operating season

EPIDEMIOLOGY WELLNESS & COMMUNICABLE DISEASE CONTROL DIVISION					
#	**Measure**	**Target**	**Q1-Q2 Results 2019**		**Comments**
OBJECTIVE: Increase Collaboration in the Development of a City-Wide Drug and Opioid Strategy					
P16	% of partner organizations who are satisfied with the Hamilton Drug Strategy	90%	89%	(65/73)	The Hamilton Drug Strategy will continue to improve its methods of engagement (i.e. format of workgroup meetings, increasing diversity within the group).

#	Measure	Target	Q1-Q2 Results 2019		Comments
OBJECTIVE: Increase Community Partnerships to Deliver Targeted Harm Reduction Services					
P17	% of eligible external stakeholders providing naloxone through the Ontario Naloxone Program	60%	35.5%	(11/31)	The Harm Reduction program is continuing to work with partners to expand naloxone distribution in the community. The program actively seeks out and helps agencies with the application process and to meet the requirements for distribution.
OBJECTIVE: Increase Access to Harm Reduction Supplies					
P18	% of Needle Exchange Van service requests responded to	90%	83.3%	(2132/2558)	Demand for the services of the Needle Exchange Van continue to rise, however, the program does not have the capacity and resources for the van to make more stops during the hours of services.
P19	% of naloxone kits distributed that were used by clients	27%	31.6%	(2043/6466)	2019 data has demonstrated an improvement in usage of naloxone kits among clients. In 2018 Q1 and Q2, 25% of naloxone kits distributed were used by clients.
OBJECTIVE: Increase Testing and Appropriate Treatment of STIs					
P20	% of confirmed HIV cases where follow up was closed and complete within 2 months	75%	93.3%	(14/15)	HIV causes significant health impacts on clients and the community and warrants timely follow-up counselling, connection to appropriate care and partner notification.
P21	% of confirmed gonorrhea cases who received first line treatment	80%	79.8%	(170/213)	In 2018, the result for this measure was 75.4%.

<table>
<tr><td></td><td>Additional Monitoring Measures</td><td colspan="5">Trend</td><td>Comments</td></tr>
<tr><td rowspan="3">M1</td><td rowspan="3">Sexually Transmitted & Blood Borne Infections</td><td></td><td>2016</td><td>2017</td><td>2018</td><td>2019</td><td rowspan="3">Since 2006, the City of Hamilton there has been a continued rise in reported sexually transmitted infections. In response, a Sexual Health Clinic review is underway to improve services and implement targeted health promotion efforts for identified priority populations.</td></tr>
<tr><td>Q1-Q2</td><td>1113</td><td>1147</td><td>1216</td><td>1393</td></tr>
<tr><td>Total</td><td>2215</td><td>2374</td><td>2638</td><td>TBD</td></tr>
<tr><td>#</td><td>Measure</td><td colspan="2">Target</td><td colspan="3">Q1-Q2 Results 2019</td><td>Comments</td></tr>
<tr><td colspan="8">OBJECTIVE: Increase Mental Health Promotion</td></tr>
<tr><td>P22</td><td>% of identified Mental Health Promotion strategic actions that are complete</td><td colspan="2">25%</td><td colspan="3">N/A</td><td>The Mental Health Strategy is being finalized. Data will be available for the 2019 Q3-Q4 Report.</td></tr>
<tr><td colspan="8">OBJECTIVE: Increase Access to Immunization</td></tr>
<tr><td>P23</td><td>% of 7 year olds vaccinated for all Immunization of School Pupil’s Act (ISPA) designated diseases</td><td colspan="2">95%</td><td>92.9%</td><td>(5399/5810)</td><td></td><td>Includes vaccines for Measles, Mumps, Rubella, Diphtheria, Tetanus, Pertussis, Polio, Meningitis C, and Varicella</td></tr>
<tr><td>P24</td><td>% of 17 year olds vaccinated for all Immunization of School Pupil’s Act (ISPA) designated diseases</td><td colspan="2">95%</td><td>92.1%</td><td>(5811/6309)</td><td></td><td>Includes vaccines for Measles, Mumps, Rubella, Diphtheria, Tetanus, Pertussis, Polio, and Meningitis C</td></tr>
<tr><td>P25</td><td>% of school-aged children who have completed immunizations for hepatitis B</td><td colspan="2">75%</td><td>71.2%</td><td>(4236/5946)</td><td></td><td>Hep B is not mandated under the ISPA.</td></tr>
<tr><td>P26</td><td>% of school-aged children who have completed immunizations for meningococcus</td><td colspan="2">90%</td><td>89.1%</td><td>(5297/5946)</td><td></td><td>N/A</td></tr>
<tr><td>P27</td><td>% of school-aged children who have completed immunizations for Human Papilloma Virus (HPV)</td><td colspan="2">65%</td><td>61.5%</td><td>(3659/5946)</td><td></td><td>HPV is not mandated under the ISPA.</td></tr>
</table>

#	Measure	Target	Q1-Q2 Results 2019		Comments
OBJECTIVE: Improve Accountability of Vaccine Management in the Community					
P28	% of publicly funded vaccine doses that are wasted annually	< 5%	7.2%	(7745/107494)	The target was not reached due to the high number of flu vaccine returns from community health care providers despite multiple reminders from PHS.
P29	% of inspected vaccine storage locations that meet storage and handling requirements	95%	100%	(115/115)	N/A
P30	% of refrigerators storing publicly funded vaccines that have received a completed routine annual cold chain inspection	100% by the end of Q4	26%	(118/453)	It is expected that 100% of refrigerators will receive an inspection by the end of Q4, as has been achieved in prior years.
OBJECTIVE: Increase Compliance with the Infectious & Communicable Diseases Prevention & Control Standard					
P31	% of iGAS cases where follow-up initiated within 24 hrs of notification to PHS	100%	100%	(30/30)	N/A
P32	% of contacts of active Tuberculosis (TB) where follow up completed	80%	76.4%	(81/106)	Follow-up relies on contacts to complete TB skin testing. Even if the health unit has successfully initiated contact investigation and provided testing directly to the client, in some situations, contacts can no longer be located.
P33	% of licensed day nurseries which receive an annual infection control inspection	95% by the end of Q4	76.1%	(178/234)	Inspected on a yearly basis. The program is on schedule to reach target by the end of the year.
P34	% of personal service settings inspected annually	95% by the end of Q4	42.5%	(343/807)	Inspected on a yearly basis. The program is on schedule to reach target by the end of the year.
P35	% of Hepatitis A cases where follow-up initiated within 24 hrs of notification to PHS	100%	N/A		No Hep A cases were reported between Jan 1 – Jun 30, 2019.

#	Measure	Target	Q1-Q2 Results 2019		Comments
P36	% of animals investigated that are current on their rabies vaccinations at the time of a reported bite	50%	Total: 53.2%	(304/571)	N/A

HEALTHY ENVIRONMENTS DIVISION					
#	Measure	Target	Q1-Q2 Results 2019		Comments
OBJECTIVE: Promote the Development of Built Environments to Support Health					
P37	% of elementary and secondary schools with a School Travel Plan	62%	62%	(98/158)	For 2019, 20 new schools were engaged as planned.
P38	% of elementary and secondary schools with a school travel plan that have active transportation policies	50%	22.4%	(22/98)	Additional efforts (e.g., formation of a corporate/community working group, advocating for Active & Sustainable School Travel at Board of Trustees and School Councils) are planned to increase the overall number schools with active transportation policies
P39	% of total food items on City of Hamilton Recreation concession menus that fit green choice guideline	10%	3.3%	(4/123)	Public Health Services continues to work with the Recreation Division to advocate for more “green choice” menu items. No corporate policy currently requires these choices to be present.
OBJECTIVE: Promote the Development of Natural Environments to Support Health					
P40	% of assigned milestones completed from the Bay Area Climate Change Partnership project	65%	83.3%	(5/6)	N/A
P41	% of assigned milestones completed from the Air Quality Task Force Action Plan 2019	30%	7.7%	(1/13)	8 / 13 air quality action plan milestones are in progress.

#	Measure	Target	Q1-Q2 Results 2019				Comments
OBJECTIVE: Reduce Risk of Vector Borne Disease Transmission to Hamiltonians							
	Additional Monitoring Measures	Trend					Comments
M2	Animal Bites		2016	2017	2018	2019	The raccoon rabies outbreak has been active since 2015. Public awareness through program efforts may be contributing to the decreasing number of animal bites reported.
		Q1-Q2	730	714	690	669	
		Total	1508	1543	1502	TBD	
M3	Tick Submissions		2016	2017	2018	2019	A combination of public awareness and education activities and the declaration of an "Estimated Risk Area" for black-legged ticks in Hamilton has resulted in a higher number of ticks being submitted from the public. Tick populations are expected to continue to grow over time due to climate change.
		Q1-Q2	229	667	425	524	
		Total	296	892	567	TBD	
OBJECTIVE: Increase Capacity in Chronic Disease Prevention Among Community Members							
P42	% of targeted community partner staff with increased knowledge, skills and/or confidence following Chronic Disease Prevention education (physical literacy & food and nutrition program training)	70%	N/A				Data will be available for the 2019 Q3-Q4 Report.
P43	% of targeted immigration service providers who report using information disseminated in the e-health communique for action	70%	73.8%	(31/42)			N/A
P44	% of key partner agencies that report using Nutritious Food Basket information for action or decision-making	60%	67%	(10/15)			N/A

#	Measure	Target	Q1-Q2 Results 2019		Comments
OBJECTIVE: Reduce Non-Compliance with Guidelines and Laws that Govern Food & Water Safety					
P45	% of special events requiring an inspection that were inspected	100%	100%	(25/25)	N/A
P46	% of recreational water premises requiring re-inspections due to water safety concerns	< 20%	7.2%	(16/222)	Includes Class A, B, and C recreational water premises.
P47	% of inspections among high-risk and moderate-risk premises that resulted in an infraction	N/A	38.4%	(98/255)	N/A

	Additional Monitoring Measures	Trend					Comments
M4	Food Handler Certifications		2016	2017	2018	2019	The Food Safety team was tasked with finding efficiencies for the food handler certification program. Based on a program review, exam size and exam times offered were adjusted to align with regular business hours. The changes instituted resulted in savings for the program and a corresponding decrease in the number of certifications issued.
		Q1-Q2	1439	1521	854	887	
		Total	2572	2390	1607	TBD	
M5	Red Signs Posted		2016	2017	2018	2019	No access to hot water, unsanitary conditions, and presence of pests were the most common causes of restaurant closures in the first-half of 2019.
		Q1-Q2	11	14	18	23	
		Total	25	23	50	TBD	
M6	Food Inspections/Enforcement		2016	2017	2018	2019	In January 2017, enforcement of the Healthy Menu Choices Act began, resulting in more food safety inspections completed in 2017. Since then, the Food Safety team has incorporated these requirements into their routine inspections. In 2019, Residential Care Facility food inspections were transferred to the Food Safety team which also contributed to the growing number of inspections over time.
		Q1-Q2	2827	2931	3072	3300	
		Total	5351	6141	6536	TBD	
M7	Food Complaints		2016	2017	2018	2019	The Food Safety team is receiving more complaints compared to previous years because the responsibility for follow-up of suspect foodborne illness complaints was transferred from the Infectious Disease Program to Food Safety team. This does not necessarily represent more food complaints received.
		Q1-Q2	152	98	258	234	
		Total	249	214	523	TBD	

	Additional Monitoring Measures	Trend					Comments
M8	Water Inspections/Enforcement		2016	2017	2018	2019	The Province of Ontario issued a revised public pool regulation in January of this year with an effective date of July 1st, 2018. This change reduced the number of inspections required for seasonal recreational water facilities.
		Q1-Q2	363	394	343	331	
		Total	884	884	797	TBD	

#	Measure	Target	Q1-Q2 Results 2019		Comments
OBJECTIVE: Improve Safe-Food Handling Knowledge					
P48	% of food handler exam writers who passed the exam	90%	84%	(745/887)	Past practices did not flag where exam writers were experiencing problems. An evaluation has been implemented to help determine what exam writers are struggling with to improve this indicator.
OBJECTIVE: Increase Compliance with Laws that Govern Smoking					
P49	% of tobacco vendors in compliance with youth access legislation at the time of last inspection	90%	89.3%	(326/365)	2019 Q1 & Q2 SFOA youth compliance inspections resulted in 39 convictions.
P50	% of tobacco retailers inspected once per year for compliance with display, handling, and promotion sections of the Smoke-Free Ontario Act	100% by the end of Q4	40.5%	(148/365)	The Ministry of Health and Long-Term Care’s Tobacco Information System (TIS) has been updated to a new version, which may be impacting 2018/19 statistics during the reporting period. The program is on track to complete the required inspections.

	Additional Monitoring Measures	Trend					Comments
M9	Smoke Free Ontario Act Tobacco Inspections (Legal Enforcement)		2016	2017	2018	2019	Electronic cigarettes first became regulated under the Electronic Cigarette Act (2015), it was then combined under the revised Smoke-Free Ontario Act in 2017. The Tobacco Control Program has been working to educate the public on the act and enforce its requirements with vendors and is likely the reason why the number of enforcement activities continues to decline over time.
		Q1-Q2	795	709	771	448	
		Total	1465	1271	1390	TBD	
M10	Smoke Free Ontario Act Tobacco Inspections (Complaints)		2016	2017	2018	2019	Refer to M9 above
		Q1-Q2	138	102	122	77	
		Total	274	213	218	TBD	
M11	Smoke Free Ontario Act Electronic Cigarette Inspections (Legal Enforcement)		2016	2017	2018	2019	Refer to M9 above
		Q1-Q2	180	205	165	227	
		Total	544	427	299	TBD	
M12	Smoke Free Ontario Act Electronic Cigarette Inspections (Complaints)		2016	2017	2018	2019	Refer to M9 above
		Q1-Q2	15	5	9	4	
		Total	17	8	16	TBD	
M13	CoH By-Law No. 11-080 Prohibiting Smoking within City Owned Parks and Recreation Property (Legal Enforcement)		2016	2017	2018	2019	Refer to M9 above
		Q1-Q2	44	34	12	23	
		Total	73	60	25	TBD	
M14	CoH By-Law No. 11-080 Prohibiting Smoking within City Owned Parks and Recreation Property (Complaints)		2016	2017	2018	2019	A new data collection system capturing complaints, as well as the changes in provincial legislation (SFOA, 2017), may have resulted in a higher number of complaints submitted from the public compared to the past.
		Q1-Q2	9	9	5	23	
		Total	28	25	28	TBD	

#	Measure	Target	Q1-Q2 Results 2019	Comments
OBJECTIVE: Increase Access to Tobacco Cessation Services				
P51	% of smokers that have attended a tobacco Cessation Clinic at least once after registering	68%	65.3% (905/1385)	Client appointment attrition has been identified as a Continuous Quality Improvement project for 2019 to improve tobacco cessation services provided at Public Health.
OBJECTIVE: Increase Capacity in Injury Prevention				
P52	% of schools who have a concussion policy implemented	90%	100% (162/162)	N/A

HEALTHY FAMILIES DIVISION				
#	**Measure**	**Target**	**Q1-Q2 Results 2019**	**Comments**
OBJECTIVE: Increase Access to Vision Health Care for School-Age Children				
P53	% of SK students screened from all schools in Hamilton	N/A	N/A	Vision screening was piloted during the 2018/2019 school year in 2 schools. 99 Junior Kindergarten students were eligible, of those 81 were screened and 54 were referred to a comprehensive eye exam. Efforts are in place to begin vision screening for all other schools in the 2019/2020 school year.
P54	% of SK students who screened positive received an eye exam by last notification	N/A	N/A	Vision screening will begin in 2019/2020 school year.
OBJECTIVE: Increase Access to Dental Care for Low Income Individuals				
P55	% of eligible children enrolled in Healthy Smiles Ontario who accessed the service	N/A	N/A	Data to be provided by the Ministry of Health and will be available for the 2019 Q3-Q4 Report
P56	% of eligible children enrolled in Healthy Smiles Ontario	N/A	N/A	Data to be provided by the Ministry of Health and will be available for the 2019 Q3-Q4 Report

#	Measure	Target	Q1-Q2 Results 2019		Comments
OBJECTIVE: Improve Parenting Skills for Clients					
P57	% of targeted community partner staff with increased knowledge, skills and/or confidence on all session objectives following child health education (in-service training session)	90%	82.5%	(94/114)	Safe Sleep and Nutrition sessions were held for community partners. The Safe Sleep session had the lowest percentage increase in knowledge, skills and/or confidence. Based on feedback given by community partners, the session will be revised to better meet their needs.
P58	% of client participants with increased knowledge, skills and/or confidence on all session objectives following child health education (group session)	90%	90.8%	(227/250)	Includes these group sessions: • Car Seat Clinics • Canada Prenatal Nutrition Program • Feeding young Children – Client Session • Feeding Your Baby – Client Session • Parenting – Client Session • Parenting – Group Triple P • Parenting – Parenting with Love • Parenting – Triple P Discussion Group • Prenatal classes • Safe Sleep – Client Session
P59	% of Nurse Family Partnership (NFP) clients who graduate from the program	40%	46.8%	(22/47)	Graduation rate is based on 2016 cohort, as the program duration is 2 years.
OBJECTIVE: Improve Parenting Skills for Clients					
P60	% of targeted community partner staff reached with reproductive health public health messaging	60%	N/A		There were no prenatal sessions in Q1-Q2.

