# City of Hamilton

# BOARD OF HEALTH REVISED

**Meeting #:** 20-001
**Date:** January 13, 2020
**Time:** 9:30 a.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 December 2, 2019

## 5. COMMUNICATIONS

5.1 Correspondence from the Haliburton, Kawartha, Pine Ridge District Health Unit respecting More Stringent Vaping Regulations to Address the Rise in Vapour Products Use in Youth and Other Vulnerable Populations

Recommendation: Be endorsed.

5.2 Correspondence from the Middlesex-London Health Unit respecting Strengthened Measures to Limit Youth Access, Appeal and Advertising of Vaping Products

Recommendation: Be endorsed.

5.3 Correspondence from the Medical Officer of Health and the Board of Health, Peterborough Public Health, respecting Vaping and Youth

Recommendation: Be endorsed.

5.4 Correspondence from the Medical Officer of Health and Board of Health, Leeds, Grenville and Lanark District Health Unit, respecting Vapour Product Use Among Youth

Recommendation: Be endorsed.

5.5 Correspondence from the Medical Officer of Health and Secretary to the Board of Health, Public Health Sudbury & Districts, respecting E-Cigarettes and Aerosolized Products Prevention and Cessation

Recommendation: Be endorsed.

5.6 Correspondence from the Association of Local Public Health Agencies, respecting the Proceedings of the 2019 Fall Symposium.

Recommendation: Be received.

5.7 Correspondence from the Chief Medical Officer of Health respecting a Provincial Immunization Registry

Recommendation: Be received.

*5.8 Correspondence from the Honourable Christine Elliott, Deputy Premier and Minister of Health, and Dr. David Williams, Chief Medical Officer of Health respecting Capital One-Time Funding for Seniors Dental Care

Recommendation: That the Medical Officer of Health be authorized and directed to receive, utilize, and report on the one-time funding from the Ministry of Health to support the delivery of services related to the Seniors Dental Care Program.

## 6. DELEGATION REQUESTS

## 7. CONSENT ITEMS

7.1 Food Advisory Committee Minutes - October 8, 2019

## 8. PUBLIC HEARINGS / DELEGATIONS

## 9. STAFF PRESENTATIONS

## 10. DISCUSSION ITEMS

10.1 2020 Public Health Services Risk Management Plan (BOH20003) (City Wide)

10.2 Food Advisory Committee 2020 Budget Request (BOH20001) (City Wide)

10.3 Public Health Modernization (BOH 200004)

10.4 Appendix A, B and C to City of Hamilton Licensing (No. 07-170) By-law Schedule 20 Residential Care Facilities Inspections (BOH20005) (City Wide)

Discussion of Item 14.1, City of Hamilton Licensing (No. 07-170) By-law Schedule 20 Residential Care Facilities Inspections (BOH20005) (City Wide), in Closed Session is pursuant to Section 8.1, Sub-section (b) of the City's Procedural By-law 18-270, and Section 239(2), Sub-section(b) of the Ontario Municipal Act, 2001, as amended, as the subject matter pertains to personal matters about an identifiable individual, including municipal or local board employees.

## 11. MOTIONS

## 12. NOTICES OF MOTION

*12.1 Public Health Services' Procurement and Purchase of a Dental Services Bus

## 13. GENERAL INFORMATION / OTHER BUSINESS

## 14. PRIVATE AND CONFIDENTIAL

14.1 City of Hamilton Licensing (No. 07-170) By-law Schedule 20 Residential Care Facilities Inspections (BOH20005) (City Wide)

Pursuant to Section 8.1, Sub-section (b) of the City's Procedural By-law 18-270, and Section 239(2), Sub-section(b) of the Ontario Municipal Act, 2001, as amended, as the subject matter pertains to personal matters about an identifiable individual, including municipal or local board employees.

See Item 10.1 for Appendix A, B and C of the City of Hamilton Licensing (No. 07-170) By-law Schedule 20 Residential Care Facilities Inspections (BOH20005) (City Wide).

## 15. ADJOURNMENT

# BOARD OF HEALTH
# MINUTES 19-012

**1:30 p.m.**
**Monday, December 2, 2019**
**Council Chambers**
**Hamilton City Hall**

**Present:** Mayor F. Eisenberger (Chair),
Councillors M. Wilson (Vice-Chair), J. Farr, N. Nann, S. Merulla, C. Collins, T. Jackson, E. Pauls, J.P. Danko, M. Pearson, B. Johnson L. Ferguson, A. VanderBeek and T. Whitehead

**Absent with Regrets:** Councillor B. Clark – Personal; Councillors L. Ferguson and J. Partridge - City Business

**THE FOLLOWING ITEMS WERE REFERRED TO COUNCIL FOR CONSIDERATION:**

**1. Municipal Actions to Reduce Harms Associated with Alcohol Use (BOH19032) (City Wide) (Item 9.1)**

**(Whitehead/Wilson)**

(a) That the Board of Health approve the initiation of a review of the Municipal Alcohol Policy, including the formation of a Workgroup made up of relevant municipal departments;

(b) That Public Health Services report back to the Board of Health with recommended updates to the Municipal Alcohol Policy by Q3 2020; and,

(c) That item 2019-N, "Correspondence from Hastings Prince Edward Public Health respecting Concerns with Announced Expansion of the Sale of Alcohol Beverages in Ontario" be removed from the Outstanding Business List.

**Result: Motion CARRIED by a vote of 13 to 0, as follows:**

YES - Vice-Chair - Ward 1 Councillor Maureen Wilson
YES - Ward 2 Councillor Jason Farr
YES - Ward 3 Councillor Nrinder Nann
YES - Ward 4 Councillor Sam Merulla
YES - Ward 5 Councillor Chad Collins

YES - Ward 6 Councillor Tom Jackson
YES - Ward 7 Councillor Esther Pauls
YES - Ward 8 Councillor John-Paul Danko
YES - Chair Fred Eisenberger
NOT PRESENT - Ward 15 Councillor Judi Partridge
YES - Ward 14 Councillor Terry Whitehead
YES - Ward 13 Councillor Arlene VanderBeek
NOT PRESENT - Ward 12 Councillor Lloyd Ferguson
YES - Ward 11 Councillor Brenda Johnson
YES - Ward 10 Councillor Maria Pearson
NOT PRESENT - Ward 9 Councillor Brad Clark

**2. Clean Air Hamilton 2018 Progress Report (BOH19039) (City Wide) (Item 9.2)**

**(VanderBeek/Whitehead)**
That Report BOH19039 respecting the Clean Air Hamilton 2018 Progress Report, be received.

**CARRIED**

**3. Alcohol, Drug & Gambling Services and Mental Health and Street Outreach Program Budgets (BOH19025) (City Wide) (Item 10.1)**

**(Whitehead/Jackson)**

(a) That the 2019-2020 Alcohol, Drug and Gambling Services, Choices and Changes program budget, funded by the Ministry of Children, Community and Social Services be approved, including the reduction of a 0.05 social worker position FTE, and, that the Medical Officer of Health or delegate be authorized and directed to receive, utilize, report and execute all Service agreements and contracts, in a form satisfactory to the City Solicitor, required to give effect to the 2019-2020 Alcohol, Drug and Gambling Services Choices and Changes program budget;

(b) That the 2019-2020 Alcohol, Drug and Gambling Services, Other Funding Grants program budget be approved, including the increase of a 0.2 social worker position FTE, and, that the Medical Officer of Health or delegate be authorized and directed to receive, utilize, report and execute all service agreements and contracts, in a form satisfactory to the City Solicitor, required to give effect to the 2019-2020 Alcohol, Drug and Gambling Services Other Funding Grants programs budget; and,

(c) That the 2019-2020 Mental Health and Street Outreach Program, Mental Health Good Shepherd program budget be approved, including the increase of a 0.1 social worker position FTE, and, that the Medical Officer of Health or delegate be authorized and directed to receive, utilize, report and execute all Service agreements and contracts, in a form satisfactory to the City Solicitor, required to give effect to the 2019-2020 Mental Health and Street Outreach Program Mental Health Good Shepherd program budget.

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

YES - Vice-Chair - Ward 1 Councillor Maureen Wilson
YES - Ward 2 Councillor Jason Farr
YES - Ward 3 Councillor Nrinder Nann
NOT PRESENT - Ward 4 Councillor Sam Merulla
NOT PRESENT - Ward 5 Councillor Chad Collins
YES - Ward 6 Councillor Tom Jackson
YES - Ward 7 Councillor Esther Pauls
YES - Ward 8 Councillor John-Paul Danko
YES - Chair Fred Eisenberger
NOT PRESENT - Ward 15 Councillor Judi Partridge
YES - Ward 14 Councillor Terry Whitehead
YES - Ward 13 Councillor Arlene VanderBeek
NOT PRESENT - Ward 12 Councillor Lloyd Ferguson
YES - Ward 11 Councillor Brenda Johnson
YES - Ward 10 Councillor Maria Pearson
NOT PRESENT - Ward 9 Councillor Brad Clark

**FOR INFORMATION:**

**(a) CEREMONIAL ACTIVITIES (Item 1)**

There were no ceremonial activities.

**(b) CHANGES TO THE AGENDA (Item 2)**

The Committee Clerk advised the Board that there were no changes to the agenda.

**(Collins/Pauls)**
That the agenda for the November 18, 2019 Board of Health be approved, as presented.

**Result: Motion CARRIED by a vote of 10 to 0, as follows:**

NOT PRESENT - Vice-Chair - Ward 1 Councillor Maureen Wilson
YES - Ward 2 Councillor Jason Farr
YES - Ward 3 Councillor Nrinder Nann
YES - Ward 4 Councillor Sam Merulla
YES - Ward 5 Councillor Chad Collins
NOT PRESENT - Ward 6 Councillor Tom Jackson
YES - Ward 7 Councillor Esther Pauls
YES - Ward 8 Councillor John-Paul Danko
YES - Chair Fred Eisenberger
NOT PRESENT - Ward 15 Councillor Judi Partridge
YES - Ward 14 Councillor Terry Whitehead
NOT PRESENT - Ward 13 Councillor Arlene VanderBeek

NOT PRESENT - Ward 12 Councillor Lloyd Ferguson
YES - Ward 11 Councillor Brenda Johnson
YES - Ward 10 Councillor Maria Pearson
NOT PRESENT - Ward 9 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) November 18, 2019 (Item 4.1)

**(Whitehead/Johnson)**
That the Minutes of the November 18, 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 - Ward 1 Councillor Maureen Wilson
YES - Ward 2 Councillor Jason Farr
YES - Ward 3 Councillor Nrinder Nann
YES - Ward 4 Councillor Sam Merulla
YES - Ward 5 Councillor Chad Collins
NOT PRESENT - Ward 6 Councillor Tom Jackson
YES - Ward 7 Councillor Esther Pauls
YES - Ward 8 Councillor John-Paul Danko
YES - Chair Fred Eisenberger
NOT PRESENT - Ward 15 Councillor Judi Partridge
YES - Ward 14 Councillor Terry Whitehead
NOT PRESENT - Ward 13 Councillor Arlene VanderBeek
NOT PRESENT - Ward 12 Councillor Lloyd Ferguson
YES - Ward 11 Councillor Brenda Johnson
YES - Ward 10 Councillor Maria Pearson
NOT PRESENT - Ward 9 Councillor Brad Clark

## (e) COMMUNICATIONS (Item 5)

### (i) Correspondence from Kingston, Frontenac and Lennox & Addington Public Health respecting Municipal Policies and Municipal Policy Options to Mitigate Alcohol Harms (Item 5.1)

**(Pearson/Johnson)**
That the Correspondence from Kingston, Frontenac and Lennox & Addington Public Health respecting Municipal Policies and Municipal Policy Options to Mitigate Alcohol Harm, be received.

**CARRIED**

**(ii) Correspondence from the Association of Local Public Health Agencies respecting a Statement of Principles for Public Health Modernization, November 2019 (Item 5.2)**

**(Pearson/Johnson)**
That the Correspondence from the Association of Local Public Health Agencies respecting a Statement of Principles for Public Health Modernization, November 2019, be received and referred to staff to consider in upcoming consultation responses to the province.

**CARRIED**

**(f) STAFF PRESENTATION (Item 9)**

**(i) Municipal Actions to Reduce Harms Associated with Alcohol Use (BOH19032) (City Wide) (Item 9.1)**

Jordan Walker, addressed the Board with a presentation respecting Municipal Actions to Reduce Harms Associated with Alcohol Use (BOH19032), with the aid of a PowerPoint presentation.

**(Whitehead/VanderBeek)**
That the presentation respecting Municipal Actions to Reduce Harms Associated with Alcohol Use (BOH19032), be received.

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

For further disposition, refer to Item 1.

**(ii) Clean Air Hamilton 2018 Progress Report (BOH19039) (City Wide) (Item 9.2)**

Dr. Newbold, Chair of Clean Air Hamilton, addressed the Board with a presentation respecting Clean Air Hamilton 2018 Progress Report (BOH19039) with the aid of a PowerPoint presentation.

**(Whitehead/Wilson)**
That the presentation respecting the Clean Air Hamilton 2018 Progress Report (BOH19039), be received.

**CARRIED**

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

For further disposition of this matter, refer to Item 2.

## (g) DISCUSSION ITEMS (Item 10)

### (i) Ontario Ministry of Health Discussion Paper: Public Health Modernization (Item 10.2)

**(Whitehead/Jackson)**
That the Ontario Ministry of Health Discussion Paper: Public Health Modernization, be received and referred back to staff to draft a response to the Ontario Ministry of Health, for approval by the Board of Health at the January 13, 2020 meeting.

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

YES - Vice-Chair - Ward 1 Councillor Maureen Wilson
YES - Ward 2 Councillor Jason Farr
YES - Ward 3 Councillor Nrinder Nann
NOT PRESENT - Ward 4 Councillor Sam Merulla
NOT PRESENT - Ward 5 Councillor Chad Collins
YES - Ward 6 Councillor Tom Jackson
YES - Ward 7 Councillor Esther Pauls
YES - Ward 8 Councillor John-Paul Danko
YES - Chair Fred Eisenberger
NOT PRESENT - Ward 15 Councillor Judi Partridge
YES - Ward 14 Councillor Terry Whitehead
YES - Ward 13 Councillor Arlene VanderBeek
NOT PRESENT - Ward 12 Councillor Lloyd Ferguson
YES - Ward 11 Councillor Brenda Johnson
YES - Ward 10 Councillor Maria Pearson
NOT PRESENT - Ward 9 Councillor Brad Clark

## (h) GENERAL INFORMATION AND OTHER BUSINESS (Item 13)

### (i) Amendments to the Outstanding Business List:

**(Danko/Pauls)**
That the following amendments to the Board of Health Outstanding Business List, be approved:

#### (a) Revised Due Dates:

2015-A
Review of the City of Hamilton's Pest Control By-law November 16, 2015 (Item 9.1)
Due Date: December 2019
Revised Due Date: January 2020

2019-H
Hamilton Millennial Survey Study – Employment Precarity April 15, 2019, 19-004 (Item 8.1)
Due Date: December 2019
Revised Due Date: June 2020

**(b) Items to be Removed:**

2019-N
Correspondence from Hastings Prince Edward Public Health respecting Concerns with Announces Expansion of the Sale of Alcohol Beverages in Ontario
July 10, 2019, 19-007 (Item 5.1)
Addressed in Item 9.1 on today's agenda

2019-P
Pollution Surrounding the Parkview Community – Community Event
August 14, 2019, 19-008 (Items 6.1-6.13)
Event held November 21, 2019

2019-R
Semi-Annual Public Health Services Performance and Monitoring Report (Q1 & Q2 2019) (BOH19030) (City Wide)
October 18, 2019, 19-010 (Item 7.2)
Correspondence sent to Minister of Health

2019-S
Immunization of School Pupils Act Overview (BOH19029) (City Wide)
October 18, 2019, 19-010 (Item 9.1)
Correspondence sent to Minister of Health

2019-T
Seniors Oral Health (BOH19026(a)) (City Wide)
October 18, 2019, 19-010 (Item 9.2)
Correspondence sent to Minister of Health

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

YES - Vice-Chair - Ward 1 Councillor Maureen Wilson
YES - Ward 2 Councillor Jason Farr
YES - Ward 3 Councillor Nrinder Nann
NOT PRESENT - Ward 4 Councillor Sam Merulla
NOT PRESENT - Ward 5 Councillor Chad Collins
YES - Ward 6 Councillor Tom Jackson
YES - Ward 7 Councillor Esther Pauls
YES - Ward 8 Councillor John-Paul Danko
YES - Chair Fred Eisenberger
NOT PRESENT - Ward 15 Councillor Judi Partridge

YES - Ward 14 Councillor Terry Whitehead
YES - Ward 13 Councillor Arlene VanderBeek
NOT PRESENT - Ward 12 Councillor Lloyd Ferguson
YES - Ward 11 Councillor Brenda Johnson
YES - Ward 10 Councillor Maria Pearson
NOT PRESENT - Ward 9 Councillor Brad Clark

**(i) ADJOURNMENT (Item 15)**

**(VanderBeek/Pearson)**
That, there being no further business, the Board of Health be adjourned at 3:17 p.m.

**CARRIED**

Respectfully submitted,

Mayor Fred Eisenberger
Chair, Board of Health

Loren Kolar
Legislative Coordinator
Office of the City Clerk

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

www.hkpr.on.ca • info@hkpr.on.ca
1-866-888-4577

November 21, 2019

Honourable Patty Hajdu
Minister of Health, Canada
House of Commons
Ottawa, ON K1A 0A6
Sent via email: patty.hajdu@parl.gc.ca

Honourable Christine Elliott, Deputy Premier
Minister of Health, Ontario
Hepburn Block 10th Floor 80 Grosvenor Street Toronto,
ON M7A 1E9
Sent via email: christine.elliott@pc.ola.org

Dear Minister Hajdu/Minister Elliott:

The Haliburton, Kawartha, Pine Ridge District Health Unit would like to commend the Ontario Government on the decision to prohibit the promotion of vapour products in convenience stores and gas stations as of January 1, 2020. However, we believe that further steps are necessary to protect our youth and prevent the continued rise in vapour product use in youth and other vulnerable populations.

Vaping has been rapidly increasing in our youth, with a 74% increase in vaping among Canadian youth aged 16-19 reported from 2017 to 2018[1]. While vaping products have been regarded as safer than combustible tobacco cigarettes, recent reports of severe pulmonary illness associated with vaping in the United States and Canada have given rise to concerns about the use of vaping products, especially among youth. Most vaping products contain nicotine at varying levels. This is concerning as children and youth may become dependent on nicotine more rapidly than adults leading to addiction and physical dependence[2]. Research has demonstrated that youth are especially susceptible to the negative effects of nicotine, as it can alter their brain development and can affect memory and concentration.[2,3] There are thousands of flavours of e-liquids available, including candy and fruit flavoured varieties that are greatly appealing to youth, and there is a strong body of evidence to support that flavours attract youth to e-cigarette use where research concludes that flavour influences youth to try and buy e-cigarettes and the appeal of ads promoting flavours is linked to uptake of vaping by youth[4].

[1] Hammond, D., Reid, J.L., Rynard, V.L., Fong, G.T., Gummings, K.M., McNeill, A., & O'Conner, R. (2019). Prevalence of vaping and smoking among adolescents in Canada, England, and the United States: repeat national cross-sectional surveys. BJM, 365, I2219.
[2] Health Canada. (2019-02-04). Vaping: Get the Facts. Retrieved November 2019 from: tobacco/vaping/risks.html?utm_source=google&utm_medium=cpc_en&utm_content=risks_2&utm_campaign=vapingprevention2019&utm_term=%2Bvape
[3] England, L.J., Bunnell, R.E., Pechacek, T.F., Tong, V.T. and McAfee, T.A., 2015. Nicotine and the developing human: a neglected element in the electronic cigarette debate. American journal of preventive medicine, 49(2), pp.286-293.
[4] Vasiljevic M, Petrescu DC, Marteau TM. Impact of advertisements promoting candy-like flavoured e-cigarettes on appeal of tobacco smoking among children: an experimental study, Tobacco Control, 2016:25(e2):e107-e112.

.../2

At its meeting held on November 21, 2019, the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit approved a motion to write to you to request more stringent vaping regulations, similar to those regulating tobacco products, to address the rise in vapour product use in youth and other vulnerable populations.

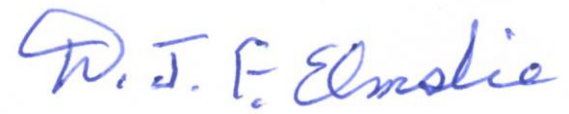
These recommended regulations include:

- Require a ban on flavoured e-cigarettes to help prevent the further uptake of vaping by youth.
- Restrict the nicotine concentration in all vaping products.
- Require health and toxicity warnings on all vapour products.
- Require mandatory testing and reporting for vapour products.
- Require standardized and tamper proof packaging on all vapour products.
- Require an age of 21 years for tobacco, vaping and cannabis sales.
- Develop a robust and sustainable monitoring and surveillance strategy to ensure compliance.
- Revise the Federal *Tobacco and Vaping Products Act* (TVPA) to ban display, promotion and advertising, mirroring the restrictions on tobacco in the TVPA.

Thank you for your attention to this very important matter for the protection of the health of our youth.

Sincerely

BOARD OF HEALTH FOR THE HALIBURTON, KAWARTHA,
PINE RIDGE DISTRICT HEALTH UNIT



Doug Elmslie, Chair, Board of Health

DE/lm

Cc (via email): The Hon. Doug Ford, Premier
Jamie Schmale, MP, Haliburton-Kawartha Lakes-Brock
Philip Lawrence, MP, Northumberland-Peterborough South
The Hon. Laurie Scott, MPP Haliburton-Kawartha Lakes-Brock
David Piccini, MPP Northumberland-Peterborough South
Dr. David Williams, Ontario Chief Medical Officer of Health
Dr. Paul Roumeliotis, Chair, Council of Medical Officers of Health
Ontario Boards of Health
Loretta Ryan, Association of Local Public Health Agencies

**From:** Elizabeth Milne
**To:** allhealthunits@lists.alphaweb.org
**Subject:** Strengthened Measures to Limit Youth Access, Appeal and Advertising of Vaping Products
**Date:** November 25, 2019 3:46:26 PM
**Attachments:** image001.jpg
MLHU-vaping-2019-10-17-report-059-19.pdf

**ATTENTION: ONTARIO BOARDS OF HEALTH**
****************************************

At its meeting on October 17, 2019 the Middlesex-London Board of Health voted to send a copy of the attached report, and its appendices, to local members of the federal and provincial parliaments, and to Ontario Boards of Health.

Kind regards,
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

REPORT NO. 059-19

TO: Chair and Members of the Board of Health

FROM: Christopher Mackie Medical Officer of Health / CEO

DATE: 2019 October 17

---

# COLLABORATIVE ACTION TO ADDRESS VAPING CONCERNS

## *Recommendations*

***It is recommended that the Board of Health:***

1. ***Receive Report No. 059-19 re: "Collaborative Action to Address Vaping Concerns";***
2. ***Endorse the HEAL Youth Advisory Council's (HEALYAC) position statement "Vaping in Schools and Student Health," attached as Appendix A, expressing its support of youth advocacy on vaping;***
3. ***Submit a letter, attached as Appendix B, along with the HEALYAC's position statement, to the Tobacco Control Directorate of Health Canada and the federal Minister of Health, expressing its support for strengthened measures to limit youth access, appeal, and advertising of vaping products;***
4. ***Submit a letter, attached as Appendix C, along with the HEALYAC's position statement, to the Ontario Minister of Health, expressing its support for strengthened measures to limit youth access, appeal, and advertising of vaping products; and,***
5. ***Send a copy of this report and its appendices to local members of the provincial and federal parliaments, and to the Association of Local Public Health Agencies for dissemination to all Ontario boards of health.***

### Key Points

- The number of cases of severe pulmonary illness associated with vaping continues to rise across the United States, and investigations are ongoing across the United States and Canada to understand the scope of this issue and the health consequences associated with vaping.
- The Middlesex-London Board of Health has a history of supporting the enactment of strong policy measures to help prevent the initiation of vaping product use and to promote a smoke-free and vapour-free culture.
- Western University's Human Environments Analysis Laboratory Youth Advisory Council (HEALYAC) identified vaping as one of the most important health issues facing youth in the London community, and created a position statement (attached as Appendix A) highlighting recommendations for action.
- Due to growing concerns related to the health consequences of vaping and the uptick in youth vaping across Canada, Health Unit staff prepared letters for Board of Health approval (Appendices B and C) to express its support for strengthened measures to limit youth access, appeal, and advertising of vaping products.

## Growing Concerns Related to Health Harms Associated with Vaping

The number of cases of severe pulmonary illness associated with vaping continues to rise across the United States. According to the Centres for Disease Control and Prevention (CDC), as of October 3 there were 18 confirmed deaths and more than 1,000 cases of illness under investigation, affecting almost every state. At the time of writing of this report, the source of these illnesses remains unclear; however, according to the CDC, chemical exposure is likely the cause, with no consistent product, substance, or additive being identified.

While investigations are ongoing in the United States, the Public Health Agency of Canada and the Council of Chief Medical Officers of Health have convened a federal, provincial, and territorial task group to develop a uniform approach to identifying and reporting cases of severe pulmonary illness related to vaping. With the growing number of cases under investigation across Canada and the United States, the reporting of confirmed and probable cases will provide information necessary to understand the scope of this issue and the health consequences associated with vaping. Health Unit staff will continue to monitor this situation.

## Vaping in Schools and Student Health

Public Health Nurses from the Child Health and Young Adult teams, the Health Unit's Enforcement Officers, and the Vaping Prevention Health Promoter have been working in collaboration with Southwestern Public Health staff to support school administrators in their efforts to address the increased use of vaping products by youth. This collaboration is creating a comprehensive vaping strategy that includes staff education, vaping curriculum supports, in-school vaping awareness and educational activities for students, cessation supports for students, parent outreach, and enforcement. Implementation of a public awareness campaign, using social media and targeted paid advertisements, is planned for later this fall in partnership with health units from the Southwest Tobacco Control Area Network.

In 2018, Western University's Human Environments Analysis Laboratory (HEAL) established a Youth Advisory Council (HEALYAC) with the goal of integrating youth voices and perspectives into research. The HEALYAC is comprised of fourteen high school students aged 13 to 18, representing diverse communities within the City of London, who work collectively toward the goal of improving the health of young people through authentic collaboration and participatory research with the HEAL. In 2019, the HEALYAC identified vaping as one of the most important health issues facing youth in the London community and suggested that youth input would strengthen future actions aimed at minimizing vaping among young people. In order to share their concerns with stakeholders and community members, the HEALYAC collectively wrote a position statement (attached as Appendix A) that provides an overview of the problem of vaping in schools and advances several key recommendations to address the issue. Leveraging its strong relationships with school and community partners, the Health Unit intends to work in partnership with the HEALYAC to support the development and implementation of a "by youth, for youth" vaping prevention campaign to be disseminated through media channels frequented by youth in Middlesex-London in 2020.

## Opportunity for Protective Policy Measures through Federal and Provincial Regulation

The Board of Health has a history of supporting the enactment of strong policy measures to prevent the initiation of vaping product use and to promote a smoke-free and vapour-free culture (see reports 016-18, 048-18, 068-18, 026-19, and 040-19). Due to growing concerns related to the health harms associated with vapour product use and the uptick of youth vaping across Ontario and Canada, Health Unit staff prepared two letters for Board of Health approval (attached as Appendices B and C) in support of strengthened measures to limit youth access, appeal, and advertising of vaping products. Vapour products that contain nicotine are addictive and alter brain development in youth, including areas of the brain that control memory, concentration, impulse control, and addiction pathways. With a 74% increase in youth vaping and a 45% increase in youth smoking in Canada from 2017 to 2018 (Report 055-19), and given the growing concerns about the health harms associated with vapour product use, the public health sector should be concerned about growing rates of nicotine addiction among young people following decades of decline in youth smoking rates.

This report was prepared by the Healthy Living Division.

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

HUMAN ENVIRONMENTS ANALYSIS LABORATORY

YOUTH ADVISORY COUNCIL

*The HEALYAC is a Youth Advisory Council (YAC) in London, Ontario, Canada that informs youth-related health research conducted by the Human Environments Analysis Laboratory (HEAL). The HEALYAC represents the diverse voices and perspectives of 14 teenagers from across the city.*

# POSITION STATEMENT: VAPING IN SCHOOLS AND STUDENT HEALTH

We, the HEALYAC, are concerned about the rising prevalence of vaping in our schools. Easy access to these products leaves all high school students, both those who vape and their peers, vulnerable to the uncertain consequences of vaping. The lack of evidence and awareness involving the health effects of vaping and the impacts of exposure to vaping, is a key health issue facing teenagers in Canada. We are calling for additional research, and immediate implementation of government regulation, improved detection and enforcement in schools, and cessation and coping support for youth

## THE PROBLEM

### Vaping Enforcement and Exposure

In recent years, vaping products have gained significant traction in Canada [1-2]. Vapes, or e-cigarettes, are becoming especially popular amongst teenagers, particularly in school settings [3-4]. As members of the HEALYAC, we are not only concerned about our daily involuntarily exposure to vaping, but also the distraction that e-cigarette use causes in educational environments. Despite potential consequences, many teens are using vaping products on school property at an alarming rate. This could be attributed to the fact that vaping is largely undetected and restrictions remain unenforced. The undetectable nature of vaping allows for high school students to vape not only on the property surrounding schools, but also in classrooms, gyms, and bathrooms [3,5]. This poses both a distraction and a barrier to learning. We feel that most vaping occurs in areas that are not monitored or have little to no security, including bathrooms. This frequent and involuntary exposure can lead to students feeling pressured by peers to experiment with vaping. Thus, we strongly encourage stricter enforcement in schools to mitigate this issue and reduce the prevalence of vaping in educational settings. Optimizing enforcement and restricting vaping within and around schools would improve adolescent health and foster safe spaces for learning.

### Access to Products

The Tobacco and Vaping Products Act regulates the marketing, sale, and use of vaping devices and their associated products in Canada. Legally, only those of majority age (typically 19+) in their province or territory may purchase vaping devices and products. However, teenagers have reported significantly elevated use of nicotine and other products via vaping devices [6-7]. In Canada, users report purchasing their devices from traditional retail outlets, which highlights that the lack of regulatory enforcement enables teenagers to easily access vaping products in their community [8]. In addition, online sales of vaping products in Canada do not require age verification upon purchase, and only include a loosely enforced guideline for age verification on delivery [7]. It is clear the lack of enforcement, and desire to balance regulatory demands, has made it easier for us, and other teenagers, to access vaping devices, and associated nicotine-based products.

### Vaping and Mental Health

In our schools, many students experience academic stress and anxiety, and we have noticed that some students are using vaping to cope with these feelings. We are deeply concerned about associated risks with vaping that can lead to nicotine addiction and physical dependence. Those who wish to quit may experience the hardships of withdrawal [9]. Exposure to nicotine can lead to reduced impulse control, and cognitive and behavioural problems [9]. Youth are especially susceptible to its negative effects, as it is known to alter their brain development and can affect memory and concentration [10]. Stress during adolescence is a risk factor for the initiation of nicotine consumption and studies have shown that vaping is a mediator in the decision to start smoking in previously nonsmoking adolescents [11, 12]. Stress during adolescence may further augment the rewarding properties of nicotine and alter behavioral responses to nicotine later in life. In addition, nicotine addiction can exacerbate symptoms of depression and anxiety [13]. Further, given the prevalence of vaping in our schools, we believe that it has not only become a classroom distraction, but has also a new avenue for peer pressure to consume controlled substances.

### Lack of Evidence and Awareness Related to Health Impacts of Vaping

There is a lack of scientific evidence available for young people to make informed decisions about vaping. The liquid solution used in vapes contains several ingredients that are potentially harmful and addictive, including nicotine, propylene, and glycol. Vaping devices can also be used to consume marijuana or cannabis products [3]. While the long-term consequences of inhaling vaping products are unclear, recent studies provide preliminary evidence related to the health effects of nicotine and tobacco use. For example, studies show that daily e-cigarette use is associated with an elevated risk of heart attack [14], and with regard to youth and adolescents specifically, nicotine use has been found to negatively affect brain development [10,15,16] and lead to tobacco smoking initiation [17]. Furthermore, the risk that vaping fumes may pose to bystanders is unknown. Our concerns are that teens are either unaware of the potential health effects of vaping or that the uncertainty of the evidence around vaping is leading to an assumption that there are no negative consequences.

Given the serious consequences that vaping can have on youth's health and wellbeing, we believe immediate action is necessary. As representatives of youth in our community, we propose the following recommendations to address this complex public health issue.

## RECOMMENDATIONS

### Conduct Longitudinal Research

Although research is limited on the health impacts of vaping, we believe there is enough evidence to justify efforts to prevent the use of vaping products by youth. The long-term safety of inhaling some of the chemicals found in vaping liquid is unknown and should continue to be assessed. Identifying the health impacts of these chemicals and the differences between adolescents and adults in response to vaping, particularly on measures associated with nicotine addiction and mental health, is critical to creating effective prevention and reduction programs and policies.

### Promote Mental Health and Coping Strategies

Vaping is not intended for youth and non-smokers, nor is it an appropriate tool for stress management. Early addiction to nicotine can exacerbate symptoms of depression and alter brain development. Since stress is often cited as a reason to engage in vaping, effective stress management programs that are age appropriate should be created. Conversations with youth should include facts of mental health issues and consequences of nicotine addiction that may arise from vaping. We should have improved access to support and healthier alternatives to vaping to cope with stress and anxiety. Teachers, school administrators, parents, and students should be provided with information on effective vaping prevention and cessation strategies, as well as mental health resources for teens.

### Control Access to Products

In no case should those younger than 19 years be able to access vaping devices and associated products. We recommend that local, provincial, and federal regulations be modified to introduce strict marketing rules, and new safeguards on the online purchase of vaping products.

**Local**: Local governments should dedicate resources to the monitoring and inspection of retail outlets selling vaping devices and their products. In addition, the sale of vaping devices and their products should be banned at establishments frequented by youth.

**Provincial**: The health curriculum should be modified to discourage vaping and inform students about the negative health effects of using vaping-associated products. The province should work with the federal government to establish a secure electronic identity system to verify the age of online purchasers of vaping products.

**Federal**: Government agencies should invest in research to understand the health effects and uptake of vaping among young people, and work with local and provincial governments to ensure enforcement of existing regulations on vaping.

### Develop Youth-Oriented Educational Campaigns

Given the overall uncertainty and lack of awareness surrounding vaping, we emphasize that, in addition to policy and government action to restrict vaping, greater efforts should be made to educate students and the wider public about the potential health-related consequences. We feel that the current messaging from the government about the consequences of vaping need to be more youth oriented. We recommend that health education campaigns about vaping be developed with content and messaging relevant to and targeted at youth, and subsequently disseminated through channels and platforms accessed by youth.

### Improve Enforcement and Reduce Exposure

We would like to see vaping prohibited on school property. We recommend that education infrastructure is a key area for intervention, specifically in relation to detection, training and awareness, and security.

**Detection**: Infrastructure additions, such as vape detection sensors, could reduce the prevalence of vaping in schools and deter teens from vaping on school property.

**Training**: Training for teachers and school staff to recognize and detect the presence of vaping on school property could prove to be an effective means for enforcing vaping regulations in schools.

**Security**: Additional security and monitoring in educational settings may curb the use of vapes and e-cigarettes. Regular supervision of common 'places of usage', or areas that have high instances of vaping (i.e., gyms, hallways, classrooms, libraries) is needed.

## REFERENCES


1. Reid, J. L., Rynard, V. L., Czoli, C. D., & Hammond, D. (2015). Who is using e-cigarettes in Canada? Nationally representative data on the prevalence of e-cigarette use among Canadians. Preventive Medicine, 81(1), 180-183. doi: 10.1016/j.ypmed.2015.08.019
2. Heart & Stroke. (2018). E-cigarettes in Canada. Retrieved from https://www.heartandstroke.ca/-/media/pdf-files/position-statements/ecigarettesincanada.ashx?la=en&hash=8939FF52C37A5E11C551176982F2E4AC5D38D605
3. Morean, M. E., Kong, G., Camenga, D. R., Cavallo, D. A., & Krishnan-Sarin, S. (2015). High School Students' Use of Electronic Cigarettes to Vaporize Cannabis. Pediatrics, 136(4), 611-616. doi:10.1542/peds.2015-1727
4. Patrick, M. E., Miech, R. A., Carlier, C., O'Malley, P. M., Johnston, L. D., Schulenberg, J. E. (2016). Self-reported reasons for vaping among 8th, 10th, and 12th graders in the US: Nationally-representative results. Drug and Alcohol Dependence, 165(1), 275-278. doi:10.1016/j.drugalcdep.2016.05.017
5. Allem, J., Dharmapuri, L., Unger, J. B., & Cruz, T. B. (2018). Characterizing JUUL-related posts on Twitter. Drug and Alcohol Dependence, 190(1), 1-5. doi:10.1016/j.drugalcdep.2018.05.018
6. Gostin, L. O., & Glasner, A. Y. (2014). E-cigarettes, vaping, and youth. Journal of the American Medical Association, 312(6), 595-596. doi: 10.1001/jama.2014.7883
7. House of Commons Canada. (2019). Vaping: toward a regulatory framework for e-cigarettes. Report of the Standing Committee on Health. Retrieved from: https://www.ourcommons.ca/DocumentViewer/en/41-2/HESA/report-9
8. Braak, D. C., Cummings, K. M., Nahhas, G. J., Heckman, B. W., Borland, R., Fong, G. T.,,...& Shang, C. (2019). Where do vapers buy their vaping supplies? Findings from the International Tobacco Control (ITC) 4 Country Smoking and Vaping Survey. International journal of environmental research and public health, 16(3), 338.
9. Canada, Health. "Government of Canada." Risks of Vaping - Canada.ca, Government of Canada, 14 June 2019, www.canada.ca/en/health-canada/services/smoking-tobacco/vaping/risks.html#a3.
10. England, L. J., et al. (2015). Nicotine and the developing human: a neglected element in the electronic cigarette debate. American journal of preventive medicine 49(2), 286-293.
11. Miech R, Patrick ME, O'Malley PM, et al E-cigarette use as a predictor of cigarette smoking: results from a 1-year follow-up of a national sample of 12th grade students Tobacco Control 2017;26:e106-e111.
12. Ontario Agency for Health Protection and Promotion (Public Health Ontario), Berenbaum E, KellerOlaman S, Manson H, Moloughney B, Muir S, Simms C, Singh H, Watson K. Current evidence on ecigarettes: a summary of potential impacts. Toronto, ON: Queen's Printer for Ontario; 2018.
13. Dierker, L., Rose, J., Selya, A., Piasecki, T. M., Hedeker, D., & Mermelstein, R. (2015). Depression and nicotine dependence from adolescence to young adulthood. Addictive behaviors, 41, 124–128. doi:10.1016/j.addbeh.2014.10.004
14. Czoli, C. D., Fong, G. T., Goniewicz, M. L., & Hammond, D. (2019). Biomarkers of Exposure Among "Dual Users" of Tobacco Cigarettes and Electronic Cigarettes in Canada. *Nicotine & tobacco research : official journal of the Society for Research on Nicotine and Tobacco*, *21*(9), 1259–1266. doi:10.1093/ntr/nty174
15. England, L. J., Bunnell, R. E., Pechacek, T. F., Tong, V. T., & McAfee, T. A. (2015). Nicotine and the Developing Human: A Neglected Element in the Electronic Cigarette Debate. *American journal of preventive medicine*, *49*(2), 286–293. doi:10.1016/j.amepre.2015.01.015
16. Yuan, Menglu & Cross, Sarah & Loughlin, Sandra & Leslie, Frances. (2015). Nicotine and the adolescent brain. The Journal of physiology. 593. 10.1113/JP270492.
17. Hammond, D., Reid, J. L., Cole, A. G., & Leatherdale, S. T. (2017). Electronic cigarette use and smoking initiation among youth: a longitudinal cohort study. *Canadian Medical Association Journal*, *189*(43), E1328 LP-E1336. https://doi.org/10.1503/cmaj.161002


HEAL
HUMAN ENVIRONMENTS ANALYSIS LABORATORY
YOUTH ADVISORY COUNCIL

BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT

Appendix B to Report No. 059-19

October 18, 2019

James Van Loon, Director General
Tobacco Products Regulatory Office
Tobacco Control Directorate, Controlled Substances and Cannabis Branch
Health Canada
Address Locator 0301A, 150 Tunney's Pasture Driveway
Ottawa, Ontario K1A 0K9
Email: hc.tcp.questions-plt.sc@canada.ca

Dear Mr. Van Loon;

The Middlesex-London Board of Health and its staff share Health Canada's concerns regarding the increase in vapour product use by young people in Canada. The Board of Health applauds Health Canada's commitment to work with provincial and territorial partners to enhance national collaborative and cooperative efforts to reduce youth vaping. With the growing concerns related to the health consequences of vaping, and the ongoing investigation of severe pulmonary illnesses across the United States and Canada, the need for strengthened policy measures to limit youth access, vapour product appeal and advertising is amplified.

At it's meeting on October 17, 2019, the Middlesex-London Board of Health heard a delegation from Western University's Human Environments Analysis Laboratory Youth Advisory Council (HEALYAC). HEALYAC is comprised of 14 high school students (13-18 years) representing diverse communities within the city of London. The HEALYAC identified vaping as one of the most important health issues facing youth in the London community. To share their concerns with public health and other community stakeholders, they wrote the attached Position Statement, "*Vaping in Schools and Student Health*". The Board of Health and its staff share the concerns that are outlined in the HEALYAC position statement, which is attached for your consideration, and commend them for their youth advocacy.

With a 74% increase in youth vaping and a 45% increase in youth smoking from 2017 to 2018 in Canada (Hammond, D. et al., 2019), in addition to growing concerns about the health harms associated with vapour product use, the Board of Health is concerned about the growing rates of nicotine addiction in young people, after decades of decline in youth smoking rates. To reduce youth access, appeal and advertising of vapour products, please consider the following regulatory measures under the *Tobacco and Vaping Products Act:*

- Align the restrictions for vaping product advertising with the approach taken to regulate the promotion and advertising of tobacco products: promotion of vaping products should be prohibited at premises where vape products are sold and youth are permitted access, in/at all places of entertainment, and on all forms of broadcast media, including online advertisements.
- Restrict the retail display of vaping products, as well as all images and models of these products in places where children and youth have access.
- Strengthen the current approach to regulating flavoured e-substances to include tighter prohibitions on the manufacturing and sale of e-substance flavours that are attractive to youth and adolescents, with an overall reduction/market cap on the number of flavours available for sale in Canada.
- The nicotine concentration level for e-substances should not exceed 21 mg/ml, which is in alignment with the European Union Tobacco Products Directive, which states that this concentration allows for delivery of nicotine that is comparable to a standard cigarette.
- Use the same approach that has been applied to tobacco and cannabis products, by enacting plain and standardized vapour product design and packaging requirements, and the enactment of stringent health warnings.

- Strict age-verification measures should be required for online sales, including age-verification at time of purchase (photo technology of government-issued ID) and proof of legal age at delivery. Online sales should be enforced by Health Canada.
- Vaping products are not regulated as an approved cessation aid in Canada; therefore, a prohibition on the use of cessation and health claims by manufacturers, distributors, and retailers about vaping products is warranted.
- Product manufacturers should be held to the same level of accountability and scrutiny as tobacco product manufacturers, through the enactment of vapour product information and reporting regulations.
- Dedicate research funding to better understand the potential benefits and risks associated with the use of vapour products. Research findings can be used to inform the development of future regulations.

Growing concerns related to health harms associated with vaping product use and the uptick of vaping across Ontario and Canada is a significant public health concern, and we thank you for your consideration and continued efforts to develop and refine health protective measures that will help to safeguard the health of our community. The Middlesex-London Board of Health and its staff are committed to working with Health Canada to address this emerging issue of public health concern.

Sincerely,

Trish Fulton, Chair
Middlesex-London Board of Health

***Attachments:***
*Middlesex-London Board of Health Report 059-19, "Collaborative Action to Address Vaping Concerns"*
*HEALYAC Position Statement: Vaping in Schools and Student Health*

cc: The Honourable Ginette Petitpas Taylor, Minister of Health
hcminister.ministresc@canada.ca

Mr. Peter Fragiskatos, MP London North Centre
Peter.Fragiskatos@parl.gc.ca

Ms. Irene Mathyssen, MP London-Fanshawe
Irene.Mathyssen@parl.gc.ca

Ms. Karen Vecchio, MP Elgin-Middlesex-London
Karen.Vecchio@parl.gc.ca

Ms. Kate Young, MP London West
Kate.Young@parl.gc.ca

Appendix C to Report No. 059-19
October 18, 2019

The Honourable Christine Elliott
Deputy Premier and Minister of Health
Ministry of Health and Long-Term Care
777 Bay Street, 5th Floor
Toronto, Ontario M7A 2J3
Email: Christine.Elliott@ontario.ca

Dear Minister Elliott;

The Middlesex-London Board of Health and its staff share the Ministry of Health's concerns regarding the increase in vapour product use by young people in Ontario and the growing concerns related to severe pulmonary illness related to vaping. The Board of Health commends you for issuing the Minister's Order under section 77.7.1 of the *Health Protection and Promotion Act*, and for the work that is being done collaboratively with the Public Health Agency of Canada and the Council of Chief Medical Officers of Heath, to establish a uniform approach to identifying and reporting cases of severe pulmonary illness related to vaping. With the growing number of cases under investigation across Canada and the United States, the reporting of confirmed and probable cases will provide information necessary to understand the scope of this issue and the health consequences associated with vaping.

At it's meeting on October 17, 2019, the Middlesex-London Board of Health heard a delegation from Western University's Human Environments Analysis Laboratory Youth Advisory Council (HEALYAC). HEALYAC is comprised of 14 high school students (13-18 years) representing diverse communities within the city of London. The HEALYAC identified vaping as one of the most important health issues facing youth in the London community. To share their concerns with public health and other community stakeholders, they wrote the attached Position Statement, "*Vaping in Schools and Student Health*". The Board of Health and its staff share the concerns that are outlined in the HEALYAC position statement, which is attached for your consideration, and commend them for their efforts to be a voice for young people within our community.

With a 74% increase in youth vaping and a 45% increase in youth smoking from 2017 to 2018 in Canada (Hammond, D. et al., 2019), in addition to growing concerns about the health harms associated with vapour product use, the Board of Health is concerned about the growing rates of nicotine addiction in young people, after decades of decline in youth smoking rates.

To reduce youth access, appeal and advertising of vapour products, please consider an amendment to the *Smoke-Free Ontario Act, 2017 (SFOA, 2017)* that would prohibit the promotion and advertising of vaping products in/at places where vaping products are sold and youth have access. In Middlesex-London, there are electronic screen ads, lit display cases, signs affixed to gas pumps and even 7-foot tall stand up displays at gas stations and convenience stores across our jurisdiction. The promotional materials use slogans like "Bold and Stylish", "Genius", "Experience the Breakthrough – make the switch", and "You've Got to Try it", which are attractive and enticing to young people, perpetuating misinformation that these products are safe to use without risk.

Secondly, to reduce youth access to vapour products from retailers with a history of routine non-compliance, please consider amending Section 22 of the *SFOA, 2017* to include vapour product sales offences. The automatic prohibition policy measure has proven effective in curbing tobacco sales to persons under the age of 19 years. Age restrictions for the sale and supply of vaping products have been in effect in Ontario since 2016; the inclusion of vaping product sales offences within the automatic prohibition order is timely.

*-continued on the next page*

…///2

Growing concerns related to health harms associated with vaping product use and the uptick of vaping across Ontario and Canada is a significant public health concern, and we thank you for your consideration and continued efforts to develop and refine health protective measures that will help to safeguard the health of our community. The Middlesex-London Board of Health and its staff are committed to working with the Ministry of Health and the Ontario Government as a whole, to address this emerging issue of public health concern.

Sincerely,

Trish Fulton, Chair
Middlesex-London Board of Health

***Attachments:***
*Middlesex-London Board of Health Report 059-19, "Collaborative Action to Address Vaping Concerns"*
*HEALYAC Position Statement: Vaping in Schools and Student Health*

cc: The Honourable Jeff Yurek, Minister of Environment, Conservation and Parks, MPP Elgin-Middlesex-London
jeff.yurek@pc.ola.org

The Honourable Monte McNaughton, Minister of Labour, MPP Lambton-Kent-Middlesex
monte.mcnaughton@pc.ola.org

Mr. Terence Kernaghan, MPP London North Centre
TKernaghan-QP@ndp.on.ca

Ms. Peggy Sattler, MPP London West
Psattler-qp@ndp.on.ca

| | |
|---|---|
| **From:** | Alida Gorizzan |
| **To:** | allhealthunits@lists.alphaweb.org |
| **Subject:** | FW: CORRESPONDENCE: PPH Board of Health re: Vaping |
| **Date:** | November 29, 2019 11:44:33 AM |
| **Attachments:** | 191128 Hajdu Vaping ns.pdf<br>encl 190918 SMDHU Ministers Vaping Display and Promotion.pdf<br>encl 190927 rev KFLA Reg 268.pdf |
| **Importance:** | High |

*Please note I have updated the attachment from KFLA…*

**ATTN: ONTARIO BOARDS OF HEALTH**

**From:** Alida Gorizzan
**Sent:** Friday, November 29, 2019 9:49 AM
**To:** Patty.Hajdu@parl.gc.ca
**Cc:** 'christine.elliott@pc.ola.org' <christine.elliott@pc.ola.org>; drtheresa.tam@canada.ca; 'Dr.David.Williams@ontario.ca' <Dr.David.Williams@ontario.ca>; Maryam Monsef (Maryam.Monsef@parl.gc.ca) <Maryam.Monsef@parl.gc.ca>; Philip Lawrence (Philip.Lawrence@parl.gc.ca) <Philip.Lawrence@parl.gc.ca>; Jamie Schmale - Conservative (Jamie.Schmale@parl.gc.ca) <Jamie.Schmale@parl.gc.ca>; Dave Smith (dave.smith@pc.ola.org) <dave.smith@pc.ola.org>; Dave Piccini (david.piccini@pc.ola.org) <david.piccini@pc.ola.org>; 'laurie.scott@pc.ola.org' <laurie.scott@pc.ola.org>; 'info@alphaweb.org' <info@alphaweb.org>; Rosana Salvaterra <rsalvaterra@peterboroughpublichealth.ca>; 'Carolyn Doris (cdoris@peterboroughpublichealth.ca)' <cdoris@peterboroughpublichealth.ca>
**Subject:** CORRESPONDENCE: PPH Board of Health re: Vaping
**Importance:** High

Good morning Minister Hajdu,

Please see the attached correspondence, sent on behalf of Councillor Kathryn Wilson, Board Chair, regarding the above-noted matter.

With thanks,
Alida Gorizzan

**Alida Gorizzan**
*Executive Assistant to Dr. Rosana (Pellizzari) Salvaterra,*
*Medical Officer of Health and the Board of Health*
Peterborough Public Health
Jackson Square, 185 King St., Peterborough, ON K9J 2R8
P: 705-743-1000 or 1-877-743-0101, ext. 264|F: 705-743-1810
E: agorizzan@peterboroughpublichealth.ca
*www.peterboroughpublichealth.ca*

**Celebrating 130 years of local and strong public health**
**www.peterboroughpublichealth.ca/130**

**Follow us on** Twitter | Facebook

**Peterborough Public Health serves the residents of Curve Lake and Hiawatha First Nations, and the County and City of Peterborough.**

Peterborough Public Health
1889-2019 LOCAL & STRONG

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

November 29, 2019

The Honourable Patty Hajdu
Minister of Health
House of Commons
Ottawa, ON K1A 0A6
***Sent via e-mail: Patty.Hajdu@parl.gc.ca***

Dear Minister Hajdu,

Congratulations on your appointment as Federal Minister of Health. We look forward to working with you to advance the health and well-being of all Canadians.

Peterborough Public Health (PPH) has been long involved in raising concerns regarding the impact of vaping on non-smokers and in particular, youth. Continuing with this advocacy in order to protect youth in our community is critical. At the October 9, 2019 meeting of the Board of Health, communications from both the Simcoe Muskoka District Health Unit and Kingston Frontenac Lennox & Addington Boards of Health (attached) were reviewed regarding vaping in Ontario.

PPH has provided feedback to a number of Health Canada consultations related to vaping and youth including advertising of vaping products (March 2019), regulatory measures to reduce youth access and appeal of vaping products (June 2019) and labelling and packaging of vaping products (August 2019). PPH responses to these consultations have noted that while vaping may be less harmful than smoking tobacco, it is not harm free. This has been demonstrated most recently by the hospitalization of a young person in the Middlesex-London Health Unit area, following hundreds of hospitalizations and deaths in the United States as a result of vaping-related pulmonary illness.[1]

On September 19, 2019, representatives from eight health organizations (Action on Smoking and Health, Canadian Cancer Society, Canadian Medical Association, Canadian Lung Association, Coalition québécoise pour le contrôle du tabac, Heart & Stroke, Ontario Campaign for Action on Tobacco and Physicians for a Smoke-Free Canada) made an appeal for immediate federal action to curb the marketing of vaping products.[2] These groups urged all federal political parties to commit to an urgent interim order that would put vaping products under the same kind of restrictions that are currently in place for tobacco products. Acceptance of this interim order would result in having protective restraints in place this calendar year using the powers of the Department of Health Act within sixty (60) days of a forming government.

We ask that action using the interim order is taken immediately to curb the marketing of vaping products in order to protect youth and reverse the current trend in both youth vaping and tobacco rates. Vaping products must be under the same kind of restrictions that are currently in place for tobacco products. Acceptance of an interim order using the powers of the Department of Health Act would result in having protective restraints in place this calendar year. Placing stronger restrictions on vape promotion is one of the most obvious solutions to protect the health of Canadians.

Sincerely,

***Original signed by***

Councillor Kathryn Wilson
Chair, Board of Health

/ag
Encl.

cc: Hon. Christine Elliott, Ontario Minister of Health
Dr. Theresa Tam, Chief Public Health Officer of Canada
Dr. David Williams, Chief Medical Officer of Health, Ontario
Local MPs and MPPs
Ontario Boards of Health
Association of Local Public Health Agencies

---

[1] CBC London (September 2019) Ontario teen was on life-support after respiratory illness linked to vaping. Retrieved from: https://www.cbc.ca/news/canada/london/middlesex-london-heatlh-unit-vaping-respiratory-illness-1.5288065

[2] CTV News (September 2019) Canadian health groups concerned about teen vaping call for urgent government action. Retrieved from: https://www.ctvnews.ca/health/canadian-health-groups-concerned-about-teen-vaping-call-for-urgent-government-action-1.4601027

simcoe muskoka
DISTRICT HEALTH UNIT

September 18, 2019

Honourable Ginette Petitpas Taylor
Minister of Health of Canada
House of Commons
Ottawa, ON K1A 0A6

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

Dear Ministers:

On September 18, 2019 the Board of Health for the Simcoe Muskoka District Health Unit approved a motion to write to the Ontario and the federal Ministers of Health calling for stringent restrictions on the display and promotion of vaping products and to ban flavoured e-cigarettes to help prevent the further uptake of vaping (and with it, the potential risk of smoking commencement) by youth.

Vaping has been rapidly increasing in our youth. A 74% increase in vaping among youth aged 16-19 in Canada was reported from 2017 to 2018 (jumping to 14.6% from 8.4%).[1] Cigarette smoking in the same period increased 45% to reach 15.5% of youth in this age group from 10.7% a year earlier. This is a concerning given that surveys initiated prior to 2018 had reported an ongoing decline in youth smoking; a finding which is consistent with the conclusions of research suggesting that vaping increases the risk of smoking in youth.[2] Research has also demonstrated that marketing of vaping products at retail stores is associated with youth and young adult initiation of vaping.[3]

Although vaping is likely to be less harmful than smoking, vaping is not harm free. Vaping can cause ear, eye, and throat irritation. The fine particles and chemicals that are inhaled into the lungs can aggravate existing lung conditions making it harder to breath.[4] The risk of heart attack increases with vape use and using both cigarettes and e-cigarettes increases this risk further.[5] Nicotine addiction is a significant concern associated with youth vaping. Nicotine can change how the teenage brain develops

[1] Hammond, D., Reid, J.L., Rynard, V.L., Fong, G.T., Gummings, K.M., McNeill, A., & O'Conner, R. (2019). Prevalence of vaping and smoking among adolescents in Canada, England, and the United States: repeat national cross sectional surveys. Bjm, 365, I2219.
[2] http://nationalacademies.org/hmd/Reports/2018/public-health-consequences-of-e-cigarettes.aspx
[3] Loukas, A, Paddock, M., Li, S., Harrell, M., Pasch, E., Perry, C (2019) Electronic Nicotine Delivery Systems Marketing and Initiation Among Youth and Young Adults
[4] Health Canada. (2019-02-04). Vaping: Get the Facts.
[5] Hess, CA., Olmedo, P., Navas-Acien, A., Goessier, W., Cohen, JE., & Rule, AM. E-cigarettes as a source of toxic and potentially carcinogenic metals. Environmental Research, 2017; 152:221 DOI: 10. 1016/j.envres.2016.09.026

affecting cognitive functions like memory and concentration as well as impulse control and can cause behavioural problems[6].

A number of serious lung issues associated with vaping occurring in the United States with an unknown etiology has also recently been reported. Health Canada warned in a recent safety alert that vaping products can carry a risk of pulmonary illness. This follows five recent deaths in the U.S. that have been linked to vaping. Health Canada reported that no similar pulmonary illness incidents have been reported in Canada, but the agency is in communication with the Centre for Disease Control (CDC) who is investigating 450 cases in 33 states which involve e-cigarettes or other vaping product use.[7]

Complicating matters further in lieu of regulation and restriction are flavoured vapour products. There are over 7000 flavours of e-juice available including candy and fruit flavoured varieties with names that appeal to youth.[8] There is a strong body of evidence to support that flavours attract youth to e-cigarette use where research concludes that flavour influences youth to try and buy e-cigarettes and the appeal of ads promoting flavours is linked to uptake of vaping by youth.[9]

Presently, there are limited federal restrictions associated with the marketing and promotion of e-cigarettes. Unlike cigarettes, vaping advertising is currently permitted on main stream media including television, radio, newspapers, outdoor signs, print and billboards. There are some regulations to protect youth related to the sale, promotion and flavour of vaping products; however, these regulations are clearly not adequate to stem the increasing uptake of vaping by youth.

Provincially, the Smoke-Free Ontario Act, 2017 (SFOA, 2017) originally put comprehensive restrictions on the display and promotion of vaping products similar to tobacco. However, those restrictions were not implemented by the Ontario provincial government before the SFOA, 2017 was enacted. As a result, point of sale display and promotion of vapour products at corner convenience stores, gas stations and grocery chains is widespread and promotional materials from posters to three-dimensional cutouts and packaging displays.

In order to prevent a further increase of vaping among youth and non-smokers in Simcoe Muskoka and to prevent the associated possible risk of cigarette smoking uptake, bans on the display and promotion of vapour products at both the Federal and Provincial level are required immediately. Provincially, the Smoke-Free Ontario Act regulations need to be strengthened to include a ban on flavoured vape products, as well on the display and promotion of vapour products mirroring the ban on tobacco products. Federally, the Tobacco and Vaping Products Act (TVPA) should also be revised to ban display, promotion and advertising, also mirroring the restrictions on tobacco in the TVPA.

---

[6] England, L.J., Bunnell, R.E., Pechacek, T.F., Tong, V.T. and McAfee, T.A., 2015. Nicotine and the developing human: a neglected element in the electronic cigarette debate. American journal of preventive medicine, 49(2), pp.286-293.

[7] https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html

[8] Zhu SH, Sun JY, Bonnevie E, Cummins SE, Gamst A, YinL, Lee M. Four hundred and sixty brands of e-cigarettes and counting: implications for product regulation. Tobacco Control, 2014 Jul 1:23(suppl 3)ciii3-9

[9] Vasiljevic M, Petrescu DC, Marteau TM. Impact of advertisements promoting candy-like flavoured e-cigarettes on appeal of tobacco smoking among children: An experimental study, Tobacco Control, 2016:25(e2):e107-e112.

Thank you for your attention to this very important matter for the protection of the health of our youth.

Sincerely,

**ORIGINAL Signed By:**

Anita Dubeau
Board of Health Chair

Cc: Ontario Boards of Health
Association of Local Public Health Agencies
Ontario Public Health Association
Ontario Tobacco Research Unit
Ontario Campaign for Action on Tobacco
Municipal Councils of Simcoe Muskoka
Members of Parliament in Simcoe Muskoka
Members of Provincial Parliament in Simcoe Muskoka
Central Local Health Integration Network
North Simcoe Muskoka Local Health Integration Network

KFL&A Public Health

October 11, 2019

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

Dear Minister Elliott:

**Re: Vapour Products Display and Promotion**

The Kingston, Frontenac and Lennox & Addington (KFL&A) Board of Health is writing to you to express deep concerns about the on-going promotion of vaping products in Ontario.
While vapour products are generally regarded as safer than combustible tobacco cigarettes, these products are not risk-free and are known to contain and emit potentially toxic substances. KFL&A Board of Health is alarmed by the rising vaping rates among youth. The sharp increase in youth vaping rates is especially concerning given the availability and promotion of nicotine containing vapour products, the impact of nicotine on the developing brain, and the recent upward trending of cigarette smoking among this population. Our concerns are further compounded by the vaping related pulmonary disease reports emerging from the United States, Quebec and our own province.

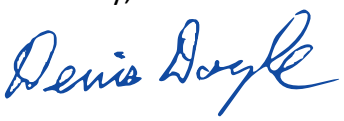
A suite of robust regulatory measures is needed to address the rise in vapour product use and to protect our most vulnerable populations from the harms associated with these products. Because exposure to vapour products marketing and advertising decreases the perception of the associated risk of vaping and increases the odds of trying these products, immediate action is needed to limit youth's exposure to product promotion. Our youth and young adults are frequently being exposed to vaping advertising on the internet, at point of sale in convenience stores and gas stations, as well as on television, magazines, billboards, social media, and public transit. To that end, KFL&A Board of Health passed the following motion on 2019-09-25:

> **THAT the KFL&A Board of Health urge the Provincial Government to immediately remove Sections 21 and 22 of Regulation 268 of the Smoke-Free Ontario Act, 2017, so that retailers of vaping products will not be allowed to promote them and so that the promotion and display of vape products are subject to the same prohibition as tobacco products.**

. . . /2

KFL&A Board of Health applauds the Government of Ontario's recently expressed concerns about youth vaping and the health risks and your willingness to find evidence-informed solutions to address this emerging public health issue.

Sincerely,



Denis Doyle, Chair
KFL&A Board of Health

*Copy to:* *Ian Arthur, MPP Kingston and the Islands*
*Randy Hillier, MPP Lanark-Frontenac-Kingston*
*Daryl Kramp, MPP Hastings-Lennox and Addington*
*Mark Gerretsen, MP Kingston and the Island*
*Scott Reid, MP Lanark-Frontenac-Kingston*
*Mike Bossio, MP Hastings-Lennox and Addington*
*Ginette Petitpas Taylor, Minister, Health Canada*
*Dr. David Williams, Chief Medical Officer of Health, Ministry of Health*
*Dr. Theresa Tam, The Chief Public Health Officer*
*Loretta Ryan, Association of Local Public Health Agencies*
*Ontario Boards of Health*

| | |
|---|---|
| **From:** | Bruce, Heather |
| **To:** | (Allhealthunits@lists.alphaweb.org) |
| **Subject:** | Vapour Product Use Among Youth |
| **Date:** | December 2, 2019 10:43:00 AM |
| **Attachments:** | Vapour Products .pdf |

---

Attention:  Ontario Boards of Health

Good morning,

Please see the attached letter from Doug Malanka, Board Chair, for the Leeds, Grenville and Lanark District Health Unit urging continued work to protect youth by supporting Bill 151, the Smoke-Free Ontario Amendment Act (Vaping is not for Kids), 2019.

Thank you,

Heather Bruce CAP, OM
Executive Assistant to the Medical Officer of Health and Board of Health
Leeds, Grenville and Lanark District Health Unit
458 Laurier Blvd.
Brockville, ON  K6V 7A3
Tel: (613) 345-5685 Ext. 2248
Fax: (613) 498-1096

---

| | |
|---|---|
| **From:** | Rachel Quesnel |
| **To:** | "allhealthunits@lists.alphaweb.org" |
| **Cc:** | Penny Sutcliffe; René Lapierre |
| **Subject:** | E-Cigarette and Aerosolized Product Prevention and Cessation Board of Health motion Public Health Sudbury & Districts |
| **Date:** | December 3, 2019 3:58:53 PM |
| **Attachments:** | E-Cigarette_and_Aerosolized_Product_Prevention_and_Cessation_2019_12_03.pdf |

ATT: Ontario Boards of Health

Please see attached correspondence and motion from the Board of Health of Public Health Sudbury & Districts addressed to the Minister of Health.

Thank you.

**Rachel Quesnel**

Executive Assistant to the Medical Officer of Health and Secretary to the Board of Health
Adjointe de direction et Secrétaire du Conseil de santé

Public Health Sudbury & Districts / Santé publique Sudbury et districts

1300 rue Paris Street, Sudbury, Ontario P3E 3A3

quesnelr@phsd.ca | Tel#: 705.522.9200 ext. 291 | Fax#: 705.677.9606

**From:** Rachel Quesnel
**Sent:** December 3, 2019 3:49 PM
**To:** 'Christine Elliott (ccu.moh@ontario.ca)' <ccu.moh@ontario.ca>
**Cc:** 'premier@ontario.ca' <premier@ontario.ca>; 'Dr.David.Williams@ontario.ca' <Dr.David.Williams@ontario.ca>; 'JWest-CO@ndp.on.ca' <JWest-CO@ndp.on.ca>; 'fgelinas-co@ndp.on.ca' <fgelinas-co@ndp.on.ca>; 'mmantha-co@ndp.on.ca' <mmantha-co@ndp.on.ca>; 'loretta@alphaweb.org' <loretta@alphaweb.org>; 'pwalsh@opha.on.ca' <pwalsh@opha.on.ca>; 'attorneygeneral@ontario.ca' <attorneygeneral@ontario.ca>; 'Alton Hobbs' <clerktreasurer@eastlink.ca>; 'Barbara Major (Acting Clerk replacing Chelsea Swearengea until approx June 2020)' <clerk@chapleau.ca>; 'Belinda Ketchabaw' <nairncentre@personainternet.com>; 'Bonnie Bailey (also for Manitoulin Municipal Association - MMA)' <burpeemills@vianet.ca>; 'Brigitte Sobush' <Brigitte.Sobush@greatersudbury.ca>; 'Candy Beauvais' <cbeauvais@municipalityofkillarney.ca>; 'Carrie Lewis' <clerk@gordonbarrieisland.ca>; 'Carrie Lewis (Barrie Island)' <clerk@gordonbarrieisland.ca>; 'Cockburn Island - Brent St. Denis' <brentstdenis@gmail.com>; 'Cynthia Townsend' <town@espanola.ca>; 'Julie Lalonde' <julie.lalonde@greatersudbury.ca>; 'Karin Bates' <karin@baldwin.ca>; 'Kathy McDonald' <clerktreasurer@billingstwp.ca>; 'Kim Sloss' <kasloss@sables-spanish.ca>; 'Marc Gagnon' <cao@frenchriver.ca>; 'Melanie Bouffard' <mbouffard@frenchriver.ca>; 'Melissa Lamontagne' <melissa.lamontagne@greatersudbury.ca>; 'Pam Cress' <pcress@townofnemi.on.ca>; rforgette@markstay-warren.ca; 'Roy Hardy' <twptehk@amtelecom.net>; 'Ruth Frawley' <centralm@amtelecom.net>; 'Stasia Carr' <scarr@gorebay.ca>; 'Tammy Godden' <tgodden@stcharlesontario.ca>; 'Brigitte Sobush' <brigitte.sobush@greatersudbury.ca>; 'Julie Lalonde' <Julie.lalonde@greatersudbury.ca>; 'Lisa Locken' <lisa.locken@greatersudbury.ca>; 'Melissa Lamontagne' <melissa.lamontagne@greatersudbury.ca>; Penny Sutcliffe <sutcliffep@phsd.ca>; René Lapierre <lapierrer@phsd.ca>
**Subject:** E-Cigarette and Aerosolized Product Prevention and Cessation Board of Health motion,

Public Health Sudbury & Districts

Good afternoon,
Attached is a letter from René Lapierre, Board of Health Chair for Public Health Sudbury & Districts regarding the need for a comprehensive tobacco and e-cigarette strategy.
Thank you,
Rachel

**Rachel Quesnel**
Executive Assistant to the Medical Officer of Health and Secretary to the Board of Health
Adjointe de direction et Secrétaire du Conseil de santé
Public Health Sudbury & Districts / Santé publique Sudbury et districts
1300 rue Paris Street, Sudbury, Ontario P3E 3A3
quesnelr@phsd.ca | Tel#: 705.522.9200 ext. 291 | Fax#: 705.677.9606

Public Health
Santé publique
SUDBURY & DISTRICTS

December 3, 2019

*VIA EMAIL*

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

Dear Minister Elliott:

**Re: E-Cigarette and Aerosolized Product Prevention and Cessation**

On behalf of the Board of Health for Public Health Sudbury & Districts, I am very pleased to convey our congratulations on your recent decision to protect Ontarians by banning the promotion of vapour products in corner stores and gas stations. This is an important first step in reducing exposure and accessibility to vapour products and working toward improving the health of Ontarians.