#	Measure	Target	Q1-Q2 Results 2019	Comments
P61	% of targeted community partner staff with any increased knowledge, skills and/or confidence on all session objectives following reproductive health education (e.g. in-service training session)	90%	N/A	There were no prenatal sessions in Q1-Q2.
P62	% of client participants with increased knowledge, skills and/or confidence on all session objectives following reproductive health education (group sessions)	90%	92.2% (261/283)	Includes: • Canada Prenatal Nutrition Program (CPNP) • Maternity Home – Client Session • Prenatal Classes
OBJECTIVE: Improve Mental Wellbeing for Children and Youth				
P63	% of Counselling and Therapy (C&T) clients with improved emotional behavioural T-Scores by domain	N/A	N/A	C&AS implemented a comprehensive assessment system in May 2019. Data is currently being collected and will be available by year end.
P64	% of clients who report positive outcomes after receiving services	N/A	N/A	C&AS implemented a comprehensive assessment system in May 2019. Data is currently being collected and will be available by year end.

Hamilton

PHYSICIAN RECRUITMENT AND RETENTION STEERING COMMITTEE REPORT 19-001

Wednesday, September 11, 2019
2:00 p.m.
Room 192, Hamilton City Hall
71 Main Street West, Hamilton

Present:	Councillors T. Whitehead (Chair) Dr. D. DiValentino (Vice-Chair), Councillor A. VanderBeek, K. Loomis, Dr. B. Julian, Dr. S. Kinzie
Absent with Regrets:	Mayor F. Eisenberger – City Business, Councillor S. Merulla – City Business

---

THE PHYSICIAN RECRUITMENT AND RETENTION STEERING COMMITTEE PRESENTS REPORT 19-001 AND RESPECTFULLY RECOMMENDS:

1. Appointment of Chair and Vice-Chair (Item 1)

(a) That Councillor Whitehead be appointed as Chair of the Physician Recruitment and Retention Steering Committee for the balance of the 2018-2022 term of Council; and

(b) That Dr. DiValentino be appointed as Vice-Chair of the Physician Recruitment and Retention Steering Committee for the balance of the 2018-2022 term of Council or until a successor is appointed by Council.

2. Physician Recruitment and Retention Terms of Reference Review – REVISED (Item 10.1)

That the Physician Recruitment and Retention Steering Committee Terms of Reference, be received.

3. Key Performance Indicators, Current Statistics, Physicians by Community, and Conferences and Events (Item 10.2)

That the Key Performance Indicators, Current Statistics, Physicians by Community, and Conferences and Events summaries, be received.

4. Budget and Cash Flow (Item 10.3)

(a) That the Year 16 (2019) Budget for December 1, 2018 to June 30, 2019, be received; and,

(b) That the Cash Flow Statement for December 1, 2018 to November 30, 2019, be received;

5. Review of Position of Director, Physician Retention (Item 11.1)

That the General Manager, Finance and Corporate Services, the General Manager, Healthy and Safe Communities, and the Executive Director, Human Resources and Organizational Development, or their designates, be asked to participate in the meetings of the Working Group of the Physician Recruitment and Retention Steering Committee, as required.

6. Funding Update (Item 13.1)

That Jane Walker, Councillor Whitehead, and Keanin Loomis meet with Rob MacIsaac, President and CEO, Hamilton Health Sciences, to discuss securing funding for the Physician Recruitment Program.

7. Contract Renewal (Item 14.1)

(Loomis/Kinzie)

(a) That Jane Walker's resignation from the position of Director, Physician Recruitment, effective November 22, 2019, be received; and,

(b) That the Terms and Conditions of Employment for the Director, Physician Recruitment contract between the Employee and the City of Hamilton and the Hamilton Chamber of Commerce, be received.

FOR INFORMATION:

(a) APPROVAL OF AGENDA (Item 2)

The Committee Clerk advised of the following change to the agenda:

1. DISCUSSION ITEMS (Item 10)

10.2 Key Performance Indicators, Current Statistics, Physicians By Community, and Conferences and Events

Page two of the Conferences and Events Report was included in error and is being withdrawn.

The agenda for the September 11, 2019 meeting of the Physician Recruitment and Retention Steering Committee was approved, as amended.

(b) DECLARATIONS OF INTEREST (Item 3)

There were no declarations of interest.

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

(i) June 22, 2018 (Item 4.1)

The Minutes of the June 22, 2018 meeting of the Physician Recruitment and Retention Steering Committee were approved, as presented.

(ii) Clerk's Report – May 29, 2019 (Item 4.2)

The Clerk's Report – May 29, 2019 was received, as presented.

(d) REVIEW OF POSITION OF DIRECTOR, PHYSICIAN RECRUITMENT (Item 11.1)

The Working Group of the Physician Recruitment and Retention Steering Committee was directed to meet to:

(a) begin work to fill the position of Director, Physician Recruitment as soon as possible, including, but not limited to, examining the logistics of the hiring process, exploring the possibility of converting the position to a permanent position, and taking into consideration the realities and challenges associated with the role; and,

(b) to discuss the position of the Physician Recruitment Coordinator and the realities and challenges associates with converting the position into a long-term contract or permanent position.

For further disposition of this matter, please refer to Item 5.

(e) GENERAL INFORMATION/OTHER BUSINESS (Item 13)

(i) Funding Update (Item 13.1)

Jane Walker, Director, Physician Recruitment, addressed the Committee respecting updates to funding sources.

The Funding Update respecting funding opportunities for the Physician Recruitment program, was received.

(f) PRIVATE AND CONFIDENTIAL (Item 14)

(i) Contract Renewal (Item 14.1)

The Committee determined that discussion of Item 14.1, respecting the Contract Renewal for a Director, Physician Recruitment was not required, as the Director of Physician Recruitment has submitted her resignation, so the matter was addressed in Open Session.

For further disposition of this matter, please refer to Item 7.

(g) ADJOURNMENT (Item 15)

There being no further business, the Physician Recruitment and Retention Steering Committee meeting was adjourned at 3:12 p.m.

Respectfully Submitted,

Councillor Whitehead, Chair
Physician Recruitment and
Retention Steering Committee

Tamara Bates
Legislative Coordinator
Office of the City Clerk

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	October 18, 2019
SUBJECT/REPORT NO:	Annual Performance & Financial Report to the Public (BOH19033) (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

In addition to the Ontario Public Health Standards (Standards), the Ministry of Health and Long-Term Care (Ministry) has developed organizational requirements to enable boards of health to demonstrate accountability for the work they do, how they do it, and the results achieved. It is an organizational requirement that all boards of health produce an annual performance and financial report to the general public. The Standards also include a Transparency Framework (BOH17010(c)) which outlines the type of information that boards of health are required to publicly disclose to support enhanced transparency in the public sector and promote public confidence in the public health system.

Appendix A to Report BOH19033 Public Health Services 2018 Annual Performance & Financial Report to the Public satisfies the annual public reporting expectations of the organizational requirements. The Annual Report highlights work conducted across Public Health Services in 2018 and provides an opportunity to increase awareness in the community on current public health issues and public health services offered in Hamilton.

As part of the Transparency Framework, it is the responsibility of boards of health to ensure the annual performance and financial report is posted on the board of health website. To fulfil this requirement, the Annual Report will be made available to the public on the City of Hamilton website at https://www.hamilton.ca/public-health/reporting.

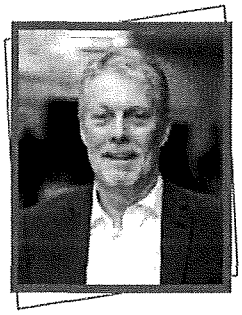
APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report BOH19033	Public Health Services 2018 Annual Performance & Financial Report to the Public

Hamilton

ANNUAL PERFORMANCE AND FINANCIAL REPORT

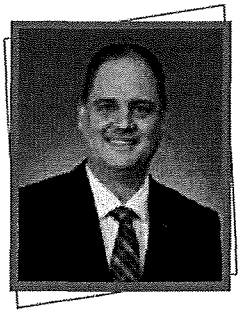
Appendix A to BOH19033
Annual Performance & Financial Report to the Public
October 18, 2019



MESSAGE FROM MAYOR FRED EISENBERGER

On behalf of Hamilton Public Health Services' Board of Health, I am pleased to share with you the 2018 Annual Report. Public Health Services has taken the lead on several City-wide initiatives aimed at addressing complex health issues in our community such as taking action on climate change, improving access to oral health services, and reducing the harms associated with drug and alcohol use through the Hamilton Drug Strategy.

The work of Public Health Services supports many of the focus areas within the City's Strategic Plan and has propelled us forward in achieving our vision of being the best place to raise a child and age successfully.



MESSAGE FROM PAUL JOHNSON GENERAL MANAGER, HEALTHY & SAFE COMMUNITIES DEPARTMENT

Health is influenced by many factors that affect the conditions in which individuals and communities live, learn, work, and play. Reducing factors which have negative impacts on the health of our communities requires collective action. This report showcases key initiatives from 2018 carried out in collaboration with many partners to address health inequities and make Hamilton a healthier and safer community.

The accomplishments described in this report demonstrate the dedication and passion of our public health staff. I would like to thank them for the outstanding work they do each and every day.

MESSAGE FROM DR. ELIZABETH RICHARDSON MEDICAL OFFICER OF HEALTH

I am pleased to present the 2018 Annual Report. Working together with our partners across health, education, and social services we continue to partner to create a healthier Hamilton for all. Partnerships are key to us achieving a collective impact and moving forward on our priority health issues of healthy weights, health equity, and mental health and addictions. I am immensely proud of all of the work of Public Health Services over the past year and am eager to see what we can accomplish together and with our partners in the future.

HEALTHY WEIGHTS

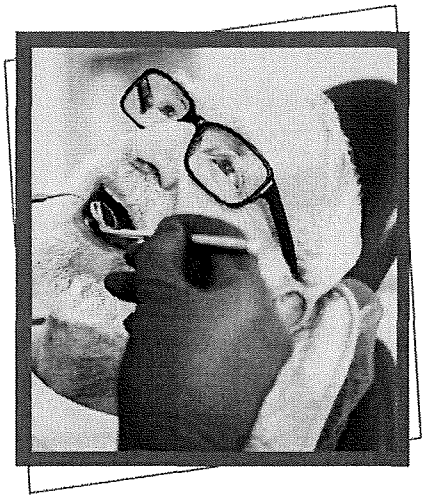
Creating a Healthier Food Environment at Recreation Facilities

Our City recreation facilities are key community assets that promote and support healthy, active lifestyles. Together with the City's Recreation Division, Public Health developed a three-year Recreation Healthy Food and Beverage Action Plan. This three-year plan aims to change the food environment at recreation facilities increasing access to municipal drinking water and healthy foods. The implementation of the plan will be guided by six principles:

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

HEALTH EQUITY

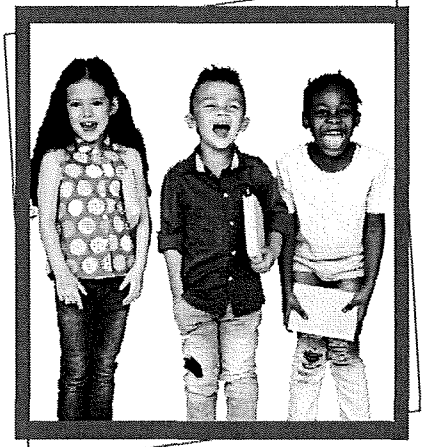
Oral Health Investment



To reduce oral health inequities, the City partnered with Hamilton Community Foundation to improve access to services for residents with little or no dental coverage. A $1 million grant was received from Green Shield Canada. A three-year strategy was implemented with Ontario Works that includes:

- Increased capacity and hours of operation of the Dental Health Bus
- Implementation of a "Smiles with Confidence" pilot program that provides dental care to working-age adults to increase their employability and overall well-being
- Enhanced supplemental denture coverage for low-income seniors

Child & Youth Health Atlas

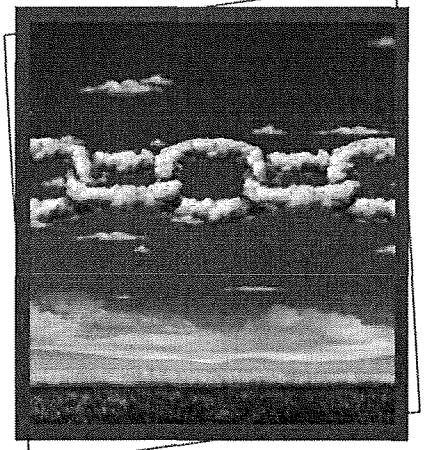


We want every child in Hamilton to grow up to meet their full potential and be physically, mentally, and socially healthy.

To support this, a Child & Youth Health Atlas was developed that provides data on the health of school-age children including income, education, mental health, immunization, early childhood development, and health behaviours. The Atlas has been used by City departments and our school board partners to develop shared priorities and take collective action to protect and improve the health of our children and youth.

View the Child & Youth Health Atlas

Air Summit



Air quality remains an important health and environmental concern in Hamilton. In September, leading experts and professionals in the fields of air quality, engineering, and public health attended the City of Hamilton's Air Summit to build stronger partnerships and discuss ways to address complex air quality issues in Hamilton and across the province.

Hamilton's Airshed Model was also completed after years of hard work with our partners. This model will be used to create a healthier built environment that minimizes citizens' exposure to air pollution and promotes an active lifestyle.

MENTAL HEALTH & ADDICTIONS

Hamilton Drug Strategy

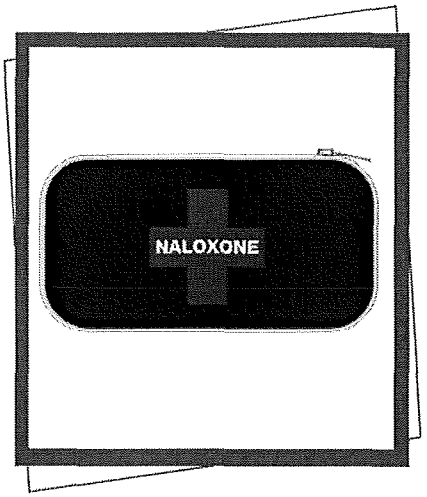
A Summit was held in March to kick off the Hamilton Drug Strategy, a city-wide collaboration of over 100 local agencies and organizations to address the harms associated with substance use.

Through a series of consultations and engagement events, each of the four working groups developed action plans that focus on prevention, harm reduction, social justice / justice, and treatment.

Learn more about the Hamilton Drug Strategy

Hamilton's Continued Response to Opioids

In response to the opioid crisis, Public Health Services has collaborated with several community agencies to increase the distribution and availability of naloxone in Hamilton. Naloxone is a safe, highly effective medication that reverses the effects of opioids. Free naloxone kits and training are now available at the following community agencies: The AIDS Network, St. Joseph's Healthcare Hamilton outpatient clinics and emergency department, Hamilton Urban Core Community Health Centre, and Alternatives for Youth.



The Hamilton Fire Department, Hamilton Police Services and St. John's Ambulance also signed on in 2018 to carry naloxone to respond to emergency situations. Public Health continues to work with community agencies to sign onto the Naloxone Expansion Program to increase the availability of naloxone.

Learn more about Hamilton's opioid response

Public Health Cannabis Strategy

In preparation for the legalization of non-medical cannabis in October 2018, a Cannabis Strategy was developed that complements federal and provincial initiatives. The four goals of the Cannabis Strategy are to:

- Educate on safer, legal, and responsible use of cannabis
- Prevent or delay the age of cannabis use and reduce the likelihood of harm from use
- Promote a culture of moderation
- Increase knowledge of the impacts of consuming cannabis while parenting or pregnant

Learn more about the risks associated with cannabis

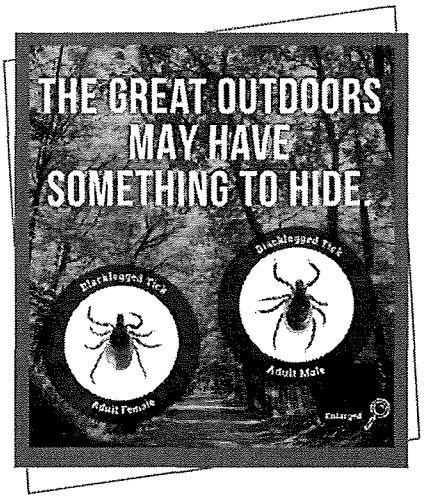
OTHER INITIATIVES

Tick Talk

As tick populations spread northwards due to climate change, more areas are likely to become risk areas for Lyme disease. In March, Hamilton became what is known as an estimated risk area for Lyme disease after tick surveillance activities found evidence of established blacklegged tick populations.

In response, we collaborated with partners across the City to enhance public education to raise awareness of ticks and tick prevention, along with measures all of us can take to minimize our risk.

Learn more about Lyme disease and ticks



Online Health Inspection Results

Public health inspectors are responsible for inspecting over 11,000 businesses and facilities in Hamilton each year. In January, even more inspection results became publicly available online including:

- personal service settings (tattoo parlours, piercing, hair and nail salons, etc.)
- licensed child care facilities
- public pools and spas
- small drinking water systems
- tanning facilities
- residential camps
- tobacco and e-cigarette retailer convictions

Inspection results for food premises (restaurants, grocery stores, food trucks, etc.) have been available online since 2009.