By the enclosed resolution, the Board of Health further urges the adoption of an expert-informed comprehensive tobacco and e-cigarette strategy to address flavoured e-juice, online sales to minors, treatment programs for youth cessation, and public education.

Minister, we recognize that your Ministry is committed to establishing a patient centered system for health, and to ensuring system sustainability for Ontarians now and into the future. To this end, we strongly endorse that any vaping strategy is firmly grounded in the connect between vaping and tobacco use.

As you are aware, although vaping is not without risk, tobacco causes nearly 16 000 deaths per year[i] and costs Ontario nearly $7 billion ($2.7 billion direct health care, $4.2 billion indirect costs) annually.[ii] Cigarettes are known to be toxic and cause cancer, lung, and heart disease when used as intended[iii] and nearly one in five Ontarians continue to smoke[iv]. Reducing supply and exposure to products must be part of the system sustainability goal. This holds true for tobacco and anything that may

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

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

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

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

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

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

**Toll-free / Sans frais**
1.866.522.9200

**phsd.ca**
@PublicHealthSD

promote or normalize its use, such as vaping. Below, we are sharing a compelling infographic developed by Public Health Sudbury & Districts to convey this important message to our publics.

Thank you again for your leadership in the protection of youth from the risks of vaping. We urge you to consider in your next steps the linkages between vaping and tobacco and develop a comprehensive tobacco and e-cigarette strategy. Please know that the Board of Health for Public Health Sudbury & Districts is a committed local partner in this important work.

Sincerely,

René Lapierre, Chair
Board of Health, Public Health Sudbury & Districts

Enclosures (2)

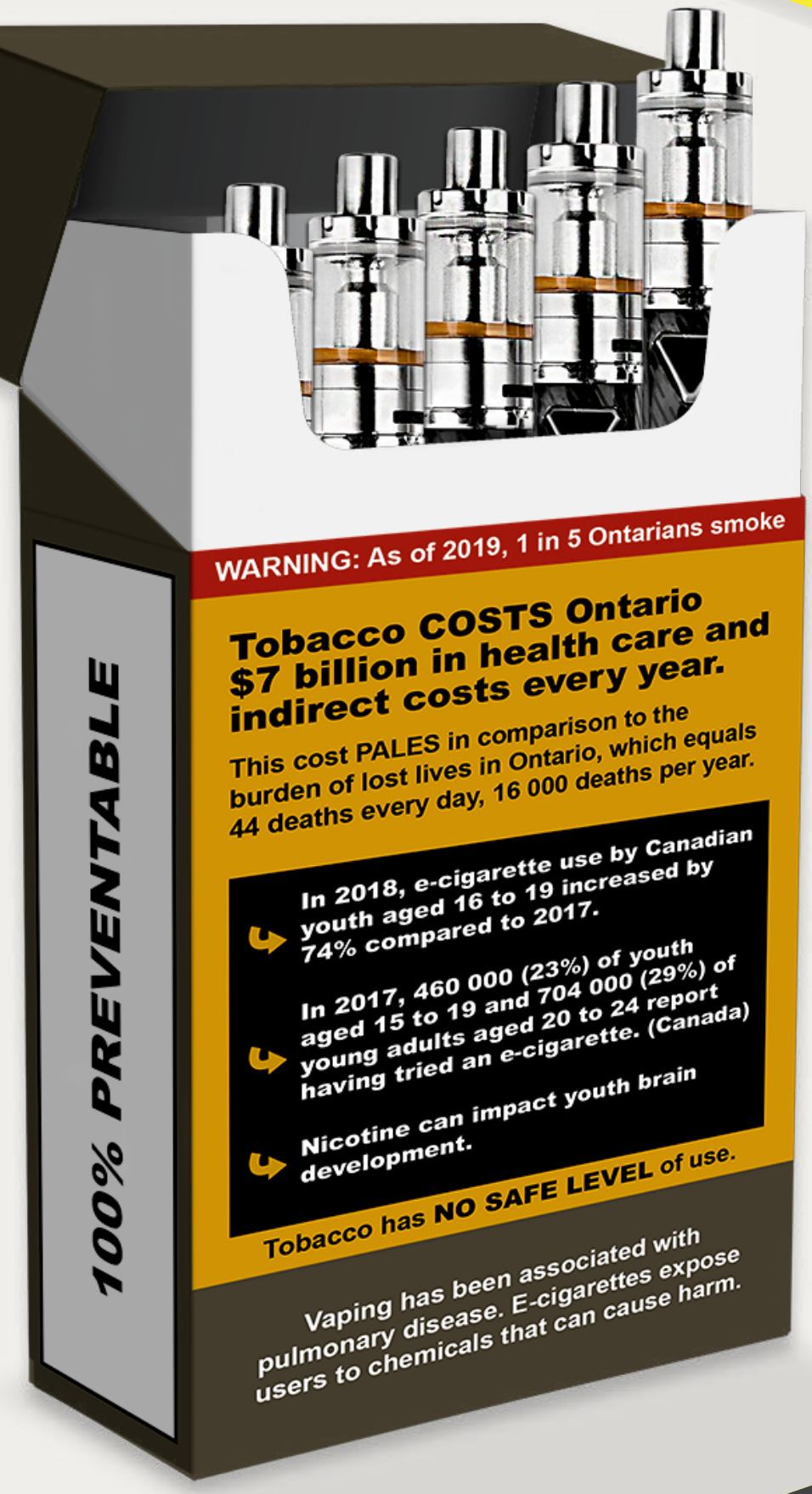
cc: The Honourable Doug Ford, Premier, Minister of Intergovernmental Affairs
All Ontario Boards of Health
Dr. David Williams, Chief Medical Officer of Health
The Honourable Jamie West, MPP, Sudbury
The Honourable France Gélinas, MPP, Nickel Belt
The Honourable Michael Mantha, MPP, Algoma-Manitoulin
Council of Ontario Medical Officers of Health
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Pegeen Walsh, Executive Director, Ontario Public Health Association
Constituent Municipalities within Public Health Sudbury & Districts
The Honourable Doug Downey, Attorney General of Ontario

[i] Ministry of Health and Long-Term Care. (2018, May 3) Minister of Health and Long-Term Care. Letter. Smoke-Free Ontario Strategy.

[ii] CCO and Ontario Agency for Health Protection and Promotion (Public Health Ontario). (2019). The burden of chronic diseases in Ontario: key estimates to support efforts in prevention. Toronto: Queen's Printer for Ontario.

[iii] Health Canada. (2019). Smoking, vaping and tobacco. Retrieved from https://www.canada.ca/en/health-canada/services/smoking-tobacco/vaping.html

[iv] Ministry of Health and Long-Term Care. (2018). Smoke-Free Ontario: The Next Chapter – 2018. Toronto: Queen's Printer for Ontario. Retrieved from http://www.health.gov.on.ca/en/common/ministry/publications/reports/SmokeFreeOntario/SFO_The_Next_Chapter.pdf




# The need for a comprehensive tobacco and e-cigarette strategy

The **rapid** proliferation of e-cigarette use is fuelling mass recruitment of new consumers by an established industry, which profits from nicotine addiction.

Many e-cigarette users are **unaware** of the potential harms of regular or occasional use. There is evidence that e-cigarette use **increases youth uptake of tobacco**.

**Tobacco** continues to kill its users and cause cancer, lung and heart disease, and grips 1.8 million Ontarians daily.

Ingredients of a **comprehensive tobacco and e-cigarette strategy** include cessation, prevention (denormalization, education, taxation), and protection (enforcement, controls, regulations).

In time, e-cigarettes may be proven to help people quit smoking. What's the message to everyone else?

**IF YOU DON'T SMOKE, DON'T VAPE.**

Public Health
Santé publique
SUDBURY & DISTRICTS

December 2019

*Moved by Hazlett - Thain*
*Approved by Board of Health for Public Health Sudbury & Districts, November 21, 2019*

## 48-19 E-CIGARETTE AND AEROSOLIZED PRODUCT PREVENTION AND CESSATION

WHEREAS the Board of Health for Public Health Sudbury & Districts has a longstanding history of proactive and effective action to prevent tobacco and emerging product use and to promote tobacco use cessation; and

WHEREAS electronic cigarettes are increasingly popular in Canada, especially among youth and among smokers, including 15% of Canadian youths and 10% of local youths reporting having tried e-cigarettes; and

WHEREAS there is increasing concern about the health hazards of using e-cigarettes including nicotine addiction, transition to tobacco products especially among youth, and emerging risks of severe pulmonary illness; and

WHEREAS the Ontario government recently announced restrictions on the promotion of e-cigarettes and products that will come into effect January 2020;

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts, while congratulating the Minister of Health on the restrictions on e-cigarette promotion, urge the adoption of an expert-informed comprehensive tobacco and e-cigarette strategy to address flavoured e-juice, online sales to minors, treatment programs for youth cessation, and public education; and

FURTHER that the Board urge the Minister to work with provincial, territorial and federal counterparts to adopt other evidence-informed strategies such as taxation, use prohibition, industry denormalization, and cross-Canada public education to address this emerging public health issue.

CARRIED WITH FRIENDLY AMENDMENTS

**From:** Gordon Fleming
**To:** All Health Units
**Subject:** Proceedings - alPHa Fall Symposium - November 6, 2019
**Date:** November 26, 2019 2:48:09 PM
**Attachments:** image001.jpg
alPHa_Fall_Symposium_2019_Proceedings.pdf

---

**ATTENTION**
**MEDICAL OFFICERS OF HEALTH**
**CHAIRS, BOARDS OF HEALTH**
*****************************

Please find attached the proceedings of this year's alPHa Fall Symposium. Summaries of the sessions, links to presentations and speaker bios are included therein. Please feel free to distribute to additional staff in your shops as appropriate.

Gordon WD Fleming, BA, BASc, CPHI(C)
Manager, Public Health Issues
Association of Local Public Health Agencies
2 Carlton St. #1306
Toronto ON M5B 1J3
416-595-0006 ext. 23

alPHa Banner

alPHa
Association of Local PUBLIC HEALTH Agencies

2019 FALL SYMPOSIUM
Wednesday, November 6, 2019
6th Floor, Room 610 Auditorium
Dalla Lana School of Public Health
Health Sciences Building, University of Toronto
155 College Street, Toronto, ON M5T 3M7

**PROCEEDINGS**
**alPHa Fall Symposium, Wednesday, November 6th, 2019**
**Dalla Lana School of Public Health, University of Toronto**
**Health Sciences Building, 155 College Street, 6th Floor**
**Toronto, ON M5T 3M7**

*Speaker Biographies are included following the session summaries.*

## Update on Public Health Modernization

***Speakers:*** **Dr. David Williams**, Chief Medical Officer of Health; **Alison Blair**, Public Health Modernization Executive Lead and Assistant Deputy Minister, Emergency Health Services; **Jim Pine**, Special Advisor on Public Health and Emergency Health Services. ***Moderator*****: Dr. Robert Kyle,** Commissioner & Medical Officer of Health for the Regional Municipality of Durham.

Dr. Robert Kyle introduced the panelists from the Public Health and Emergency Health Services Modernization team and invited them to make introductory remarks prior to the discussion. Jim Pine spoke of his previous experiences in consultation and assured the assembly that the Government wants to do the right thing and that there are no predetermined outcomes.

Alison Blair indicated that her role is to support Jim and to ensure that the lines of communication remain open while also ensuring that the day-to-day work of public health at the provincial level can continue under the leadership of the CMOH. She also mentioned that the common municipal link between EHS and PH is the only reason that both are being addressed in the same conversation and that there is no intent to amalgamate the two. She reiterated that the purpose of the consultation is entirely to seek our advice on what will make public health better and that the focus of the conversation will be on structures and practices, not content.

Dr. David Williams continued by reflecting on where we are in the process. He reminded delegates that different versions of this have arisen over the years, and the common question has always been about what systemic supports are required to address known shortcomings. He characterized this as a great opportunity, because the Government has demonstrated an understanding of public health's roles and responsibilities and an interest in making the system better in and of itself.

The consultation will be launched via webinar in the coming weeks and feedback will be guided by a discussion paper to be released around the same time. The consultation will be broad, and feedback will be

welcome in a variety of formats (regional visits, remote participation, written feedback). It will also be responsive to new ideas and questions that emerge along the way.

During the ensuing discussion, clarification was given that the approaches and timelines proposed in the original 2019 budget announcement no longer apply (other than the already-confirmed change to the cost-sharing) but also that the status quo is an unlikely end point. The impetus for this initiative is to ensure that issues that have been identified in several assessments of the public health system over the years can be appropriately addressed. These will be outlined in the discussion paper, which is designed to gather the best ideas and experience from the field to inform solutions. Jim Pine reiterated that his primary job is to listen and that the team is receptive to any and all ideas.

Members took the opportunity to provide preliminary advice on both the process and the content of the consultation, as well as to express ongoing concerns about the absence of information provided since the budget announcement, the potential effects of transformation on daily public health work, and the implication that "modernization" assumes that the public health system as a whole is out-of-date.

Alison Blair then outlined her best estimate of the consultation timeline, which will see the consultation launch in the coming weeks and continue into the winter, followed by a synthesis and communication of what they've heard along with some preliminary proposals for further comment. She guessed that presenting something to the government that is acceptable to the field will not occur until early spring.

**alPHa Strategic Plan**

alPHa President Carmen McGregor announced that alPHa's new strategic plan for 2020-2023 has just been finalized and endorsed. The previous Strategic Plan served the association well, putting members at the centre of activities and built upon five areas of focus: promoting members; representing members; enriching members; supporting members; and connecting members.

Following a review of the plan that began in 2018, which included member outreach, survey and consultation sessions as

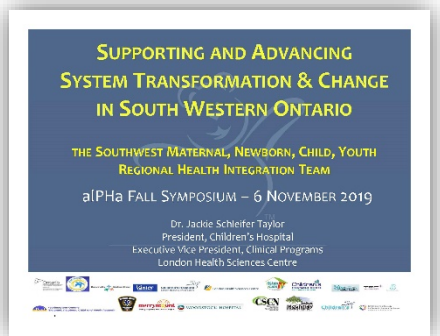
well as frequent discussions by the alPHa Board, it was determined that while key elements of the previous plan would be retained, the new plan would have a more outward focus.

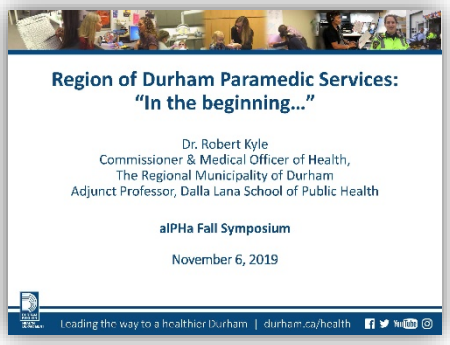


**Transformation and Change**

***Panelists***: **Dr. Jackie Schleifer Taylor**, President, Children's Hospital, Executive Vice President, Clinical Programs, London Health Sciences Centre; **Dr. Robert Kyle,** Commissioner & Medical Officer of Health for the Regional Municipality of Durham; **Janice Sheehy,** Commissioner, Human Services Peel Region. ***Moderator***: **Cynthia St. John,** CEO of Southwestern Public Health.

Panel moderator Cynthia St. John introduced the concept of radical change, which reorients systems and people in new directions and encourages new ways of thinking and acting. She introduced the panelists, who are from other sectors that have undergone such transformative change and invited them to share their experiences in navigating challenges, provide insights, outline lessons learned, and offer advice. Each of the presenters has provided detailed slide decks that reflect the content of their talks.







**Minister of Health and Deputy Premier Christine Elliott**

Minister Christine Elliott provided welcoming remarks to the assembled delegates and confirmed that keeping patients as healthy as possible in their communities and out of hospitals through investments in health protection and promotion is a key pillar in Ontario's comprehensive plan to end hallway health care. She also provided updates on the Public Health Modernization consultations, approaches to reducing youth vaping and the launch of this year's Universal Influenza Immunization Program.

Much of what she said about Public Health Modernization was reflected in the Government's Fall Economic Statement, which was released later that day.

On vaping, she acknowledged that the Minister's Order to gather data about vape-related hospitalizations and the decision to ban point-of-sale promotion of vape products (effective January 1, 2020) were just first steps in an effort to curb vaping among youth in Ontario.

Finally, the Province is about to launch its annual Universal Influenza Immunization campaign, with the recognition that getting vaccinated is important not just for personal health but also that of the community, which is an important contributor to reducing hallway health care.

**Public Health and the News – What's Making the Front Page?**

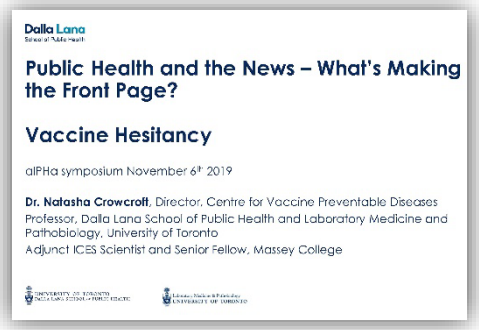
***Panelists**: **Dr. Michael Rieder,** CIHR-GSK Chair in Paediatric Clinical Pharmacology University of Western Ontario Professor; **Professor Robert Schwartz,** Dalla Lana School of Public Health, Executive Director, Ontario Tobacco Research Unit, University of Toronto; **Professor Natasha Crowcroft,** Dalla Lana School of Public Health, ICES and LMP, University of Toronto. **Moderator**: **Dr. Paul Roumeliotis** Medical Officer of Health and Chief Executive Officer, Eastern Ontario Health Unit; Chair, Council of Ontario Medical Officers of Health (COMOH).*

Dr. Paul Roumeliotis introduced the session with a slide deck capturing the themes of the panel discussion and invited panelists to provide their perspectives on these three areas where public health and mediated public perception are often misaligned.

Dr. Michael Rieder gave an outline of the legalization and subsequent issues related to cannabis use.


Professor Robert Schwartz gave a timeline of the slow development and sudden emergence of e-cigarettes as a popular technology whose harm reduction attributes are grossly overstated when measured against alarming youth uptake.

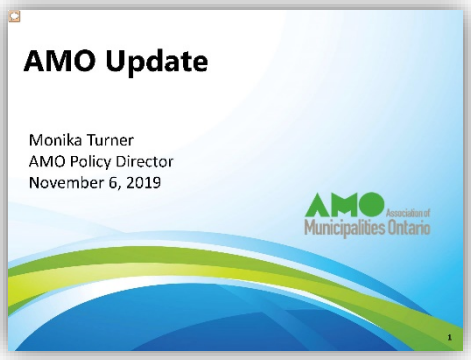

Professor Natasha Crowcroft outlined the issue of vaccine hesitancy, its connection to political and social issues, and the proliferation of misinformation and eroding trust in science.




**Update from the Association of Municipalities of Ontario**

***Speakers***: **Monika Turner**, Director, Policy, AMO and **Jamie McGarvey**, President, AMO

**Monika Turner's** updates are captured in detail in her accompanying slide deck and a full transcript of **Jamie McGarvey's** remarks is available here.




**Death, disease and destitution: understanding global catastrophic biological risk.** Speaker: Dr. Peter Donnelly, President & CEO, Public Health Ontario. Co-hosted by the Dalla Lana School of Public Health, University of Toronto, and alPHa.

As a special addition to the alPHa Symposium, Dr. Peter Donnelly provided an informative and entertaining evening lecture on catastrophic biological risks, their potentially widespread effects on health, economy and society, and the importance of preparation. The central message was that such catastrophes can and do happen anywhere and at any time, and that investment, vigilance and the capacity to recall and apply lessons learned is essential to any kind of response.

alPHa
Association of Local PUBLIC HEALTH Agencies

# SPEAKER BIOGRAPHIES
# 2019 FALL SYMPOSIUM

**The Honourable Christine Elliott**
**Deputy Premier of Ontario and Minister of Health**

As a mother, lawyer, businesswoman, and entrepreneur, Christine Elliott knows how to bring people together. She knows the importance of balancing a family budget and how to manage a successful business.

Christine graduated from the University of Western Ontario with a Bachelor of Laws degree. She then built a successful career in business and law, working first as an auditor at one of Canada's largest banks. Christine later co-founded a law firm with her late husband Jim Flaherty, where she specialized in real

estate, corporate law, and estate law. Christine has worked tirelessly to help businesses all across the province expand and thrive.

Christine also used her business and legal expertise to pursue her commitment to public service. Her pro bono legal work for charitable organizations gained her the recognition as a Rotary International Paul Harris Fellow, the highest award with Rotary. As well, Christine is a co-founder of the Abilities Centre in Whitby, a facility built with the vision of celebrating all people, regardless of ability. The centre has become a hub of its community, hosting various Parapan Am Games events in 2015.

In 2006, Christine was elected MPP. She has won five elections, and for nine years has served the people of Ontario at Queen's Park, including six years as Deputy Leader of the PC Party.
In 2016, Christine became Ontario's Patient Ombudsman, where she fought for better access to health care for all.

She currently serves as the Deputy Premier of Ontario, Minister of Health and is the MPP for Newmarket-Aurora.

Christine has triplet sons, John, Galen and Quinn.

**Alison Blair**
**Assistant Deputy Minister, Emergency Health Services Division, and Executive Lead, Public Health Modernization, Ministry of Health**
Alison Blair is the Assistant Deputy Minister of the Emergency Health Services (EHS) Division, and Executive Lead, Public Health Modernization, in the Ministry of Health. The EHS division provides and regulates services to all Ontarians ranging from emergency health services in land and air ambulances, to advocacy and rights advice services to patients in psychiatric facilities across the province.

Alison was previously the Executive Director of the Emergency Health Services Office, Hospitals and Emergency Services Division in the Ministry of Health and Long-Term Care. Prior to this role, Alison served as the acting Assistant Deputy Minister, Direct Services Division of the Ministry of Health and Long-Term Care where she provided leadership and oversight on emergency health services in land and air ambulances, funding programs for assistive devices and medical supplies to Ontario residents with long term physical disabilities, programs under the OHIP program, advocacy and rights advice services to patients in psychiatric facilities across the province.

Alison brings with her a wealth of experience in strategy development, stakeholder management, and implementation, through roles within government and in the health sector. Alison has a Master of Business Administration, McMaster University, specialization in Health Services Management and a Bachelor of Arts and Sciences (Honours), McMaster University.

**Professor Natasha Crowcroft**
**Dalla Lana School of Public Health, ICS and LMP, University of Toronto**
Dr. Crowcroft is a public health medical practitioner with more than 25 years' experience in public health at local, national and global levels, and two decades of senior management and leadership experience in infectious disease surveillance, prevention, control and outbreak response. She has published over 250 peer-reviewed scientific papers including in Lancet, BMJ, NEJM, with an h-factor of 47 (Google scholar). She is an Associate Editor for Eurosurveillance and on the International Advisory

Board of Lancet Infectious Diseases. With a strong track record of research funding, she reviews for a variety of national and global funding bodies. Her research aims to maximize the health benefits of immunization.

Dr. Crowcroft's expert role includes as current co-chair of the Canadian Association for Immunization Research, Evaluation and Education (CAIRE), and member of the Canadian Immunization Research Network. Globally, she is an expert for PAHO, SEARO and WHO and also serves on the Independent Review Committee of Gavi.

Dr. Crowcroft trained in medicine and public health at the Universities of Cambridge and London, UK, and in field epidemiology in the European Programme for Intervention Epidemiology Training (EPIET) in Belgium. From 1997-2007 Dr. Crowcroft was a medical consultant in the Immunisation Department at the national centre for England. In 2007 she was recruited to be one of the founding leadership group at Public Health Ontario, Canada, helping to rebuild the public health system post-SARS. She became Director of Surveillance and Epidemiology in 2008, Chief of Infectious Disease in 2012, Chief of Applied Immunization Research and Evaluation in 2015, and Chief Science Officer in 2019. In 2019, Dr. Crowcroft launched the Centre for Vaccine Preventable Diseases at the University of Toronto as its inaugural Director.

**Dr. Peter Donnelly**
**President and CEO, Public Health Ontario**

Dr. Donnelly is President and CEO of Public Health Ontario (PHO), which provides evidence for policy formulation and undertakes public health capacity building, as well as provides integrated public health laboratory and surveillance systems. Prior to joining PHO, Dr. Donnelly was the Professor of Public Health

Medicine at the University of St. Andrews in Scotland, where he established and led public health medicine research and teaching. From 2004 to 2008 he was the Deputy Chief Medical Officer to the Scottish Government, providing senior leadership and coordination at a national level. As the Director of Public Health in two jurisdictions, he was responsible for the delivery of local public health services and programs.

**Dr. Robert Kyle**
**Commissioner and Medical Officer of Health, Durham Region**

Dr. Kyle has been the Commissioner & Medical Officer of Health for the Regional Municipality of Durham since 1991. He is an active member of many provincial and regional health organizations. For example, he is currently Past President of the Association of Local Public Health Agencies, having assumed the presidency from June 2018 to June 2019. He is also Chair of the Durham Nuclear Health Committee; Past Chair of the Port Hope Community Health Centre; Past Chair of the Public Health Ontario Board of Directors and Past Chair of its Governance Committee. Dr. Kyle is a former Medical Officer of Health for the Peterborough County-City Health Unit and Associate Medical Officer of Health for the Borough of East York Health Unit. He is also an Adjunct Professor, Dalla Lana School of Public Health, University of Toronto.

**Jamie McGarvey**
**President, Association of Municipalities of Ontario**

Jamie was acclaimed President of the Association of Municipalities of Ontario (AMO) on August 22, 2018 at the Association's 2018 conference in Ottawa. He has served on municipal councils for more than 30 years, including the last nine as the Mayor of Parry Sound. Jamie has been on the AMO board for nine years. The AMO President serves as the voice of a 43-member Board made of up of elected officials and senior municipal staff from across Ontario. The AMO Board represents a cross-section of Ontario's diverse municipalities, including rural, northern and urban communities from all regions of the province.

**Carmen McGregor**
**President, alPHa**

Carmen is a Municipal Councillor with Chatham-Kent. She joined the alPHa Board in June 2015 as the South West region's Boards of Health Representative and became alPHa Vice President in June 2016. She served as alPHa President from June 2017 to June 2018 and Past President from June 2018 to June 2019.

Prior to municipal council, Carmen was a publicly elected School Board Trustee for the Lambton Kent District School Board for 11 years. She served as Chairperson for 3 years and Vice Chair for 2 years. Her responsibilities included many different committees including representing her board provincially as Director to the Ontario Public School Board Association (OPSBA) and Vice President of the Western Region group of Public School Boards.

Along with her political career Carmen is the Office Manager of a law firm and has continued to be an active volunteer within her community. She is the Past President and a current Director of the Wallaceburg and District Chamber of Commerce, a member of the Chatham-Kent Not-for-Profit Network, a member of the Age Friendly Committee, a Toastmaster and she has chaired the Wallaceburg, United Way of Chatham-Kent Campaigns, 1999, 2009 & 2013.

**Jim Pine**
**Special Advisor on Public Health and Emergency Services**
Jim is currently the Chief Administrative Officer (A) of the County of Hastings, having been in the municipal affairs business for nearly 39 years. He has worked as a chief administrative officer in small municipalities, as a city administrator and, for the past seventeen years, has been leading the administration of the County of Hastings. Jim started his career with the Ministry of Municipal Affairs and Housing and served in various positions in his 9 years with the Ministry including as Regional Director for Eastern Ontario.

Jim is also co-chairing the ONWARD Initiative which includes major municipal staff organizations in Ontario dedicated to promoting local government as a career and supporting succession planning in municipalities across the province. He has also taken an active role in municipal advocacy through his work with the Association of Municipalities of Ontario, where he served in a number of roles including Secretary-Treasurer and member of the Board of Directors.

Jim is a past president of the Ontario Municipal Administrators' Association. He has participated in many municipal reform projects, including the *Provincial-Municipal Fiscal and Services Delivery Review*. Along

with his two panel partners, he authored a wide-ranging review of Ontario's water and waste water sector entitled: *Watertight: A Case for Change.*

**Dr. Michael Rieder**
**CIHR-GSK Chair in Paediatric Clinical Pharmacology**
**University of Western Ontario**

Dr. Rieder obtained his MD at the University of Saskatchewan in 1980 and his Ph.D. at the University of Toronto in 1992. His paediatric resident training was at the Children's Hospital of Michigan and he completed fellowships in Paediatric Clinical Pharmacology and Paediatric Emergency Medicine at the Hospital for Sick Children in Toronto.

Dr. Rieder is a Professor with the Department of Paediatrics, Physiology and Pharmacology and Medicine at Western University and a Scientist at the Robarts Research Institute. He is the Past President of the Canadian Society of Pharmacology and Therapeutics and is a member of the Drug Therapy Committee of the Canadian Paediatric Society and has served as a consultant to Health Canada, the NIH, the MRC and the Canadian College of Academies. Dr. Rieder's research focuses on drug safety and adverse drug reactions as well as on optimal therapeutics in children. This includes studying genetic variations and their impact on drug efficacy and safety and mechanistic studies of drug hypersensitivity. He is the author of the CPS Statement on Medical Marijuana in Children and has spoken on this topic in many venues.

Dr. Rieder has been the recipient of many awards including the 1994 and 1996 Young Investigator of the Year for the Canadian and American Societies of Clinical Pharmacology, the Senior Investigator Award of the Canadian Society of Clinical Pharmacology and the Academic Leadership Award in Clinical Investigation from the Paediatric Chairs of Canada as well as Sumner Yaffe Lifetime Achievement Award for Pediatric Pharmacotherapy. Other distinguished awards include the Harvard Macy Scholar Award, the Douglas Bocking Award, several Teacher of the Year Awards, Fellowships from the Royal Colleges of Physicians and Surgeons of Glasgow and Edinburgh and a Distinguished University Professor award at Western. He holds the CIHR-GSK Chair in Paediatric Clinical Pharmacology, the only endowed Chair in Paediatric Clinical Pharmacology in Canada.

**Dr. Paul Roumeliotis**
**Medical Officer of Health and CEO, Eastern Ontario Health Unit & COMOH Section Chair**

Dr. Roumeliotis is the Medical Officer of Health and Chief Executive Officer of the Eastern Ontario Health Unit since 2017. He received his medical degree in 1983 at McGill University and trained as a pediatrician at the Montreal Children's Hospital. He was Director of Continuing Medical Education in the Department of Pediatrics and founding Director of Multiformat Health Communications at McGill. Dr. Paul created and directed the Montreal Children's Hospital Asthma Centre and Pediatric Consultation Centre in 1990. He also holds a Master of Public Health (MPH) Degree from the Johns Hopkins School of Public Health, where he is now an Associate Faculty member. In May 2013, he completed the Advanced Management Diploma program at the Harvard Business School. In February 2018, he received the Canadian Certified Physician Executive (CCPE) credential designation by the Canadian Society of Physician Leaders.

**Trudy Sachowski**
**Vice Chair, Northwestern Board of Health & Boards of Health Section Chair, alPHa**

Trudy is a Provincial Appointee, is the Vice Chair of the Northwestern Board of Health and Chair of the Board's Executive Committee. Trudy is a retired corporate leadership consultant. Trudy's extensive community and volunteer involvement includes serving as: Chair of the Ontario Parent Council, Chair of the Northwestern Healthy Living Partnership, Chair of the Dryden Public Library Board, Vice-Chair of the Northwestern Early Years Steering Committee, Board member of Points North Family Health Team and numerous provincial, regional and local initiatives. She is also currently a member of the alPHa Board of Directors.

**Dr. Jackie Schleifer Taylor**
**President, Children's Hospital**
**Executive Vice President, Clinical Programs**
**London Health Sciences Centre**

With over 20 years' experience in local to international health sector leadership, Dr. Jackie Schleifer Taylor has been recognized for her demonstrated successes in systems development and strategy implementation. Jackie promotes and advances leadership/administrative best practices in operations management to support innovation in health sector business and practice management. Equally important to her is the call to volunteerism. She has served on a number of committees, boards, and think tanks. Her scope of service includes appointments on Boards of health care service provider agencies, advisory committees of government (regionally, provincially, nationally and internationally), regional agencies, international think tanks, regulatory bodies (provincially, nationally), and appointments at academic institutions. Currently, provincially Dr. Schleifer Taylor holds several appointments, including serving as Chair of the Provincial Council of Maternal and Child Health. Nationally, she serves on the Board of Children's Healthcare Canada. Her academic credentials include Baccalaureate degrees in Science, and Health Sciences from McMaster University, where she graduated from Physical Therapy. Jackie also holds two graduate degrees, a Master of Science and a PhD, from the University of Toronto.

**Professor Robert Schwartz**
**Dalla Lana School of Public Health**
**Executive Director, Ontario Tobacco Research Unit, University of Toronto**

Robert Schwartz is Executive Director of the Ontario Tobacco Research Unit, Professor at the Institute of Health Policy, Management and Evaluation in the Dalla Lana School of Public Health at the University of Toronto and Senior Scientist, Centre for Addiction and Mental Health. Dr. Schwartz is Director of the U of T Collaborative Specialization in Public Health Policy. At OTRU, Dr. Schwartz directs research, evaluation, knowledge exchange and capacity building programs. His research interests include (1) Tobacco Control Policy, (2) e-cigarettes (3) Strategy design and evaluation, (3) Evaluation of Tobacco Control Programs and Policies, (4) Public Health Policy (5) Accountability (6) The Politics and Quality of Evaluation, (7) Performance Measurement and Performance Auditing, He has published widely about tobacco control, accountability, public health policy, policy change, program evaluation and government – third sector relations.

**Janice Sheehy**
**Commissioner, Human Services**
**The Regional Municipality of Peel**

Janice joined the Region of Peel in March 2016 as Commissioner, Human Services. In this role she provides strategic leadership to programs and services in the areas of housing and homelessness, early learning and childcare, as well as social assistance and employment support. Janice shares accountability with the executive leadership team for successfully implementing Peel's strategy to achieve Regional Council's long-term vision.

Over the course of her 30-year career, Janice has had the opportunity to work in various leadership roles within the public sector. Before joining the Region of Peel, she was the General Manager of Finance and Treasurer with the City of Guelph and employed with Halton Region, the City of Hamilton, the Ministry of the Attorney General, and the Ministry of Municipal Affairs and Housing - all in senior management roles.

Throughout her career Janice has held positions that provide connections between her strong financial background and her desire to make an impact on the lives of residents. Janice's focus is on delivering the best possible customer service that will have a positive effect on clients and tenants.