View health inspection results

QUICK FACTS

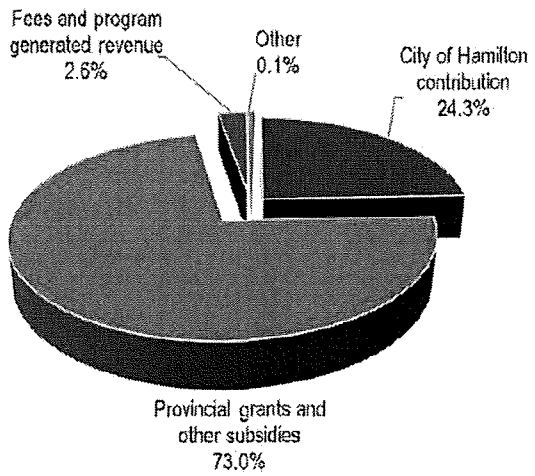
11,374	total inspections completed
1,714	tobacco inspections
6,536	food inspections
797	water inspections
550	residential care facility inspections
967	personal service setting inspections
528	day care inspections
4,827	infectious disease cases investigated
96%	of the 1550 rabies exposures were investigated within 1 day
97%	of health hazard investigations initiated within 24 hours
6,302	health connection calls from families
4,464	clients seen at dental clinics
1,418	clients seen at dental bus
8,716	home visits to families during pregnancy, infancy & early childhood
31,869	immunizations given
70,000+	student immunization records reviewed and addressed
6,412	naloxone doses distributed
568	people reported as being revived by Public Health's naloxone kits

Public Health Services Funding

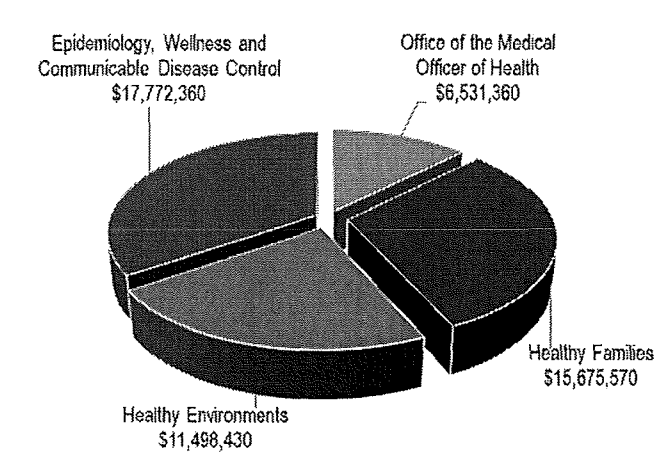
In 2018 the Government of Ontario provided funding for 73% of Hamilton Public Health Services' budget, with 24.3% contributed by the City of Hamilton and 2.6% from program generated revenue.

2018 Approved Budget: $51,477,720

Funding Sources



Approved Budget by Division



Hamilton

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	October 18, 2019
SUBJECT/REPORT NO:	AMOH Coverage Plan (BOH19035) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Elizabeth Richardson (905) 546-2424 Ext. 3502
SUBMITTED BY: **SIGNATURE:**	Dr. Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services

COUNCIL DIRECTION:

Not applicable

INFORMATION

There will be a temporary vacancy in one of the Associate Medical Officer of Health positions for the next six months due to a leave for Dr. Ninh Tran. In order to ensure the necessary expertise and consultation for response to community needs and program demands during this time, coverage is being provided as follows:

- Dr. Harvey will be providing consultation and medical direction for the Sexual Health, Immunization and Infectious Diseases Programs, in addition to his portfolio with the Healthy Environments Division and as Site Director for the Public Health & Preventive Medicine Program.

- Dr. Richardson will be providing consultation and medical direction for the Healthy Families Division, in addition to overall Public Health Services management and leadership, and consultation and medical direction for the Population Health Assessment, Epidemiology and Evaluation, Health Strategy and Health Equity and Mental Health programs.

- Three local physicians with the required expertise are being contracted to provide consultation and direction on a project basis on major initiatives that were within Dr. Tran's portfolio, including vision screening and senior's dental program implementation.

This will be accomplished within the existing PHS budget.

APPENDICES AND SCHEDULES ATTACHED

None

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	October 18, 2019
SUBJECT/REPORT NO:	Organizational Risk Management Plan: 2019 Progress Report (BOH18032(a)) (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

There are two types of risk that boards of health regularly encounter:

1. Issues that may be creating a risk to the public's health; and,
2. Issues that place the organization at risk of not meeting established business objectives.

Public Health Services (PHS) addresses risks to the public's health by delivering effective public health programs and services that are informed by population health assessment, evidence, and ongoing surveillance and monitoring strategies. The contents of this report relate to the second type of risk, organizational. As part of the Public Health Accountability Framework and Organizational Requirements, boards of health are required to develop a risk management framework, create action plans to mitigate risks, and submit an annual risk management report to the Ministry of Health and Long-Term Care (Ministry).

Engaging in risk management practices is a proactive approach that works to identify organizational risk and reduce uncertainty before it happens. Development of action plans that minimize the likelihood and impact of risk occurring sets boards of health up for greater success in achieving organizational objectives.

The PHS Risk Management Framework focuses on organizational risk, supporting the Board of Health in identifying and mitigating issues that place PHS at risk of not meeting established business objectives. Action plans for 2019 were developed last year to mitigate and monitor risks that had the highest likelihood of occurring and the greatest potential to impact operational capabilities (BOH18032). These risks included financial, technology, governance and organizational, and information/knowledge. It is important to note that the original plan was made prior to the municipal election and the recruitment of the new City Manager, and the risks identified reflect that time period. The progress made throughout 2019 in implementing these risk reduction strategies is what is outlined in Appendix "A" to Report BOH18032(a). This information will be submitted to the Ministry as part of the Q3 Standards Activity Report at the end of October.

It is important to note that this is a particularly challenging and uncertain time for public health. On April 11, 2019, major changes were announced by the province including public health system restructuring and adjustments to the funding formula. These changes pose a significant risk as they are external to the organization and beyond PHS' control. As a result, several risk ratings have increased from the initial assessment despite the successful implementation of the 2019 risk management action plans. Overall, the likelihood and potential impact ratings increased for three previously identified risks: financial, governance and organization, and political. PHS continues to monitor these emerging risks and has put additional mitigation strategies in place (Appendix "A" to BOH18032(a)).

Next Steps

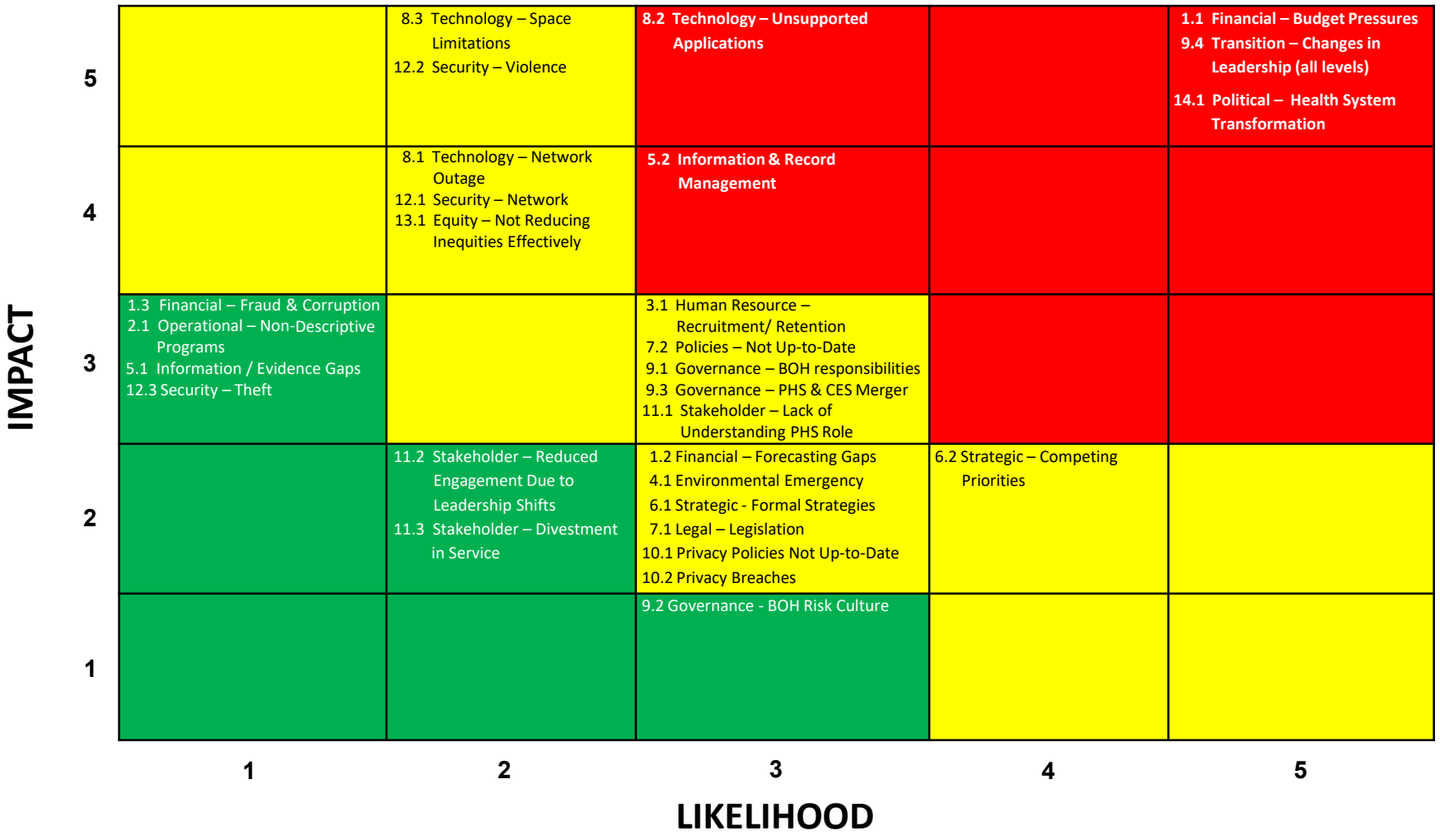
In Q4 2019, the PHS leadership team will continue to use the Ontario Public Service Risk Management Framework (Appendix "B" to BOH18032(a)) to identify new organizational risks and reassess existing risks to inform the 2020 PHS Risk Management Plan. Action plans for mitigation and monitoring will be developed for those risks that have the highest likelihood of occurring and greatest potential impact on operations. The 2020 PHS Risk Management Plan will come forward to the Board of Health for approval in Q1 2020.

APPENDICES AND SCHEDULES ATTACHED

Appendix "A" to BOH18032(a):	2019 PHS Risk Management Progress Report
Appendix "B" to BOH18032(a):	Ontario Public Service Risk Management Strategy & Process Toolkit

2019 PHS Risk Management Progress Report

The chart below indicates the overall rating for <u>each</u> organizational risk at year-end following implementation of the 2019 Action Plans.



Overall Risk Rating

= Low Risk
= Medium Risk
= High Risk

2019 PHS Risk Management Progress Report

1.1 Financial – Budget Pressures

Category	**Financial Risk**	
Description	**The Board of Health may not be able to maintain current service delivery levels due to increased budget pressures / funding formula changes and organizational restructure are expected over the next several years.**	
Source	Low tax increases, provincial funding formula changes, rising operational costs. Provincial government changes impacting PHS and other areas that Council funds. Provincial funding levels for 2020 were announced in August 2019.	
Initial Rating	**High:** Likelihood 4, Impact 3	
Action Plan	**Planned Actions**	**Progress to Date**
	1. Implement continuous improvement strategy to ensure regular review of programs and services for effectiveness and efficiency.	Implementation is in progress. CQI learning module is now available. CQI technical competences are being reviewed corporately. A process to identify CQI ideas, track project progress and document outcomes / benefits is in development.
	2. Include identification of opportunities for improvement into annual program planning with actions for improvement recorded in 2020 Program Plans.	Implementation of the Annual Planning Process is in progress. Priority populations have been identified for all program areas. This info will be considered together with compliance assessments and current program performance to identify gaps and actions for improvement. Areas for improvement were identified by the priority workgroups and recommended actions will be documented in the 2020 Program Plans.
	3. Link progress in Program Plans to performance measurement and budget allocation to inform planning for upcoming year.	Program performance is being considered along with other evidence / data to identify the most appropriate and effective interventions to include in the 2020 Program Plans. Development of scorecards for PHLT and all program areas is currently in progress to ensure performance data required to inform program planning and resource allocation is available. A holistic review of the 2020 Program Plans will take place in Q4 and will be used to inform resource allocation decisions.
	4. Advocate and engage in discussion with provincial government regarding the proposed funding changes and organizational restructuring.	Staff at all levels have been engaged in advocacy efforts and discussion with the province at the appropriate levels (i.e., Mayor, City Manager, General Manager, MOH, PHLT, etc).
Residual Risk	**Current Risk Level: High** – Likelihood 5, Impact 5	
	Expected residual risk once action plan has been fully implemented: **Medium** – Likelihood 3, Impact 3	

2019 PHS Risk Management Progress Report

5.2 Information & Record Management

Category	**Information / Knowledge Risk**	
Description	**The Board of Health may be at risk due to unreliable information management systems and practices.**	
Source	Varying information management practices and absence of formalized processes in this area could lead to loss of information, prevent staff from accessing information, privacy breaches or non-compliance with records retention schedule.	
Initial Rating	**High:** Likelihood 4, Impact 4	
Action Plan	**Planned Actions**	**Progress to Date**
	1. Develop and implement Records and Information Management Framework	The RIM Framework has been developed and will be posted and communicated to staff in Q4 2019. New RIM Specialist in place since January 2019.
	2. Create and rollout policies to support the Records and Information Management Framework	Further revisions are being made to the supporting policy based on the RIM Framework. RIM gap analysis was completed and areas for improvement were incorporated in the RIM workplan.
	3. Approval of public health revisions to Records Retention By-Law	Corporate Records Retention By-Law was amended to include a section related to Public Health. It was approved by Council September 2018.
	4. Coordinated clean-up of staff personal drives (m-drive)	Decision to focus on email retention. RIM Specialist will provide email retention education and guidance to staff in Q3/Q4.
	5. Establish and implement consistent practices for information management on shared drives	Work on reconfiguration of shared drive (N: Drive) is on-hold pending revisions to the RIM policy (see above).
Residual Risk	**Current Risk Level: High** – Likelihood 3, Impact 4	
	Expected residual risk once action plan has been fully implemented: **Low** – Likelihood 2, Impact 2	

2019 PHS Risk Management Progress Report

8.2 Technology – Unsupported Applications

Category	**Technology Risk**	
Description	**The Board of Health may be at risk due to use of unsupported technology.**	
Source	End of life applications, non-supported programs (OSCAR)	
Initial Rating	**High:** Likelihood 3, Impact 5	
Action Plan	**Planned Actions**	**Progress to Date**
	1. Procure contractor to support OSCAR application	OSCAR contract is being reviewed by the consultant. Expect to have a signed contract by end of September 2019. Included consultation re: OSCAR server upgrade in the contract. Upgrading server will reduce risk by increasing processing speed, efficiency, and space / storage.
	2. Identify alternatives for client interaction documentation (OSCAR replacement)	Currently on-hold – COMOH Steering Committee will meet Q3 / Q4 to develop a set of planning considerations for the public health restructuring.
Residual Risk	**Current Risk Level: High –** Likelihood 3, Impact 5	
	Expected residual risk once action plan has been fully implemented: **Medium** – Likelihood 2, Impact 5	

2019 PHS Risk Management Progress Report

9.1 Governance – Board of Health Responsibilities

Category	**Governance / Organizational Risk**	
Description	**The Board of Health may be at risk due to challenges elected officials may experience balancing their municipal responsibilities with their responsibilities for public health.**	
Source	Board members may not have the necessary time to fulfil all their responsibilities as Board members	
Initial Rating	**High:** Likelihood 4, Impact 4	
Action Plan	**Planned Actions**	**Progress to Date**
	1. Implement a revised experiential approach to Board of Health orientation in addition to overview of formal roles and responsibilities	An overview of public health governance was presented at the first BOH meeting with newly elected officials. Showcase took place in January to provide BOH members with an experiential orientation that showed *Public Health Across the Lifespan* and *A Healthy Day in Hamilton.*
	2. Ongoing education built into Board of Health reports and presentations.	Information about the role and function of public health has been incorporated into BOH reports and presentations where appropriate. Online modules developed to provide guidance on preparing BOH reports emphasize importance of building education into materials.
Residual Risk	**Current Risk Level: Medium – Likelihood 3, Impact 3**	
	Expected residual risk once action plan has been fully implemented: **Medium** – Likelihood 3, Impact 3	

2019 PHS Risk Management Progress Report

9.4 Governance – Changes in Leadership

Category	**Governance / Organizational Risk**	
Description	**The Board of Health may be at risk of changing priorities due to changes in positions having influence over public health operations.**	
Source	Board of Health changes in membership have been addressed through orientation and ongoing education. Staff are working with Board of Health and City Manager regarding the new provincial government decisions that could significantly impact the programs and services delivered by public health. Major changes were announced on April 11 as part of the 2019 Ontario Budget including significant restructuring of the public health system and adjustments to the current funding formula.	
Initial Rating	**High:** Likelihood 4, Impact 4	
Action Plan	**Planned Actions**	**Progress to Date**
	1. Implement a revised experiential approach to Board of Health orientation in addition to overview of formal roles and responsibilities	Same as previous
	2. Ongoing education built into Board of Health reports and presentations.	Same as previous
	3. Ongoing discussion with new City Manager about public health mandate.	Ongoing discussions with City Manager and H&SC General Manager regarding provincial changes and public health system transformation.
	4. Identify opportunities for advocacy to provincial government.	All levels within the City have been engaged in advocacy and discussion with the province as appropriate. Consultations with other single-tier and regional municipalities regarding provincial changes are ongoing.
	5. Engage in provincial consultation processes as available to provide feedback on public health issues and operations.	Planned Ministry consultation for July / August 2019 was deferred. The Ministry will distribute a white discussion paper in the Fall after which consultation will begin.
	6. Advocate for the appointment of a BOH Vice-Chair – Recommendation from the results of the 2018 BOH Self-Evaluation	A BOH Vice-Chair was appointed in May 2019 to increase consistency and assist the BOH Chair in providing leadership to Council regarding public health issues and governance, and to advise on the educational needs of the BOH. Maureen Wilson, BOH Vice-Chair, is also the Central-West Region Representative on the Association of Local Public Health Agencies Board of Directors.
Residual Risk	**Current Risk Level: High** – Likelihood 5, Impact 5	
	Expected residual risk once action plan has been fully implemented: **Medium** – Likelihood 3, Impact 4	

2019 PHS Risk Management Progress Report

14.1 Political – Health System Transformation

Category	**Political Risk**	
Description	**The Board of Health may be at risk of significant disruptions and high opportunity costs related to health system transformation**	
Source	Major changes were announced on April 11 when the 2019 Ontario Budget was released including significant restructuring of the public health system and adjustments to the current funding formula. Provincial funding levels for 2020 were announced in August 2019.	
Initial Rating	**Medium:** Likelihood 3, Impact 4	
Action Plan	**Planned Actions**	**Progress to Date**
	1. Advocate and engage in discussion with provincial government regarding the proposed funding / budget changes and organizational restructuring.	All levels within the City have been engaged in advocacy and discussion with the province as appropriate.
Residual Risk	**Current Risk Level: High** – Likelihood 5, Impact 5	
	Expected residual risk once action plan has been fully implemented: **Medium** – Likelihood 3, Impact 4	

Ontario

Risk Management Strategy & Process Toolkit

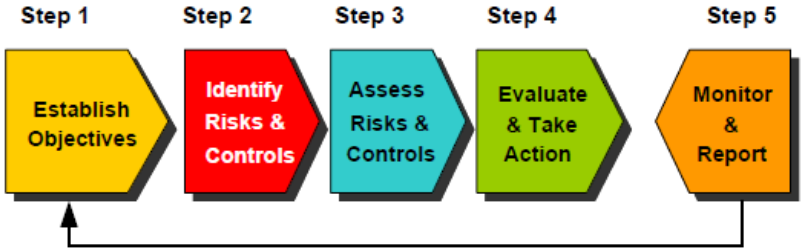
Step 1: Establish objectives

- Risks must be assessed and prioritized in relation to an objective
- Objectives can be at any level; operational, program, initiative, unit, branch, health system
- Each objective can be general or can include specific goals, key milestones, deliverables and commitments

Risk
The future event that may impact the achievement of established objectives. Risks can be positive or negative.