Janice has a Bachelor of Commerce (B.Com.) and has achieved certified designations with the Association of Certified Fraud Examiners (CFE), Institute of Internal Auditors (CIA), and Institute of Chartered Professional Accountants (CPA).

**Cynthia St. John**
**CEO, Southwestern Public Health**

Cynthia is the CEO of Southwestern Public Health, formed in 2018 by the merger of the former Oxford County Public Health and Elgin-St. Thomas Public Health. Prior to the merger, Cynthia presided as the Executive Director of Elgin-St. Thomas Public Health for 18 years. Cynthia now leads an organization of approximately 200 employees responsible for providing public health programming to a population of over 200,000 in southwestern Ontario. Cynthia began her career in the charitable sector having had the privilege of working with exceptional organizations such as the YWCA, the Anne Johnston Community Health Centre, and Dying with Dignity Canada. She holds a Masters of Business Administration with a specialization in Leadership and is currently a member of alPHa's Board of Directors.

**Monika Turner**
**Director of Policy, Association of Municipalities of Ontario**

Monika is the Director of Policy for the Association of Municipalities of Ontario (AMO). She joined AMO in 2010 after 25 years with the Ontario Government as both a public servant and a political assistant. Monika worked at the Ministry of Health and Long-Term Care twice. From 1998 to 2003, she led a series of physician compensation negotiations on behalf of the province. In 2006, Monika returned to the MOHLTC as the Director of Public Health Standards and oversaw the development of the 2008 Ontario Public Health Standards. She has a Masters of Law degree (ADR) from Osgoode Law School and received her Masters of Public Health from the University of Waterloo in 2011.

**Dr. David Williams**
**Chief Medical Officer of Health, Ontario Ministry of Health**

Dr. Williams is currently the Chief Medical Officer of Health for the province of Ontario and was appointed on February 16, 2016. Dr. Williams assumed the Interim Chief Medical Officer of Health position on July 1, 2015 having been in the position of Medical Officer of Health for the Thunder Bay District Board of Health from October 2011 to June 30, 2015. Prior to that, Dr. Williams had been at the Ontario Ministry of Health and Long-Term Care from 2005 to 2011 as the Associate Chief Medical Officer of Health, Infectious Disease and Environmental Health Branch Director. During this time he was also the Acting Chief Medical Officer of Health for Ontario from November 2007 to June of 2009. Before working at the province Dr. Williams was the Medical Officer of Health and CEO for the Thunder Bay District Health Unit from 1991 to 2005.

Ontario

**Ministry of Health**

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

Tel.: 416 212-3831
Fax: 416 325-8412

**Ministère de la Santé**

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

Tél. : 416 212-3831
Téléc. : 416 325-8412

DEC 10 2019 DEC 17 2019

Fred Eisenberger
Mayor of Hamilton
71 Main Street West, 2nd Floor
Hamilton ON L8P 4Y5

Dear Mr. Eisenberger:

Thank you for your letter to the Honourable Christine Elliott, Deputy Premier and Minister of Health, and myself regarding a seamless provincial immunization registry.

Immunization is a core component of Ontario's public health system, saving lives through the prevention of disease. The Immunization of School Pupils Act helps to protect children from many serious diseases by ensuring their vaccinations are up-to-date. Local public health units play an important role in supporting the successful implementation of the immunization requirements under the Act.

The Ministry of Health (the ministry) has been working over the last several years to provide appropriate digital tools to the public, health care providers, and public health to enable them to access and maintain their (or their patient's) complete immunization history. The provincial Digital Health Immunization Repository (DHIR) has been improving since its inception, with the ultimate goal being a fully interoperable system for immunization records in Ontario. In November 2018, the ministry began working with eHealth Ontario, OntarioMD, and electronic medical record vendors to enable transmission of immunization information from electronic medical records to the DHIR.

The ministry is committed to work towards the integration of immunization records across health care providers and organizations and to a strong and effective immunization system which will result in healthier children, healthier communities, and safer schools throughout the province

The Minister and I thank you for taking the time to share your views on this important public health matter and for your continued collaboration as we work together to improve the health and well-being of all Ontarians.

Yours truly,

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

361-2019-10117

| | |
|---|---|
| **From:** | Patel, Vijay (MOHLTC) |
| **To:** | Office of the Mayor; Richardson, Dr. Elizabeth |
| **Cc:** | Trevisani, David; Williams, Dr. David (MOHLTC); Walker, Elizabeth S. (MOHLTC); Gartner, Amy (MOHLTC); Feeney, Brent (MOHLTC) |
| **Subject:** | City of Hamilton, Public Health Services: 2019-20 Capital One-Time Funding for the Ontario Seniors Dental Care Program |
| **Date:** | December 9, 2019 10:13:51 AM |
| **Attachments:** | Hamilton_Amending Agreement.pdf<br>Hamilton_CMOH"s Letter.pdf<br>Hamilton_Minister"s Letter.pdf |
| **Importance:** | High |

Please find attached the 2019-20 one-time capital 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, to support the Ontario Seniors Dental Care Program.

Also attached are new Schedules to the Public Health Funding and Accountability Agreement that outline the terms and conditions governing the one-time capital funding.

If you have any questions, please contact SeniorsDental@ontario.ca.

Thank you for continued collaboration on this important initiative.

Dianne Alexander
Director
Health Promotion and Prevention Policy and Programs Branch
Office of the Chief Medical Officer of Health, Public Health
Ministry of Health

# 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<br>(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<br>(FOR THE PERIOD OF APRIL 1, 2019 TO MARCH 31, 2020, UNLESS OTHERWISE NOTED) | |
|---|---|
| **Projects / Initiatives** | **2019-20 Approved Allocation ($)** |
| Ontario Seniors Dental Care Program: Dental Clinic Upgrades – Centre de santé Communautaire (100%) | 137,700 |
| Ontario Seniors Dental Care Program: Mobile Dental Clinic Bus (100%) | 550,000 |
| Public Health Inspector Practicum Program (100%) | 10,000 |
| **Total Maximum One-Time Funds[3]** | **697,700** |

(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

| 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.

| 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.

| 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:

| 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

| 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*.

| 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 used 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.).

| 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,

| 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;

| 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.

| 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.

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

## *Ontario Seniors Dental Care Program: Dental Clinic Upgrades – Centre de santé Communautaire (100%)*

As part of the Ontario Seniors Dental Care Program, one-time funding is being provided to support capital investments in public health units, Community Health Centres and/or Aboriginal Health Access Centres across the province for enhancing infrastructure to increase clinical spaces and capacity to deliver dental care services for eligible seniors.

One-time funding must be used by the Board of Health to convert existing space into a restorative dental operatory. Eligible costs include renovations, and furniture and equipment.

Other requirements of this one-time funding include:

- Any changes to the scope of the project, including anticipated timelines, require prior review and approval by the Province.
- One-time funding is provided with the understanding that no additional operating funding is required, nor will it be made available by the Province, as a result of the completion of this project.
- The Board of Health must ensure that any goods and services acquired with this one-time funding should be procured through an open and competitive process that aligns with municipal and provincial procurement directives to the greatest extent possible.
- The Board of Health must ensure that this project is compliant with associated legislated standards (i.e., Building code/associated Canadian Standards Association requirements) and infection/prevention and control practices as appropriate to the programs and services being delivered within the facility.

## *Ontario Seniors Dental Care Program: Mobile Dental Clinic Bus (100%)*

As part of the Ontario Seniors Dental Care Program, one-time funding is being provided to support capital investments in public health units, Community Health Centres and/or Aboriginal Health Access Centres across the province for enhancing infrastructure to increase clinical spaces and capacity to deliver dental care services for eligible seniors.

One-time funding must be used by the Board of Health to expand the public health unit's mobile clinical service capacity with a 9 foot ADI wheelchair accessible Mobile Dental Clinic (bus). Eligible costs include replacement of the existing bus with a new bus equipped with Adec dental equipment and will include 2 dental operatories, a reception area, and laboratory.

Other requirements of this one-time funding include:

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

- Any changes to the scope of the project, including anticipated timelines, require prior review and approval by the Province.
- One-time funding is provided with the understanding that no additional operating funding is required, nor will it be made available by the Province, as a result of the completion of this project.
- The Board of Health must ensure that any goods and services acquired with this one-time funding should be procured through an open and competitive process that aligns with municipal and provincial procurement directives to the greatest extent possible.
- Funding for this mobile dental clinic bus is conditional on the Board of Health making best efforts to enter into Service Level Agreements with adjacent Boards of Health to provide dental services to enrolled clients in the adjacent public health units to address access issues, as needed.
- The Board of Health must ensure that this project is compliant with associated legislated standards (i.e., Building code/associated Canadian Standards Association requirements) and infection/prevention and control practices as appropriate to the programs and services being delivered within the facility, as well as wheel-chair accessible.

## *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.

| 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.

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-2019-01767

DEC 0 9 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 $687,700 in one-time funding to support capital and infrastructure improvements for the Ontario Seniors Dental Care Program.

Please find attached to this letter a new Schedule A (Grants and Budget) and Schedule B (Related Program Policies and Guidelines) that, pursuant to section 3.4 of the Agreement shall replace the existing Schedules A and B. 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 Dianne Alexander, Director, Health Promotion and Prevention Policy and Programs Branch (HPPPPB), at 416-212-7637 or by e-mail at Dianne.Alexander@ontario.ca.

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
Dianne Alexander, Director, HPPPPB, MOH
Elizabeth Walker, Director, Accountability and Liaison Branch, MOH

**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

Ontario

iApprove-2019-01767

DEC 0 9 2019

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

Dear Mayor Eisenberger:

I am pleased to advise you that the Ministry of Health will provide the Board of Health for the City of Hamilton, Public Health Services up to $687,700 in one-time funding to support capital and infrastructure improvements for the Ontario Seniors Dental Care Program.

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.

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

Sincerely,

Christine Elliott

Christine Elliott
Deputy Premier and Minister of Health

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

Hamilton

# Minutes
# FOOD ADVISORY COMMITTEE

October 8, 2019
7:00 – 9:00 p.m.
City Hall, Rooms 192-193, 1st Floor
71 Main Street West, Hamilton

**Present:** Elly Bowen (Co-chair), Krista D'aoust, Vicky Hachey, Laurie Nielsen, Barbara Stares, Kyle Swain, Drew Johnston, Biniam Mehretab, Jennifer Silversmith, Andrew Sweetnam, Brian Tammi (Secretary), Sandy Skrzypczyk (Staff Liaison)

**Absent with Regrets:** Councillor Merulla, Frank Stinellis, Maria Biasutti, Jordan Geertsma, Mary Ellen Scanlon, Edward Whittall, Vivien Underdown (Chair)

## 1. CHANGES TO THE AGENDA

**(Johnston/Mehretab)**
Motion to add discussion item regarding inviting FAC members to share articles/studies of interest that are relevant to food issues

**CARRIED**

## 2. DECLARATIONS OF INTEREST

There were no declarations of interest.

## 3. APPROVAL OF MINUTES OF PREVIOUS MEETING

**(Nielson/Johnston)**
That the minutes of the Sept 10, 2019 meeting of the Food Advisory Committee be approved as presented.

**CARRIED**

## 4. PRESENTATION

**4.1** Presentation on the Hamilton Community Food Centre by Amy Angelo, Manager of Food Access and Skills was received. The 15-minute presentation outlined the activities of Hamilton Community Garden Network (HCGN) and the Neighbour2neighbour Hamilton Community Food Centre. The community activities of these organizations directly relate to the Food Strategy and the mandate of the FAC.

This was followed by 15 minutes of Q & A where A. Angelo answered FAC member questions.

## 5. DISCUSSION ITEMS

### 5.1 Summary of Food Literacy Month Event

The FAC members who attended the recent Food Literacy Month event presented their take-aways from the event to rest of FAC present at meeting.

### 5.2 Other Food Literacy Event Options

General discussion of ideas for attending future events similar to the recent Food Literacy Month event. No final decisions were made.

### 5.3 Food Strategy Forum Update

S. Skrzypczyk informed FAC of finalized schedule and speakers at the upcoming Food Strategy Forum (FSF). Most of FAC plans to attend FSF, and the event is now free. Everyone must register if they plan on attending. Members were encouraged to engage their personal networks and invite people who they think should attend.

### 5.4 2020 Budget request report

S. Skrzypczyk informed FAC that the Committee will have spent $1,478.48 this year and have $1021.52 left in our budget. The previous FAC membership from 2018 requested a one-time funding increase of $1000 (for a total of $2500).

General discussion followed regarding how best to save and use these funds in 2020.

**(Mehretab/Johnston)**
That the remaining FAC budget go into the FAC reserves and be requested for 2020.

**CARRIED**

**(Mehretab/Johnston)**
That FAC request $1,500 for 2020 base budget and to request $1,000 from the Food Advisory Committee reserves for a total of $2,500 for the Committee's 2020 budget.

**CARRIED**

## 6. NOTICES OF MOTION

None

## 7. GENERAL INFORMATION & OTHER BUSINESS

E. Bowen informed FAC of a recent study from University of Guelph regarding food waste reduction. D. Johnson shared that he recently learned about a local aquaculture farm that he would like to find out more about and bring that information back to the Committee.

E. Bowen invited FAC members to suggest presenters that we would like to line up for the next meeting. S. Skrzypczyk suggested Alvaro Venturelli, Co-owner of Plan B Organic farms and Farmer at McQuesten Urban Farm. The Chair, Co-chair, and Secretary will work with the Staff Liaison to invite a presenter from the list of names generated at a previous FAC meeting.

V. Hachey **i**nquired if A. Angelo received an honorarium for presenting to FAC. E. Bowen confirmed that A. Angelo did not receive any funds from FAC for her presentation at this meeting.

## 8. ADJOURNMENT

**(D'aoust/Nielson)**
That there be no further business, the Food Advisory Committee be adjourned at 9:00 PM.

**CARRIED**

Respectfully submitted,

V. Underdown, Chair
Food Advisory Committee

Sandy Skrzypczyk
Staff Liaison
Public Health Services

# CITY OF HAMILTON
## PUBLIC HEALTH SERVICES
### Office of the Medical Officer of Health

| | |
|---|---|
| **TO:** | Mayor and Members<br>Board of Health |
| **COMMITTEE DATE:** | January 13, 2020 |
| **SUBJECT/REPORT NO:** | 2020 Public Health Services Risk Management Plan (BOH20003) (City Wide) |
| **WARD(S) AFFECTED:** | City Wide |
| **PREPARED BY:** | Carolyn Hureau (905) 546-2424 Ext. 6004 |
| **SUBMITTED BY:**<br><br>**SIGNATURE:** | Dr. Elizabeth Richardson, MD, MHSc, FRCPC<br>Medical Officer of Health<br>Public Health Services |

## RECOMMENDATION

That Appendix "A" to Report BOH20003 2020 Public Health Services Organizational Risk Management Plan be approved by the Board of Health.

## EXECUTIVE SUMMARY

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 (Ministry).

The Public Health Leadership Team has reassessed existing risks and identified new risks to inform the 2020 PHS Organizational Risk Management Plan (Appendix "A" to BOH20003). Organizational risks that have the highest likelihood of occurring and greatest potential impact on operations in 2020 are that the Board of Health may be at risk of:

- Not maintaining service delivery levels due to increased budget pressures, public health downloading, and other municipal and provincial changes;
- Not meeting program targets due to the distraction of public health modernization;
- Inadequate acquisition and retention of key personnel due to uncertainty regarding public health modernization;
- Higher employee absenteeism due to increased stress;
- Information loss or privacy breaches due to unreliable information management systems and practices;
- Data loss and business disruption due to use of unsupported technology;
- Incomplete risk management practices due to the appetite for risk culture not being clearly defined or articulated for staff; and,
- Significant disruptions and high opportunity costs related to public health downloading and modernization.

Action plans for mitigation and monitoring will be implemented by staff in 2020 (Appendix "A" to BOH20003). The Public Health Leadership Team will continue to review and update the action plans on a semi-annual basis.

**Alternatives for Consideration – See Page 4**

**FINANCIAL – STAFFING – LEGAL IMPLICATIONS**

Financial: No financial implications.

Staffing: No staffing implications.

Legal: Approval and submission of the 2020 PHS Risk Management Plan will ensure compliance with the Public Health Accountability Framework and Organizational Requirements. It also supports the Board of Health in practicing good governance and due diligence by mitigating potential organizational risks.

**HISTORICAL BACKGROUND**

In 2018, the Ministry introduced the new Ontario Public Health Standards (Standards) to support ongoing transformation of the public health system in Ontario. The Ministry also developed the Public Health Accountability Framework and Organizational

Requirements to ensure that boards of health have the necessary foundations within the four domains of program and service delivery, financial management, governance and public health practice to successfully implement the Standards (BOH17010(b)).

As part of the Public Health Accountability Framework and Organizational Requirements, public health units must have a formal risk management framework in place to identify, assess and address organizational risks. To demonstrate compliance with this requirement, boards of health must submit a risk management report annually to the MOHLTC.

In October 2017, the Board of Health received a report and presentation on risk management (BOH17039). Following this, the Public Health Leadership Team developed the 2018 PHS Risk Management Plan that identified organizational risks across 14 risk categories. This plan was based on the Ontario Public Service Risk Management Framework (BOH17039).

Each year, the PHS Risk Management Plan is reviewed and updated by the Public Health Leadership Team. Action plans to mitigate the organizational risks that have the greatest likelihood of occurring and greatest potential impact on operations are monitored and updated on a semi-annual basis. Progress on the implementation of these action plans and risk reduction strategies is reported to the BOH on an annual basis. The last update was provided in October 2019 (Report BOH18032(a)).

## POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

Development of a risk management plan and submission of an annual risk management report to the Ministry is a requirement within the Public Health Accountability Framework and Organizational Requirements. The Board of Health is held accountable to these requirements through the Public Health Funding and Accountability Agreement.

## RELEVANT CONSULTATION

Following the introduction of the new Ontario Public Health Standards in 2018, a consultation on the development of the PHS 2018 Risk Management Plan (BOH17039(a)) was conducted with Corrine Berinstein, Senior Audit Manager, Health Audit Services Team of the Ontario Internal Audit Division. Corrine provided guidance on the interpretation and use of the Ontario Public Service Risk Management Framework. During this time, consultation was also sought from Charles Brown, Director of Audit Services, City of Hamilton, to ensure the 2018 plan was in alignment with the future direction for enterprise risk management at the City of Hamilton. The same framework used in the PHS 2018 Risk Management Plan has been applied to the 2020 plan.

## ANALYSIS AND RATIONALE FOR RECOMMENDATION(S)

The PHS Risk Management Plan focuses on organizational risk and supports the Board of Health in identifying and mitigating issues that place PHS at risk of not meeting established business objectives. To inform the 2020 PHS Organizational Risk Management Plan, the Public Health Leadership Team reassessed risks from the 2019 plan (BOH18032) and identified new risks. The most significant organizational risks in the 2020 plan are that the Board of Health may be at risk of:

- Not maintaining service delivery levels due to increased budget pressures, public health downloading, and other municipal and provincial changes*;
- Not meeting program targets due to the distraction of public health modernization*;
- Inadequate acquisition and retention of key personnel due to uncertainty regarding public health modernization*;
- Higher employee absenteeism due to increased stress*;
- Information loss or privacy breaches due to unreliable information management systems and practices;
- Data loss and business disruption due to use of unsupported technology;
- Incomplete risk management practices due to the appetite for risk culture not being clearly defined or articulated for staff; and,
- Significant disruptions and high opportunity costs related to public health downloading and modernization*.

It is important to note that five (*) of the eight risks listed above are related to public health modernization and downloading by the Ministry. This illustrates the multiple dimensions of risk that this issue poses to the organization. Action plans were developed for all eight of the high-risk items listed above as they have the highest likelihood of occurring and greatest potential impact on operations (Appendix “A” to BOH20003).

## ALTERNATIVES FOR CONSIDERATION

The Board of Health could choose to amend the 2020 PHS Organizational Risk Management Plan.

## 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.

### Our People and Performance

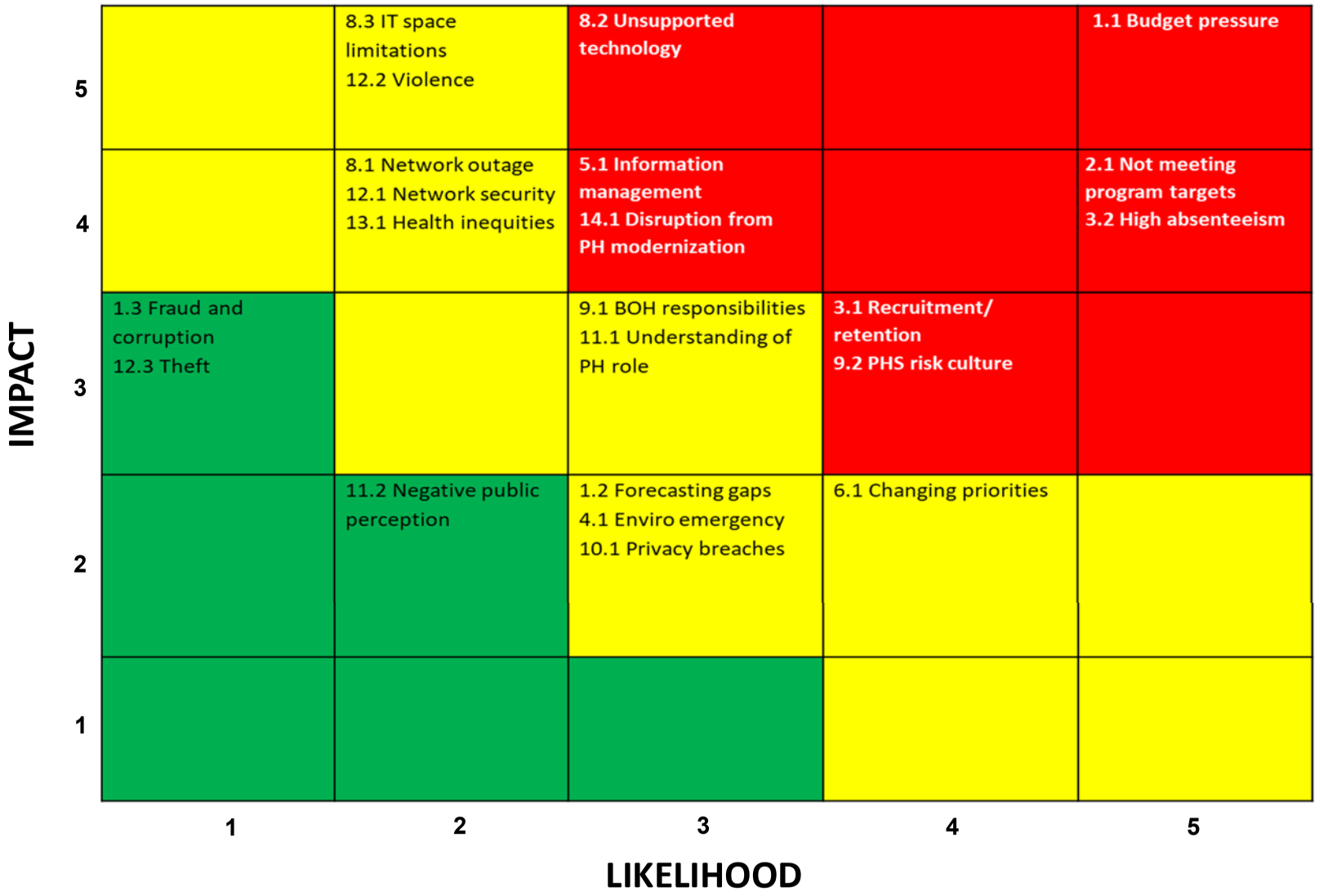
Hamiltonians have a high level of trust and confidence in their City government.

## APPENDICES AND SCHEDULES ATTACHED

| | |
|---|---|
| Appendix “A” to Report BOH20003: | 2020 PHS Organizational Risk Management Plan |

# 2020 PHS Organizational Risk Management Action Plan

The chart below shows the risks identified for 2020 categorized by low, medium, and high.




**Overall Risk Rating**

= Low Risk

= Medium Risk

= High Risk

# 2020 PHS Organizational Risk Management Plan

**Overall Objective: PHS will use a formal risk management framework that identifies, assesses and addresses risk.**

**** Related to Public Health Downloading and System Modernization**

| RISK IDENTIFICATION | | | | RISK ASSESSMENT | | RISK REDUCTION | | |
|---|---|---|---|---|---|---|---|---|
| ID # | Risk Exposure | Description of Risk | Cause/Source of Risk | Current Mitigation Strategies (what are we doing) | Rating Scale 1 (low) -5 (high) (Likelihood x Impact) | Action Plan (what else can we do?) | Timelines | Residual Risk (Likelihood x Impact) |
| **1. Financial Risks** | | | | | | | | |
| 1.1 ** | The Board of Health may not be able to maintain current service delivery levels due to increased budget pressures and public health downloading, and other municipal and provincial changes. | Funding changes resulting from the public health modernization may not leave local public health units with enough resources to carry out it's functions. Funding may not off-set rising operational costs which will impact operations. | Public health modernization, rising operational costs, low tax increases | Assessment of compliance against Ontario Public Health Standards, continuous quality improvement, program performance measurement and monitoring, and monthly review of Divisional financial dashboards. | L5, I5 | 1. Implement continuous improvement strategy to ensure regular review of programs and services for effectiveness and efficiency.<br>2. Include identification of opportunities for improvement into annual program planning with actions for improvement recorded in 2021 Program Plans.<br>3. Implement the Program Performance Management & Monitoring System to monitor program efficiency and effectiveness, and inform program and budget planning.<br>4. All levels within the City to advocate and engage in discussion with provincial government regarding the public health downloading and transition costs (if applicable).<br>5. Advocate for improved public health leadership and coordination of strategies, particularly with respect to chronic diseases and population-level health promotion. | 1. Ongoing<br>2. Q3 2020<br>3. Q1-Q3 2020<br>4. Ongoing<br>5. Ongoing | L4, I4 |
| **2. Operational or Service Delivery Risks** | | | | | | | | |
| 2.1 ** | The Board of Health may be at risk of not meeting program targets due to the distraction of public health modernization. | Change fatigue combined with uncertainty regarding public health modernization may result in lower productivity and inefficient use of time. | Public health modernization. | Use change management strategies to assist staff in maintaining current service delivery levels and quality in the midst of uncertainty. | L5, I4 | 1. Continue implementing change management strategies to support staff and maintain current service delivery levels.<br>2. Update and implement action plans from Our People Survey to address workplace culture issues. | 1. Ongoing<br>2. Ongoing | L3, I3 |
| **3. People / Human Resources** | | | | | | | | |
| 3.1 ** | The Board of Health may be at risk due to inadequate acquisition and retention of key personnel. | Uncertainty regarding public health modernization has caused concerned about job security. Resignations and retirements will create voids in key positions impacting the delivery of programs and services. | Public health modernization, workplace culture, increased workload, job security. | Succession planning, workforce planning, regular assessment of current vacancies across the department, change management strategies including open and transparent communication about system changes. | L4, I3 | Continue with current mitigation strategies. | N/A | L4, I3 |
| 3.2 ** | The Board of Health may be at risk of higher employee absenteeism resulting from increased stress. | Several factors including amount of change and uncertainty at PHS over the past few years, impacts of the economy, change in pace of evolution have led to higher levels of stress. This can negatively impact mental well-being and may result in prolonged absences.<br>Also, impacts of last restructuring with increased supervision and performance monitoring (individual and program-level). | Change fatigue, uncertainty related to public health modernization, personal stress. | PHS Well-Being Committee, employee resources (i.e., Employee Family Assistance Program), continue consistent implementation of the new supervisor model and performance monitoring. | L5, I4 | 1. Ensure clarity and alignment around priorities, strategic plans, and program plans.<br>2. Continue to ensure focus on priorities and deferral of non-important work. When emerging issues arise review priorities, strategic, and program plans and determine trade-offs as appropriate.<br>3. Ensure execution on strategies to manage workload and program change.<br>4. Work with management group on follow through with decisions. Include in all PAD expectations for 2020 (people leadership - 3 level). Include relevant competencies in staff PAD.<br>5. Hold PHS Leadership Forum with Managers | 1. Ongoing<br>2. Ongoing<br>3. Ongoing<br>4. Q4 2020<br>5. Q2 2020 | L5, I3 |

# 2020 PHS Organizational Risk Management Plan

**Overall Objective: PHS will use a formal risk management framework that identifies, assesses and addresses risk.**

**** Related to Public Health Downloading and System Modernization**

| RISK IDENTIFICATION | | | | RISK ASSESSMENT | | RISK REDUCTION | | |
|---|---|---|---|---|---|---|---|---|
| ID # | Risk Exposure | Description of Risk | Cause/Source of Risk | Current Mitigation Strategies (what are we doing) | Rating Scale 1 (low) -5 (high) (Likelihood x Impact) | Action Plan (what else can we do?) | Timelines | Residual Risk (Likelihood x Impact) |
| **5. Information/Knowledge Risks** | | | | | | | | |
| 5.1 | The Board of Health may be at risk due to unreliable information management systems and practices. | Varying information management practices and absence of a formalized records management platform could lead to loss of information, privacy breaches or non-compliance with records retention schedule, and could prevent staff from accessing information. | Absence of formalized records and information management platform. | Internal Privacy, Security and Information Management work group at public health to address information management concerns. | L3, I4 | 1. Implement Records and Information Management Framework<br>2. Create and rollout policies to support Records and Information Management Framework<br>3. Coordinated clean up of staff personal drives (m-drive) and shared drives<br>4. Establish and implement consistent practices for information management on shared drives<br>5. Explore implementation of Document & Records Management Software | 1. Q1 2020<br>2. Q1 / Q2 2020<br>3. Q3 / Q4 2020<br>4. Q3 / Q4 2020<br>5. Q3 / Q4 2020 | L3, I3 |
| **8. Technology Risks** | | | | | | | | |
| 8.2 | The Board of Health may be at risk due to use of unsupported technology. | New technology is not being adopted quickly enough resulting in the use of outdated and unsupported applications and systems. Potential for data loss, business disruption, impact to service delivery, and inefficient business processes. | Outdated technology, IT Governance is lacking for new and existing software technology resulting in the use of unstable or unsupported applications/ systems. | Development of data management policies and procedures. | L3, I5 | 1. Implementation of data management policies and procedures<br>2. Develop and maintain records information management (RIM) metadata for an inventory of software applications in use by PHS.<br>3. Participate in COMOH Digital Health Steering Committee to develop a set of recommendations regarding a digital strategy for public health including EMR solutions. | 1. Q2 2020<br>2. Q4 2020<br>3. Ongoing | L2, I4 |
| **9. Governance / Organizational Risks** | | | | | | | | |
| 9.2 | The Board of Health may be at risk of incomplete risk management due to the appetite for risk culture not being clearly defined and articulated for staff. | Risk management and mitigation plans require an understanding of risk management principles. This has not been shared at the program-level. | Formalized risk management is new to public health work. | Continue using the PHS Risk Management Framework to identify and assess organizational risks. | L4, I3 | 1. Incorporate the PHS Risk Management Framework into program and project planning. | 1. Q1 2020 | L3, I2 |
| **14. Political Risks** | | | | | | | | |
| 14.1 ** | The Board of Health may be at risk of significant disruptions and high opportunity costs related to public health downloading and modernization. | Service delivery and policy implications associated with changes resulting from public health downloading and modernization. | Public health downloading and modernization. | Engage in consultation with Ministry of Health where possible. | L3, I4 | 1. All levels within the City to advocate and engage in discussion /consultation with the provincial government regarding public health modernization. | 1. Ongoing | L3, I3 |

# CITY OF HAMILTON
## HEALTHY & SAFE COMMUNITIES
## Public Health Services

| | |
|---|---|
| **TO:** | Mayor and Members<br>Board of Health |
| **COMMITTEE DATE:** | January 13, 2020 |
| **SUBJECT/REPORT NO:** | Food Advisory Committee 2020 Budget Request (BOH20001) (City Wide) |
| **WARD(S) AFFECTED:** | City Wide |
| **PREPARED BY:** | Sandy Skrzypczyk (905) 546-2424 Ext. 3523 |
| **SUBMITTED BY:**<br><br>**SIGNATURE:** | Kevin McDonald<br>Director, Healthy Environments Division<br>Public Health Services |

**RECOMMENDATION**

(a) That the Food Advisory Committee 2020 base budget submission attached as Appendix "A" to Report BOH20001 in the amount of $1,500, be approved and referred to the 2020 budget process for consideration;

(b) That, in addition to the base funding, a one-time budget allocation for 2020 of $1,000, funded by the Food Advisory Committee Reserve, be approved and referred to the 2020 budget process for consideration.

**EXECUTIVE SUMMARY**

The Food Advisory Committee requests that a total budget of $2,500 be referred to the 2020 budget process for consideration. This budget request consists of the Food Advisory Committee's annual base budget of $1,500 to cover basic committee expenses, plus an additional $1,000 from the Food Advisory Committee Reserve to conduct relevant community engagement/events and research.

**Alternatives for Consideration – See Page 3**

## FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: N/A

Staffing: N/A

Legal: N/A

## HISTORICAL BACKGROUND

The Food Advisory Committee was created as a result of the City's 2014 advisory committee review process and the City's 2016 endorsement of the Hamilton Food Strategy. This committee consolidated attention toward food issues that were previously addressed on two separate advisory committees. The Food Advisory Committee can accommodate 13 to 18 members who are appointed by Council. Membership includes a range of food system expertise in farming and food businesses, food literacy, food access and waste, policy, non-profit/community-based food programs, and a non-voting Staff Liaison from Public Health, Healthy Environments Division.

Since 2016, the Food Advisory Committee has advised the Board of Health on Hamilton's Food Strategy actions and focused on community food security with a broader health-promoting food system lens. Since May 2019, when this term's membership started, they have informed and participated in two Food Strategy events and intend to continue to advise and support the implementation of Food Strategy actions in 2020.

## POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

No policy implications or legislated requirements.

## RELEVANT CONSULTATION

Corporate Finance Services were consulted regarding the process and template to use for submitting Advisory Committee budget requests, along with ensuring adequate funds were available in the Food Advisory Committee's Reserves.

## ANALYSIS AND RATIONALE FOR RECOMMENDATION(S)

The Food Advisory Committee has put forward a base budget request of $1,500 to cover basic expenses. To continue to effectively implement their mandate, including conducting relevant community engagement/event(s) and research, an additional $1,000 from their Reserves is required.

The Food Advisory Committee budget request is attached as Appendix "A" to Report BOH20001.

The Food Advisory Committee's full mandate is outlined in their Terms of Reference, attached as Appendix "B" to Report BOH20001.