Control / Mitigation Strategy
Controls / mitigation strategies reduce negative risks or increase opportunities.

The risk management process



Consequences
- Identify the specific consequences of each risk
- Consider financial, non-financial, performance, etc.

Vulnerability
- Identify exposure to risk
- Vulnerability may vary with each situation and change over time

Cause/Source of Risk
- Understand the cause/source of each risk
- Use a fish-bone diagram

Step 2: Identify risks & controls

Identify risks - What could go wrong?
- Consider each category of risk
- Obtain available evidence
- Brainstorm with colleagues and/or stakeholders
- Examine trends and consider past risk events
- Obtain information from similar organizations or projects
- Increase awareness of new initiatives/ agendas and regulations

Identify existing controls – What do you already have in place?
- Preventive controls
- Detective controls
- Recovery / Corrective controls

14 categories of risk

RISK	Description
Financial	Uncertainty around obtaining, committing, using, losing economic resources; or not meeting overall financial budgets/commitments.
Operational or Service Delivery	Uncertainty regarding the activities performed in carrying out the entity's strategies or how the entity delivers services.
People / Human Resources	Uncertainty as to the capacity of the entity to attract, develop and retain the talent needed to meet the objectives.
Environmental	Uncertainty usually due to external risks facing an organization including air, water, earth, forests. . An example of an environmental, ecological risk would be the possible occurrence of a natural disaster and its impact on an organization's operations.
Information / Knowledge	Uncertainty regarding access to, or use of, inaccurate, incomplete, obsolete, irrelevant or untimely information; unreliable information systems; inaccurate or misleading reporting.
Strategic / Policy	Uncertainty around strategies and policies achieving required results; or that old and/or new policies, directives, guidelines, legislation, processes, systems, and procedures fail to recognize and adapt to changes.
Legal / Compliance	Uncertainty regarding compliance with laws, regulations, standards, policies, directives, contracts, MOUs and the risk of litigation.
Technology	Uncertainty regarding alignment of IT infrastructure with technology and business requirements; availability of technological resources.
Governance / Organizational	Uncertainty about maintenance or development of appropriate accountability and control mechanisms such as organizational structures and systems processes; systemic issues, culture and values, organizational capacity, commitment, and learning and management systems, etc.
Privacy	Uncertainty with regards to exposure of personal information or data; fraud or identity theft; unauthorized data.
Stakeholder / Public Perception	Uncertainty around managing the expectations of the public, other governments, Ministries, or other stakeholders and the media to prevent disruption or criticism of the service and a negative public image.
Security	Uncertainty relating to breaches in physical or logical access to data and locations (offices, warehouses, labs, etc).
Equity	Uncertainty that policies, programs, or services will have a disproportionate impact on the population.
Political	Uncertainty that events may arise from or impact the Minister's Office/Ministry, e.g. a change in government, political priorities or policy direction.

Ontario

RISK MANAGEMENT STRATEGY & PROCESS TOOLKIT

Step 3: Assess Risks & Controls

Assess inherent risks

- *Inherent likelihood* – Without any mitigation, how likely is this risk?
- *Inherent impact* – Without any mitigation, how big will be the impact of the risk on your objective?

Assess controls

- Evaluate possible preventive, detective, or corrective mitigation strategies.

Reassess residual risks

- Re-assess the impact, likelihood and proximity of the risk with mitigation strategies in place.
- *Residual likelihood* – With mitigation strategies in place, how likely is this risk?
- *Residual impact* – With mitigation strategies in place, how big an impact will this risk have on your objective?

Key Risk Indicators (KRI)

- Leading Indicators - Early or leading indicators that measure sources or causes to help prevent risk occurrences
- Lagging Indicators - Detection and performance indicators that help monitor risks as they occur.

Risk Tolerance

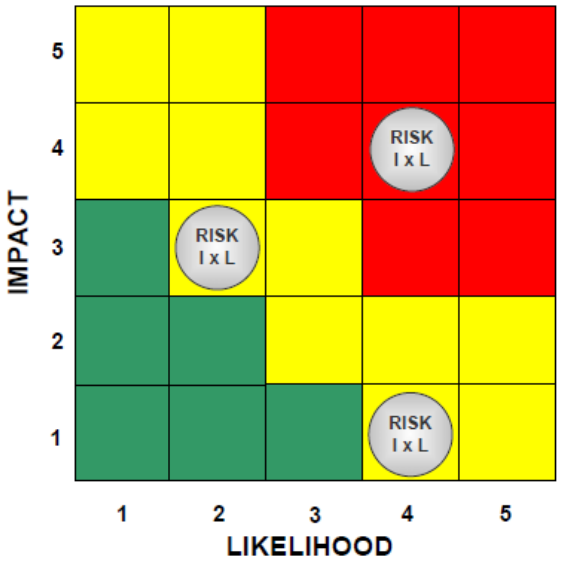
- The amount of risk that the area being assessed can manage

Risk Appetite

- The amount of risk that the area being assessed is willing to manage

The tolerance and risk appetite values may differ e.g. Staff can afford to lose email capabilities for five hours (risk tolerance) but only be willing to lose email capabilities for one hour (risk appetite).

RISK PRIORITIZATION MATRIX



Step 4: Evaluate & Take Action

- Identify risk owners.
- Identify control owners.
- Have mitigation strategies reduced the risk rating (Impact x Likelihood) enough that the risk is below approved risk tolerance levels?
- Do you need to implement further mitigation strategies?
- Develop SMART (Specific, Measurable, Achievable, Realistic, Time-specific) actions that will either reduce the likelihood of the risks or minimise the impact.
- Develop detailed action plans with timelines, responsibilities and outline deliveries.

Step 5: Monitor & Report

- Have processes in place to review risk levels and risk mitigation strategies as appropriate.
- Monitor and update by asking:
  - Have risks changed? How?
  - Are there new risks? Assess them
  - Do you need to report or escalate risks? To whom? When? How?
- Develop and monitor risk indicators

Definitions

VALUE	LIKELIHOOD	IMPACT	PROXIMITY	*SCALE*
1	Unlikely to occur	Negligible Impact	More than 36 months	*Very Low*
2	May occur occasionally	Minor impact on time, cost or quality	12 to 24 months	*Low*
3	Is as likely as not to occur	Notable impact on time, cost or quality	6 to 12 months	*Medium*
4	Is likely to occur	Substantial impact on time, cost or quality	Less than 6 months	*High*
5	Is almost certain to occur	Threatens the success of the project	Now	*Very High*

CITY OF HAMILTON
PUBLIC HEALTH SERVICES
Epidemiology, Wellness, and Communicable Disease Control Division

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	September 16, 2019
SUBJECT/REPORT NO:	Immunization of School Pupils Act Overview (BOH19029) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Julie Prieto (905) 546-2424 Ext. 3528
SUBMITTED BY: **SIGNATURE:**	Kevin McDonald on behalf of Michelle Baird Director, Epidemiology, Wellness and Communicable Disease Control Division Public Health Services

RECOMMENDATION(S)

(a) That the Board of Health endorse the position of the Council of Ontario Medical Officers of Health in support of a seamless immunization registry, whereby health care providers directly input immunization information at the time of vaccine administration;

(b) That the Board of Health circulate Report BOH19029 to the Minister of Health, the Chief Medical Officer of Health, City of Hamilton Members of Provincial Parliament, the Association of Local Public Health Agencies, the Council of Ontario Medical Officers of Health and the other 34 Ontario Boards of Health.

EXECUTIVE SUMMARY

This report provides information on how Public Health Services, Vaccine Program meets the requirement to enforce the *Immunization of School Pupils Act* (ISPA) - an Ontario law that requires children under the age of 18 years attending school to have an up-to-date

immunization record, or valid exemption, on file with their local public health unit for designated publicly funded childhood immunizations.

Key Points:

- Enforcement of the *Immunization of School Pupils Act* is a tool that is used to improve vaccine coverage rates amongst school-aged children, monitor trends and patterns in vaccine coverage, and support public health response to vaccine-preventable disease cases or outbreaks; and,
- Administration of the *Immunization of School Pupils Act* in the City of Hamilton would be enhanced if the provincial government were to create a provincial Electronic Medical Record and merge this record with the existing Digital Health Immunization Repository. This would ensure that any time a vaccine was administered by a health care provider, it was automatically captured in the central provincial vaccine registry.

Alternatives for Consideration – Not Applicable

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

There are none currently. Greater efficiencies could be gained with the creation of a seamless immunization registry. If the Province were to implement such a registry, impacts would be reported back to the Board of Health at that time.

Financial: Not Applicable.

Staffing: Not Applicable.

Legal: Not Applicable.

HISTORICAL BACKGROUND

Immunizations are one of the most successful and cost-effective public health interventions, as they protect individuals from the harmful effects of vaccine-preventable diseases. In addition, they provide community-level protection known as herd immunity, which reduces the risk of disease for those who cannot receive a vaccine because of their age or a medical condition.

The Vaccine Program is responsible for implementing the *Immunization of School Pupils Act* (ISPA), and has done so since 1990.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

The Board of Health is mandated to enforce the *Immunization of School Pupils Act 1990*, for school-aged children and the *Child Care and Early Years Act 2014*, for children attending licensed child care centres. Program specific requirements are outlined in the Ontario Public Health Standards and associated protocols, and include the requirement to assess vaccine records, maintain vaccine records, and report on the immunization status of children enrolled in schools and licensed child care centres.

ISPA requires each public health unit to have a record that students attending school have been immunized according to the Ontario immunization schedule. Under ISPA, students under the age of 18 years must provide proof of up-to-date immunizations against the following designated diseases:

- Diphtheria;
- Tetanus;
- Polio;
- Measles;
- Mumps;
- Rubella;
- Pertussis (whooping cough);
- Varicella (chicken pox); and,
- Meningococcal disease.

For students who are unable to receive vaccines for medical reasons (e.g. allergies, immunocompromised, etc.), a health care provider must complete a medical exemption form and provide it to public health. Parents/guardians may also choose to exempt their child from receiving vaccines for religious or conscientious reasons. As per ISPA, to obtain a non-medical exemption, parents/guardians must attend an education session provided by public health as well as complete a "statement of conscience or religious belief" form and have it notarized by an authorized notary public. Completion of either exemption places a student in compliance with ISPA.

RELEVANT CONSULTATION

Not Applicable.

ANALYSIS AND RATIONALE FOR RECOMMENDATION(S)

Rationale

Children receive most childhood immunizations through their primary health care provider. Following immunization, health care providers typically provide a paper

immunization record to the parent and/or guardian (the “yellow card”) and the child’s medical record is also updated. Parents/guardians are then responsible for reporting their child’s immunization record to public health. Parents can report by phone, fax, drop-in or online. To date, most records are reported either by phone or fax. Public Health enters this information into the provincial Digital Health Immunization Repository.

The Digital Health Immunization Repository is the provincial electronic immunization database that stores all student immunization information. Immunization records can only be entered by Public Health and the information within the database is only accessible to Public Health. Health care providers who administer vaccines to children do not have access to this system.

Previous attempts were made to create online portals where patients and health care providers could securely submit immunization information to the Digital Health Immunization Repository. For example, Immunization Connect Ontario (ICON) developed a platform for both the public as well as primary health care providers to enter vaccine information. Although the Vaccine Program adopted ICON for public use in 2016, there are barriers to universal adoption of ICON by primary health care providers and public health units across Ontario, such as additional time to log into a parallel system and double document the immunization.

The provincial government recently announced plans to create a provincial Electronic Medical Record and merge it with the Digital Health Immunization Repository. Moving forward with this plan would allow for the seamless reporting of immunization information by health care providers at the time of administration thereby removing the onus from parents/guardians to report vaccine records to Public Health.

Analysis

To orient and support parents and guardians to have their children immunized and protected against vaccine preventable diseases, the Vaccine Program regularly promotes immunizations and vaccine reporting. This includes answering calls from parents, guardians and health care providers, having a dedicated web page, doing community presentations, as well as providing educational resources at kindergarten registration events. The Vaccine Program also engages in a screening only process in the summer months for parents and guardians of Kindergarten 1 (formerly JK) children to familiarize them with the annual process starting in the following school year.

Annually, the Vaccine Program engages in a screening and suspension process which ensures parents and guardians are adequately notified of ISPA requirements. The program is responsible for assessing and maintaining vaccine records of over 70,000 students enrolled in Hamilton elementary and secondary schools. Between the age of two months and 16 years, children may receive up to 18 different vaccines. Because the vast majority of vaccine record reporting is done by phone or fax, Vaccine Program staff

are responsible for manually entering most vaccine records into the provincial database. The program currently has five data clerks who are primarily responsible for accurate transcription and entering of all vaccine records.

Details of the screening and suspension process as well as supportive processes can be found in Appendix "A" to BOH19029.

In 2018-2019, after the assessment of vaccine records of over 70,000 students, approximately 16,000 students were notified that they did not have an up-to-date record on file with public health. This was either because a student had not received all required vaccines or the student's vaccine record was not reported to public health by the parent and/or guardian. Of these students, approximately 3400 were suspended from school as records had not been received despite reminders; most orders of suspension were rescinded within the first week.

For the 2018-2019 school year, at the completion of the screening and suspension process, the compliance rate ranged between 94.3% to 98.5% for 7 to 8 year old school students and 93.1% to 99.8% for 17 to 18 year old school students. Further details of compliance for each type of vaccine can be found in Appendix "B" to BOH19029.

These compliance values are used as an approximate indication of immunization coverage; however, these estimates include a small proportion of non-immunized exempt students (2.6% to 3.4% varying by immunization and age). If an outbreak of one of these vaccine-preventable diseases were to occur in a school, those who are not up to date on their immunizations may be excluded during the outbreak in order to protect both them and others.

This data provides evidence of the effectiveness of the process in reaching over a 90% vaccine coverage rate for all designated vaccines. Although ISPA is an effective tool to ensure individual and community level immunity, the process is resource intensive both from a staff and time perspective. This is a result of most vaccine records requiring manual input into the provincial database by program staff, and follow-up required on records received that are missing information such as date of administration of vaccine, required demographics or a fax error.

Immunization Support

The goal of the Vaccine Program is to improve vaccine coverage, not suspend children from school. Enforcement of the ISPA is a last resort when information is not provided as required under the Act. To support parents and ensure timely access to vaccines, the program runs several different clinics. Throughout the year three community clinics per month (in the east end, mountain and downtown) are held for children unable to access vaccines through a health care provider or who were unable to receive the vaccines administered at Grade 7 school-based immunization clinics (Hepatitis B, Menactra and

Human Papillomavirus). As well, based on the observation that high school students tended to be missing vaccines rather than not reporting them, two years ago high school clinics were initiated as a means of decreasing barriers for students and parents. This effort has been highly successful with over 2800 students receiving vaccines in the last two years. Finally, vaccine clinics are held the day before, day of, and day after suspension day. The clinics are open to students who require vaccines to either prevent or rescind a suspension order.

Improving ISPA with a Seamless Immunization Registry

A major challenge to the administration of ISPA is the lack of a provincial immunization registry to seamlessly transfer immunization information from primary and community health care providers at the time a vaccine is given to the Digital Health Immunization Repository. Furthermore, public health units across Ontario do not have a process to verify the vaccine information received from parents/guardians with their health care provider as this would be both labour intensive and costly.

The introduction of a seamless immunization registry whereby health care providers directly input immunization information at the time of vaccine administration would:

- Eliminate the burden on parents/guardians to report vaccines to public health;
- Reduce the risk of inaccurate information being reported by parents;
- Reduce staff time and resources needed to manually input vaccine records; and,
- Reduce the number of suspensions due to the lack of reporting by parents.

In March 2019, the Council of Ontario Medical Officers of Health, a subgroup of the Association of Local Public Health Agencies representing Associate Medical Officers of Health and Medical Officers of Health across the province, wrote to the Minister of Health supporting the Ministry's proposed plan to develop a provincial Electronic Medical Record and merge it with the Digital Health Immunization Repository. This Electronic Medical Record-Digital Health Immunization Repository integration project would allow for the seamless reporting of immunizations from primary health care providers at the time of vaccine administration directly to local public health.

Public Health Services is very supportive of the recommendation made by the Council of Ontario Medical Officers of Health that the Ministry assume the role of health information custodian for the Digital Health Immunization Repository. The Ministry has previously assumed this role with the Ontario Laboratory Information System and the Digital Health Repository. The Ministry taking on the role of health information custodian, instead of 35 Medical Officers of Health doing so would ensure a more consistent approach in obtaining consent for the collection of vaccine information not covered under ISPA.

Conclusion

Hamilton Public Health is committed to protecting the health of the community by preventing vaccine-preventable diseases. To achieve this goal, Public Health Services

will continue to collaborate and support parents and local school boards to ensure compliance with *Immunization of School Pupils Act*. Moving toward a seamless immunization registry would increase efficiencies in the screening and suspension process while reducing the parental burden to report vaccines to public health.

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.

The Immunization of Student Pupils Act aligns with the strategic plans and the City of Hamilton's vision to be the best place to raise a child and age successfully. Enforcement of the act ensures both individual and community level protection against vaccine-preventable diseases.

APPENDICES AND SCHEDULES ATTACHED

Appendix "A" to BOH19029: Details of Screening and Suspension Process
Appendix "B" to BOH19029: Immunization of School Pupils Act Overview

Screening and Suspension Process

The screening and suspension process takes place from November to May of each school year; schools are divided into six ‘waves’ to make the process more manageable from a program resource perspective. During the 2018-19 school year Kindergarten 2 (previously known as Senior Kindergarten) to Grade 11 students were included in this process. For the upcoming school year, Kindergarten 1 students (previously known as Junior Kindergarten) will also be added.

Every fall, the Vaccine Program receives enrolment information, including student demographics, from all elementary and secondary schools in Hamilton (Public, Catholic, French and Private schools). This enrolment information allows the vaccine program to carry out the reporting requirements needed to identify students who have: 1) not reported all required vaccines to public health or 2) not received all required ISPA vaccines.

1) Screening and suspension process

The process begins with identifying students who do not have an up-to-date vaccine record on file with public health.

Parents and guardians of these students are then notified of the missing vaccine information via a mailed screening letter, **five weeks** prior to a suspension day. The letter contains detailed information about:

- lSPA
- their child’s specific information on what vaccines are needed to meet ISPA requirements
- medical and conscientious exemptions
- how to access vaccines
- how to report vaccines to public health (in person, fax, phone or online)

On suspension day, schools are provided with a list of students who did not meet the ISPA requirements and therefore must be excluded from school. It is important to note that the suspension order is to the principal requiring them to suspend the students that do not meet ISPA requirements. As soon as public health is provided with the required information that the vaccine has been received or an exemption form submitted, the suspension order is immediately rescinded, and the school is advised that the student may return. An order of suspension can be enacted for up to 20 school days and can be renewed.

2) Efforts to support ISPA process

Suspension is a last resort for public health. As such, the vaccine program actively supports schools and parents/guardians in order to prevent a student from being suspended or, if suspended, to resolve the issues quickly to allow the student to return to school as quickly as possible.

Information to school boards

Early in the fall, school boards are provided with the screening and suspension plan which outlines suspension dates for all schools. Public Health also provides a brief information document for principals outlining ISPA and its requirements. Ongoing support is available to principles to address school or parent concerns.

Immunization support

To support parents and ensure timely access to vaccines, the program runs vaccine clinics the day before, day of, and day after suspension day. The clinics are open to students who require vaccines to either prevent or rescind a suspension order.

The vaccine program also runs three community clinics per month (in the east end, mountain and downtown) for children unable to access vaccines through a health care provider or who were unable to receive the vaccines administered at Grade 7 school-based immunization clinics (Hepatitis B, Menactra and Human Papillomavirus).

Two years ago, the program initiated high school clinics as a means of decreasing barriers for students and parents. This effort has been highly successful with over 2800 students receiving vaccines in the last two years. The program will continue to provide this valuable clinical service.

Follow-up with schools and parents

Approximately one week following a suspension day, nurses begin follow up with schools to ensure compliance with the suspension order. Challenges with the order are addressed and nurses offer to follow up with parents as needed. After school follow-up has been completed, nurses then attempt to contact parents to address any barriers to either obtaining their child’s vaccine record, completing an exemption or accessing needed vaccines. Nurses will also follow up with family physician practices at the request of a parent. Follow-up with parents may not be successful if wrong contact information is on file.

Immunization Compliance For School Pupils

City of Hamilton Profile

Hamilton

In order to prevent diseases from spreading in our community, a certain percentage of people must be immunized (known as "herd immunity").

Ontario's Immunization of School Pupils Act (ISPA) directs public health units to maintain a record of immunization for each pupil attending school in their jurisdiction. Compliance with ISPA is shown below at Age 7 and 17 years which are key milestones in the immunization schedule.

Overall 2018/2019 School Year in Hamilton

5,810
7 year-old students eligible for ISPA vaccines

6,309
17 year-old students eligible for ISPA vaccines

92.9%
Percent of 7 year-old students fully compliant with ISPA

92.1%
Percent of 17 year-old students fully compliant with ISPA

Compliance (%) by Antigen

	7 year-old students		17 year-old students	
School Year:	2015-16	2018-19	2015-16	2018-19
Measles	97.6%	95.7%	97.1%	98.7%
Mumps	97.6%	95.7%	97.0%	98.5%
Rubella	98.7%	98.5%	97.5%	99.8%
Diphtheria	95.8%	94.8%	78.9%	93.4%
Tetanus	95.8%	95.3%	78.9%	93.3%
Pertussis	95.8%	94.8%	77.7%	93.1%
Polio	95.9%	95.6%	96.8%	98.3%
Meningococcal	95.8%	98.1%	93.6%	99.4%

Data notes: This is an assessment of student compliance with the Immunization of School Pupils Act (ISPA). Students are considered compliant if they have reported proof of immunization or a valid exemption. Exemptions for immunizations ranged between 2.6-3.4%. Data source: Panorama. 2018-2019 [Extracted Jul 2019]; 2015-2016 [Extracted May-Aug 2016].

IMMUNIZATION OF SCHOOL PUPILS ACT (ISPA)

BOH19029

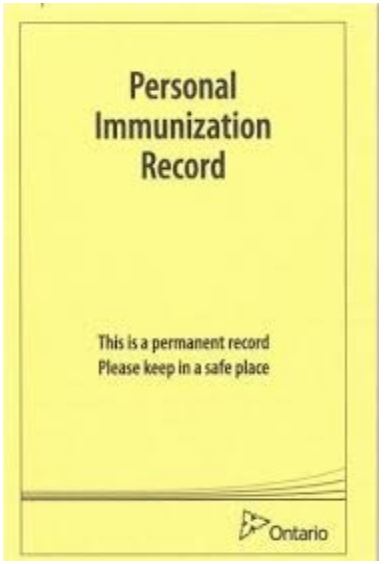
September 16, 2019

Outline

1) Overview of Immunization of School Pupils Act (ISPA)
2) Screening and Suspension Process
3) Supporting the process
4) Compliance
5) Moving forward and recommendations

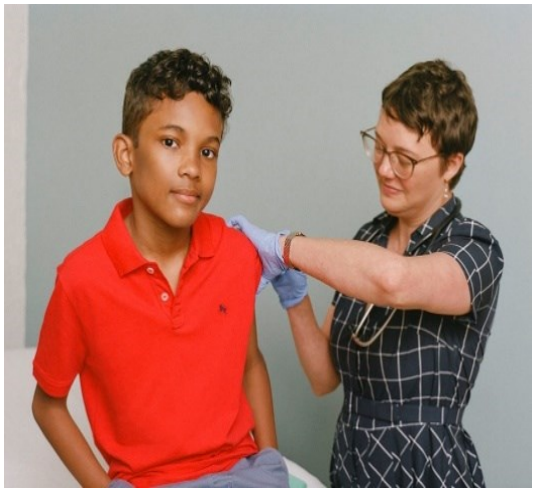
Immunization of School Pupils Act (ISPA) Overview

- Ontario law requiring certain vaccines to be given for a child to attend school
- To protect school aged children from vaccine preventable diseases
- Parents and guardians are responsible for reporting vaccines



ISPA Overview- Compliance

- Child receives designated vaccines in accordance with the Publicly Funded Immunization Schedule



- Exemption (medical and non-medical)

ISPA Overview- Medical and Non-Medical Exemptions

Medical

- unable to receive vaccine for a medical reason
- exemption form must be completed by health care provider and include: exempted vaccines, length of exemption and reason for exemption

Non-Medical

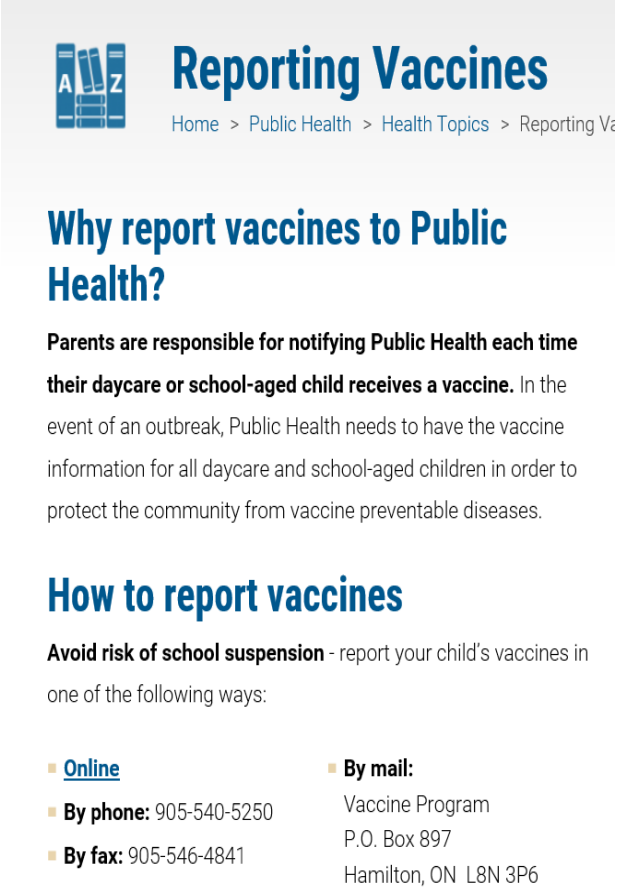
- completed for conscientious or religious reasons
- education session is mandatory
- “statement of conscience or religious belief” form must be notarized

ISPA Overview - Vaccine Record Reporting

- Parents/guardians are responsible for reporting vaccines to public health
- Reporting options include: phone, fax, drop-in or online
  - Phone and fax most frequent

Promoting and orienting parents and guardians

- Web page
- Phone line
- Community presentations
- Promotional materials to kindergarten registration sessions
- Screening only process – summer – for K1/JK students



Reporting Vaccines

Home > Public Health > Health Topics > Reporting Va

Why report vaccines to Public Health?

Parents are responsible for notifying Public Health each time their daycare or school-aged child receives a vaccine. In the event of an outbreak, Public Health needs to have the vaccine information for all daycare and school-aged children in order to protect the community from vaccine preventable diseases.

How to report vaccines

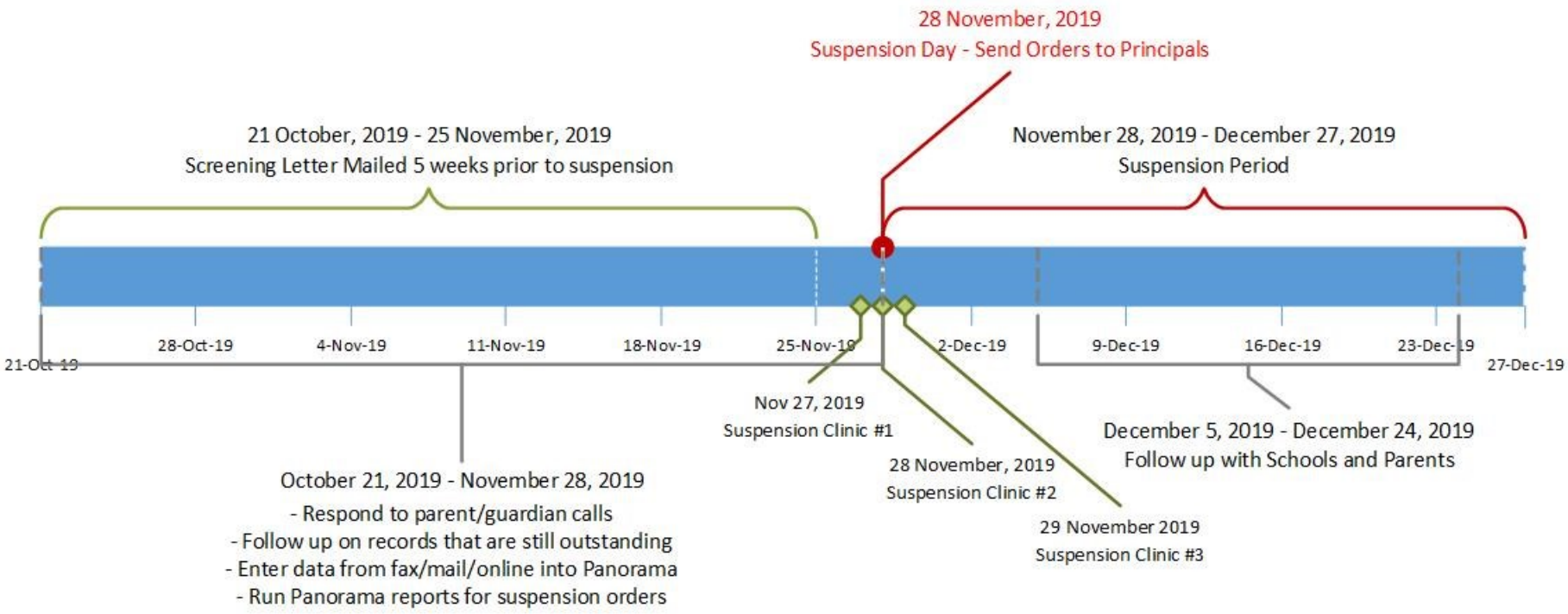
Avoid risk of school suspension - report your child's vaccines in one of the following ways:

- Online
- **By phone:** 905-540-5250
- **By fax:** 905-546-4841
- **By mail:**
  Vaccine Program
  P.O. Box 897
  Hamilton, ON L8N 3P6

Screening and Suspension Process

- November-May of each school year
- Schools divided into waves
- 2018-2019 – kindergarten 2 to grade 11
- 2019-2020- kindergarten 1&2 to grade 11
- All school boards included (Public, Catholic, French & Private)

Immunization School Pupils Act (ISPA) – Public Health Timeline



Hamilton
Public Health Services

Vaccine Program
Mail: P.O. Box 897, Hamilton ON, L8N 3P6
Phone: 905.540.5250 Fax: 905.546.4841
www.hamilton.ca/vaccines

To«Skip Record If...» **«First_Name» «Last_Name»**
Or parent/legal guardian if less than 16 years of age
«Street_Address»
«City», ON «Postal_Code»

Birth Date: «Date_of_Birth»
School: «School_Daycare»

For Office Use Only
Client ID:

By law, Public Health Units need a complete vaccine record or an exemption for diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella and meningococcal diseases.

Our record for **«First_Name» «Last_Name»** is shown on the back of this letter and is missing vaccines for the following diseases: **«DiseasesAgents»**.

1. Please let us know if your child's / your information at the top of the letter needs to be updated.
2. Check your records and report any missing vaccines and dates.
   - See the back of this letter for the vaccine record on file with Public Health
   - Record the missing vaccines and dates on the back of this letter and return it using the enclosed envelope
   - Call 905.540.5250
   - Fax 905.546.4841

   Note: Doctors do not give us vaccine records.

If the missing vaccine information is not provided by [DAY, MMM DD, YYYY], «First_Name» «Last_Name» may be suspended from school.

3. If needed, get the missing vaccines and then report them to public health (not the school). Note: Complete a legal form if there is a medical reason a vaccine cannot be given or you have strong beliefs against getting vaccines. The legal forms are posted under Vaccines and the Law at www.hamilton.ca/vaccines.

Vaccine Record for «First_Name» «Last_Name» on File with Public Health

DATE GIVEN	At Age	Diphtheria	Tetanus	Pertussis	Polio	Measles	Mumps	Rubella	Varicella	Meningococcal Disease	Vaccine

Write the missing vaccines and dates below or attach a copy of the record.

Vaccine Given	Date Given			Doctor / Clinic Name and Phone Number
	YYYY	MM	DD	

Collection and Use of Personal Health Information

The information collected on this form is being collected in accordance with section 36(1), subsection h of the Personal Health Information Protection Act, 2004 and section 12(2) of the Immunization of School Pupils Act, 1990.

The information will be used for the purposes of keeping your vaccine records up to date, meeting Immunization of School Pupils Act legislation, and the collection of statistics.

If you have questions about the collection of your information, contact:
Vaccine Program Representative
Hamilton Public Health Services
110 King Street West 2nd Floor
Hamilton ON L8P 4S6
905-540-5250
Visit www.hamilton.ca/phsprivacy to learn more.