## ALTERNATIVES FOR CONSIDERATION

Council could choose not to refer the Food Advisory Committee budget request to the budget process for Advisory Committees.

**Financial:** The Food Advisory Committee would not have a budget to operate.
**Staffing:** N/A
**Legal:** N/A

**Policy:** Community engagement was undertaken in 2016 to develop this Committee's mandate; discontinuing funds for the Committee could be seen as not adhering to the City's commitment to community engagement.

**Pros:** Not funding the Committee may leave additional funds in the Food Advisory Committee Reserve to be used another year or allocated elsewhere.

**Cons:** Not funding the Committee may result in lower or inequitable engagement and potential loss of volunteer members if base funds to cover the committee's parking reimbursement, refreshments, training/education and meeting supplies are not available. Not increasing the Committee's budget from the Food Advisory Committee Reserve restricts their ability to fulfil their mandate in any meaningful manner to support and advise the Hamilton Food Strategy implementation. In addition, the Advisory Committee Review recommendations of reforming and amalgamating food related committees would not be followed if budget was not assigned to the Food Advisory Committee.

## ALIGNMENT TO THE 2016 – 2025 STRATEGIC PLAN

### Community Engagement & Participation
*Hamilton has* an open, transparent and accessible approach to City government that engages with and empowers all citizens to be involved in their community.

### Economic Prosperity and Growth
*Hamilton has* a prosperous and diverse local economy where people have opportunities to grow and develop.

**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 BOH20001: Completed Advisory Committee Budget Template

Appendix “B” to Report BOH20001: Terms of Reference Food Advisory Committee

# CITY OF HAMILTON

## 2020

## ADVISORY COMMITTEES

## BUDGET SUBMISSION

## FOOD ADVISORY COMMITTEE

# PART A: General Information

**ADVISORY COMMITTEE MEMBERS:**

| | |
|---|---|
| Elly Bowen (Co-Chair) | Jennifer Silversmith |
| Maria Biasutti, | Barbara Stares |
| Krista D'aoust | Frank Stinellis |
| Vicky Hachey | Kyle Swain |
| Laurie Nielsen | Andrew Sweetnam |
| Jordan Geertsma | Brian Tammi (Secretary) |
| Drew Johnston | Vivien Underdown (Chair) |
| Biniam Mehretab | |
| Mary Ellen Scanlon | |

**MANDATE:**

As a volunteer advisory committee to the Board of Health, the Food Advisory Committee will support and advise on the implementation of Hamilton's Food Strategy, and the development of inclusive and comprehensive food related policies and programs at the individual, household, and community/population level based on internationally recognized principles of healthy public policy and best practices/available evidence.

# PART B: Strategic Planning

**STRATEGIC OBJECTIVES:**

- Identify and inform, where appropriate, innovative community food security policies and programs that align with the vision and goals of the Hamilton Food Strategy, Hamilton Food Charter, and other City strategies
- Identify and advise on emerging issues affecting Hamilton's food system
- Facilitate connections and share information and resources between members, the Board of Health, City staff, and as appropriate, further disseminate these lessons and resources among community organizations, businesses, citizens, and other groups that have an impact on community food security
- Support research, monitoring, and evaluation efforts, and identify gaps and opportunities that may inform community food security policies and program modifications
- Facilitate the cross-promotion of community food security within existing programs, events, policies, services, and other actions

## ALIGNMENT WITH CORPORATE GOALS:

| Please check off which Council approved Strategic Commitments your Advisory Committee supports | | | |
|---|---|---|---|
| **1) Community Engagement & Participation** | x | **2) Economic Prosperity & Growth** | x |
| **3) Healthy & Safe Communities** | x | **4) Clean & Green** | x |
| **5) Built Environment & Infrastructure** | x | **6) Culture & Diversity** | x |
| **7) Our People & Performance** | | | |

# PART C: Budget Request

## INCIDENTAL COSTS:

| | |
|---|---|
| Parking<br>Materials, supplies & printing | 600<br>400 |
| **SUB TOTAL** | **$1000.00** |

## SPECIAL EVENT/PROJECT COSTS:

| | |
|---|---|
| Training/Education<br>Event(s) | 500<br>1000 |
| **SUB TOTAL** | **$1,500.00** |

| | |
|---|---|
| **TOTAL COSTS** | **$ 2,500.00** |

| | |
|---|---|
| **Funding from Advisory Committee Reserve (only available to Advisory Committees with reserve balances)** | **$ 1,000.00** |

| | |
|---|---|
| **TOTAL 2020 BUDGET REQUEST (net of reserve funding)** | **$ 2,500.00** |
| **PREVIOUS YEAR (2019) APPROVED BUDGET)** | **$ 2,500.00** |

**CERTIFICATION:**

Please note that this document is a request for a Budget from the City of Hamilton Operating budget. The submission of this document does not guarantee the requested budget amount. Please have a representative sign and date the document below.

**Representative's Name:** **Vivien Underdown, Chair**

**Signature:** V. Underdown

**Date:** November 12, 2019

**Telephone # :** 289-683-2843

# Food Advisory Committee

## Terms of Reference

### Committee Mandate

As a volunteer advisory committee to the Board of Health, the Food Advisory Committee will support and advise on the implementation of Hamilton's Food Strategy, and the development of inclusive and comprehensive food related policies and programs at the individual, household, and community/population level based on internationally recognized principles of healthy public policy and best practices/available evidence.

More generally, the Food Advisory Committee will:

- Identify and inform, where appropriate, innovative community food security policies and programs that align with the vision and goals of the Hamilton Food Strategy, Hamilton Food Charter, and other City strategies;
- Identify and advise on emerging issues affecting Hamilton's food system;
- Facilitate connections and share information and resources between members, the Board of Health, City staff, and as appropriate, further disseminate these lessons and resources among community organizations, businesses, citizens, and other groups that have an impact on community food security;
- Support research, monitoring, and evaluation efforts, and identify gaps and opportunities that may inform community food security policies and program modifications; and
- Facilitate the cross-promotion of community food security within existing programs, events, policies, services, and other actions.

### Membership

The Food Advisory Committee will be comprised of 13 to 18 voting members, striving for a balance of representation from all the components within the food system as follows:

- Food Production: 2-3 members (e.g., representation from rural and urban agriculture, including large and small scale farmers, gardeners, soil specialists, horticulturalists);
- Processing & Distribution: 2-3 members (representation from large and small scale food production and distribution, including food entrepreneurs, managers/operators of incubators, food banks, food hubs, food box delivery programs, warehousing, storage, etc.);
- Buying & Selling: 2-3 members (e.g., representation from large and small scale food retail, including grocers, restauranteurs, Farmers Markets managers, social enterprise food entrepreneurs, specialty food stores owners, street vendors, etc.);
- Consumption: 2-3 members (e.g., representation from community and neighbourhood based food programs and cultural groups, including food literacy educators, consumers, chefs, food enthusiasts, etc.);
- Food Waste Management: 2-3 members (representation from food waste management, including researchers/consultants, managers, operators of

environmental groups, gleaning programs, experts/experienced individuals in composting/resource management, etc.);
- 3 members at large (citizens at large, local food advocates, etc.); and
- 2 City Councilors (non-voting, one representing urban and one representing rural wards).

Committee members will be selected through the City of Hamilton's standardized application process for Advisory Committees. New members will be formally appointed by the Board of Health at the beginning of each term of Council, or as needed. Individuals who do not live in Hamilton but work in the City of Hamilton in a food-related business or organization would be eligible for membership on the Food Advisory Committee based on their ability to provide valuable expertise to advise on food policies and programs in the City.

Food Advisory Committee members are appointed based on their individual qualifications in the following areas:
- Their professional or community work reflects the values and principles within the Hamilton Food Strategy, Hamilton Food Charter, Food Advisory Committee, and Public Health Services;
- They bring skills and experience (including lived experience) in at least one aspect of community food security that allows them to contribute to progressive and innovative policy and program development within the Committee;
- They have skills, knowledge, experience, or a genuine interest in at least one area of Hamilton's food system;
- They represent at least one element of the rich diversity of the Hamilton population's food security skills, talents, and needs;
- They can help the Food Advisory Committee facilitate dialogue and partnerships with at least one distinct population grouping in Hamilton's urban, suburban, and rural communities;
- They respect the complexity and sensitivity of the Food Advisory Committee's work with diverse partners, and appreciate the need for personal and group skills, problem-solving, and "getting to yes;" and
- They are able to attend monthly meetings of the Food Advisory Committee on a regular basis and can participate in occasional working group meetings.

**Roles & Responsibilities**

Members of the Food Advisory Committee shall endorse the Vision, Mission, Goals, and Values of the City of Hamilton Food Charter and make themselves familiar with the committee's Terms of Reference and mandate. General expectations of members include the following:
- Submit an annual progress report of the Committee's activities by November of each calendar year to the Board of Health and consider various options to keep Council up to date on the committee's activities;
- Demonstrate a respect for governance and protocol;

- Active participation and a commitment to attend meetings on a regular basis;
- Be accountable to other members and to citizens;
- Work as a team and follow through with commitments;
- Communicate appropriately and be clear about which interest are represented when speaking;
- Communicate all information occurring at the Food Advisory Committee to contacts within their sector, as appropriate; and
- Bring issues/concerns and represent their sector's interests at the Committee.

**Chair/ Co-Chair**

Members will, at the beginning of each term, elect from its membership two Co-Chairs, one of which shall be a Citizen member and one a Councillor Liaison member.

In addition to the general roles and responsibilities, Co-Chairs are expected to:

- Build the meeting agendas following the City of Hamilton template;
- Invite guests, in consultation with members and Staff Liaison;
- Preside at meetings;
- Facilitate dialogue among members between meetings;
- Liaise with City Staff Liaison and keep them informed of all Committee issues and actions; and
- Act as spokespeople on behalf of the Food Advisory Committee, as per Standard Operating Procedure #08-001.

**Secretary**

Members will, at the beginning of each term, elect from its membership a Secretary, which shall be a Citizen member.

In addition to the general roles and responsibilities, the Secretary is expected to:

- Provide relevant information, ideas, and opinions as a participant in the meeting;
- Record without note or comment all resolutions, decisions, and other proceedings at the meeting (as per the Municipal Act, 2001);
- Keep an accurate set of minutes of each meeting;
- Keep an up-to-date membership/contact list;
- Distribute minutes to members and notifying them of upcoming meetings;
- Keep a list of all advisory committees and members;
- Help the Chair with preparing the agenda, advise on meeting procedure, and reference materials and information retrieved from the records; and
- Make meeting and physical set-up arrangements (Note: room bookings with City Facilities will be coordinated through the Advisory Committee's Staff Liaison).

**City Staff Liaisons**

City of Hamilton staff will be assigned to this committee as non-voting members to

provide technical and content expertise and support, including:

- Public Health Services: 1 - 2 with expertise in nutrition, food systems, policy, and health protection;
- Emergency and Community Services: 1 - 2 with expertise in social policy and community programs;
- Planning and Economic Development: 1 – 2 with expertise in land use planning, licensing, and economic development related to agriculture and food; and
- Public Works Department: 1 – 2 with expertise in urban agriculture and food waste management.

**Staff Liaison Role**

The role of the Staff Liaison is to function as system experts. The City of Hamilton Public Health Services will appoint personnel with knowledge of nutrition policy, community food systems, and food security to provide support and coordination to the Food Advisory Committee.

The duties of the staff liaison include

- Coordinate, develop, and deliver the Orientation Session for the Advisory Committee;
- Liaise with Food Advisory Committee members, providing technical advice from Public Health Services for the preparation of reports, correspondence, etc.;
- Assist with the preparation of reports to the Board of Health, including an annual progress report of the Committee's activities by November of each calendar year;
- Assist with agenda preparation, review minutes, and ensure approved minutes are submitted to the Board of Health; and
- Provide background information, advice, and context for implementation of priorities.

City of Hamilton may assign staff to work on specific projects for a specific period of time.

**Councillor Liaisons**

Two (2) members of City Council will be appointed as representatives to the Food Advisory Committee with a requirement for each Councillor to attend a minimum of (but not limited to) one (1) meeting per year. Council members who are appointed as liaisons would not count toward the committee's quorum and do not have voting privileges.

**Staff Clerk/ Other Staff Support(s)**

The duties of the staff clerk include providing procedural process advise to the Staff Liaison and Co-Chairs as needed.

**Term of Membership**

Food Advisory Committee members are appointed for four (4) year terms with the possibility of renewal. Effort will be made to stagger appointments to ensure continuity.

- Members who miss three (3) consecutive meetings without Committee approval shall be considered as resigning from the committee;
- Any member who is absent for more than fifty percent (50%) of the meetings during their term shall not be eligible for reappointment; and
- Upon appointment to the Food Advisory Committee, members are required to sign an Acknowledgement (Declaration) Form and return it to the Office of the City Clerk prior to attending the first meeting of this committee.

**Meeting Frequency**

Meetings will occur monthly, with the exception of the months of July, August, and December (minimum of five and maximum of nine times per year). At the call of the Co-Chairs, additional meetings can occur on an 'as-needed' basis.

Should the Food Advisory Committee not meet a minimum of three times during a Council term, the Committee will be automatically disbanded at the end of the Council Term.

**Decision Making**

Food Advisory Committee members value and will make every effort to reach consensus in decision making, including a full discussion of the issue, review of all relevant information, discussion of possible solutions or actions, and the formulation of a statement of general agreement/consensus, or develop a motion and vote on it. The Committee requires consensus to make formal decisions and must follow the procedural processes outlined in the Advisory Committee Procedural Handbook, May 2015.

City of Hamilton staff are non-voting members.

**Quorum**

Quorum consists of half the voting members plus one. In order to ensure a broad range of perspectives are included in discussions and decision making, this minimum threshold must include a representative from each of the food system components, plus a minimum of one member at large.

**Code of Conduct/Conflicts of Interest**

All members shall adhere to all City of Hamilton policies, including those respecting code of conduct and conflict of interest. At a minimum, it is expected that members are to

- Maintain an atmosphere of respectful discussion and professionalism;
- Respect the confidentiality of all matters before the Food Advisory Committee;
- Actively contribute their expertise, resources, and individual experiences to further

the mandate of the Committee; and
- Declare a conflict of interest when it arises so it may be recorded in the minutes.

**Reports to**
- Board of Health

**Review of Terms of Reference**
- To be reviewed on an annual basis, at a minimum.

**Approved on:**
- May 2016

# CITY OF HAMILTON
## PUBLIC HEALTH SERVICES
## Office of the Medical Officer of Health

| | |
|---|---|
| **TO:** | Mayor and Members<br>Board of Health |
| **COMMITTEE DATE:** | January 13, 2020 |
| **SUBJECT/REPORT NO:** | Public Health Modernization (BOH20004) (City Wide) |
| **WARD(S) AFFECTED:** | City Wide |
| **PREPARED BY:** | Carolyn Hureau (905) 546-2424 Ext. 6004 |
| **SUBMITTED BY:**<br><br>**SIGNATURE:** | Dr. Elizabeth Richardson, MD, MHSc, FRCPC<br>Medical Officer of Health<br>Public Health Services |

## RECOMMENDATION

(a) That the Board of Health submit the attached letter (Appendix "A" to Report BOH20004) to the Minister of Health in response to the Discussion Paper on Public Health Modernization (Appendix "B" to Report BOH20004); and,

(b) That the Chair and Vice-Chair of the Board of Health participate in the in-person consultation with the Ministry on February 11, 2020 to further discuss public health modernization.

## EXECUTIVE SUMMARY

The Ministry of Health released a discussion paper on public health modernization in November 2019 (Appendix "B" to Report BOH20004). The discussion paper outlines key strengths of public health in Ontario and identifies four key challenges:

1. Insufficient capacity;
2. Misalignment of health, social, and other services;
3. Duplication of effort; and,
4. Inconsistent priority setting.

The paper also included 21 specific discussion questions about how to best address these challenges and build on existing strengths in order to modernize and transform the role of public health in improving the health of Ontarians at both the provincial and local levels.

An online survey for staff, consultations with senior leadership, a review of previous correspondence from the Board of Health and other organizations, as well as relevant reports, informed this report and the attached letter to the Minister of Health (Appendix "A" to Report BOH20004).

In preparing Hamilton Public Health Services' response, the following key principles of public health modernization were taken into consideration:

- That the unique mandate of public health be maintained;
- That the core functions of public health be continued;
- That the focus of local public health agencies be maintained at the local level;
- That sufficient funding and human resources be ensured;
- That a risk management approach to public health modernization be used to identify where the greatest capacity challenges are and focus on those first; and,
- That both provincial and local level public health agencies need to be strengthened and coordinated as a public health system for Ontarians.

The following recommendations were developed based on the key themes from the consultations and review:

- That an overarching provincial public health system strategy be developed that clearly outlines the roles and responsibilities of the Ministry of Health, Public Health Ontario, and local public health units;
- That local public health services continue to be responsive and tailored to the health needs and priorities of each local community, including those of vulnerable groups or those with specific needs such as the Indigenous community;
- That public health senior and medical leadership be maintained at the local level to provide advice to municipal councils and participate in strategic community partnerships;
- That Ontario's public health system remain financially and administratively separate and distinct from the health care system;
- That any changes to the public health system leverage and build on the strong partnerships and collaborations that currently exist at the both provincial and local levels;
- That local governance have strong accountability and leadership;
- That mechanisms be included to ensure that the total funding envelope is stable and protected for the full delivery of all public health programs and services;

- That the Ministry of Health and Public Health Ontario provide stronger leadership and centralized support for policy and strategy development, health promotion messaging and campaigns, research, and competency development;
- That Public Health Ontario and local public health units have distinct and complementary roles with respect to population health assessment, epidemiology, and evaluation;
- That any changes to the public health system utilize a risk management approach to identify where the greatest capacity, or other challenges are and focus on those first; and,
- That Hamilton Public Health Services remain as an organization within the City of Hamilton, and its jurisdiction also remain the same, as it serves a good size population, and has the support and strategic benefits of being amalgamated within the City.

**Alternatives for Consideration – See Page 6**

**FINANCIAL – STAFFING – LEGAL IMPLICATIONS**

Financial: No financial implications.

Staffing: No staffing implications.

Legal: No legal implications.

**HISTORICAL BACKGROUND**

On April 11, 2019 the Ontario Budget was announced which included plans to modernize the public health system by consolidating 35 health units into 10 new regional Public Health Entities. The budget also recommended a $2 million reduction in total provincial funding by 2022, including adjustments to the current funding formula that would download a significant portion of costs to municipalities.

On August 19, 2019 the Minister of Health announced the Province had heard the need for more time and consultation with respect to public health modernization. In addition, the Province notified public health units that they would:

- Hold-off on funding changes until January 2020 at which point the funding formula would shift to a 70% provincial and 30% municipal share for all public health programs under the Ontario Public Health Services except for the new Ontario Seniors Dental Care Program and Healthy Babies, Healthy Children;

- Cap the impact on municipalities from this funding shift to 10% of current funding levels for 2020; and,
- Provide public health units with one-time funds to help with the transition.

On October 10, 2019, the Ministry of Health appointed Jim Pine (Chief Administrative Officer for the County of Hastings) as Special Advisor and Alison Blair (Assistant Deputy Ministry for Emergency Health Services) as Executive Lead for the renewed consultations on strengthening and modernizing public health and emergency health services. Shortly after, the Ministry of Health released a discussion paper on public health modernization with 21 questions to guide meaningful conversations. Since then, the Ministry of Health has been gathering feedback through a variety of avenues including an online survey, written submissions, and in-person stakeholder consultations.

## POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

At this time, there are no policy implications or legislated requirements. The Ministry of Health has indicated that the renewed consultations are an information gathering exercise and has reiterated that no decisions regarding public health modernization have been made at this point.

## RELEVANT CONSULTATION

An online survey containing the 21 questions from the Discussion Paper on Public Health Modernization was sent out to all staff in December 2019. In addition, consultation meetings were held with the General Manager of Health & Safe Communities and the City Manager.

## ANALYSIS AND RATIONALE FOR RECOMMENDATION

To inform Hamilton Public Health Services' collective response to the discussion paper, feedback obtained from the staff survey and leadership consultations was collated and analysed. Previous correspondence from the Board of Health and other organizations, as well as relevant reports were also reviewed.

The following key principles of public health modernization were used to guide Hamilton Public Health Services' response:

- That the unique public health mandate of keeping people healthy, preventing disease, and reducing health inequities be maintained;

- That the core functions of public health including population health assessment and surveillance, promotion of health and wellness, disease prevention, health protection and emergency management and response be continued;
- That the focus of local public health agencies be maintained at the local level to ensure services are tailored to the health needs and priorities of the community;
- That sufficient funding and human resources to fulfill public health's unique mandate be ensured;
- That a risk management approach to public health modernization be used to identify where the greatest capacity or other challenges are and focus on those first; and,
- That both provincial and local level public health agencies need to be strengthened and coordinated as a public health system for Ontarians.

Listed below are the recommendations that were developed based on the key themes from the collective input of staff and senior leadership:

- That an overarching provincial public health system strategy be developed that clearly outlines the roles and responsibilities of the Ministry of Health, Public Health Ontario, and local public health units;
- That local public health remains at the community level. It is imperative that local public health services be responsive and tailored to the health needs and priorities of each local community, including those of vulnerable groups or those with specific needs such as the Indigenous community;
- That there be local public health senior and medical leadership to provide advice on public health issues and participate in strategic community partnerships;
- That Ontario's public health system remain financially and administratively separate and distinct from the health care system;
- That any changes to the public health system leverage and build on the strong partnerships and collaborations that currently exist;
- That local governance have strong accountability and champion public health issues in the community, and that boards of health have proportionate representation to the communities they serve;
- That mechanisms be included to ensure that the total funding envelope is stable, predictable, and protected for the full delivery of all public health programs and services;
- That the Ministry of Health and Public Health Ontario provide stronger leadership and centralized support for the following areas:
  - Development of policies and strategies (especially related to health promotion and disease prevention) that include delineation of provincial and local roles and responsibilities, and include measurable goals;

  - Development of a digital health strategy that includes data standardization and interoperability of digital health solutions (e.g., electronic medical records) across both the public health system and broader health system;
  - Development and coordination of health promotion messaging, campaigns, and social marketing, with complementary local campaigns where appropriate;
  - Evidence reviews/synthesis and library services;
  - Development of a research agenda to inform best practice standards and evidence-informed strategies in collaboration with Ontario's post-secondary institutions and research institutes;
  - Coordination with other provincial ministries to ensure public health programs and services are planned and delivered more efficiently; and,
  - Competency development and capacity building (e.g., Indigenous cultural competency training).

- That Public Health Ontario and local public health units have distinct and complementary roles with respect to population health assessment, epidemiology, and evaluation. Public Health Ontario should provide scientific and technical expertise and conduct provincial-level analysis, while local public health units conduct local-level analysis and determine how best to execute provincial priorities and respond to local health issues within the community;
- That any changes to the public health system utilize a risk management approach to identify where the greatest capacity, or other challenges are and focus on those first; and,
- That Hamilton Public Health Services remain as an organization within the City of Hamilton, and its jurisdiction also remain the same as it serves a good size population, and has the support and strategic benefits of being amalgamated within the City.

Additional suggestions and perspectives on each of the four key challenges identified in the discussion paper are provided in the letter to the Minister of Health (Appendix "A" to Report BOH20004).

## ALTERNATIVES FOR CONSIDERATION

The Board of Health could choose not to submit a response or engage in provincial consultation; however, this alternative is not recommended.

## 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.

**Our People and Performance**
Hamiltonians have a high level of trust and confidence in their City government.

## APPENDICES AND SCHEDULES ATTACHED

| | |
|---|---|
| Appendix “A” to Report BOH20004: | Letter to the Minister of Health |
| Appendix “B” to Report BOH20004: | Discussion Paper: Public Health Modernization |

**DRAFT: Letter to the Minister of Health**

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

Dear Minister Elliott,

Thank you for the opportunity to provide feedback on behalf of City of Hamilton Public Health Services in response to the November 2019 *Discussion Paper: Public Health Modernization*[i]. We would like to commend you and your colleagues for taking a renewed approach to public health modernization that includes more extensive consultation across the province.

The contents of this letter represent the collective perspectives of City of Hamilton Public Health Services staff and the Board of Health. A review of relevant reports and correspondence from other organizations was also conducted to inform our response. We hope that you find the breadth and depth of the input provided to be of assistance as you consider next steps.

City of Hamilton Public Health Services recognizes and supports the need to modernize and strengthen Ontario's public health system in order to achieve the following:

- Better consistency and equity of service delivery;
- Improved clarity and alignment of roles and responsibilities between the Province, Public Health Ontario and local public health;
- Better and deeper relationships with primary care and the broader health system; and,
- Improved public health delivery and system sustainability.

It is important to highlight the key role that the broad range of local public health programs – such as infectious disease control, physical activity promotion, food premise inspections, tobacco control, immunization, and healthy growth and development – play to keep people and our communities healthy, prevent disease and reduce health inequities and, as such, making important contributions toward the provincial government's goal of eliminating "hallway medicine".

For this reason, we strongly advocate that public health's unique mandate to keep people and our communities healthy, prevent disease, and reduce health inequities be maintained. We also recommend there be a continued focus on the core functions of public health, including population health assessment and surveillance, promotion of health and wellness, disease prevention, health protection and emergency management and response.

To modernize and strengthen public health in Ontario, the City of Hamilton Public Health Services recommends that:

- The Province consider using a risk management approach to public health modernization to identify where the greatest capacity challenges are and focus on those first;
- It is strongly recommended that Hamilton Public Health Services remain as an organization within the City of Hamilton, and its jurisdiction remain the same – given that

it serves a good size population and has the support and strategic benefits of being amalgamated within the City;

- An overarching provincial public health system strategy be developed that clearly outlines the roles and responsibilities of the three entities that form Ontario’s public health system – the Ministry of Health, Public Health Ontario, and local public health units. Once the strategy has been implemented, the need for a regional level (in addition to the local and provincial levels) could be re-evaluated;
- Local public health remain at the community level. It is imperative that local public health services be responsive and tailored to the health needs and priorities of each local community, including those of vulnerable groups or those with specific needs such as the Indigenous community. Also, there is a need to maintain and work with community partners including health care system partners at the community level;
- Ontario’s public health system remain financially and administratively separate and distinct from the health care system;
- Any changes to the public health system leverage and build on the strong partnerships and collaborations that currently exist. Engaged and empowered communities and stakeholders are essential for public health. Local public health units are best positioned to lead strategic community partnerships with municipalities, school boards, health care organizations, community agencies and residents;
- Local governance have strong accountability and leadership on community issues and that boards of health have proportionate representation to the communities they serve;
- Local public health senior and medical leadership is maintained to provide advice to municipal councils on public health issues and participate in strategic community partnerships;
- Sufficient funding and human resources to fulfill public health’s unique mandate be ensured. Mechanisms must be included to ensure that the total funding envelope is stable, predictable, and protected for the full delivery of all public health programs and services;
- The Ministry of Health and Public Health Ontario take on a stronger leadership role in the following areas:
  - Development of policies and strategies (especially related to health promotion and disease prevention) that include delineation of provincial and local roles and responsibilities, and include measurable goals;
  - Development of a digital health strategy that includes data standardization and interoperability of digital health solutions (e.g., electronic medical records) across both the public health system and the broader health system;
  - Development of health promotion messaging, campaigns, and social marketing with complementary local campaigns where appropriate;
  - Evidence reviews/synthesis and library services;
  - Development of a research agenda to inform best practice standards and evidence-informed strategies in collaboration with Ontario’s post-secondary institutions and research institutes;
  - Coordination with other provincial ministries to ensure public health programs and services are planned and delivered more efficiently; and,
  - Competency development and capacity building (e.g., Indigenous cultural competency training).

City of Hamilton Public Health Services would be willing to reallocate relevant resources either permanently and/or through secondments to support implementation of new roles or central functions at the provincial level. Secondments would help build competency of local public health staff and promote a stronger connection between provincial and local public health agencies; and,

- Public Health Ontario and local public health units have distinct and complementary roles with respect to population health assessment, epidemiology, and evaluation. Public Health Ontario should provide scientific and technical expertise and conduct provincial-level analysis to support local public health units with the identification of priority populations and health needs. It is imperative that epidemiological capacity be maintained at local public health unit level in order to conduct local population health assessment and determine how best to execute provincial priorities and respond to local health issues within the community.

Further feedback and additional perspectives related to the key challenges raised in the discussion paper are provided below.

**Insufficient Capacity**

As noted in *Discussion Paper: Public Health Modernization*[i], “…the capacity of health units varies significantly across the province”. Implementing a one size fits all approach such as regionalization of all public health units (including those who currently have sufficient capacity) would not be an effective way to address this variability. Instead, the Province should consider using a risk management approach to public health modernization to identify where the greatest capacity challenges are and focus on those first (e.g., merging smaller health units or other areas identified through audits or health units themselves). Any amalgamation of existing public health units must be predicated on evidence-based conclusions that it will demonstrably improve the capacity to deliver public health programs and services to the residents of that area.

It is strongly recommended that the City of Hamilton Public Health Services and its jurisdiction remain the same – it serves a good size population and is a good size organization. Furthermore, the City of Hamilton currently has sufficient capacity to carry out public health functions locally. There is also value in being part of a municipality in that significant legal and administrative support is provided and surge capacity is available for emergency response. Being embedded within a municipality has afforded the opportunity to work with other City departments (e.g., public works, by-law enforcement, planning & economic development) to build stronger relationships, streamline services, and provide wrap-around supports for clients.

Strong and effective accountability mechanisms at both the provincial and local level, including an integrated performance monitoring framework (e.g., accreditation, accountability, performance measurement) are critical to identifying and addressing insufficient capacity or other challenges. Strengthening accountability supports a culture of continuous quality improvement and ensures health units are performing appropriately.

Increased support from the Province and Public Health Ontario in specific areas could also be used to bolster capacity among public health units who currently have an insufficient amount. Examples of functions that would benefit from increased provincial support and stronger leadership are outlined in the section below.

**Duplication of Efforts**

Preservation of strong provincial and local roles coupled with effective leadership is essential for a robust public health system. Clarifying roles and responsibilities of the Ministry of Health, Public Health Ontario, and local public health units would reduce duplication. For example, within the Healthy Communities work, there are levers to improve both the provincial and local roles. The Province should focus on providing support through legislation, policy development, and the provision of funding, while the local level leads collaboration with community stakeholders (e.g., municipalities, school boards, etc.) to implement provincial strategies within the local context. It is often easier for public health units situated within municipal organizations to impact and influence levers at the local level due to their unique position. It is recommended that both provincial and local roles be preserved in a manner that maintains and fosters innovation, effective leadership, and responsiveness to diversity across the system.

To further reduce duplication, Public Health Ontario and local public health units should have distinct and complementary roles with respect to population health assessment, epidemiology, and evaluation. Public Health Ontario should provide scientific and technical expertise and conduct provincial-level analysis to support local public health units with the identification of priority populations and health needs. It is imperative that epidemiological capacity be maintained at local public health unit level in order to conduct local population health assessment and determine how best to execute provincial priorities within the community.

Stronger leadership and centralized support from the Ministry of Health and Public Health Ontario in the following areas is required to reduce duplication and increase consistency:

- Development of policies and comprehensive strategies for provincial priority areas that leverage multiple levels of actions for specific health issues as recommended in the *2017 Ontario Auditor General Report*[ii] and the *2019 Standing Committee on Public Accounts Report*[iii];
- Development of a digital health strategy that uses a standardized approach to data and information governance including common data standards and interoperability of digital health solutions (e.g., electronic medical records) across the public health system and broader health system;
- Investment in common digital solutions and applications to facilitate data-sharing, increase accessibility, enhance data quality and meet the demand for real-time information;
- Development of health promotion messaging, campaigns, and social marketing (e.g., Healthy Smiles Ontario) with complementary local campaigns where appropriate;
- Evidence reviews/synthesis and library services;
- Development of a research agenda with priorities and timelines to inform best practice standards and evidence-informed strategies in collaboration with post-secondary and research institutions across the province to leverage their substantial capacity;
- Coordination with other provincial ministries to ensure public health programs and services are planned and delivered in a more efficient and integrated manner; and,
- Competency development and capacity building (e.g., Indigenous cultural competency training) that is aligned with the principles of adult learning including workshops and conferences as well as provincial task forces and secondments to the Ministry of Health or Public Health Ontario.

Front-line services that work to implement provincial directions in ways that meet the needs of the community should remain at the local public health level. Examples include (but are not limited to) clinic services, dental programs, collaboration with schools and school boards on healthy school programming such as that to improve physical activity and nutrition, emergency response, collaboration with local planners on healthy community design and health inspections. Public heath staff at the local level have a deep understanding of the community context in which they work, enabling them to respond quickly and appropriately to local needs and emerging issues.

Overall, increased communication and transparency with regards to what is being done at both the provincial and local levels (e.g. evidence reviews, pilot projects, data collection, etc.) would further reduce duplication and promote a coordinated approach.

**Misalignment of Health, Social, and Other Services**

City of Hamilton Public Health Services has a rich history of community collaboration, working together with larger health, social services, and education sectors, as well as NGO’s/not for profits in our City on initiatives to improve health outcomes and health equity. Hamilton Public Health has longstanding connections with FHT, primary care, acute care hospitals, post-secondary institutions, McMaster Department of Family Medicine, school boards, early years sector, municipalities, social services, and the business community.

Most recently, the Hamilton Health Team was established bringing over 20 health and social service partners to the same table. Local public health has a role to play to collaborate with the Ontario Health Teams in their jurisdiction. Making drastic changes to public health at this time, such as regionalization, would create further barriers to effective collaboration. If the Hamilton Health Team were to carry on without strong public health representation, opportunities to inform system planning, encourage and collaborate on disease prevention and health promotion, and ensure alignment of services would be weakened if not lost. Especially important is the shared focus on health equity and chronic diseases.

There is also a need to increase alignment of health, social, and other services at the provincial level. Clarity of roles and better coordination among provincial ministries would help ensure that public health programs are delivered in a more efficient, streamlined manner. For example, the Ministry of Health should work collaboratively with the Ministry of Education, and the Ministry of Children, Community and Social Services to coordinate the planning, development, and delivery of programs for children and youth.

**Inconsistent Priority Setting**

The Province is uniquely positioned to enable shared and consistent priority setting across the public health system. Robust local data is needed to drive priority setting at both the provincial and local level. The Province could play a crucial role in collaborating and coordinating with other sectors such as police, emergency services, and hospitals to increase data sharing. The creation of provincial data platforms that are standardized and more accessible would help ensure data is provided in a timely manner for decision-making and ongoing monitoring. Standardization of evidence-based approaches, strategies, tools and methods with the ability to tailor at the local level would also support consistent priority setting.

From a local governance perspective, strong accountability and leadership on local public health issues is essential. In addition, representation on boards of health should be proportionate to

the community it serves. If the Province were to go ahead with making all boards of health special purpose bodies to increase consistency in government structure for local public health, the following principles should be applied:

- Boards of health should have representation that is proportionate to the community it serves;
- Boards of health should have the latitude to make independent decisions based on community needs within the *Ontario Public Health Standards* and expectations; and,
- Boards of health should continue working in collaboration with the health care system while remaining financially and administratively separate and distinct.

**Indigenous and First Nation Communities**

In keeping with the principles of respect, trust, self-determination, and commitment – “*Nothing about us without us*” – we reached out to the Indigenous community in Hamilton to gather feedback about how best to strengthen relationships between local public health and Indigenous communities. A key theme throughout this consultation was that Indigenous communities want to be empowered and resourced to implement public health initiatives themselves, with support from public health units as they determine, as opposed to local public health units doing this work. Provincial legislative changes are required to make this a reality.

Collaboration between the City of Hamilton Public Health Services and local Indigenous communities has evolved over the past few years. Hiring an Indigenous Health Strategy Specialist who is an Indigenous person has been critical for establishing and supporting these relationships and building trust. To advance this work further, it is recommended that additional Indigenous people be hired.

Local public health units should work alongside Indigenous communities to develop positive and meaningful relationships and advocate for support and education to create a healthy community for Indigenous people. Understanding and incorporating Indigenous Traditional Knowledge is essential. Spiritual health is as important as mental health; a wholistic model of healing recognizes this. It is also imperative that the principles of respect, trust, self-determination, and commitment be respected and incorporated into all of the work.

Special consideration will need to be given to the effects of any proposed organizational change on Ontario’s many Indigenous communities. Opportunities to further improve these relationships must be explored as part of the public health modernization process.

**Francophone Communities**

In the City of Hamilton, hiring bilingual staff who have the ability to engage with the Francophone community and partners has been important in the planning, delivery, and evaluation of public health services. The availability of French resources, auditory interpretation services, and translation services (funded by the Ministry of Health) has also enabled staff to deliver services to Francophone populations within Hamilton. To better meet the needs of this population, the following areas for improvement were identified:

- Increasing the number of bilingual employees, assessing appropriate resource requirements to meet the needs of the population;
- Continuing to grow intentional and collaborative engagement with the Francophone community to identify gaps in service and program planning;

- Continuing to consider local Francophone needs and voices to inform local decisions for services; and,
- Increasing Ministry involvement in translation services including facilitation of reliable and accurate software translation tools.

**Transition and Modernization Considerations**

All changes resulting from public health modernization must serve the goal of strengthening the Ontario public health system’s capacity to improve population health in all of Ontario’s communities through the effective and efficient local delivery of evidence-based public health programs and services. In addition, any new organizational structure must build on the current strong collaborative relationships among the public health agencies and the assets of current local boards of health.

A thoughtful, deliberative approach that includes good change management practices, while ensuring ongoing service delivery should be used when carrying out any future transitions. Provincial supports (e.g., financial, legal, administrative) must be provided to assist existing local public health agencies in their transition to any new state without interruption to front-line services.

**Questions for Consideration**

1. What are the roles of the three public health entities (the Ministry of Health, Public Health Ontario, and local public health units) with respect to the Ontario Health Teams? Are there clinical services that should be integrated with the Ontario Health Teams (e.g., sexual health, vision screening, etc.)?
    - It is important to work together with Ontario Health Teams to understand the state of the population’s health (i.e., population health assessment) while working together on shared priorities.
2. What is the delineation of roles and responsibilities between the Ministry of the Environment, Conservation and Parks and public health at both the provincial and local level?
    - Local public health does not currently have sufficient capacity to engage in work that is not currently part of the public health mandate and is not focused on human health. If there is a desire for local public health to take on more of this work, including work that relates to the health of the environment, there needs to be a deliberate conversation regarding roles and resource requirements.
3. Is the Province willing to lead policy and strategy development with respect to land use planning and public health?
    - Land use planning is a significant area of work with opportunities for public health.

For the health of our population, it is critical that public health continue to have a population health mandate, remain at the local level, and continue to be empowered to work with all sectors and partners that influence health to enable cross-sector collaboration to promote, prevent, and protect health.

We look forward to working with you to modernize and strengthen public health in Ontario to improve the health of all Ontarians.

Sincerely,

Fred Eisenberger
Mayor

(on behalf of the Board of Health, City of Hamilton)

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

---

[i] Ministry of Health. (2015). *Discussion Paper: Public Health Modernization.* Retrieved from: http://health.gov.on.ca/en/pro/programs/phehs_consultations/docs/dp_public_health_modernization.pdf

[ii] Office of the Auditor General of Ontario. (2017). Public Health: Chronic Disease Prevention. *Annual Report 2017*. Retrieved from:http://www.auditor.on.ca/en/content/annualreports/arreports/en17/2017AR_v1_en_web.pdf.

[iii] Standing Committee on Public Accounts. (2019). *Public Health: Chronic Disease Prevention*. Retrieved from: https://www.ola.org/sites/default/files/node-files/committee/report/pdf/2019/2019-11/42_1_PA_Public%20Health_28102019_en.pdf

Ministry of Health

# Discussion Paper:

## Public Health Modernization

November 2019

Ontario

# Purpose

At the Ministry of Health, we are committed to ending hallway health care and ensuring the people of Ontario have access to high quality services, both now and in the future. To meet this goal, changes are needed to create strong, sustainable foundations for our health system. As an integral part of this system, we need to consider how we are delivering public health services to ensure these services continue to meet the evolving needs of people across Ontario.

Following the introduction of the government's proposals, we clearly heard and responded to the need for more extensive consultations across the province on how best to move forward. This discussion paper is intended to frame a meaningful conversation on how we can update and improve public health in Ontario. We are asking for your input and advice on specific key issues for the sector, both through the responses to the questions posed in this paper and in upcoming in-person consultations with public health and municipal stakeholders.

We look forward to hearing from you.

# Introduction

The Ontario government is transforming the whole health care system to improve patient experience and strengthen local services. This means a connected health care system through the establishment of Ontario Health Teams, and a new model to integrate care and funding that will connect health care providers and services focused on patients and families in the community. These changes will strengthen local services, making it easier for patients to navigate the system and transition among providers. Changes will also include the integration of multiple provincial agencies into a single agency – Ontario Health – to provide a central point of accountability and oversight for the health care system.

While the broader health care system undergoes transformation, a clear opportunity has emerged to transform and strengthen the role of public health as a foundational partner in improving the health of all Ontarians.

This comes at a time when there are many challenges facing today's world that require a coordinated public health sector that is resilient and responsive to the province's evolving health needs. This includes the unpredictable nature of infectious diseases that seldom respects geographic boundaries, recognition that disease risk factors are related to a multitude of social conditions, and the rise of unprecedented emergencies such as opioids, vaping and vaccine hesitancy. A modernized public health system that is not only well-coordinated, but also integrated with other sectors, is imperative to addressing these challenges.

As we transform and strengthen the role of public health, we will work toward the following outcomes:

- Better consistency and equity of service delivery across the province;
- Improved clarity and alignment of roles and responsibilities between the province, Public Health Ontario and local public health;
- Better and deeper relationships with primary care and the broader health care system to support the goal of ending hallway health care through improved health promotion and disease prevention; and
- Improved public health delivery and the sustainability of the system.

As the system modernizes, it is also important that the strengths of public health are harnessed as they are critical elements to the success of a modern public health system. Key strengths of the current public health sector include a focus on health protection, health promotion, and health equity, as well as its local presence, relationship with municipalities, highly trained workforce, relationships outside the health care system, and an in-depth understanding of, and capacity to, assess population-level health. Public health can broker relationships among health care, social services, municipal governments, and other sectors to create healthier communities. We will maintain and expand these key strengths.

# Public Health in Ontario

The work of public health is focused on the health of populations and is embedded in the daily lives of the people of Ontario. Public health interventions have made the food we eat

safer, protected us from infectious diseases and environmental threats to health, and created healthier environments to support and inform choices about risks, including those related to tobacco and alcohol. Public health interventions and initiatives also impact communities by developing policies to support healthier built environments, promoting social conditions that improve health, and responding to public health emergencies.

Our public health system reflects the diversity of Ontario's population. Boards of health serve populations large and small, in urban and rural settings. Each board of health has responsibility for delivering local public health programs and services within its geographic borders, defined in legislation as the "health unit." Most boards of health follow geographic boundaries aligned with municipal borders. There are currently 35 boards of health, far more than any other province in the country. For example, public health in British Columbia is delivered by five regional health authorities, and by 18 Regional Public Health Authorities in Quebec. The size of populations served by Ontario's boards of health ranges from less than 34,000 to almost 3,000,000.

The majority of boards of health in Ontario have an autonomous governance structure, meaning they are an independent corporation separate from any municipal organization. There are four other board of health governance models currently operating in Ontario, each of which have varying degrees of connection with their local municipal organization. Of the 35 current public health units, the majority have Medical Officers of Health (MOH) who also hold a Chief Executive Officer (CEO) role, while a number have a designated CEO position that is separate from the MOH.

Public Health Ontario is a key partner in the public health system. It provides scientific and technical advice and support directly to public health units and the Ministry of Health, and it conducts over 5 million public health laboratory tests for public health units, hospitals, and physicians every year.

# Key Challenges

The public health system is at the frontline of delivering programs and services that keep Ontarians healthy and addressing emerging threats to the population's health. Building on the findings from several reports over the past 20 years, including Ontario's independent Auditor General, there are a number of critical challenges in the public health sector (see

section "Learning from Past Reports" for more information). The following sections identify these key challenges and include:

- Insufficient capacity;
- Misalignment of health, social, and other services;
- Duplication of effort; and
- Inconsistent priority setting.

# Insufficient Capacity

## Current State

All of the reports have noted that the capacity of public health units varies significantly across the province. Some boards of health have had well-documented challenges in recruiting and retaining skilled public health personnel, both in leadership and in front-line staff. This means that some public health units do not have sufficient human resources to deliver the full scope of the Ontario Public Health Standards, which are the mandated public health programs and services that public health units are required to deliver, such as food safety, infectious and communicable disease prevention and control, healthy growth and development, immunization, safe water, school health, chronic disease prevention as well as monitoring population health data and managing outbreaks. For example, in 2017 the Auditor General reported that some public health units do not have the required time and/or staff expertise to review and analyze epidemiological data and some were not evaluating or measuring the effectiveness of new programs. Both activities are requirements in the Ontario Public Health Standards. This has resulted in **inequities** across the province with some Ontarians not receiving the same public health programs and services as others. It also means **parts of the province are vulnerable** when the public health unit is called on to prevent and prepare for public health threats and emergencies.

Some public health units are too small to have the minimum amount of resources, expertise and capacity needed to deliver all programs and services (critical mass) and to meet unexpected surges in demand (surge capacity). Every public health unit needs specialized staff that perform specific duties, often to fulfill statutory requirements, including epidemiology and data analysis and emergency preparedness and coordination. Public health units also need program teams that are large enough to allow for surge capacity, coverage for vacancies and vacations, development opportunities, and an adequate mix of skill sets and experiences. Some public health units are lacking these core capacity needs.

## Strengths to Build On

Despite these challenges, individuals working in public health deliver core programs and services every day, and prepare for and respond to emerging threats. This is accomplished because of some of the sector's key strengths, including leveraging **strong local relationships and partnerships** that allows the work of public health to be based in and responsive to the needs of their communities. But there are opportunities to address the variations of capacity in the province that would help public health units provide a more nimble response to emerging threats and emergencies, bolster the public health workforce to meet the evolving health needs of the province and improve public health service delivery for Ontarians.

## Questions for Discussion

- What is currently working well in the public health sector?
- What are some changes that could be considered to address the variability in capacity in the current public health sector?
- What changes to the structure and organization of public health should be considered to address these challenges?

# Misalignment of Health, Social, and Other Services

## Current State

It has also been well documented that there are **barriers to collaborating effectively** among public health, health care and social services. This locks the value of public health away in siloes and makes the work of public health harder to do by impeding progress on key public health goals. Much of what affects the health of Ontarians depends on factors outside the health sector – housing, education, working conditions and the environment all play a role. Public health units must engage with these areas to make progress on improving population health, while also playing an active role in the health system by providing immunizations, delivering sexual health services and case management and contact tracing for infectious diseases, to name a few. Furthermore, public health's prevention focus complements the functions of the health care system and has the ability to stop patients from entering the health care system in the first place, which is critical for ending hallway health care. In the current organization and structure of the public health sector, fostering action on shared goals across sectors, such as disease prevention and

health promotion, requires significant effort and resources. If action is not taken to break down these siloes, there is concern that opportunities to improve the health of Ontarians will be missed.

### Strengths to Build On

Despite these challenges, one of the public health sector's strengths is as a **broker between the health system and social services**, to support individuals and communities as they engage across sectors. Public health's understanding of local health needs can help **identify top priorities for the health system** while at the same time informing health policies and services. These collaborative relationships also lend themselves to the integration of health protection and promotion interventions that can be delivered in other sectors to improve population health. These are significant opportunities that can be harnessed through the modernization of the public health sector.

### Questions for Discussion

- What has been successful in the current system to foster collaboration among public health, the health sector and social services?
- How could a modernized public health system become more connected to the health care system or social services?
- What are some examples of effective collaborations among public health, health services and social services?

## Duplication of Effort

### Current State

Within the public health system there is duplication, unnecessary redundancies, inconsistencies and lack of coordination. For example, there is currently a disconnect amongst evidence products, policy and delivery among public health units. In 2017, the Auditor General reported that public health units are **poorly coordinated and duplicating work**. It notes, "significant inefficiencies exist across the public health units because there are limited formal systems in place to co-ordinate their activities and share best practices." Many public health units reported independently conducting research, obtaining data and reviewing the same evidence and best practices on various health promotion programs as

other public health units. Research and evidence activities that are not locally specific are being duplicated at multiple public health units when there are opportunities to leverage others in undertaking and sharing this work. As well, public health units tend to work individually to develop systems to collect data and the type of data collected differs, which is not conducive to being compared among public health units. Similar duplication was also found in the development of chronic disease programming and campaigns.

## Strengths to Build On

One of the strengths of the public health sector is its **expertise in population health assessment, data and analytics** related to population level health. The public health sector provides critical information on the state of the population's health and on the health status and needs of local communities. Addressing the duplication and lack of coordination can strengthen research capacity, knowledge exchange and shared priority setting among public health units. Research, evidence and program development are all critically important to the work of public health. However, these activities can be better organized and coordinated so that information is shared among public health units and effort is not duplicated across the system, while also creating more bandwidth for individual health units to concentrate on localized research projects. There are also opportunities to leverage technology for more efficient and effective information sharing and service provision.

## Questions for Discussion

- What functions of public health units should be local and why?
- What population health assessments, data and analytics are helpful to drive local improvements?
- What changes should the government consider to strengthen research capacity, knowledge exchange and shared priority setting for public health in the province?
- What are public health functions, programs or services that could be strengthened if coordinated or provided at the provincial level? Or by Public Health Ontario?
- Beyond what currently exists, are there other technology solutions that can help to improve public health programs and services and strengthen the public health system?

# Inconsistent Priority Setting

## Current State

At a time when there are critical public health challenges that are facing Ontario, there are inconsistencies across the province in how priorities are set and decisions made regarding public health programs and services. To address these issues, public health units need to be aligned with one another and focused in their response. Meanwhile, individual public health units must also be responsive to their own local needs and issues. The variation in public health unit's governance and leadership models may contribute to inconsistent priority setting. There are five governance models in the current system, which means that the **balance of local needs and system priorities for decision making is different across the province**. This can make it hard for the sector to take collective action on public health issues that span the province. The variation in leadership models also means that organizational decision making and accountability within public health units is inconsistent, which presents challenges in how public health units collaborate among themselves and other sectors to address societal challenges that impact population health.

## Strengths to Build On

Public health units are **embedded in their local communities** and deeply aware of the issues and opportunities that can affect their population's health. This is one of the key assets of public health. As the public health sector modernizes, it needs to be grounded in strong leadership and governance structures that preserve the local relationship and expertise of the public health units. In addition, there may be opportunities to shift responsibility for certain public health activities, programs and service delivery to different organizations within the system, particularly those that address province-wide issues.

## Questions for Discussion

- What processes and structures are currently in place that promote shared priority setting across public health units?
- What should the role of Public Health Ontario be in informing and coordinating provincial priorities?
- What models of leadership and governance can promote consistent priority setting?

Figure 1: Overview of the current challenges and path to a modern public health system.

| | Current Challenges | What We Want to Achieve |
|---|---|---|
| **Insufficient Capacity** | Challenges retaining and recruiting skilled public health personnel resulting in inequities in service delivery across Ontario<br><br>Insufficient critical mass and surge capacity in some smaller public health units resulting in lack of capacity for public health response | Highly-skilled public health workforce and improved access to professional resources available in all parts of Ontario<br><br>Nimble response to emerging public health threats and emergencies |
| **Misalignment** | Instances of misalignment with the broader health system and social services resulting in added complexity for collaboration and missed opportunities | Continuous local collaboration with health and social services to improve population health |
| **Duplication of Effort** | Duplication and lack of coordination resulting in disconnect between evidence products, policy and delivery | Strengthened research capacity, knowledge exchange and common evidence base to support shared priority setting |
| **Inconsistent Priority Setting** | Inconsistencies in priority setting and decision making across the province | Strong accountability, leadership, and governance capacity that balances local needs and system priorities |

**Leverage Existing Strengths**

- Focus on health protection, health promotion and health equity
- Local presence and relationships with municipalities
- A highly trained workforce
- In-depth understanding of population level health
- Collaborative relationships outside the health care system

# Indigenous and First Nation Communities

The Indigenous population in Ontario is comprised of the First Nations, Métis and Inuit peoples who may live on and off reserve, in urban, rural and remote areas, each with their own histories, languages, cultures, organizational approaches and jurisdictional realities. Both the provincial and federal governments provide public health services to Indigenous People in Ontario, including First Nations. Provincially, boards of health are required to engage in public health practice that results in decreased health inequities such that everyone has equal opportunities for optimal health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances.

It has been widely recognized that Indigenous communities in Ontario (including First Nations peoples living on and off-reserve, Metis and Inuit) do not experience the same level of health status as other populations in Ontario. Historically, relationships between Indigenous communities/organizations and boards of health have varied across the province, and jurisdictional responsibilities split between the federal and provincial governments, as well as differing interpretations of the legislative responsibility of health units to form relationships with Indigenous communities and organizations, have complicated the effective delivery of public health services.

To improve the access issues currently experienced, it is fundamental to recognize that the approach to Indigenous engagement will differ across the province and within communities, depending on local culture and demographics, proposed initiatives and existing relationships. Recently, developing relationships with Indigenous communities and organizations in a culturally safe and meaningful way was added as a requirement for boards of health in the Ontario Public Health Standards. This requirement is further supported by The Relationship with Indigenous Communities Guideline, 2018 which was developed in partnership with Indigenous organizations, and provides information to support and/or build these partnerships.

There are several examples of existing initiatives where Indigenous communities and organizations have been establishing integrated public health service delivery models and/or moving towards achieving greater control and decision-making on how public health services and programs are delivered and by whom. There are also currently three formal agreements in place in the province where First Nation communities have agreed to

purchase services from their local public health unit (as per section 50, under the *Health Protection and Promotion Act*).

Any changes made to modernize public health across Ontario must build on these initiatives and consider ways of enhancing opportunities for partnerships in a meaningful and respectful way.

### Questions for Discussion

- What has been successful in the current system to foster collaboration among public health and Indigenous communities and organizations?
- Are there opportunities to strengthen Indigenous representation and decision-making within the public health sector?

# Francophone Communities

While the French Language Services Act (FLSA) does not currently apply to boards of health, the Ontario Public Health Standards address the needs of the Francophone populations and state that "boards of health should bear in mind that in keeping with the FLSA, services in French should be made available to French-speaking Ontarians located in designated areas." The Ontario Public Health Standards also require boards of health to consider the needs of priority populations in the planning, delivery and evaluation of public health programs and services.

### Question for Discussion

- What has been successful in the current system in considering the needs of Francophone populations in planning, delivery and evaluation of public health programs and services?
- What improvements could be made to public health service delivery in French to Francophone communities?

# Learning from Past Reports

The issues outlined above (among others) have been identified and considered by many reports, some of which are listed in Table 1 below. These reports have consistently called for significant reforms to public health to strengthen the sector. Most recently in 2017, the Minister's Expert Panel on Public Health was asked to provide advice on changes to the structure, organization and governance of public health to address the lack of integration of public health with the broader health sector and improve public health capacity and delivery. Prior to this, a series of reports following both Walkerton and SARS identified critical challenges in the sector that were seen to contribute to these crises. These reports raised common issues such as a lack of capacity and critical mass, structural governance challenges and skills gaps in boards of health, misalignment of public health with other health and social services, as well as challenges with the public health workforce, including with recruitment, retention and leadership, among others. The table below outlines select findings identified in the reports that persist today, and the recommendations that were provided.

Table 1: Findings and recommendations of previous reports

| Report | Findings | Recommendations |
|---|---|---|
| Ontario Auditor General Report (2017) | • Inefficiencies as a result of duplication of effort and inconsistencies among public health units, particularly related to research and program development<br>• Lack of epidemiological and evaluation capacity in some public health units | • Develop a central approach to update, co-ordinate and share research and best practices<br>• Evaluate feasibility of centralizing epidemiological expertise |

| Report | Findings | Recommendations |
|---|---|---|
| Minister's Expert Panel on Public Health (2017) | • Lack of critical mass and surge capacity and challenges recruiting and retaining public health personnel, causing inequities in service delivery<br>• Lack of capacity of smaller health units<br>• Wide variety of governance models, gaps in skills on some boards of health, and challenges with provincial and municipal appointments<br>• Lack of mechanisms to coordinate across public health units and work within the health sector | • Establish fewer regional public health entities<br>• Establish autonomous boards of health to have a consistent, independent governance structure<br>• Establish regional public health entities with one CEO, a regional MOH, and senior public health leaders; maintain local delivery with a local MOH |
| Revitalizing Ontario's Public Health Capacity: The Final Report of the Capacity Review Committee (2006) | • A need to strengthen the critical capacity of public health units<br>• A need to ensure quality governance with a province-wide public health system<br>• A need to revitalize the public health work force, including related to recruitment, retention, and leadership | • Amalgamate certain public health units to achieve critical mass and strengthen public health capacity<br>• Establish autonomous, locally-based boards of health that focus primarily on the delivery of public health programs and services<br>• MOHs should be able to serve as CEOs of public health units; did not reach consensus on whether the role of CEO should be assumed by non-MOHs. |

| Report | Findings | Recommendations |
|---|---|---|
| The SARS Commission: Volume 5 SARS and Public Health Legislation, Second Interim Report (2005) | • Weak governance structures and practices in local boards of health<br>• Medical Officers of Health require independence from political and bureaucratic pressures | • Establish qualifications for board membership, including demonstrated experience or interest in public health and board members should reflect the community to be served.<br>• Amend legislation to state that the MOH is the CEO of the public health unit. |
| Reports of the Ontario Expert Panel on SARS and Infectious Disease Control (2003, 2004) | • Lack of capacity and critical mass in smaller public health units<br>• Misalignment of public health with other health and social sector boundaries | • Consolidate the number of public health units while retaining local presence. |

While a number of reports have made recommendations on these issues, there is a need to consider the challenges and potential solutions in the current context.

### Questions for Discussion

- What improvements to the structure and organization of public health should be considered to address these challenges?
- What about the current public health system should be retained as the sector is modernized?
- What else should be considered as the public health sector is modernized?

# Your Feedback

With the release of this paper, we are renewing our consultation process to discuss the way forward on modernizing the public health sector. We hope to receive your input on the questions in this paper. Feedback can be submitted by completing our survey. The submission deadline is Feb 10, 2020.

We will also be conducting in-person consultation sessions where we look forward to continuing the conversation about how we build a modernized public health sector.

**CITY OF HAMILTON**

# BY-LAW NO. 07-170

## BEING A BY-LAW TO LICENSE AND REGULATE VARIOUS BUSINESSES

**CONSOLIDATION**

*This By-law is a consolidated version and includes amendments made by those amending by-laws listed on the following page. This consolidation is prepared for purposes of convenience only and is not the official or legal version of the By-law. For accurate reference to the By-law, certified copies should be obtained through the City Clerk's Office.*

**CITY OF HAMILTON**

**CONSOLIDATED BY-LAW NO. 07-170**

**Incorporating amendments made by:**

| ***By-Law No:*** | ***Effective Date:*** | |
|---|---|---|
| 08-099 | April 23, 2008 | Amendment to Schedule 25, paragraph 64 |
| 08-131 | May 28, 2008 | Housekeeping and technical amendments<br>General Provisions<br>Schedule 1<br>Schedule 3<br>Schedule 9<br>Schedule 17<br>Schedule 19<br>Schedule 20<br>Schedule 21<br>Schedule 23<br>Schedule 25<br>Schedule 30<br>Schedule 31 |
| 08-175 | July 10, 2008 | Replacement of Appendix 1 of Schedule 25 (Taxi Cabs) |
| 08-186 | August 7, 2008 | City of Hamilton Licensing Committee name change to Hamilton Licensing Tribunal |
| 08-225 | September 24, 2008 | Deletion of Schedule 15 (Public Baths) |
| 08-255 | October 29, 2008 | Amendment to definition of Lodging House |
| 08-267 | November 12, 2008 | Replacement of Schedule 1 (Adult Entertainment Establishments) and Replacement of Schedule 13 (Personal Aesthetic Services) |
| 08-285 | December 10, 2008 | Amendment to Schedule 25, paragraph 64 |
| 09-024 | January 28, 2009 | Amendment to Schedule 25, subsection 20 |
| 09-026 | February 11, 2009 | Amendment to Schedule 25, subsection 20 |
| 09-039 | February 25, 2009 | Amendments to General Provisions, section 4; Schedule 13, section 3; and Schedule 25 subsection 20 |
| 09-040 | February 25, 2009 | Amendment to General Provisions, section 5 |
| 09-058 | April 1, 2009 | Replacement of Appendix 3 of Schedule 25 |

| ***By-Law No:*** | ***Effective Date:*** | |
|---|---|---|
| 09-111 | May 27, 2009 | Amendments to General Provisions, section 11, paragraph 12, section 31, section 32; addition of Schedule 21.1 Hess Village Entertainment District; and repeal of By-Law 06-234 |
| 09-152 | July 9, 2009 | Replacement of Schedule 20 (Residential Care Facilities) |
| 09-156 | July 9, 2009 | Housekeeping and technical amendments<br>General Provisions<br>Schedule 3<br>Schedule 10<br>Schedule 12<br>Schedule 18<br>Schedule 19<br>Schedule 29 |
| 09-170 | August 13, 2009 | Re-enactment of Schedule 20 (Residential Care Facilities) |
| 09-237 | November 11, 2009 | Amendment to Schedule 25, paragraph 64 |
| 10-077 | April 14, 2010 | Housekeeping and technical amendments<br>General Provisions<br>Schedule 1<br>Schedule 4<br>Schedule 25 |
| 10-078 | April 14, 2010 | Replacement of Schedule 20 (Residential Care Facilities) |
| 10-106 | May 12, 2010 | Amending to Schedule 29, provide for licensing of Sprinkler and Fire Protection Installers |
| 10-126 | May 26, 2010 | Replacement of Appendix 3 of Schedule 25 |
| 10-198 | August 12, 2010 | Replacement of Schedule 26 (Mobile Sign Leasing or Renting) |
| 10-314 | December 15, 2010 | Replacement of Schedule 21 (Food Premises) and deletion of Schedule 21.1 |
| 11-017 | January 12, 2011 | Addition of Schedule 15 (Personal Wellness Services Establishments) |

| ***By-Law No:*** | ***Effective Date:*** | |
|---|---|---|
| 11-111 | April 13, 2011 | Housekeeping and technical amendments<br>General Provisions<br>Schedule 1<br>Schedule 4<br>Schedule 12<br>Schedule 14<br>Schedule 16<br>Schedule 22<br>Schedule 23<br>Schedule 25<br>Schedule 26<br>By-law 10-221 |
| 11-125 | May 11, 2011 | Housekeeping and technical amendments to Schedule 25 with respect to the Priority List |
| 11-142 | May 25, 2011 | Replacement of Schedule 1 (Adult Entertainment Establishments) |
| 11-230 | September 28, 2011 | Housekeeping and technical amendments<br>General Provisions<br>Schedule 25<br>By-law 10-142<br>By-law 10-118<br>By-law 10-197<br>By-law 10-260 |
| 12-021 | January 25, 2012 | Replacement of Schedule 22 (Salvage and Second-Hand Goods, Pawnbroker, and Jewellery and Precious Metals Businesses), Deletion of Schedules 6, 11, and 14 |
| 12-069 | March 28, 2012 | Replacement of Schedule 3 (Bed and Breakfasts, Hotels and Motels) |
| 12-101 | April 25, 2012 | Amendments to the General Provisions to have the Licensing Tribunal make the final decision to refuse, suspend, revoke or attach conditions to a licence instead of Council. |
| 12-118 | May 25, 2012 | Addition of New Schedule 28 (Tow Trucks) |
| 12-150 | June 27, 2012 | Deletion of Schedule 19 (Refreshment Vehicles) and addition of Schedule 6 (Food Service Vehicles) |
| 12-219 | October 10, 2012 | Amendments to Schedule 20 (Residential Care Facilities) |

| ***By-Law No:*** | ***Effective Date:*** | |
|---|---|---|
| 12-249 | November 14, 2012 | Amendments to Schedule 25 (Taxicabs) to have accessible taxicab owner licenses issued in 2013 and 2014 |
| 12-250 | November 14, 2012 | Amends Schedule 22 (Salvage and Second-Hand Goods, Pawnbroker, and Jewellery and Precious Metals Businesses), Section 5 |
| 13-060 | February 27, 2013 | Amends Schedule 25 (Taxicabs), Sections 55 – 59 |
| 13-081 | March 27, 2013 | Amends Schedule 28 (Tow Trucks) |
| 13-302 | December 11, 2013 | Amends Schedule 25 (Taxicabs), Appendix 1, Tariff/Fares |
| 14-119 | May 14, 2014 | Amends Schedule 6 (Food Service Vehicles) |
| 14-181 | July 11, 2014 | Amends Schedule 25 (Taxicabs) |
| 15-130 | May 13, 2015 | Amends Schedule 21 (Food Premises) |
| 15-232 | October 14, 2015 | Amends Schedule 3 (Bed and Breakfasts, Hotels and Motels) |
| 16-053 | February 24, 2016 | Addition of Schedule 11 (Payday Loan Businesses) |
| 16-105 | April 13, 2016 | Amends General Provisions by deleting the following Licensing Categories:<br>Building Exterior Cleaners (Schedule 5)<br>Mobile Home s and Mobile Home Parks (Schedule 10)<br>Sign Posters and Bill Distributors, Etc. (Schedule 24) |
| 17-011 | January 25, 2017 | Amends General Provisions |
| 17-012 | January 25, 2017 | Amends Schedule 25 – Taxicabs |
| 17-013 | January 25, 2017 | Provides for the addition of Schedule 24 to Licence Personal Transportation Providers |
| 17.054 | March 29, 2017 | Delete and replace Schedule 22 – Auctioneers |
| 17-055 | March 29, 2017 | Delete Schedule 18 – Recreational Camping Establishments |
| 17-056 | March 29, 2017 | Delete and replace Schedule 27 – Tobacco Retailers |
| 17-069 | April 26, 2017 | Delete and replace Schedule 7 – Kennels and Pet Shops |
| 17-116 | June 14, 2017 | Delete and replace Schedule 6 – Food Service Vehicles |

| ***By-Law No:*** | ***Effective Date:*** | |
|---|---|---|
| 17-128 | June 28, 2017 | Delete and replace Schedule 22 Second-Hand Goods, Jewellery and Precious Metals (remove Salvage Businesses and Pawnbrokers) |
| 17-129 | June 28, 2017 | Add Schedule 5 – Pawnbrokers |
| 17-130 | June 28, 2017 | Add Schedule 10 – Salvage Businesses |
| 17-216 | October 25, 2017 | Amends Schedule 21 - Food Premises (Hess Village) |
| 17-251 | November 22, 2017 | Amends Schedule 8 -Limousines |
| 17-259 | December 8, 2017 | Amends Schedule 25 - Taxicabs |
| 18-040 | February 28, 2018 | Amends Schedule 25 - Taxicabs (Accessible Taxi Plates) |
| 18-041 | February 28, 2018 | Amends Schedule 25 – Taxicabs (Replace Appendix 1 (Taxicab Tariff/Fares Meter and By Agreement Rates) |
| 18-042 | February 28, 2018 | Delete and Replace Schedule 11 (Payday Loan Businesses) |
| 18-111 | May 9, 2018 | Delete and Replace Schedule 21 (Hess Village Paid Duty Policing) |
| 18-212 | August 17, 2018 | Amend Schedule 1 (Adult Entertainment Establishments) |
| 18-252 | September 12, 2018 | Amend Schedule 24 (Personal Transportation Provider) and Schedule 25 (Taxi Cabs) |
| 18-320 | December 19, 2018 | Delete and Replace Schedule 21 (to include Drive-Thru Facilities) |
| 19-175 | July 12, 2019 | Add Schedule 14 – Tree Cutting Services |
| 19-258 | October 23, 2019 | Add 90 Centennial Parkway North as (ee) to Schedule 11 |

**CITY OF HAMILTON**

**CONSOLIDATED BY-LAW NO. 07-170**

**A By-law to License and Regulate Various Businesses**

**WHEREAS** Council considers it in the public interest to enact a by-law to license regulate and govern various classes of businesses, and to repeal the existing City of Hamilton Licensing Code being City of Hamilton By-law No. 06-213, as amended;

**AND WHEREAS** Part IV of the Municipal Act, 2001 allows the enactment of by-laws to license, regulate and govern businesses, and to impose conditions on the obtaining, holding and keeping of licences to carry on such businesses;

**AND WHEREAS** Council wishes to exercise its powers over businesses, the persons carrying on or involved in the operation of the businesses including the powers to impose conditions on the obtaining, holding or renewing of licences and for the suspension, denial and revocation of licences as this By-law and Municipal Act, 2001 provide;

**AND WHEREAS** the regulation of the businesses in this by-law, the requirement for a licence and the imposition of such conditions will aid in the application and enforcement of this by-law and other laws so as to assist in allowing, amongst other things, for the identification and qualification of the persons responsible for the operation of the business, the identification of the location of businesses, the regulation and inspection of equipment, vehicles, premises and other property used to carry on business, and allowing for the protection of persons dealing with or affected by such businesses and persons;

**AND WHEREAS** Sections 390 to 400 of the Municipal Act authorize a municipality to pass by-laws imposing fees or charges for services or activities provided or done by them;

**AND WHEREAS** pursuant to Section 151(1)(g) of the Municipal Act, Council considers it desirable to provide for a system of administrative penalties and fees as an additional means of encouraging compliance with this By-law;

**AND WHEREAS** Council is satisfied that a public meeting and reasonable public notice have been given for enactment of this by-law in accordance with the Municipal Act, 2001;

**NOW THEREFORE** the Council of the City of Hamilton enacts as follows:

**GENERAL PROVISIONS**

**DEFINITIONS and APPLICATION**

1.(1) In this By-law:

(a) "**applicant**" means a person applying for a licence or renewal of a licence thereof under this By-law;

(b) "**business**" has the same meaning as provided in section 150 of the *Municipal Act, 2001*, S.O. 2001, Chapter 25, as amended;

(c) "**City**" means the City of Hamilton as constituted by section 2 of the *City of Hamilton Act, 1999*, S.O. 1990, c.14, Schedule C;

(d) "**City Council**" or "**Council**" means the council of the City of Hamilton;

(e) "**City Treasurer**" means the treasurer of the City;

(f) "**conditions**" includes special conditions which are conditions imposed upon a business in a class that have not been imposed on all of the businesses in that class, as a requirement of obtaining, continuing to hold or renewing a licence;

(g) "**Director of Licensing"** means the Director of Licensing in Parking and By-law Services of the Planning and Economic Development Department, or his or her designate;(17-011)

(h) "**hearing**" includes a hearing or an opportunity given for a hearing, where an applicant or licensee may show cause why the licence should be granted, or not refused, revoked or suspended, with or without conditions;

(i) "**Licensing Tribunal**" means the Hamilton Licensing Tribunal established under subsection 3(1);

(j) "**Municipal Officer"** except where otherwise indicated, means an employee of the Parking and By-law Services Division of the Planning and Economic Development Department who is assigned by the Director of Licensing to enforce the provisions of this By-law;(17-011)

(k) "**person**" includes an individual, partnership, corporation, and the heirs, executors, administrators or other legal representatives of a person to whom the context can apply according to law;

(l) "**policies**" or "**policy**" means policies or a policy approved by Council under section 15;

(m) "**private club**" means an establishment which is maintained and operated by a not-for-profit corporation or unincorporated association solely for the benefit and enjoyment of its members, and which has adopted by-laws or policies regulating the admission of persons to the corporation or association, the classes and conditions of membership, the suspension and termination of membership, the qualification and membership of directors and their manner of election, and the holding of an annual general meeting of members, and which requires the payment of fees and dues by members on an annual basis, and which issues cards or other documents to members which state the name of the member and the date on which his or her membership expires;

(n) "**Secretary**" means the secretary of the Licensing Tribunal; and

(o) "**Schedule**" shall be a reference to one or all the Schedules listed in section 30, as the context requires.