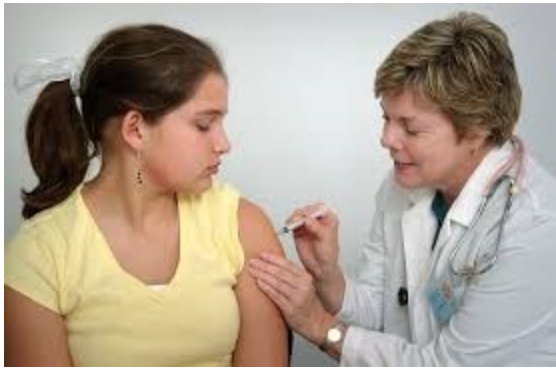
Efforts to support ISPA process

Information to school boards

- ISPA process
- Annual screening and suspension plan
- Important dates (screening letter & suspension day)

Clinical support

- Suspension clinics- day before, day of and day after
- Secondary school clinics
- Community clinics



Follow-up with schools and parents

- 1 week following suspension day to provide support, addresses barriers to accessing vaccines and/or reporting vaccines to public health

Compliance

Immunization Compliance For School Pupils

City of Hamilton Profile

Hamilton

In order to prevent diseases from spreading in our community, a certain percentage of people must be immunized (known as "herd immunity").

Ontario's Immunization of School Pupils Act (ISPA) directs public health units to maintain a record of immunization for each pupil attending school in their jurisdiction. Compliance with ISPA is shown below at Age 7 and 17 years which are key milestones in the immunization schedule.

Overall 2018/2019 School Year in Hamilton

5,810

7 year-old students eligible for ISPA vaccines

6,309

17 year-old students eligible for ISPA vaccines

92.9%

Percent of 7 year-old students fully compliant with ISPA

92.1%

Percent of 17 year-old students fully compliant with ISPA

Data notes: This is an assessment of student compliance with the Immunization of School Pupils Act (ISPA). Students are considered compliant if they have reported proof of immunization or a valid exemption. Exemptions for immunizations ranged between 2.6-3.4%. Data source: Panorama. 2018-2019 [Extracted Jul 2019]; 2015-2016 [Extracted May-Aug 2016].

Immunization Compliance For School Pupils

City of Hamilton Profile

Hamilton

Compliance (%) by Antigen

	7 year-old students		17 year-old students	
School Year:	2018-19	2015-16	2018-19	2015-16
Measles	95.7%	97.6%	98.7%	97.1%
Mumps	95.7%	97.6%	98.5%	97.0%
Rubella	98.5%	98.7%	99.8%	97.5%
Diphtheria	94.8%	95.8%	93.4%	78.9%
Tetanus	95.3%	95.8%	93.3%	78.9%
Pertussis	94.8%	95.8%	93.1%	77.7%
Polio	95.6%	95.9%	98.3%	96.8%
Meningococcal	98.1%	95.8%	99.4%	93.6%

Data notes: This is an assessment of student compliance with the Immunization of School Pupils Act (ISPA). Students are considered compliant if they have reported proof of immunization or a valid exemption. Exemptions for immunizations ranged between 2.6-3.4%. Data source: Panorama. 2018-2019 [Extracted Jul 2019]; 2015-2016 [Extracted May-Aug 2016].

Challenges with current environment

- Resource intensive
- Lack of a provincial immunization registry to seamlessly transfer immunization info from primary care to public health
- Lack of awareness that parents must report vaccines to public health
- Lack of a process to verify vaccine info received from parents/guardians

Moving Forward

- Outreach to local healthcare providers to promote adherence to the publicly funded vaccine schedule
- Use of local data to identify schools/students that require more targeted interventions
- Enhance parental notification of upcoming suspension using automated messaging
- CANImmunize

Recommendation

It is recommended that:

1. The Board of Health endorse a seamless immunization registry whereby health care providers directly input immunization information at the time of vaccine administration.
2. The BOH circulate this report to the Minister of Health, the Chief Medical Officer of Health, City of Hamilton MPP's, the Association of Local Public Health Agencies, the Council of Ontario Medical Officers of Health and the other 34 Ontario Boards of Health.

QUESTIONS?

SENIOR'S ORAL HEALTH 2018-2019

Hamilton

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

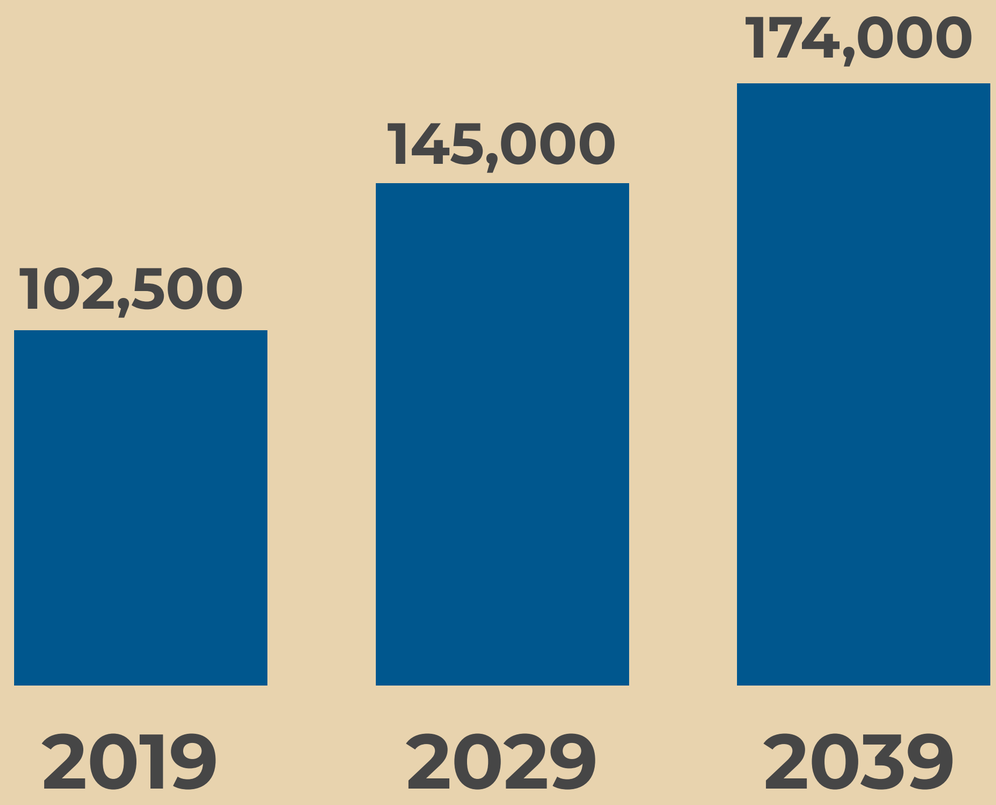
Hamilton's senior population is growing quickly, but many seniors do not have dental insurance coverage. Income status is a major determinant of oral health and seniors with lower income are more likely to have unmet dental care needs.

102,500 Number of seniors living in Hamilton

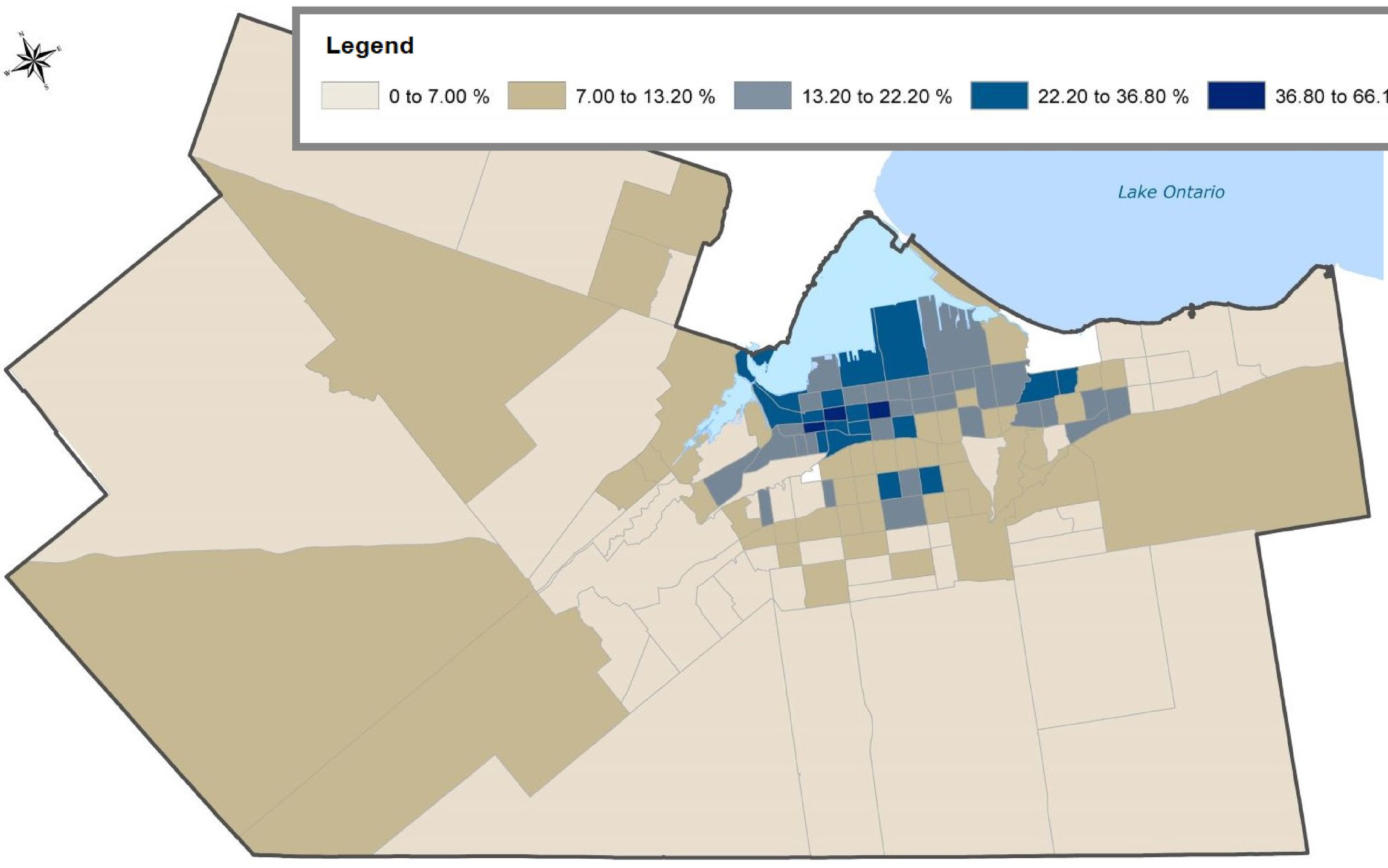
61,000 Estimated number of seniors with no dental insurance in Hamilton

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)

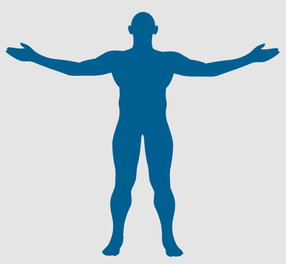


Oral Health Status of Hamilton Seniors [4]

Poor oral health is linked to:

Psycho-social well-being

Heart disease

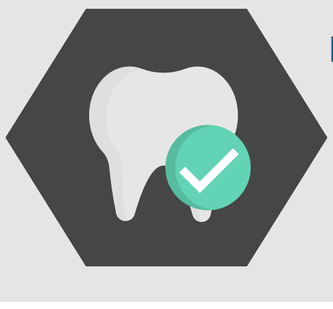


Respiratory disease

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.

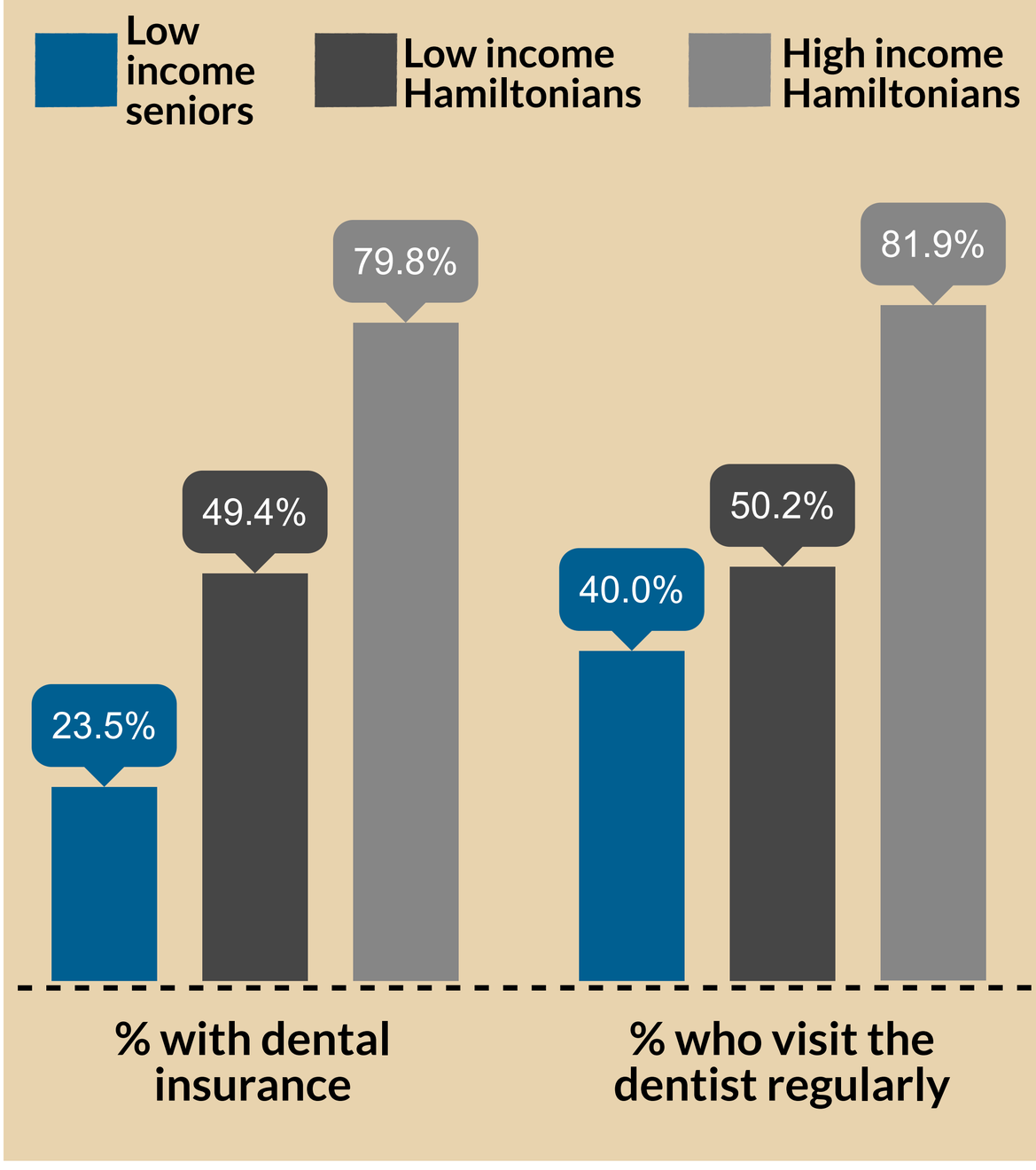
39% Hamilton seniors experienced oral/facial pain or discomfort in the past year.

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.

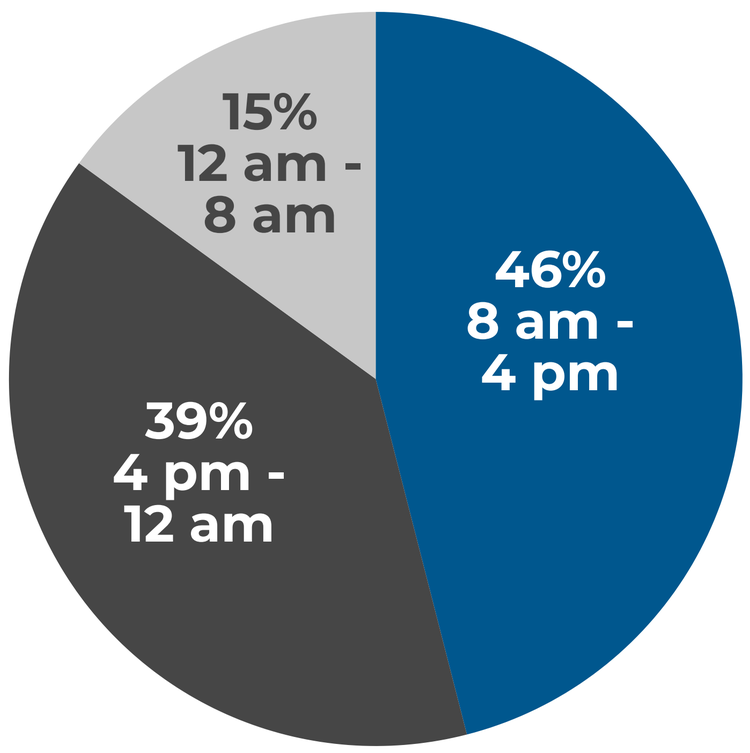
Emergency Dental Care among Seniors in Hamilton[6-7]

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

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

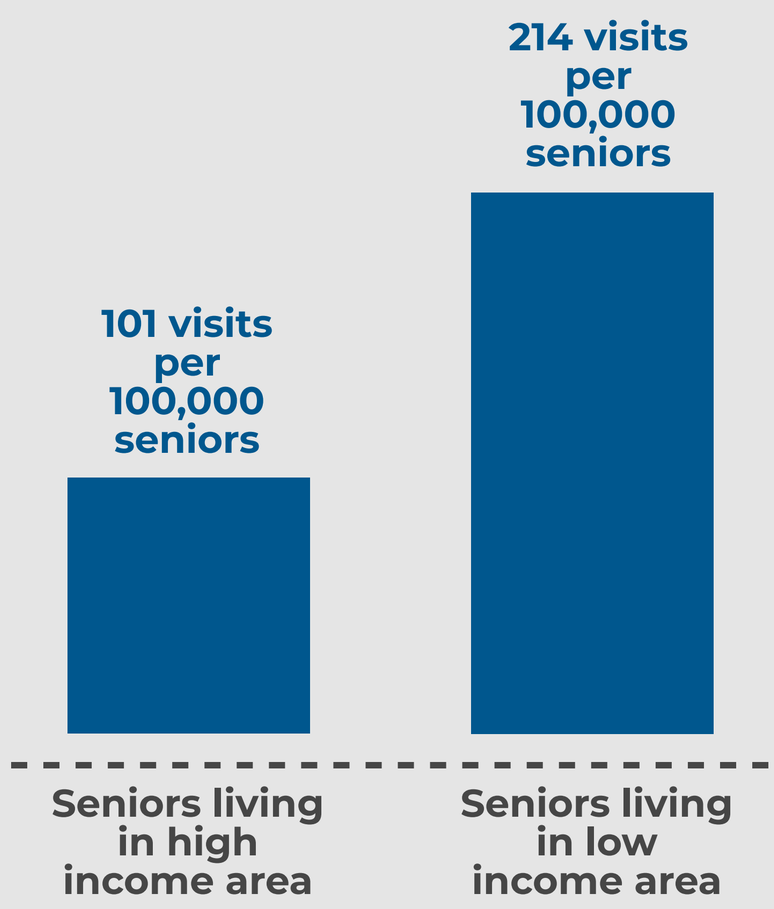
Hamilton seniors are increasingly seeking dental care from local hospital emergency departments. About 20% of this increase is explained by population growth, but most of the increase may be explained other factors.