(2) Except where otherwise provided, the provisions of this By-law apply to the engaging in or carrying on, in the City of Hamilton, of any of the businesses regulated by this By-law.

(3) This By-law is subject to the *Retail Business Holidays Act*, R.S.O. 1990, c. R.30.

**ADMINISTRATION**

2. Subject to the terms of this or other by-laws, or the directions of Council:

(a) Administration of this By-law shall be by the staff of Licencing and By-law Services Division of the Planning and Economic Development Department of the City. (19-175)

(b) Enforcement of this By-law shall be by:

(i) persons assigned by the Director of Licensing or Council for the purpose of enforcing the provisions of this By-law which shall include the following:

a. municipal law enforcement officers; and

b. inspectors appointed pursuant to the *Building Code Act, 1992,* S.O. 1992, c.23; and

(ii) police officers.

3.(1) A tribunal, composed of not fewer than three members of Council who are appointed by resolution of Council, is established pursuant to section 23.2 of the Municipal Act, 2001, under the name “Hamilton Licensing Tribunal”.

(2) The Licensing Tribunal shall select one of its members as a Chair.

(3) For the purposes of subsection (2), the Licensing Tribunal shall apply the by-laws of the Council and have the powers, duties and rights as applicable under the Statutory Powers Procedure Act, R.S.O. 1990, c. S. 22.

(4) There shall be a Secretary to the Licensing Tribunal, who may be assigned administrative duties by the Tribunal.

(5) The Secretary shall attend all meetings of the Licensing Tribunal and shall keep all necessary records and perform such other duties as may from time to time be required by the Licensing Tribunal.

4.(1) The duties of the Director of Licensing include ensuring:

(a) that the applicant, except an applicant for a licence as an attendant under Schedules 1 or 4 or as a driver under Schedule 25, is the owner or operator of the business and "owner" or "operator", unless otherwise defined in the applicable Schedule, means a person who has responsibility for carrying out the business including but not limited to:

(i) having the right to possess or occupy the premises where the business is carried on;

(ii) having significant financial responsibility for the business such as responsibility for accounts payable and accounts receivable;

(iii) managing any employees of the business such as hiring or firing such employees;

(iv) having responsibility for the business under a permission granted by the federal or provincial governments such as a liquor licence (Liquor Licence Act) or a vendor's permit (Retail Sales Tax Act).

(b) that applications are on the form applicable to the category of licence applied for, complete, and signed by the applicant, or where the application is from a partnership or corporation respectively, signed by a partner or the president or other authorized signing officer of the corporation;

(c) that the applicant has paid the fees required for the applicable licence(s) and application, for the term of the licence, prior to processing the application; and

(d) where a limited number of licences may be issued or transferred, that there is a licence approved or available for issuance or transfer.

(2) Where an application or applicant fails to comply with the requirements of paragraphs 1(a), (b) or (c), or the Director of Licensing' instructions in that regard, or where no licences are available to be issued or transferred under paragraph 1(d), the application shall not be processed and shall be returned to the applicant.

(3) Where the application is returned under subsection (2), the applicant may be:

(i) given the application and advised personally; or

(ii) sent the application by regular mail to the applicant's address as disclosed by the application or to their last known address and advised by an accompanying letter.

(4) When the Director of Licensing has refused to issue a licence under section 12 and the applicant has not requested a hearing in accordance with subsection 13(1), no further application from the applicant for the same category of licence shall be processed by the Director of Licensing for one year from the date of the refusal. Any such further application shall be returned to the applicant in accordance with subsection (3).

(5) Notwithstanding subsection (4), where the only reason for the refusal is the failure of premises to meet one or more requirements under this By-law, a further application may be processed if the premises, whether they are the same or different premises, meet all requirements under this By-law. Any such further application is subject to all of the requirements under this By-law including the requirements under this section.

(6)(a)

Notwithstanding any of the provisions of this By-law that apply to an applicant for a licence that is:

(i) a partnership, the Director of Licensing may issue a licence to a partnership provided that at least one partner, or other individual affiliated with the partnership as determined by the Director of Licensing, satisfies such applicable provisions;

(ii) a corporation, the Director of Licensing may issue a licence to a corporation proved that at least one director, officer, or other individual affiliated with the corporation as determined by the Director of Licensing, satisfies such applicable provisions.

(b) Paragraph (a) does not apply to Schedules 1, 4 or 25.

**LICENCE APPLICATIONS AND FEES**

5.(1) An applicant for a licence shall file the application, materials and fees, and in the case of a licensee renewing a licence, shall file the certifications, materials and fees, required to be supplied under the terms of this By-law.

(2) The applicant shall be responsible for ensuring that:

(a) all forms are properly completed and signed where necessary;

(b) truthful information is provided in forms required, or in responses supplied to enquiries made under this By-law;

(c) prior to issuance of the licence, any correction of information supplied under paragraph (a) or (b) is brought to the attention of the Director of Licensing in writing; and

(d) all necessary and required information, materials and fees are delivered to the Director of Licensing, including unpaid fines for Fees for Service or unpaid fines imposed under the Provincial Offences Act;(17-011)

(3) An applicant may withdraw the application prior to issuance of the licence.

(4) A person issued more than one licence under this By-law for the same premises at the same time shall only be required to pay the fee for the licence with the highest fee.

(5) A person holding a current and valid licence under this By-law who is issued a further licence for the same premises shall only be required to pay the administration portion of the fee plus any inspection fee for the further licence.

(6) Notwithstanding subsections (4) and (5), a person issued *a Payday Loan Business Licence under Schedule 11*(16-053) or a Tobacco and Electronic Cigarette Retailer (17-056) licence under Schedule 27 of this By-law shall be required, under all circumstances, to the pay the fee for that licence.

6.(1) The applicant shall make a written application for a licence, and shall include in or with the application:

(a) the particular class or classes of licence applied for;

(b) the full name, home address and telephone number of the applicant;

(c) any other information as may be required for the kind and class of licence by the Schedules, or as may be required by the Director of Licensing to identify the applicant, the business and its owner or operator, and the nature of the business which the applicant proposes to license, including any premises or vehicle, cycle or cart to be used;

(d) where the application is for renewal of a licence, the applicant shall either supply completed and executed certifications on the form provided to the effect that there is no change to the information as supplied in the previous application and previous records of conviction required under this By-law, or shall provide either a new application or a written and signed list of the changes in the required information from the previous application, as may be requested by the Director of Licensing; and

(e) applicants shall supply with the application, the following information:

(i) an applicant for a licence under

| | |
|---|---|
| Schedule 1 | Adult Entertainment Establishments |
| Schedule 2 | Auctioneers |
| Schedule 3 | Bed and Breakfasts, Hotels and Motels |

| | |
|---|---|
| Schedule 4 | Body Rub Parlours |
| Schedule 5 | Pawnbrokers (17-129) |
| Schedule 6 | Food Service Vehicles |
| Schedule 9 | Lodging Houses |
| Schedule 10 | Salvage Businesses (17-130) |
| Schedule 11 | Payday Loan Businesses (16-053) |
| Schedule 12 | Pedlars |
| Schedule 14 | Tree Cutting Services (19-175) |
| Schedule 16 | Public Garages - Classes A, B1, B2 and B3 only |
| Schedule 20 | Residential Care Facilities |
| Schedule 22 | Second-Hand Goods, Jewellery and Precious Metals Businesses (17-128) |
| Schedule 24 | Personal Transportation Provider(17-013) |
| Schedule 25 | Taxicabs - Cab Broker only |
| Schedule 29 | Trades |
| Schedule 30 | Transient Traders |

shall submit, as part of their application for a licence:

a. the applicant’s original criminal record, provided that if no original criminal record exists, the applicant shall submit instead original certification from the police that no such record exists; and

b. a list of any criminal or provincial offences in all jurisdictions for which the applicant has been convicted and not pardoned and which do not appear on any original criminal record submitted.

(ii) an applicant for a licence under

| | |
|---|---|
| Schedule 8 | Limousines |
| Schedule 25 | Taxicabs - Taxicab Driver and Taxicab Owner only |
| Schedule 28 | Tow Trucks |

shall submit, as part of their application for a licence:

a. the applicant's original criminal and driving records provided that if no original criminal record exists, the applicant shall submit instead original certification from the police that no such record exists; and

b. a list of any criminal, provincial or driving offences in all jurisdictions for which the applicant has been convicted and not pardoned and which do not appear on any original criminal or driving record submitted.

(iii) a licensee under

| | |
|---|---|
| Schedule 8 | Limousines |
| Schedule 25 | Taxicabs - Taxicab Driver and Taxicab Owner only |

shall submit, as part of their application to renew a licence:

a. the applicant's original driving record; and

b. a list of any driving offences in all jurisdictions for which the applicant has been convicted and not pardoned and which do not appear on any original driving record submitted.

(iv) a licensee seeking to renew a licence for the classes set out in subparagraph (i) or (ii) above, where a change of information has been noted in the criminal, provincial or driving record as applicable, shall upon request of the Director of Licensing submit the records and information required by subparagraph (i) or (ii) as applicable, with the application for renewal.

(2) The application and required materials shall be delivered in person by the applicant to the Director of Licensing, together with the applicable fees.

(3) Where the applicant for a licence application is a partnership, the application shall include the names and addresses of all partners, and each partner shall supply the information required under subparagraphs (1)(e)(i) and (ii).

(4) Where the applicant for a licence is a corporation, the application shall include the names and addresses for all directors and officers, and each director and officer of the corporation shall supply the information required under subparagraphs 1(e)(i) and (ii).

(5) A criminal record, driving record or other document referred to in subparagraphs 1(e)(i)or (ii) shall be dated not more than 36 days prior to the date on which the application is filed with the Director of Licensing.

(6) (a) Every person who is a licence holder under this By-law shall ensure that they renew the licence before it expires.
(b) In the event a licence holder fails to renew their licence before it expires, they may renew their licence no more than 60 days after it expires provided that they pay, in addition to the applicable licence fee, the applicable late payment fee.
(c) No licence shall be renewed more than 60 days after it expires.

(7) Where any premises or part thereof are to be used for a purpose requiring authorization by licence, the applicant shall ensure the application includes an accurate and complete description of such premises or of the part to be authorized to be so used, including the address and telephone number of the location, and shall make a separate application for each separate premises to be licensed.

(8) Where a motor vehicle is to be used for a purpose requiring authorization by licence, the applicant shall ensure the application includes a sufficient description of such vehicle, including the make, the model, the licence plate number, and the vehicle identification number, and shall make a separate application for each vehicle to be licensed.

7.(1) In this section, "licence" means a licence for a business of the following classes, which is not a renewal or transfer of a current and valid licence under this By-law: a flea market under Schedule 6, a lodging house under Schedule 9, any class of garage under Schedule 16, a public hall, bingo parlour, roller skating rink, billiard parlour or pool room under Schedule 17, a residential care facility under Schedule 20, or an eating establishment under Schedule 21.

(2) Every person seeking a licence for the proposed business, shall submit a plot plan in a form satisfactory to the Director of Licensing, together with the fees and documents required for a zoning verification certificate, and submit the zoning verification certificate obtained as part of the application.

8.(1) The applicable licence fee for each class or type of licence shall be the fee prescribed for each Schedule in the User Fees and Charges By-law for such type or class of licence or application, and shall be considered an annual fee unless this By-law specifies otherwise.

(2) Subject to subsection (4), applicants and licensees shall pay the fees prescribed for the application and licence applied for, and their licence when issued shall expire one year later, on the anniversary of the date of issuance, unless the applicable Schedule or this By-law provides for a shorter term.

(3) Where a licence is renewed, before, on or after its date of expiry, the date of issuance as shown on the renewed licence shall be the date of expiry of the expired licence.

(4) Where a licence has been issued or renewed subject to the fulfillment of a condition imposed by the Director of Licensing or the Licensing Tribunal, and the applicant or licensee has failed to fulfil such condition within the time specified, the applicant or licensee shall pay an additional fee of $100.00 before the licence may be continued.

(5) In spite of the expiry date determined under subsection (2), a licence shall expire:

(a) when the licence is revoked or suspended under this By-law;

(b) where the licensee ceases to be the owner or operator as defined in paragraph 4(1)(a);

(c) where the licence is issued to an individual, on the date of death of the individual, provided that a taxicab owner's licence issued under Schedule 25 shall expire in accordance with section 47 of that Schedule;

(d) where the licence is issued to a partnership or corporation, on the date of dissolution of the partnership or corporation;

(e) where any federal, provincial or municipal licence, including a permit, an approval, a registration or any other type of permission, required for the licensee to carry on or engage in their business has been revoked, suspended or has expired without renewal; or

(f) where the licensee has been prohibited from carrying on or engaging in their business under federal, provincial or municipal authority including under authority of a court order.

(6) Refunds of paid licence fees may be made, in the following amounts and circumstances:

(a) Where the applicant prior to processing the licence under section 11 withdraws an application for a licence, a refund of the licence fee may be made to the applicant;

(b) Subject to paragraph (e), where an application for a licence is withdrawn by the applicant after processing the licence under section 11 and before issuance, a refund of the licence fee may be made to the applicant;

(c) Subject to paragraph (e), where a licence or renewal of a licence is refused or denied, a refund of the licence fee may be made to the applicant;

(d) Where a licence is revoked, a refund may be made of the proportionate amount of the unexpired portion of the term of the licence; and

(e) In the case of an application for a licence other than a renewal, the processing fee as set out in the User Fees and Charges By-law is non-refundable, in the event the application is withdrawn or the licence is not issued, and for the sake of clarity in this subsection, "renewal" means renewal by the current licensee of the previous year's licence without change.

(7) The licensee, or the licensee's legal representative where the licensee has died, shall return the licence certificate, plate, sticker or photo identification to the Director of Licensing:

(a) where a licence that has expired under paragraph (5)(a), unless the licence certificate has been returned to the City at the earlier request of the Director of Licensing, within seven days of the date of approval of the suspension or revocation by Council;

(b) where a licence that has expired without renewal under subsection (2) or expired under paragraphs (5)(b), (c), (d) or (e), within seven days of the date of the expiry; or

(c) where the business licensed under this By-law ceases to operate, within seven days of the date it ceases to operate.

9. Fees shall be paid by the licensee for replacement of:

(a) a licence certificate,

(b) photo identification, and

(c) a licence plate,

in accordance with the User Fees and Charges By-law.

10. Where the City provides any form or other document to a person that requires the insertion of information, the form or document whether or not containing the inserted information in whole or in part, shall be and remain the property of the City.

**ISSUANCE of LICENCES**

11.(1) The Director of Licensing upon receipt of a proper, completed application and payment of fees for a licence under this By-law shall circulate the application to such City or provincial departments or agencies as the Director of Licensing deems necessary or as directed by Council, including but not limited to the Fire Department, Hamilton Police Services, the Planning and Economic Development Department, Public Health Services and the Public Works Department.

(2) Departments or agencies to which the application is provided under subsection (1) shall review obtainable information and provide the Director of Licensing with comments or compliance reports on whether the information indicates non-compliance with an applicable law which the department or agency enforces and which applies to the proposed business, and where an inspection is made, shall provide the Director of Licensing with a report on any non-compliance found as a result of that inspection.

(3) Where, under this By-law an applicant or licensee is to be tested, the City department responsible for the testing shall conduct the test or provide an opportunity for taking the test, and provide the Director of Licensing with the test results.

(4) Applicants and licensees, as a condition of obtaining or continuing to hold a licence, shall permit inspections or inquiries by representatives of the departments or agencies circulated under subsection (1) as may be reasonably requested, and shall undertake the tests referred to in subsection (3).

(5) Fees which are required to be paid for the making of an inspection or the conducting of a test under subsections (3) and (4) as prescribed in the User Fees and Charges By-law may be collected by the Director of Licensing before a licence is issued or renewed.

(6) The Director of Licensing may send notice of the comments or other response from the departments or agencies received under this section to the applicant or licensee.

12.(1) The Director of Licensing shall refuse to issue a licence or may recommend the suspension or revocation of a licence when:

(a) in the case of a refusal:

(i) a policy under section 15 requires a refusal;

(ii) any federal, provincial or municipal licence, including a permit, an approval, a registration or any other type of permission, required for the applicant to carry on or engage in their business has not been issued or has been suspended, revoked or has expired; or

(iii) the applicant has been prohibited from carrying on or engaging in their business under federal, provincial or municipal authority including under authority of a court order;

(b) in the case of a recommendation:

(i) the licensee has not actively carried on the business for which the licence was obtained within a reasonable period of time following the issuance or renewal of the licence; or

(ii) a policy under section 15 becomes applicable and would require a refusal or the issuance of a conditional licence if the licensee were applying for a licence; or

(c) in the case of refusal or a recommendation, the applicant or the licensee:

(i) has not met any of the requirements under this By-law including the applicable Schedule or any conditions on the licence;

(ii) has provided information in an application or by other means that is false or misleading;

(iii) has not paid any fee to be paid under this By-law including the applicable Schedule;

(iv) has not paid any fine or court awarded costs resulting from a legal proceeding related to this By-law or the applicable Schedule;

(v) has not complied with any prohibition or other court order resulting from any legal proceeding related to this By-law or the applicable Schedule; or

(vi) in the opinion of the Director of Licensing:

1. the operation of the applicant's or licensee's business would put the public safety at risk;

2. the operation of the applicant's or licensee's business is not or will not be carried on in compliance with the law; or

3. the conduct of the applicant or licensee (in the case of partnership, the conduct of its partners, employees or agents or in the case of a corporation, the conduct of its officers, directors, employees or agents) affords reasonable grounds for belief that the applicant or licensee will not carry on or engage in the business in accordance with the law or with honesty or integrity.

(2) The Director of Licensing may issue a licence:

(a) upon conditions specified as required by a policy under section 15 when paragraphs 12(1)(a) and 12(1)(c) do not apply; or

(b) when paragraphs 12(1)(a), 12(1)(c) and 12(2)(a) do not apply.

13.(1)(a) When the Director of Licensing refuses to issue a licence, the Director of Licensing shall send a dated notice of refusal to the applicant and the Secretary which includes the grounds upon which the licence is being refused.

(b) An applicant who receives a notice of refusal is entitled to request a hearing before the Licensing Tribunal.

(c) A request by an applicant for a hearing shall be made in writing, accompanied by the applicable fee and delivered to the Secretary within 30 days of the date contained in the notice of refusal. The applicant shall also include the grounds for their request.

(2)(a) When the Director of Licensing has recommended the suspension or revocation of a licence, the Director of Licensing shall send a dated recommendation to suspend or revoke to the licensee and the Secretary which includes the grounds upon with the recommendation is being made.

(b) A licensee who receives recommendation to suspend or revoke is entitled to a hearing before the Licensing Tribunal.

14.(1) Where a request for a hearing meeting the requirements of paragraph 13(1)(c) or a recommendation to suspend or revoke has been delivered to the Secretary under paragraph 13(2)(a), a hearing shall be scheduled before the Licensing Tribunal and notice of the hearing date shall be given to the parties.

(2) The parties to a hearing to refuse a licence are the applicant and the City and to a hearing to suspend or revoke a licence are the licensee and the City.

(3) A notice of hearing shall include:

(a) a statement of the time, date and purpose of the hearing; and

(b) a statement that if the applicant or licence holder does not attend the hearing, the Licensing Tribunal may proceed in their absence without notice

to them.

(4) A notice of refusal or a notice of hearing may be delivered personally to a person apparently in charge of a licensed premises, vehicle, cart or cycle or by sending it by prepaid registered mail to the last known address of the applicant or licensee on file with the City. Delivery by registered mail shall be deemed to have taken place five business days after the date of mailing.

15.(1) The Director of Licensing shall use and apply the policies, where applicable, to the decision to deny or approve licences with or without conditions, or to recommend revocation or suspension of licences, which policies are attached as Appendices "A" and "B" to these General Provisions.

(2) Director of Licensing may, at a hearing, recommend that a licence be refused, suspended or revoked or the imposition of conditions.

16.(1) The Licensing Tribunal shall hold a hearing at the time, date and place set out in a notice of hearing.

(2) A hearing shall be commenced by the Licensing Tribunal on or before 60 days from the date of delivery of a notice of hearing subject to a decision of the Licensing Tribunal to extend the time for commencing a hearing.

17.(1) Upon holding an appeal from a refusal to issue a licence or a hearing to suspend or revoke a licence, the Licensing Tribunal may:

(a) uphold the refusal to issue the licence;

(b) suspend or revoke the licence; or

(c) attach conditions to the licence.

(2) Conditions attached to a licence may include but are not limited to requiring the applicant or licensee:

(a) comply with by-laws or other laws and provide proof of such compliance;

(b) pay a fine or other court awarded costs resulting from a legal proceeding related to this By-law or the applicable Schedule and to provide proof of such payment;

(c) comply with a prohibition or other court order resulting from a legal proceeding related to this By-law or the applicable Schedule and to provide proof of such compliance;

(d) change the hours of operation of their business;

(e) take or re-take a test required under this By-law;

(f) supply additional information on criminal, provincial or driving convictions or periodic updates of such convictions or both;

(g) supply information to verify evidence given at their hearing; or

(h) ensure that the persons carrying on their business do so in accordance with the law or with honesty and integrity.

(3) The Licensing Tribunal shall have regard to the following matters where relevant, as may be raised at a hearing:

(a) this By-law and other applicable law;

(b) circumstances and facts raised by the evidence of the parties;

(d) if the business puts or could put public safety at risk; and

(e) if the business is or will be carried on in compliance with the law, and whether the conduct of the person (in the case of a partnership, the conduct of its partners, employees or agents or in the case of a corporation, the conduct of its officers, directors, employees or agents) affords reasonable grounds for belief that the person will not carry on or engage in the business in accordance with the law or with honesty or integrity.

(4) The Licensing Tribunal’s decision in respect of refusing, suspending, revoking or attaching conditions to a licence is final.

18.(1) After the Licensing Tribunal has made a decision in respect of a hearing, notice of that decision shall be sent to the applicant or licensee by personal delivery or by registered mail to the last known address of the applicant or licensee on file with the City.

(2) Where the decision of the Licensing Tribunal is:

(a) to issue a licence or conditional licence, the Director of Licensing shall issue the licence or the conditional licence, on the terms directed by the Licensing Tribunal; or

(b) to refuse or revoke a licence, any further hearing with respect to that licence shall be not considered for one year from the date of the Licensing Tribunal's decision.

**GENERAL and OFFENCES**

19.(1) Every licence certificate shall be in such form as may from time to time be authorized by the Director of Licensing and shall show on its face:

(a) the kind or class or classes of licence issued;

(b) the date of expiry;

(c) whenever the licence authorizes the use of any premises or part or parts thereof for the purpose of the licensed business, identification of such premises or part or parts; and

(d) wherever the licence authorizes the use of a vehicle, cycle or cart, identification of the vehicle, cycle or cart.

(2) Licence certificates may show conditions imposed on the licence.

(3) No licence certificate shall be valid until it is shown on the face of the certificate that the amount of the licence fee has been paid.

(4) The signature of the Director of Licensing shall be affixed to each issued licence certificate, and a mechanical reproduction of the signature may be affixed in place of the original.

(5) On behalf of the City Clerk, the Director of Licensing may sign a statement as to the licensing or non-licensing of any premises or person under this By-law as provided for under subsection 447.6(4) of the Municipal Act, 2001.

20. Every licence certificate, licence plate, identification card, form or document, shall be delivered forthwith to the City upon written or oral request of the Director of Licensing or a licence inspector acting upon his or her direction.

21.(1) Every licence is personal to the holder thereof, and no licence is transferable without the consent in writing of the Director of Licensing or Council.

(2) No licence is transferable unless a transfer is specifically provided for in the applicable Schedule.

(3) No licence authorizes the use of any premises or part thereof, or of any vehicle, cycle or cart, except that identified on the licence certificate or record of application.

22.(1) Where a licence authorizes the use of any premises or part thereof, for any purpose for which a licence is required under this By-law, the current licensee shall:

(a) post up the licence certificate; and

(b) keep the licence certificate posted up, in a position where it may readily be seen and read by persons entering the premises or part thereof.

(c) remove any licence certificate which is not current from any area which is accessible to persons entering the premises.

23. The licensee shall be responsible that the premises authorized to be used for the purposes of the licensed business are kept clean and orderly, and that every vehicle, cycle or cart authorized to be used for the purpose of the licensed business is so used only when in a clean and safe condition.

24. Persons carrying on or engaged in the businesses for which licensing is provided under this By-law, shall allow at any reasonable time, inspection of the places or premises used in the carrying on of the business and equipment, vehicles and other personal property used or kept for hire in connection with the carrying on of the business, by persons authorized to enforce the provisions of this By-law.

25. A licensee who is issued a licence on the condition that the Licensee provide further criminal or driving records, shall supply the information required by subparagraphs 6(1)(e)(i) and (ii) as applicable, on the intervals required by the conditions imposed on their licence.

25a Every licence holder shall advise the Director of Licensing immediately in writing of any change to the information required to be filed in respect of their licence under the General Provisions or the Schedule under which their licence is issued.

26.(1) Every person engaging in or carrying on any business for which a licence is required by the provisions of this By-law shall be responsible that all applicable law, including all the provisions of this By-law and the applicable Schedule or Schedules regulating such business, are complied with.

(2) Licensees shall comply with all applicable law, including all the provisions of this By-law and the applicable Schedule or Schedules, and with conditions of their licences, and no licensee shall cause or permit their employee, agent or other persons carrying on or engaging in the business on their behalf, to fail to comply with all applicable law, including the provisions of this By-law and the applicable Schedule or Schedules, and with the conditions of their licences.

(3) Compliance with all applicable law, including the provisions of this By-law and its Schedules, and with the conditions of licences is a condition of an applicant or licensee obtaining, continuing to hold or renewing a licence.

26a. (1) A person assigned to enforce this By-law may enter on land at any reasonable time for the purpose of carrying out an inspection to determine whether or not the following are being complied with:

(a) this By-Law;
(b) a direction or order made under this By-Law;
(c) a condition of a licence issued under this By-Law; or
(d) an order made under s. 431 of the *Municipal Act, 2001*.

(2) A person assigned to enforce this By-law may, for the purposes of the inspection under subsection (1):

(a) require the production for inspection of documents or things relevant to the inspection;
(b) inspect and remove documents or things relevant to the inspection for the purpose of making copies or extracts;
(c) require information in writing or otherwise as required by the person assigned to enforce this By-law from any person concerning a matter related to the inspection; or
(d) alone or in conjunction with a person possessing special or expert knowledge, make examinations or take tests, samples or photographs necessary for the purposes of the inspection.

(2.1) Any cost incurred by the City in exercising its authority to inspect under subsection (2), including but not limited to the cost of any examination, tests, sampling or photographs necessary for the purposes of the inspection, shall be paid by the person who is licensed or required to be licensed under this By-law to carry on the business being inspected.

(3) A person assigned to enforce this By-law may undertake an inspection pursuant to an order issued by a provincial judge or justice of the peace under section 438 of the *Municipal Act, 2001* where he or she has been prevented or is likely to be prevented from carrying out an inspection under subsections (1) and (2).

(4) If a person assigned to enforce this By-law is satisfied that a contravention of this By-Law has occurred, he or she may make an order requiring the person who contravened the By-Law or who caused or permitted the contravention or the owner or occupier of the property on which the contravention occurred to discontinue the contravening activity.

(5) An order under subsection (4) shall set out:

(a) reasonable particulars of the contravention adequate to identify the contravention and the location of the property on which the contravention occurred; and

(b) the date or dates by which there must be compliance with the order.

(6) If a person assigned to enforce this By-law is satisfied that a contravention of this By-law has occurred, he or she may make an order requiring the person who contravened the By-law or who caused or permitted the contravention or the owner or occupier of the property on which the contravention occurred to do work to correct the contravention.

(7) An order under subsection (6) shall set out:

(a) reasonable particulars of the contravention adequate to identify the contravention and the location of property on which the contravention occurred;

(b) the work to be completed; and

(c) the date or dates by which the work must be complete.

(8) An order to discontinue contravening activity made under subsection (4) or an order to do work made under subsection (6) may be served personally or by registered mail to the last known address of:

(a) the owner or occupier of the property where the contravention occurred; and

(b) such other persons affected by it as person assigned to enforce this By-law making the order determines.

Service by registered mail shall be deemed to have taken place five business days after the date of mailing.

(9) In addition to service given in accordance with subsection (8), an order to discontinue contravening activity made under subsection (4) or an order to do work made under subsection (6) may be served by a person assigned to enforce this By-law by placing a placard containing the order in a conspicuous place on the property where the contravention occurred.

(10) Where service cannot be given in accordance with subsection (8), sufficient service is deemed to have taken place when given in accordance with subsection (9).

(11) Where a person does not comply with a direction or a requirement, including an order, under this By-Law to do a matter or thing, the Director of Licensing, with such assistance by others as may be required, may carry out such direction or requirement at the person's expense.

(12) The City may recover the costs of doing a matter or thing under subsection (11) by action or by adding the costs to the tax roll and collecting them in the same manner as property taxes and such costs shall include an interest rate of 15 per cent commencing on the day the City incurs the costs and ending on the day the costs, including the interest, are paid in full.

(13) The Director of Licensing is authorized to give immediate effect to any direction or requirement where the costs of carrying out the direction or requirement do not exceed $10,000 and, where the costs do exceed $10,000, as the City's Council may authorize.

26b. Pursuant to Section 431 of the Municipal Act, 2001, when a person has been convicted of an offence under this By-Law, any court of competent jurisdiction may, in addition to any other penalty or other remedy imposed, make an order prohibiting the continuation or repetition of the offence.

27.(1) Every person who contravenes Schedules 1 or 4 and every director or officer of a corporation who concurs in such contravention by the corporation is guilty of an offence and upon conviction liable to a fine not exceeding $25,000 or to imprisonment for a term not exceeding one year, or to both.

(2) Every person, including every person who fails to comply with an order made under section 26a., who contravenes this By-law, except Schedules 1 or 4, and every director or officer of a corporation who concurs in such contravention by the corporation is guilty of an offence and upon conviction liable to a fine not exceeding $25,000.

(3) Where a corporation is convicted of an offence under subsection (1) or (2), the maximum penalty that may be imposed on the corporation is $50,000 and not as provided in those subsections.

28.(1) A notice given or required to be given to an applicant or licensee under this By-law, may be sent by facsimile, regular mail or registered mail to a number or address supplied by the applicant or licensee, or delivered personally to the applicant or licensee, or to a person in charge of the premises, vehicle, cart or cycle licensed or required to be licensed under this By-law.

(2) Notwithstanding any other section of this By-law, a notice of refusal to issue, or a notice of revocation or suspension of a licence is effective upon personal delivery to a person in charge of the business premises, vehicle, cart or cycle licensed.

**SEVERABILITY AND SAVING**

29. If a court of competent jurisdiction declares a part or the whole of any provision of this By-law to be invalid or of no force and effect, the provision or part is deemed severable from this By-law, and it is the intention of Council that the remainder survive and be applied and enforced in accordance with its terms to the extent possible under the law.

**SCHEDULES**

30. The following Schedules form part of this By-law:

| | |
|---|---|
| Schedule 1 | Adult Entertainment Establishments |
| Schedule 2 | Auctioneers |
| Schedule 3 | Bed and Breakfasts, Hotels and Motels |
| Schedule 4 | Body Rub Parlours |
| Schedule 5 | Pawnbrokers (17-129) |
| Schedule 6 | Food Service Vehicles |
| Schedule 7 | Kennels and Pet Shops(17-069) |
| Schedule 8 | Limousines |
| Schedule 9 | Lodging Houses |
| Schedule 10 | Salvage Businesses (17-130) |
| Schedule 11 | Payday Loan Businesses (16-053) |
| Schedule 12 | Pedlars |
| Schedule 13 | Personal Aesthetic Services |
| Schedule 14 | Tree Cutting Services (19-175) |
| Schedule 15 | Personal Wellness Services Establishments |
| Schedule 16 | Public Garages |
| Schedule 17 | Public Halls and Places of Amusement |
| Schedule 18 | (Reserved)(17-055) |
| Schedule 19 | (Reserved) |
| Schedule 20 | Residential Care Facilities |
| Schedule 21 | Food Premises |
| Schedule 22 | Second-Hand Goods, Jewellery and Precious Metals Businesses (17-128) |
| Schedule 23 | Seasonal Produce Vendors |
| Schedule 24 | Personal Transportation Providers(17-013) |
| Schedule 25 | Taxicabs |
| Schedule 26 | Mobile Sign Leasing or Renting |
| Schedule 27 | Tobacco and Electronic Cigarette Retailers(17-056) |
| Schedule 28 | Tow Trucks |

| | |
|---|---|
| Schedule 29 | Trades |
| Schedule 30 | Transient Traders |

31. City of Hamilton By-law No. 06-213 and all amendments thereto are repealed upon the coming into force and effect of this by-law.