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?

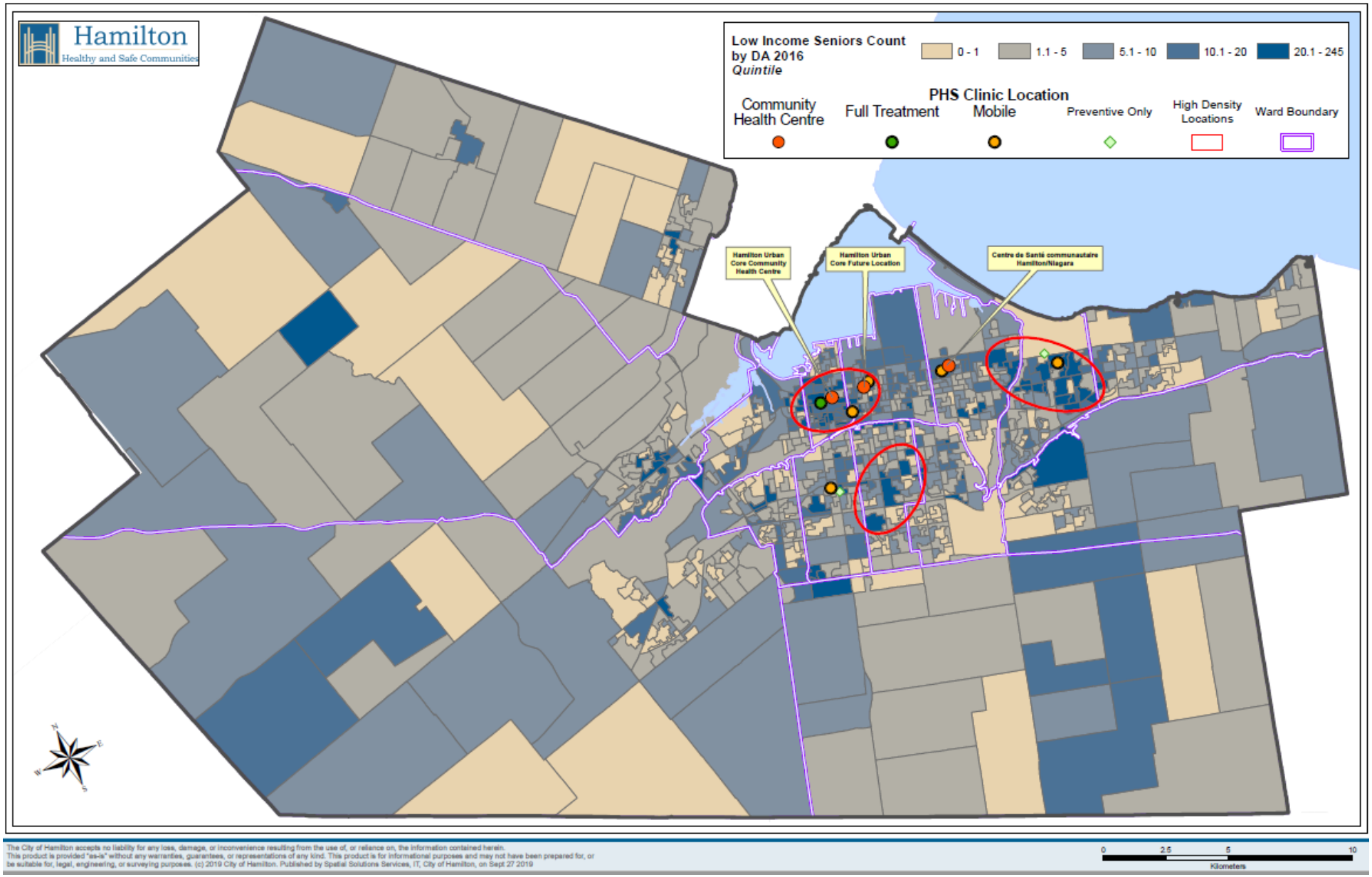


Seniors living in low income neighbourhoods in Hamilton are twice as likely to go to the emergency department for dental care. This is likely driven by very low rates of dental insurance coverage among low income seniors.

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


Hamilton
Healthy and Safe Communities
Low Income Seniors Count
by DA 2016
Quintile
0 - 1
1.1 - 5
5.1 - 10
10.1 - 20
20.1 - 245
PHS Clinic Location
Community Health Centre
Full Treatment
Mobile
Preventive Only
High Density Locations
Ward Boundary
Hamilton Urban Core Community Health Centre
Hamilton Urban Core Future Location
Centre de Santé communautaire Hamilton/Niagara
N
E
S
W
The City of Hamilton accepts no liability for any loss, damage, or inconvenience resulting from the use of, or reliance on, the information contained herein.
This product is provided "as-is" without any warranties, guarantees, or representations of any kind. This product is for informational purposes and may not have been prepared for, or be suitable for, legal, engineering, or surveying purposes. (c) 2019 City of Hamilton. Published by Spatial Solutions Services, IT, City of Hamilton, on Sept 27 2019
0
2.5
5
10
Kilometers

CITY OF HAMILTON
PUBLIC HEALTH SERVICES
Healthy Families Division

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	October 18, 2019
SUBJECT/REPORT NO:	Seniors Oral Health (BOH19026(a)) (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)

(a) That the Board of Health authorize and direct the Medical Officer of Health to receive, utilize and submit reports for the approved capital from the Ministry of Health to support the service delivery plan for low-income seniors.

(b) That the Board of Health authorize and direct the Medical Officer of Health to increase complement in the Public Health Services by 5.8 full time equivalents as outlined in BOH19026(a).

EXECUTIVE SUMMARY

Oral health impacts overall health across the lifespan. Population health data shows that poor oral health is common in Hamilton and has greater negative effects on the city's most vulnerable populations, including seniors. Many seniors in Hamilton cannot afford dental care and either pay out of pocket or forgo regular dental care. As a result, many seniors increasingly seek dental care in hospital emergency departments. Seniors living in low-income areas are two times more likely to visit hospitals than those living in high income areas.

In April 2019, the provincial government announced a new Ontario Seniors Dental Care Program (OSDCP) for low-income seniors. The goal is to help reduce unnecessary trips

to the hospital, prevent chronic disease and increase quality of life for seniors. Public Health Services (PHS) alongside key stakeholders, has been actively involved in the planning and local development of the OSDCP following the Ministry of Health's (the Ministry) prescribed criteria and multi-staged process. Over the summer a capital funds application was developed and submitted to the Ministry by the August 14 deadline.

Areas with low-income seniors are distributed across the city with higher numbers in the lower west city, lower east city and central mountain. Proposed service locations are within a five kilometre radius of the largest low-income population clusters in Hamilton.

The purpose of this report is to provide more details regarding the proposed service delivery plan for the OSDCP in Hamilton, which is summarized in Chart 1 and Chart 2.

Chart 1: Stage 1– Leveraging Existing Resources

Stage 1 Implementation	
Location	**Type of Service**
PHS downtown dental clinic	Increase restorative, preventive and denturist services
PHS dental bus	Increase restorative, preventive and emergency services
PHS dental bus services to long-term care homes	Provide additional hours for new services to low-income seniors residing in long-term care homes. To be piloted at Macassa and Wentworth Lodges in the Fall of 2019 with expansion to other sites in 2020
PHS east end clinic	Increase preventive services
PHS mountain clinic	Increase preventive services
Urban Core Community Health Centre	Increase preventive services
All sites	Increase awareness of program and support seniors to apply for coverage

Chart 2: Stage 2 – Capital Investments

Stage 2 Implementation (ranked order)	
Location	**Type of Service**
Centre de Santé Communautaire	Provide new restorative, preventive and denturist services 6 days per week
PHS mountain clinic	Expand from prevention only to include restorative and mobile services
Replacement of PHS dental bus	Maintain restorative, preventive and emergency services

Urban Core Community Health Centre	Expand from prevention only to include restorative and denturist services at new site at Cannon and Wellington
PHS downtown dental clinic	Expand capacity at PHS' downtown dental clinic to provide restorative, preventive and denturist services.

The service delivery plan will allow for over 4300 low-income seniors in Hamilton to access dental services. This includes the 1000 eligible clients in long term care homes and the expected 500 eligible seniors that can access denturist services. For the bus and clinic appointments, 77% of the appointments available will be for restorative services while 23% will be for preventive services.

The proposed service delivery plan will require a 5.8 full time equivalent (FTE) increase to PHS' Dental Program complement. In addition, 6.5 FTE of existing program staff will be moved from the Municipal dental programs and Healthy Smiles Ontario (HSO) to the OSDCP to reflect the new plan and trends in service uptake.

The Ministry has indicated further communication is forthcoming regarding the date seniors can begin to apply to the program, the final service schedule, as well as, a decision regarding the possible introduction of patient co-payments for dentures.

Staff will report on 2019/20 budget implications through in-year budget reporting and the 2020 budget process.

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: $2,248,100.00 in additional base funding from the Ministry for the OSDCP. A breakdown of funding by service site is outlined in Chart 3.

Staffing: PHS dental staffing levels will increase by 5.8 FTE, consisting of 1.2 FTE clinical dentists, 1.0 FTE supervisor, 0.6 FTE receptionist, 0.1 FTE bus driver,1.0 FTE denturist, 0.1 FTE registered dental hygienist, 1.0 FTE program secretary and 0.8 FTE dental assistant.

Existing 6.5 FTE program staff will be reallocated to the OSDCP based on current and projected numbers of clients serviced.

Chart 3: Proposed Budget for Ontario Seniors' Dental Care Program in Hamilton

Service Delivery Site	Annual Budget
Public Health Services	$1,402,683
Centre de Santé Communautaire	$255,456
Urban Core	$109,783

Contracted Dental Lab*	$200,000
Contracted Oral Surgeon*	$280,178
TOTAL	$2,248,100

*these services will be accessed by all sites

Legal: The OSDCP is part of the Ontario Public Health Standards (OPHS) under the *Health Protection and Promotion Act* and governed by the Public Health Funding and Accountability Agreement between the City and the Ministry. All partnerships between the BOH and Community Health Centres (CHCs) will be governed by a Service Level Agreement (SLA), which will outline performance expectations, funding, reporting requirements and accountability mechanisms. Denture lab work and oral surgeon services will be contracted in alignment with procurement rules.

HISTORICAL BACKGROUND

The City of Hamilton currently provides dental services to low-income seniors at the Public Health dental clinic and the dental health bus for those who cannot afford dental care in the community. Prior to the announcement of the OSDCP, these programs have been 100% funded by the Municipality.

In addition, City of Hamilton residents who require dental care can apply for funding through Ontario Works Special Supports program. In 2018, staff collaborated with Hamilton Community Foundation (HCF) to develop and implement Oral Health Enhancements including supplemental denture coverage for eligible low-income seniors who access the Special Supports program.

In April 2019, the Provincial government announced the Ontario Seniors Dental Care Program for low-income seniors.

Since May, the Ministry has held several webinars to outline Public Health Unit (PHU) requirements as well as operational roles and responsibilities.

In June, the BOH received a letter from the Ministry announcing Hamilton's annual base funding increase of $2,248,100.00 to support the new dental program. This is a 100% provincially funded program (i.e., not cost shared with municipalities).

Since June, PHS has been working collaboratively with key stakeholders to develop a service delivery plan which best services Hamilton's low-income seniors and follows the Ministry prescribed criteria and multi-staged process.

In July, the BOH approved the Senior's Oral Health report (BOH19026), delegating authority to the Medical Officer of Health to receive and utilize provincial funding and develop a local Seniors Dental Care Program.

In August, PHS submitted a capital funds application that supports implementation of the locally developed Seniors Dental Care service delivery plan. As of the writing of this report, the Ministry has not communicated the status of the application.

Staff will provide updates on any further implications for all the above programs once further details from the Ministry are received.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

Amendments to the OPHS and related protocols were released August 1, 2019 that outline PHU requirements and operational roles and responsibilities. The Ministry has indicated further communication is forthcoming regarding the date seniors can begin to apply to the program, the final service schedule and a decision regarding potential introduction of patient co-payment for dentures.

RELEVANT CONSULTATION

- PHS consulted and achieved consensus in the development of a service delivery plan with Centre de Santé Communautaire, Compass Community Health Centre, Hamilton Urban Core Community Health Centre and De dwa da dehs nye>s Aboriginal Health Center.
- PHS has consulted with Ontario Works Special Supports program and the HCF to discuss potential impacts on programming.
- The draft plan was presented to the Seniors Advisory Committee who provided valuable input about increasing awareness of and registration for the program as well as the date seniors can begin to apply to the program and outreach to vulnerable populations.
- PHS continues to consult and develop a plan with Macassa and Wentworth Lodges to address the needs of seniors in long-term care.
- Continued and expanded engagement with the broader long-term care sector and organizations providing services to seniors is planned.
- PHS is working with Legal and Procurement services to develop SLAs and Partnership contracts.
- The report was reviewed by Finance and Administration, who provided review of financial figures.

ANALYSIS AND RATIONALE FOR RECOMMENDATION(S)

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

The goal of the OSDCP is to reduce unnecessary trips to the hospital, prevent chronic disease and increase quality of life for seniors. The Ministry estimates a 40% uptake in Provincial programs and has allocated funding based on an estimated 3,986 eligible seniors applying to the OSDCP in Hamilton. The OSDCP eligibility requirements include:

- 65 years and older;
- resident of Ontario;
- annual income below thresholds (single seniors less than $19,300 and for a couple less than $32,300); and,
- no access to any other forms of dental benefits (e.g. Ontario Disability Support Program or the Federal Non-Insured Health Benefits).

Public Health Units were asked to rank projects within their catchment area based on:

- local need;
- value for money (efficient and economical approach to dental infrastructure); and,
- equity (geographically underserviced areas and vulnerable sub-populations).

Further, the Ministry provided criteria for sequential ordering of projects within the capital proposal. They are:

- build on existing infrastructure;
- expand into unoccupied space; and,
- expand into occupied space, or lease expansion/new lease

Centre de Santé Communautaire, Compass CHC, Hamilton Urban Core CHC and De dwa da dehs nye>s Aboriginal Health Center have been actively involved in the planning and local development of Hamilton's Seniors Dental Care Program based on population health data and current literature in alignment with the Ministry's prescribed criteria and multi-staged process.

In Hamilton, there are approximately 10,230 seniors who could be eligible for the new program by age, income and residence (Appendix "A" to Report BOH12026(a) - Senior's Oral Health Infographic 2018-2019). Of the 10,230, those with dental insurance will be ineligible. It is estimated:

- 23% of low-income seniors have access to other benefits;
- 1,000 eligible seniors reside in long term care homes; and,
- 47% of seniors in Hamilton wear dentures with denture replacement being required every 5-10 years.

Emergency room data shows a higher need for appointment times in the mornings; on Wednesdays, Thursdays, Fridays and the weekend. Low-income seniors are distributed across the city, however, there are 3 main clusters in the lower east city, lower west city and central mountain (Appendix "B" to Report BOH19026(a) - Seniors Oral Health Map - High Density Clusters of Low-Income Seniors in Hamilton).

Local research indicates that geographic proximity to dental services is a significant predictor of receiving dental services but only explains about 20% of why seniors do not access dental services. Cost, fear and 'not thinking it is necessary' are also significant barriers to accessing dental care. The greatest oral health inequities are associated with the following social determinants:

- low-income;
- no partner (single, separated, divorced, or widowed); and,
- housing need (affordability, unsuitable, or inadequate).

A 2009 Statistics Canada report states three quarters of all seniors had a drivers licence and only a minority of seniors used other transportation. Fewer low-income seniors are likely to have driver's licences. One kilometre is typically referred to as "walking distance" while five kilometres is referred to as a reasonable distance to travel to access services.

Application of the Ministry's criteria, a review of the population health data and literature resulted in local prioritization by key stakeholders which is summarized in Chart 4.

Chart 4: Local Prioritization

Ministry Criteria	**Local planning decisions**
Local Need	• restorative services prioritized over preventive services; • organizations with greater capacity for service volume or ability to operate for a greater number of hours prioritized.
Value for Money	• stage 1 solutions (leverage existing infrastructure) prioritized over Stage 2 solutions (capital investments); • denture lab work and oral surgeon services will be contracted.
Equity	• increasing services in east end prioritized, followed by increasing services on the mountain, followed by new service downtown; • increasing access to services by eligible seniors in LTC prioritized; • providing services by organizations that have access to marginalized populations prioritized.

Hamilton's comprehensive service delivery plan will allow for over 4300 low-income seniors to access dental services. This includes the 1000 eligible clients in long term care homes and the expected 500 eligible seniors that can access denturist services. For the bus and clinic appointments, 77% of the appointments will be for restorative services while 23% will be for preventive services. Proposed service locations are within a five kilometre radius of the largest low-income population clusters in Hamilton.

The first stage includes leveraging existing infrastructure to maximize capacity. The plan includes:

- increased capacity at PHS' downtown dental clinic for restorative, preventive and denturist services;
- increased capacity at PHS' east end and mountain clinics for preventive services;
- increased capacity at PHS' dental health bus. Increased hours will be used to support eligible low-income seniors including those residing in long-term care homes. The model of care will be piloted at Macassa and Wentworth Lodges in the Fall of 2019 with expansion to other LTC homes planned for 2020; and,
- improved and enhanced capacity at Hamilton Urban Core CHC (existing site) for preventive services.

The second stage includes capital investment projects which are listed in ranked order:

- create capacity at Centre de Santé Communautaire for preventive, restorative and denturist services 6 days per week;
- create capacity at PHS' mountain clinic to expand beyond preventive service and include restorative and mobile services;
- a replacement dental health bus to replace aging infrastructure and continue to provide service as per Stage 1;
- create capacity at Hamilton Urban Core CHC for restorative, preventive and denturist services in the new location at Cannon and Wellington; and,
- increased capacity at PHS' downtown dental clinic to provide restorative, preventive and denturist services.

To support awareness of the OSDCP a comprehensive communication plan is being developed with key stakeholders. The plan will include:

- supporting seniors and their families to improve their oral health knowledge and awareness of oral health services;
- targeting outreach to priority populations;
- assisting seniors and their families to enrol, including assistance to complete all required documentation and/or consents;
- assisting eligible seniors in finding and accessing a dental provider; and,
- increasing awareness of available oral health services among community partners.

The result of our review and program development includes the reallocation of 6.5 FTE of existing program staff to the new seniors program. A proportion of these FTE are funded by the Municipality and a proportion through Healthy Smiles Ontario (HSO). HSO is a 100% provincially funded program for eligible children 17 years of age and younger. Families may access HSO dental services through PHS or private dental clinics at their choice. PHS has improved HSO uptake through piloting and implementing the use of portable dental equipment at targeted schools. Despite ongoing attempts to increase HSO service at PHS dental clinic, HSO uptake remains steady but below previously projected numbers.

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(a): Seniors Oral Health Infographic 2018-2019

Appendix "B" to Report BOH19026(a): Seniors Oral Health Map – High Density Clusters of Low-Income Seniors in Hamilton

CITY OF HAMILTON
PUBLIC HEALTH SERVICES
Healthy Families Division

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	October 18, 2019
SUBJECT/REPORT NO:	Seniors Oral Health (BOH19026(a)) (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 Families Division Public Health Services

RECOMMENDATION(S)

(a) That the Board of Health authorize and direct the Medical Officer of Health to receive, utilize and submit reports for the approved capital from the Ministry of Health to support the service delivery plan for low-income seniors.

(b) That the Board of Health authorize and direct the Medical Officer of Health to increase complement in the Public Health Services by 5.8 full time equivalents as outlined in BOH19026(a).

EXECUTIVE SUMMARY

Oral health impacts overall health across the lifespan. Population health data shows that poor oral health is common in Hamilton and has greater negative effects on the city's most vulnerable populations, including seniors. Many seniors in Hamilton cannot afford dental care and either pay out of pocket or forgo regular dental care. As a result, many seniors increasingly seek dental care in hospital emergency departments. Seniors living in low-income areas are two times more likely to visit hospitals than those living in high income areas.

In April 2019, the provincial government announced a new Ontario Seniors Dental Care Program (OSDCP) for low-income seniors. The goal is to help reduce unnecessary trips

to the hospital, prevent chronic disease and increase quality of life for seniors. Public Health Services (PHS) alongside key stakeholders, has been actively involved in the planning and local development of the OSDCP following the Ministry of Health's (the Ministry) prescribed criteria and multi-staged process. Over the summer a capital funds application was developed and submitted to the Ministry by the August 14 deadline.

Areas with low-income seniors are distributed across the city with higher numbers in the lower west city, lower east city and central mountain. Proposed service locations are within a five kilometre radius of the largest low-income population clusters in Hamilton.

The purpose of this report is to provide more details regarding the proposed service delivery plan for the OSDCP in Hamilton, which is summarized in Chart 1 and Chart 2.

Chart 1: Stage 1– Leveraging Existing Resources

Stage 1 Implementation	
Location	**Type of Service**
PHS downtown dental clinic	Increase restorative, preventive and denturist services
PHS dental bus	Increase restorative, preventive and emergency services
PHS dental bus services to long-term care homes	Provide additional hours for new services to low-income seniors residing in long-term care homes. To be piloted at Macassa and Wentworth Lodges in the Fall of 2019 with expansion to other sites in 2020
PHS east end clinic	Increase preventive services
PHS mountain clinic	Increase preventive services
Urban Core Community Health Centre	Increase preventive services
All sites	Increase awareness of program and support seniors to apply for coverage

Chart 2: Stage 2 – Capital Investments

Stage 2 Implementation (ranked order)	
Location	**Type of Service**
Centre de Santé Communautaire	Provide new restorative, preventive and denturist services 6 days per week
PHS mountain clinic	Expand from prevention only to include restorative and mobile services
Replacement of PHS dental bus	Maintain restorative, preventive and emergency services

Urban Core Community Health Centre	Expand from prevention only to include restorative and denturist services at new site at Cannon and Wellington
PHS downtown dental clinic	Expand capacity at PHS' downtown dental clinic to provide restorative, preventive and denturist services.

The service delivery plan will allow for over 4300 low-income seniors in Hamilton to access dental services. This includes the 1000 eligible clients in long term care homes and the expected 500 eligible seniors that can access denturist services. For the bus and clinic appointments, 77% of the appointments available will be for restorative services while 23% will be for preventive services.

The proposed service delivery plan will require a 5.8 full time equivalent (FTE) increase to PHS' Dental Program complement. In addition, 6.5 FTE of existing program staff will be moved from the Municipal dental programs and Healthy Smiles Ontario (HSO) to the OSDCP to reflect the new plan and trends in service uptake.

The Ministry has indicated further communication is forthcoming regarding the date seniors can begin to apply to the program, the final service schedule, as well as, a decision regarding the possible introduction of patient co-payments for dentures.

Staff will report on 2019/20 budget implications through in-year budget reporting and the 2020 budget process.

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: $2,248,100.00 in additional base funding from the Ministry for the OSDCP. A breakdown of funding by service site is outlined in Chart 3.

Staffing: PHS dental staffing levels will increase by 5.8 FTE, consisting of 1.2 FTE clinical dentists, 1.0 FTE supervisor, 0.6 FTE receptionist, 0.1 FTE bus driver,1.0 FTE denturist, 0.1 FTE registered dental hygienist, 1.0 FTE program secretary and 0.8 FTE dental assistant.

Existing 6.5 FTE program staff will be reallocated to the OSDCP based on current and projected numbers of clients serviced.

Chart 3: Proposed Budget for Ontario Seniors' Dental Care Program in Hamilton

Service Delivery Site	Annual Budget
Public Health Services	$1,402,683
Centre de Santé Communautaire	$255,456
Urban Core	$109,783

Contracted Dental Lab*	$200,000
Contracted Oral Surgeon*	$280,178
TOTAL	$2,248,100

*these services will be accessed by all sites

Legal: The OSDCP is part of the Ontario Public Health Standards (OPHS) under the *Health Protection and Promotion Act* and governed by the Public Health Funding and Accountability Agreement between the City and the Ministry. All partnerships between the BOH and Community Health Centres (CHCs) will be governed by a Service Level Agreement (SLA), which will outline performance expectations, funding, reporting requirements and accountability mechanisms. Denture lab work and oral surgeon services will be contracted in alignment with procurement rules.

HISTORICAL BACKGROUND

The City of Hamilton currently provides dental services to low-income seniors at the Public Health dental clinic and the dental health bus for those who cannot afford dental care in the community. Prior to the announcement of the OSDCP, these programs have been 100% funded by the Municipality.

In addition, City of Hamilton residents who require dental care can apply for funding through Ontario Works Special Supports program. In 2018, staff collaborated with Hamilton Community Foundation (HCF) to develop and implement Oral Health Enhancements including supplemental denture coverage for eligible low-income seniors who access the Special Supports program.

In April 2019, the Provincial government announced the Ontario Seniors Dental Care Program for low-income seniors.

Since May, the Ministry has held several webinars to outline Public Health Unit (PHU) requirements as well as operational roles and responsibilities.

In June, the BOH received a letter from the Ministry announcing Hamilton's annual base funding increase of $2,248,100.00 to support the new dental program. This is a 100% provincially funded program (i.e., not cost shared with municipalities).

Since June, PHS has been working collaboratively with key stakeholders to develop a service delivery plan which best services Hamilton's low-income seniors and follows the Ministry prescribed criteria and multi-staged process.

In July, the BOH approved the Senior's Oral Health report (BOH19026), delegating authority to the Medical Officer of Health to receive and utilize provincial funding and develop a local Seniors Dental Care Program.

In August, PHS submitted a capital funds application that supports implementation of the locally developed Seniors Dental Care service delivery plan. As of the writing of this report, the Ministry has not communicated the status of the application.

Staff will provide updates on any further implications for all the above programs once further details from the Ministry are received.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

Amendments to the OPHS and related protocols were released August 1, 2019 that outline PHU requirements and operational roles and responsibilities. The Ministry has indicated further communication is forthcoming regarding the date seniors can begin to apply to the program, the final service schedule and a decision regarding potential introduction of patient co-payment for dentures.

RELEVANT CONSULTATION

- PHS consulted and achieved consensus in the development of a service delivery plan with Centre de Santé Communautaire, Compass Community Health Centre, Hamilton Urban Core Community Health Centre and De dwa da dehs nye>s Aboriginal Health Center.
- PHS has consulted with Ontario Works Special Supports program and the HCF to discuss potential impacts on programming.
- The draft plan was presented to the Seniors Advisory Committee who provided valuable input about increasing awareness of and registration for the program as well as the date seniors can begin to apply to the program and outreach to vulnerable populations.
- PHS continues to consult and develop a plan with Macassa and Wentworth Lodges to address the needs of seniors in long-term care.
- Continued and expanded engagement with the broader long-term care sector and organizations providing services to seniors is planned.
- PHS is working with Legal and Procurement services to develop SLAs and Partnership contracts.
- The report was reviewed by Finance and Administration, who provided review of financial figures.

ANALYSIS AND RATIONALE FOR RECOMMENDATION(S)

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

The goal of the OSDCP is to reduce unnecessary trips to the hospital, prevent chronic disease and increase quality of life for seniors. The Ministry estimates a 40% uptake in Provincial programs and has allocated funding based on an estimated 3,986 eligible seniors applying to the OSDCP in Hamilton. The OSDCP eligibility requirements include:

- 65 years and older;
- resident of Ontario;
- annual income below thresholds (single seniors less than $19,300 and for a couple less than $32,300); and,
- no access to any other forms of dental benefits (e.g. Ontario Disability Support Program or the Federal Non-Insured Health Benefits).

Public Health Units were asked to rank projects within their catchment area based on:

- local need;
- value for money (efficient and economical approach to dental infrastructure); and,
- equity (geographically underserviced areas and vulnerable sub-populations).

Further, the Ministry provided criteria for sequential ordering of projects within the capital proposal. They are:

- build on existing infrastructure;
- expand into unoccupied space; and,
- expand into occupied space, or lease expansion/new lease

Centre de Santé Communautaire, Compass CHC, Hamilton Urban Core CHC and De dwa da dehs nye>s Aboriginal Health Center have been actively involved in the planning and local development of Hamilton's Seniors Dental Care Program based on population health data and current literature in alignment with the Ministry's prescribed criteria and multi-staged process.

In Hamilton, there are approximately 10,230 seniors who could be eligible for the new program by age, income and residence (Appendix "A" to Report BOH12026(a) - Senior's Oral Health Infographic 2018-2019). Of the 10,230, those with dental insurance will be ineligible. It is estimated:

- 23% of low-income seniors have access to other benefits;
- 1,000 eligible seniors reside in long term care homes; and,
- 47% of seniors in Hamilton wear dentures with denture replacement being required every 5-10 years.

Emergency room data shows a higher need for appointment times in the mornings; on Wednesdays, Thursdays, Fridays and the weekend. Low-income seniors are distributed across the city, however, there are 3 main clusters in the lower east city, lower west city and central mountain (Appendix "B" to Report BOH19026(a) - Seniors Oral Health Map - High Density Clusters of Low-Income Seniors in Hamilton).

Local research indicates that geographic proximity to dental services is a significant predictor of receiving dental services but only explains about 20% of why seniors do not access dental services. Cost, fear and 'not thinking it is necessary' are also significant barriers to accessing dental care. The greatest oral health inequities are associated with the following social determinants:

- low-income;
- no partner (single, separated, divorced, or widowed); and,
- housing need (affordability, unsuitable, or inadequate).

A 2009 Statistics Canada report states three quarters of all seniors had a drivers licence and only a minority of seniors used other transportation. Fewer low-income seniors are likely to have driver's licences. One kilometre is typically referred to as "walking distance" while five kilometres is referred to as a reasonable distance to travel to access services.

Application of the Ministry's criteria, a review of the population health data and literature resulted in local prioritization by key stakeholders which is summarized in Chart 4.

Chart 4: Local Prioritization

Ministry Criteria	**Local planning decisions**
Local Need	• restorative services prioritized over preventive services; • organizations with greater capacity for service volume or ability to operate for a greater number of hours prioritized.
Value for Money	• stage 1 solutions (leverage existing infrastructure) prioritized over Stage 2 solutions (capital investments); • denture lab work and oral surgeon services will be contracted.
Equity	• increasing services in east end prioritized, followed by increasing services on the mountain, followed by new service downtown; • increasing access to services by eligible seniors in LTC prioritized; • providing services by organizations that have access to marginalized populations prioritized.

Hamilton's comprehensive service delivery plan will allow for over 4300 low-income seniors to access dental services. This includes the 1000 eligible clients in long term care homes and the expected 500 eligible seniors that can access denturist services. For the bus and clinic appointments, 77% of the appointments will be for restorative services while 23% will be for preventive services. Proposed service locations are within a five kilometre radius of the largest low-income population clusters in Hamilton.

The first stage includes leveraging existing infrastructure to maximize capacity. The plan includes:

- increased capacity at PHS' downtown dental clinic for restorative, preventive and denturist services;
- increased capacity at PHS' east end and mountain clinics for preventive services;
- increased capacity at PHS' dental health bus. Increased hours will be used to support eligible low-income seniors including those residing in long-term care homes. The model of care will be piloted at Macassa and Wentworth Lodges in the Fall of 2019 with expansion to other LTC homes planned for 2020; and,
- improved and enhanced capacity at Hamilton Urban Core CHC (existing site) for preventive services.

The second stage includes capital investment projects which are listed in ranked order:

- create capacity at Centre de Santé Communautaire for preventive, restorative and denturist services 6 days per week;
- create capacity at PHS' mountain clinic to expand beyond preventive service and include restorative and mobile services;
- a replacement dental health bus to replace aging infrastructure and continue to provide service as per Stage 1;
- create capacity at Hamilton Urban Core CHC for restorative, preventive and denturist services in the new location at Cannon and Wellington; and,
- increased capacity at PHS' downtown dental clinic to provide restorative, preventive and denturist services.

To support awareness of the OSDCP a comprehensive communication plan is being developed with key stakeholders. The plan will include:

- supporting seniors and their families to improve their oral health knowledge and awareness of oral health services;
- targeting outreach to priority populations;
- assisting seniors and their families to enrol, including assistance to complete all required documentation and/or consents;
- assisting eligible seniors in finding and accessing a dental provider; and,
- increasing awareness of available oral health services among community partners.

The result of our review and program development includes the reallocation of 6.5 FTE of existing program staff to the new seniors program. A proportion of these FTE are funded by the Municipality and a proportion through Healthy Smiles Ontario (HSO). HSO is a 100% provincially funded program for eligible children 17 years of age and younger. Families may access HSO dental services through PHS or private dental clinics at their choice. PHS has improved HSO uptake through piloting and implementing the use of portable dental equipment at targeted schools. Despite ongoing attempts to increase HSO service at PHS dental clinic, HSO uptake remains steady but below previously projected numbers.

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(a): Seniors Oral Health Infographic 2018-2019

Appendix "B" to Report BOH19026(a): Seniors Oral Health Map – High Density Clusters of Low-Income Seniors in Hamilton

12.1

CITY OF HAMILTON
N O T I C E O F M O T I O N

Board of Health: October 18, 2019

MOVED BY COUNCILLOR M. WILSON ……..…..……

Code Red Presentation to the Board of Health

WHEREAS, the neighbourhoods in the City of Hamilton were profiled for their socio-economic and health status and consumption of health services in the Hamilton Spectator's Code Red Project in 2010;

WHEREAS, the Code Red Project has been updated to see what has changed in Hamilton over the past decade;

WHEREAS, the purpose of the Code Red Project was to stimulate a community debate about the variation in health status between neighbourhoods in the City of Hamilton;

WHEREAS, Steve Buist (Investigations Editor, Hamilton Spectator) and Neil Johnston (Epidemiologist, Department of Medicine, McMaster University) designed and executed the Code Red Project; and

WHEREAS, the Code Red Project won a National Newspaper Award for special projects and was shortlisted for the Michener Prize and Steve Buist and Neil Johnston won the 2011 Hillman Prize for Journalism fostering social and economic justice for the Code Red Project;

THEREFORE BE IT RESOLVED:

That the Board of Health approve a presentation by Steve Buist and Dr Neil Johnston to discuss the findings of their Red Code Series to the Board of Health at the November 18, 2019 meeting.