32. City of Hamilton By-law No. 06-234 is repealed.

33. This by-law may be referred to as the “City of Hamilton Licensing Code”. A reference to the City of Hamilton Licensing Code in this or any other City of Hamilton By-Law is deemed to be a reference to this By-Law.

34. This by-law comes into force and effect on the date it is passed and enacted.

**PASSED and ENACTED** this
day of ,

MAYOR

CLERK

**SCHEDULE 20**

**RESIDENTIAL CARE FACILITIES**

**PART I: INTERPRETATION**

1. In this Schedule:

**"activities of daily living"** means the activities of an individual that maintain their sufficient nutrition, hygiene, warmth, rest and safety;

**"additional care"** means community services such as long term care services, or rehabilitative services that can be provided to a tenant either in the residential care facility or in the community;

**"ambulatory"** means in respect of an individual, that they are independently mobile, by mechanical or any other means, or with minimal assistance of another person;

**"attic"** means the space between the roof and the ceiling of the top storey of a residential care facility or between a dwarf wall and a sloping roof of a residential care facility, which is not finished in such a way as to provide suitable habitation for tenants;

**"basement"** means a storey of a residential care facility located below the first storey which is more than 50 per cent below grade or which is not finished in such a way as to provide suitable habitation for tenants;

**"care services"** means advice, information, or supervision provided to tenants in the activities of daily living and may also include:

(a) periodic personal care, as required, such as the giving of medications, bathing assistance, assistance with feeding, incontinence care, dressing assistance, assistance with personal hygiene, and ambulatory assistance;
(b) provision of recreational or social activities, housekeeping, laundry services, and assistance with transportation;

(c) personal emergency response services, including assistance in evacuating under emergency conditions due to mental limitations and/or developmental handicaps and limitations of the tenants;

**"drug"** means any substance or mixture of substances manufactured, sold or represented for use in:

(a) the diagnosis, treatment, mitigation or prevention of a disease, disorder, abnormal physical state, or the symptoms thereof, in an individual; or

(b) restoring, correcting or modifying of organic functions in an individual;

**"Guidelines"** means the guidelines for the operation of facilities licensed under this Schedule, which the Medical Officer of Health is authorized to issue under subsection 57(a);

**"long term care facility"** means a nursing home under the *Nursing Homes Act*, an approved charitable home for the aged under the *Charitable Institutions Act* or a home under the *Homes for the Aged and Rest Homes Act* provided that on the day the *Long-Term Care Homes Act, 2007* comes into force, "long term care facility" means a place that is licensed under that Act;

**"Officer"** means:

(a) a building inspector of the Building Division of the Planning and Economic Development Department;

(b) an inspector of the Fire Department;

(c) a public health inspector employed in the Public Health Services Department;

(d) a registered nurse employed in the Public Health Services Department;

(e) an officer appointed by the Director of Licensing.

**“operator”** means a person licensed under this Schedule to operate a residential care facility;

**“physician”** means a legally qualified medical practitioner;

**“prescribed”**, when used with reference to a drug or mixture of drugs, means that a legally qualified medical practitioner or a dentist has directed the dispensing of the drug or mixture of drugs to a named individual;

**“prescription drug”** means a drug that may be dispensed by a pharmacist only upon the direction of a physician or dentist;

**“rehabilitative services”** means services for a person with a physical, mental, or developmental handicap, and includes,

(a) homemaker services,

(b) day care,

(c) training and rehabilitation,

(d) casework and counselling, and

(e) training in life skills;

**“residential care facility”** means a residential complex that is:

(a) occupied or intended to be occupied by four or more persons for the purpose of receiving care services, whether or not receiving the services is the primary purpose of the occupancy; or

(b) licensed or required to be licensed under the Retirement Homes Act, 2010,

and the term “facility” has a corresponding meaning.

**“residential care facility information package”** means an information package that contains the information required to be contained in an information package under section 140 of the *Residential Tenancies Act, 2006* including notice that a complaint about the operation of the facility may be made by telephoning the City of Hamilton’s Public Health Services at 905-546-2063;

**“single facility incident”** means a situation, or the likelihood of an impending situation, which could reasonably be expected to have an abnormal effect on the health, safety, welfare, or personal property of one or more tenants of a facility, and which, because of its nature or magnitude, requires a controlled and co-ordinated response by the operator;

**“tenant of a facility”** means a person, other than an operator or employee, who

(a) resides in a residential care facility, and to whom the operator provides care services;

(b) is ambulatory; and

(c) has decreased physical or mental functional ability;

and the term “tenant” has a corresponding meaning; and

**“volunteer”** means a person, other than an operator or an employee, who, as part of an organized volunteer program, provides services or work at a residential care facility for no wage or salary.

## PART II: LICENSING

### GENERAL

2. No person shall operate a residential care facility without a licence.

2.1 The following provisions of this Schedule do not apply with respect to tenants subject to the Retirement Homes Act, 2010 but only to the extent that tenants of the same facility not subject to the Retirement Homes Act, 2010 are unaffected:
subsection 5(1)(e);
section 7;
subsection 12(c);
paragraphs 12(f)(ii) to (v);
subsection 12(g);
section 13 to the extent that the section applies to volunteers;
section 15;
section 16;
section 17;
sections 32 to 53.

3. A licence shall not be issued for a facility established after October 1, 1980, which is situated in a location where, at any hour, the noise level exceeds 58 decibels.

4. The authorized capacity of a facility, as determined by the Medical Officer of Health, and the provisions of the applicable zoning by-laws, shall be endorsed on the licence issued to the facility.

**INFORMATION TO BE PROVIDED BY APPLICANT**

5.(1) Every applicant for a licence, in addition to complying with the General Provisions of this By-law, shall submit, before the licence may be issued:

(a) a signed form certifying that the applicant is at least eighteen years of age at the time of application;

(b) a copy of an Ontario Secondary School Graduation Diploma or evidence satisfactory

to the Director of Licensing of equivalent standing from the Ontario Ministry of Education and Training;

(c) evidence satisfactory to the Director of Licensing of employment experience in work comparable to the administration of the facility which they propose to operate;

(d) a premises plan of the residential care facility showing all buildings or other structures, parking areas and walkways on the property where the residential care facility is located and all entrances/exits, bedrooms, beds, clothes closets, dining areas, sitting rooms and toilet facilities, sitting rooms in the residential care facility; and

(e) a single facility incident plan satisfactory to the Medical Officer of Health which shall include the premises plan under paragraph (d).

(2) Paragraph (1)(b) does not apply to a person who was the holder of a licence to operate a residential care facility under a by-law of a former area municipality on July 10, 2001, the date that the City of Hamilton Licensing Code, By-law 01-156, came into force.

6. Every applicant for a licence or a licence renewal, in addition to complying with the General Provisions of this By-law, shall submit to the Director of Licensing before the licence is issued or renewed, the following:

(a) upon applying for a licence and every third year thereafter, upon applying for a licence renewal, a certificate from the Electrical Safety Authority that the facility complies with the *Ontario Electrical Safety Code*;

(b) a certificate from the Medical Officer of Health, that the facility complies with the applicable health and safety standards in this Schedule;

(c) a certificate from the insurer of the facility, that the insurance coverage required under subsection 12(i) of this Schedule is in effect for the facility; and

(d) documentation as required under section 14 as to the age and education of the operator's employees.

7. Every applicant for a licence renewal, in addition to complying with the General Provisions of this By-law, shall submit to the Issuer of Licence before the licence is renewed an updated single facility incident plan satisfactory to the Medical Officer of Health.

8. Where the applicant for a licence or for a licence renewal is a corporation or a partnership, at least one officer or director of the corporation or one partner of the partnership shall submit, in respect of themselves, the certificates or other documents required to be submitted by an individual under the General Provisions of this By-law or under this Schedule.

9. Every operator shall advise the Director of Licensing immediately in writing of any change to the information required to be filed in respect of their licence under the General Provisions of this By-law or this Schedule.

**EXPIRATION**

10. No licence issued under this Schedule is transferable.

11. Where:

(a) by a transfer of existing shares, by an issue of new or existing shares, or by some other means, the controlling interest in a corporation holding a licence is determined by the Director of Licensing to have changed hands; or

(b) one or more partner in a partnership holding a licence is determined by the Director of Licensing to have ceased to be a partner or the partnership is determined by the Director of Licensing to have ceased to exist,

a licence issued under this Schedule shall be deemed to have expired.

## PART III: OPERATOR

### GENERAL

12. The operator shall:

(a) ensure that the applicable provisions of this Schedule, including the Guidelines, are complied with;

(b) provide a certificate from the Electrical Safety Authority that the facility complies with the *Ontario Electrical Safety Code* as required by the Director of Licensing;

(c) keep a copy of the single facility incident plan in the facility in a readily accessible location;

(d) ensure that there are no firearms and no prohibited or restricted weapons, as set out in federal statutes, regulations, Orders in Council or otherwise by the federal government, kept in the facility;

(e) ensure that access to a telephone is available at all times within the facility;

(i) for employees and volunteers; and

(ii) for tenants of the facility:
1. with its own, separate line;
2. in a private setting, not including a lobby, hallway or passageway;
3. where a tenant using the telephone cannot be easily overheard;

(f) post in a conspicuous place in the facility:

(i) the current licence for the facility;

(ii) a notice stating the name of the operator or an employee who is present at the facility and has the primary duty of supervising the tenants as required under

paragraph 17(2)(b);

(iii) a notice stating the operator's name, address and telephone number, and the name, address and telephone number of the employee who has been designated under paragraph 17(2)(a);

(iv) a notice stating the operator is licensed by the City of Hamilton and that a complaint about the operation of the facility may be made by telephoning the City of Hamilton at 905-546-2063;

(v) rules for the conduct of employees and tenants of the facility;

(vi) a notice of the collection of personal information in a form approved by the Director of Licensing which contains:

1. the legal authority for the collection of personal information about tenants and employees of the facility by Officers;

2. the principal purpose or purposes for which the personal information is intended to be used; and

3. the title, business address and business telephone number of an officer or employee of the City who can answer questions from individual tenants and employees of the facility about the collection of their personal information;

(g) comply with all applicable access to information and protection of privacy legislation;

(h) ensure that the authorized capacity of the facility is not exceeded; and

(i) ensure that a policy of commercial general liability insurance, including coverage for bodily injury and property damage resulting from the operation of the facility, with an inclusive limit of at least one million dollars ($1,000,000) per claim or occurrence, is in force at all times when one or more tenants is present in the facility.

(i) where both tenants who are subject to the Retirement Homes Act, 2010 and tenants who are not subject to the Retirement Homes Act, 2010 reside in the facility, ensure that:

(i) an up-to-date list of tenants who are not subject to the Retirement Homes Act, 2010 is maintained; and

(ii) the person with the primary duty of supervising the tenants under paragraph 17(2)(b) provides the list and identifies tenants who are not subject to the Retirement Homes Act, 2010 immediately upon the request of an Officer.

**EMPLOYEES AND VOLUNTEERS**

13.(1) The operator shall give every employee and volunteer a notice of the collection of information in a form approved by the Director of Licensing and the Medical Officer of Health which describes the procedures under this Schedule for the collection of personal information about employees and volunteers, at the time when an individual commences employment or volunteering at the facility.

(2) The notice under subsection (1) shall also contain:

(a) the legal authority for the collection of personal information about employees or volunteers by Officers;

(b) the principal purpose or purposes for which the personal information is intended to be used; and

(c) the title, business address, and business telephone number of an officer or employee of the City who can answer questions from an employee of or a volunteer at the facility about the collection of the employee's or volunteer's personal information.

(3) Where the operator has not given an employee or volunteer a notice under subsection (1), the operator shall give the employee or volunteer a letter in a form approved by

the Director of Licensing and the Medical Officer of Health which contains the information set out in subsections (1) and (2), within seven days after being directed to do so by the Director of Licensing.

(4) Notwithstanding subsection (1), the operator shall give a notice of the collection of personal information to an employee or volunteer within seven days after being directed to do so by an Officer.

14. The operator shall provide evidence satisfactory to the Director of Licensing, within seven days after an employee commences employment, that the employee:

(a)(i) is sixteen years of age but less than eighteen years of age; or

(ii) eighteen years of age or older;

(b) if the employee is eighteen years of age or older;

(i) has an Ontario Secondary School Certificate, or equivalent standing; or

(ii) employment experience, satisfactory to the Director of Licensing, in comparable work;

(c) whose duties require communication with the tenants, is able to communicate clearly and effectively with the tenants.

15.(1) The operator shall provide evidence satisfactory to the Director of Licensing within thirty days after an employee commences employment that the employee has successfully completed of the new staff in-service orientation training as described in the Guidelines.

(2) Where an employee’s duties involve the supervision of tenants, the operator shall provide evidence satisfactory to the Director of Licensing within thirty days of each six month period after the employee commences employment that the employee

has successfully completed at least five hours of continuing education as described in the Guidelines.

16. The operator shall provide evidence satisfactory to the Director of Licensing, within seven days after an employee commences employment or a volunteer commences volunteering, that the employee or volunteer has had a negative TB test not more than thirty days before commencing employment or volunteering.

**RESPONSIBILITY FOR OPERATION AND SUPERVISION**

17.(1) In this section “employee” means an employee who is eighteen years of age or older.

(2) The operator shall ensure:

(a) that one employee is designated as the individual responsible for the operation of the facility and can be contacted immediately at the telephone number posted for that employee under subsection 12(f) at any time when the operator cannot be contacted immediately at the telephone number posted for the operator under subsection 12(f);

(b) that at all times, the operator or an employee is present at the facility who has the primary duty of supervising the tenants and is able to carry out this duty without interference, including but not limited to any interference caused by other duties or by distractions; and

(c) the safety of the tenants while the tenants are at the facility.

**OPERATIONS AND MAINTENANCE**

**Water Supply**

18. The operator shall ensure that there is an adequate supply of potable and of hot water:

(a) which can provide at least 227.303 litres (50 gallons) for each tenant and employee, per day;

(b) of at least .362 kilograms pressure per square centimetre (8 pounds per square inch), when a fixture is in use; and

(c) for water serving all bath tubs, showers and hand basins used by tenants, of a temperature of not more than 49$^{o}$ Centigrade (120$^{o}$ Fahrenheit) and controlled by a device, inaccessible to the tenants, that regulates the temperature.

**Bedrooms and Storage**

19. The operator shall ensure that:

(a) a bedroom for a tenant or tenants in a facility established before October 1, 1980 provides a minimum of 16.8 cubic meters (600 cubic feet) of air space and 6.96 square meters (75 square feet) of floor space for each tenant;

(b) a bedroom for a tenant or tenants in a facility constructed, renovated, added to or altered on or after June 1, 1980 provides a minimum, exclusive of the space provided for built-in or portable clothes closets, of:

(i) 10.22 square meters (110 square feet) of floor space in a single-bed unit, provided that this area may be reduced to 9.30 square meters (100 square feet) where the facility provides a living room and one or more dining area;

(ii) 16.72 square meters (180 square feet) of floor space in a two-bed unit;

(iii) 25.08 square meters (270 square feet) of floor space in a three-bed unit;

(iv) 29.73 square meters (320 square feet) of floor space in a four-bed unit;

(c) a bedroom for more than one tenant shall be arranged so that all beds are at least

.91 meters (3 feet) apart;

(d) a bedroom for one or more tenants:

(i) has one or more windows to the outside that:

1. except where another means of ventilation is provided, can be opened to provide an open area of at least 5% of the floor area of the room;

2. is not less in total area than 10% of the floor area of the room; and

3. is screened from May 1 to October 31;

(ii) is not to be part of a lobby, hallway, passageway, closet, bathroom, stairway, basement, attic, kitchen, storage room, boiler room, laundry room, activity room, utility room, chapel, sitting room, administrative office, or tenant examination room;

(e) a bedroom is provided with a door and a lock which is of a type that can be:
(i) secured by the tenant or tenants of the bedroom when they are inside or outside of the bedroom; and
(ii) opened from the outside by the operator or an employee in case of an emergency;

(f) every bed provided for a tenant of a facility is of a minimum width of 91.44 centimetres (36 inches);

(g) a bedroom in a facility in respect of which a licence was not issued under a by-law of a former area municipality on July 10, 2001, the date that the City of Hamilton Licensing Code, By-law 01-156, came into force, does not contain more than two beds;

(h) where more than one bed is located in a bedroom, a moveable partition is provided between the beds to ensure the privacy of each tenant, unless the tenants who

occupy the bedroom jointly inform the operator that they do not require such a partition;

(i) sufficient clean towels, face cloths and bed linen are provided for use of the tenants of a facility, with a supply of such linen:

(i) available at all times in the facility: and

(ii) changed at least one a week;

(j) a clothes closet is provided for each tenant in their bedroom;

(k) secure storage space, no less than 0.15 $m^3$ in size and accessible only to the tenant and the operator, is provided for each tenant; and

(l) a rack on which to hang towels and face cloths is provided for each tenant.

**Dining Area**

20. The operator shall ensure that one or more dining areas is provided, with a minimum floor space of 1.85 square meters (20 square feet) per tenant and capable of accommodating at least one half of the authorized capacity of the facility at one time.

**Sitting Rooms**

21. The operator shall ensure that:

(a) one or more sitting rooms is provided within each facility;

(b) the minimum total space for a sitting room shall be the greater of:

(i) an area equal to 1.39 square meters (15 square feet) of floor space for each tenant; or

(ii) 11.148 square meters (120 square feet).

**Toilet Facilities**

22. The operator shall ensure that:

(a) a toilet room or bathroom are not within, or open directly into, any dining room, kitchen, pantry, food preparation room, or storage room;

(b) a toilet is not located within a bedroom;

(c) toilet facilities are provided in at least the following ratios:

(i) for an authorized capacity of four to seven tenants: one wash basin, one flush toilet, and one bath tub or shower;

(ii) for an authorized capacity of a fraction of seven tenants beyond the first seven: one wash basin and one flush toilet; and

(iii) for an authorized capacity of each additional seven tenants beyond the first seven: one wash basin, one flush toilet, and one bath tub or shower;

(d) a bathroom, toilet, or shower room is provided with a door and a lock which is of a type that can be readily released from the outside in case of an emergency;

(e) one bathroom toilet and shower room shall be of a type that is suitable for use by persons confined to wheelchairs, where one or more such persons have been admitted to the facility as tenants;

(f) the bottom of each bath tub is furnished with non-skid material; and

(g) each bath tub and each toilet is furnished with at least one grab bar or similar device of a type that will ensure the safety of tenants.

**Waste**

23. The operator shall ensure that waste is stored in receptacles which are:

    (i) insect and rodent-proof;

    (ii) water-tight;

    (iii) provided with a tight-fitting cover; and

    (iv) kept clean.

**Lighting**

24. The operator shall ensure that lighting of the exterior and interior of the facility complies with ANSI/IESNA RP-28-07 (the “Recommended Practice for Lighting and the Visual Environment for Senior Living” approved by the Illuminating Engineering Society of North America) as amended or replaced from time to time.

**Ventilation**

25. The operator shall ensure that every room shall be adequately ventilated by natural or mechanical means and shall be so designed and installed that it meets the applicable requirements of the Ontario Building Code.

**Ramps and Stairways**

26. The operator shall ensure that guard, handrail and slip-resistance requirements for ramps and stairways shall be so designed and installed that they meet the applicable requirements of the Ontario Building Code.

**Floors**

27. The operator shall ensure that non-skid finishes and coverings are installed on every

floor.

**Balconies**

28. The operator shall ensure that balustrades for balconies shall be so designed and installed that they meet the applicable requirements of the Ontario Building Code.

**Construction and Zoning**

29. The operator shall ensure that:

    (a) no construction, renovation, addition or alteration of a facility is carried out, except in compliance with this Schedule, ANSI/IESNA RP-28-07 as amended or repaced from time to time, the Ontario Building Code, the Ontario Fire Code, and under a valid building permit; and

    (a) the applicable zoning by-laws are complied with.

30. The operator:

    (a) shall submit to the Director of Licensing an operational plan, addressing the operation of their facility during construction, renovation, addition or alteration, a minimum of 90 days before commencing such construction, renovation, addition or alternation; and

    (b) shall not commence construction, renovation, addition or alteration of a facility until the Director of Licensing has given them written approval of the operational plan submitted under subsection (a).

**General Health and Safety**

31. The operator shall ensure that:

    a. the facility is kept in a clean and sanitary condition, including but not limited to

providing for professional pest control as needed;

(b) the facility is free from hazards to the safety of tenants of the facility, employees, volunteers or visitors;

(c) the facility is supplied with heat in accordance with City of Hamilton By-law 04-091 with respect to the supply of adequate and suitable heat for rental residential premises;

(d) all food storage, preparation and service areas meet the requirements of the Food Premises Regulation under the *Health Protection and Promotion Act*; and

(e) the facility meets all requirements of the Building Code under the *Building Code Act, 1992* and of the Fire Code under the *Fire Protection and Prevention Act, 1997*.

**PART IV: ADMISSION OF TENANTS**

32.(1) The operator shall give every individual a notice of the collection of personal information in a form approved by the Director of Licensing and the Medical Officer of Health which describes the procedures under this Schedule for the collection of personal information about tenants before obtaining an assessment of the individual under section 33.

(2) The notice under subsection (1) shall also contain:

(a) the legal authority for the collection of personal information about tenants by inspectors;

(b) the principal purpose or purposes for which the personal information is intended to be used; and

(c) the title, business address, and business telephone number of an officer or employee of the City who can answer questions from a tenant of the facility about the collection of his or her personal information.

(3) Where the operator has not given a individual the notice under subsection (1) and the individual has been admitted as a tenant, the operator shall give the individual a letter in a form approved by the Director of Licensing and the Medical Officer of Health, which contains the information set out in subsections (1) and (2), within seven days after being directed to do so by the Director of Licensing.

(4) Notwithstanding subsection (1), the operator shall give a notice of the collection of personal information to a tenant within seven days after being directed to do so by a registered nurse employed in the Public Health Services Department.

33.(1) Prior to admitting an individual as a tenant of a facility, the operator shall obtain an up-to-date assessment from a physician or other member of a regulated health profession employed by a referring agency designated in the Guidelines, which provides an opinion as to the level of care services the individual requires.

(2) An operator shall determine on the basis of the assessment referred to in subsection (1), and the criteria for admission set forth in the Guidelines, whether the level of care services which is provided in the home is adequate to meet the individual's needs in relation to the activities of daily living.

34. An operator shall not admit an individual as a tenant who is not ambulatory, who for the protection of themselves or others requires placement in a locked unit or who requires a level of care services which the operator is not authorized to provide in the facility, except in accordance with the Guidelines.

35. An operator shall not admit an individual as a tenant without:

(a) their consent; or

(b) the consent in writing of their next-of-kin, or attorney for personal care, as the case may be, if the individual has been declared mentally or physically incapable of giving consent.

36. The operator shall enter into a written tenancy agreement with each individual who is admitted as a tenant of the facility and shall give each such individual a residential care facility information package prior to entering into the tenancy agreement.

## PART V: CARE SERVICES

37. The operator shall provide care services to each tenant in a facility in accordance with the Guidelines.

### DRUGS

38. The operator shall ensure that all prescription drugs:

(a) are kept in one or more locked drug cabinets, unless the drug requires refrigeration, or must be kept with the tenant for immediate use; and

(b) are made available only:
(i) to those tenants for whom they have been prescribed, as directed by a physician;
(ii) in a unit-dose medication dispensing system as described in the Guidelines.

39. The operator shall allow self-medication by the tenants of a facility under specified conditions set out in the Guidelines.

40. If a tenant is prescribed a drug that is a controlled substance as defined in the Controlled Drugs and Substances Act (Canada) and the operator has not completed a medication course as described in the Guidelines within the preceding twelve months, then they shall complete such a medication course no more than thirty days after the drug has been prescribed.

### NUTRITIONAL CARE

41. The operator shall ensure that the tenants of a facility are served daily sufficient food of good quality and adequate nutritional and caloric value as described in the Guidelines.

**INFECTION CONTROL**

42. The operator shall ensure that all requirements for the control of infectious diseases that are set forth in Guidelines are complied with, including recommendations for tuberculosis screening, immunization programs, reporting requirements, and outbreak control measures.

**MEDICAL CARE**

43.(1) Each tenant of a facility or their next-of-kin, or attorney for personal care, as the case may be, shall arrange for emergency medical care for the tenant, as required.

(2) Where the tenant, their next-of-kin**,** or attorney for personal care is unable to arrange for emergency medical care, or where such emergency medical care is unavailable, the operator shall arrange for emergency medical care for the tenant.

44. The operator shall allow a tenant's physician or a member of a regulated health professional who is providing care or treatment to a tenant to enter the facility at any reasonable time for the purpose of attending to the health of the tenant.

**ADDITIONAL CARE**

45.(1) Wherever the tenant's physician, the operator, the Medical Officer of Health, or a member of a regulated health profession who is employed by a referring agency designated in the Guidelines, determines that a tenant requires additional care services for their special needs and the tenant, their next-of-kin**,** or attorney for personal care has not arranged for such additional care, the operator shall ensure that such additional care is made available to the tenant while the tenant continues to reside in the facility.

(2) In ensuring that additional care services are provided under subsection (1), the

operator shall:

(a) consult with the tenant, their next-of-kin, attorney for personal care and/or a community worker, and prepare a plan which shall include a description of the health issue and the services being provided to address that health issue and which may include additional care services, such as additional personal care services and/or rehabilitative services;

(b) ensure that additional personal care services are provided through a referral to a community care access centre or to a private community agency;

(c) where the tenant requires rehabilitative services, support the tenant's rehabilitative goals in the facility and in the community, which may include assisting tenant with meal preparation, laundry, household duties and self-medication.

46. The operator or the employee designated under paragraph 17(2)(a) shall inform the tenant, as soon as possible, of the provisions of section 148 of the ***Residential Tenancies Act, 2006*** and may arrange for the transfer of the tenant:

(a) to a long term care facility or other appropriate living arrangement, with the agreement of the tenant, where an operator is informed by:

(i) a community care access centre that a tenant of a facility is eligible for admission to a long term care facility;

(ii) the tenant's physician or the Medical Officer of Health, that the tenant no longer requires the level of care services which the facility is authorized to provide; or

(iii) the tenant's physician or the Medical Officer of Health, that the tenant requires a level of care services that the operator is not authorized to provide; or

(b) to a long term care facility, with the agreement of the tenant, where a tenant requires placement in a locked unit for the protection of themselves or others.

47. The operator shall ensure that no facility is equipped with a locked unit provided that the Operator of any facility with a locked unit on date of passage shall make the necessary changes such as removing locks as soon as possible to eliminate such locked units.

48.(1) Where a tenant is transferred from a residential care facility to a long term care facility or to another facility licensed under this By-law, the operator shall request the tenant, or, if they are unable to act, their next-of-kin or attorney for personal care, to complete an authorization in Form 1 for the release of information pertaining to the tenant to the long term care facility or other licensed residential care facility.

(2) Where a tenant is transferred from a residential care facility to another facility licensed under this By-law, or to a hospital, the operator shall complete a transfer in Form 2.

## PART VI: RECORDS AND REPORTS

49.(1) The operator shall maintain an up-to-date, alphabetical list of the tenants of a facility which includes the name, sex, date of birth, age and date of admission of each tenant.

(2) The operator shall maintain a separate file for each tenant, which contains the following information:

(a) sex, date of birth, age, date of admission and date of discharge or death;

(b) name, address and telephone number of next-of-kin;

(c) name and telephone number of the tenant’s attorney for personal care, if any;

(d) the name and telephone number of the tenant's physicians;

(e) completed assessment;

(f) the name, address and telephone number of any community agency which is providing support to the tenant;

(g) tuberculin or chest x-ray testing results, and the dates thereof;

(h) a brief medical history of the tenant, in respect of the care services provided by the operator under the tenancy agreement (section 36) or any additional care services made available by the operator (subsection 45(1)), from the date of their admission, including medication information, laboratory results, physicians' orders and staff notes or other records necessary to determining the level of care services provided;

(i) a residential care facility information package;

(j) particulars of each accident suffered by the tenant while in the facility; and

(k) any completed Form 1, Form 2 or Form 3.

50. The operator shall make a record in Form 3 of every occurrence with respect to a tenant of assault, injury or of death that has been reported to coroner, and shall place the completed Form 3 in the tenant's file and keep it available for inspection by the Medical Officer of Health.

51. The operator shall ensure that any document or other record of any kind which contains personal information about a tenant, other than the personal information described in subsections 49(1) and (2) and section 50, is maintained in a file which is separate from the file which is maintained pursuant to subsection 49(2) or any other provisions of this Schedule or the Guidelines.

52. The operator shall ensure that any document or other record of any kind which contains personal information about the performance of duties by an employee of their facility, other than personal information described in sections 14, 15 and 16 and subsections 12(f), is maintained in a file which is separate from the file which is maintained pursuant to the provisions of this Schedule or the Guidelines.

53. The operator shall ensure that documents or records which are kept pursuant to this Schedule or the Guidelines are kept for at least one year after the tenant, employee or volunteer ceases to be a tenant, employee or volunteer respectively.

**PART VII: INSPECTION AND ENFORCEMENT**

54.(1) The Medical Officer of Health, the General Manager of Planning and Economic Development, the Chief Fire Prevention Officer, the Chief of the City of Hamilton Police, the Director of Licensing, or an Officer, at all reasonable times, may inspect any facility and the list of tenants required by subsection 49(1) where that subsection is applicable.

(2) The Medical Officer of Health or a member of a regulated health profession authorized by them, at all reasonable times, may inspect the file of any tenant required by subsection 49(2) where that subsection is applicable.

55. The operator shall allow the Medical Officer of Health or a member of a regulated health profession authorized by them, as often as they deem reasonably necessary, to make inspections of the facility and its operation in order to determine compliance with this Schedule.

56. The Medical Officer of Health, the Director of Licensing, the General Manager of Planning and Development and the Chief Fire Prevention Officer are authorized to enforce the provisions of this Schedule which are within their respective jurisdiction, and to serve such notices and make and serve such orders as may be necessary to ensure compliance by the operator.

57. The Medical Officer of Health may:

(a) issue Guidelines for the operation of facilities licensed under this By-Law, including any matters relating to the health, safety, and well-being of the tenants of a facility, and shall provide a copy of any such Guidelines and any subsequent additions or revisions to the operator of each facility licensed under this By-Law;

(b) prescribe the format and content of any forms or other documents required under this Schedule;

(c) designate the referring agencies which may employ a member of a regulated health profession for the purposes of making an assessment under subsection 33(1) and making a determination under subsection 45(1).

# CITY OF HAMILTON
# LICENSING CODE

# SCHEDULE 20
# RESIDENTIAL CARE FACILITIES

# Guidelines

CITY OF HAMILTON LICENSING CODE –
SCHEDULE 20 – RESIDENTIAL CARE FACILITIES
GUIDELINES

# INTRODUCTION

This document contains the Guidelines as issued by the Medical Officer of Health under the City of Hamilton Licensing Code, Schedule 20 - Residential Care Facilities.

The Guidelines are defined in Schedule 20 as “guidelines for the operation of facilities licensed under this Schedule, which the Medical Officer of Health is authorized to issue under subsection 57(a).”

Subsection 57(a) states “The Medical Officer of Health may issue Guidelines for the operation of facilities licensed under this By-law, including any matters relating to the health, safety, and well-being of the tenants of a facility, and shall provide a copy of any such Guidelines and any subsequent additions or revisions to the operator of each facility licensed under this By-law.”

This document is set up with the Schedule 20 standard at the beginning of each Part and the Guideline relating to the standard directly beneath. Some of the Guidelines have an Appendix containing additional information specific to the Guideline. These Appendices are found at the end of the document.

For further information on the Guidelines, contact the Public Health Services Department, Infectious Diseases Prevention and Control Program at (905) 546-2063 during business hours (Monday to Friday, 8:30 a.m. to 4:30 p.m.).

## PART II: LICENSING

### Section 5 - Single Facility Incident Plan

**The operator shall prepare a single facility incident plan, including a premises plan, satisfactory to the Medical Officer of Health, which shall be submitted to the Issuer of Licences and to the Medical Officer of Health before a licence is issued. A copy of the single facility incident plan shall be kept in the facility, in a readily accessible location. The single facility incident plan shall be updated annually.**

- In Schedule 20, a "single facility incident" means a situation, or likelihood of an impending situation, which could reasonably be expected to have an abnormal effect on the health, safety, welfare, or personal property of one or more tenants of a facility, and which, because of its nature or magnitude, requires a controlled and co-ordinated response by the operator.

- A plan for responding to a single facility incident where tenants need to be removed for any length of time shall be prepared and followed. Examples of a single facility incident would be removal in case of a fire, flood or lack of hydro and/or heat. An updated single facility incident plan shall be submitted by the operator to the Issuer of Licenses and the Medical Officer of Health upon renewal of their licence.

- See Appendix "A" for additional guidelines on how to prepare a single facility incident plan.

- A nurse inspector will assess single facility incident plans.

- A copy of the single facility incident plan shall be kept in an easy to reach place.

- The operator, employees and tenants shall review the single facility incident plan two times a year.

## PART III: OPERATOR

### Section 15 – In-Service Orientation Training and Continuing Education

***The operator shall ensure that employees have successfully completed a new staff in-service orientation training.***

***Every employee whose duties involve the supervision of tenants shall participate in continuing education to a minimum of five hours within each consecutive six months.***

- In-service orientation training shall include a thorough review of the Schedule 20 requirements as well as the Guidelines. The employee must fully understand their role as an employee in a residential care facility.

- In Schedule 20, "continuing education" means a course, lecture, seminar or other professional activity in which an employee participates that meets the requirements, for example with respect to subject matter, of this Guideline.

- Employees who supervise tenants shall have at least five hours of education in a six month period. Continuing education hours are to be recorded as completed on an ongoing basis.

- Employees shall take continuing education in a subject matter relating to care services given in the facility, such as nutrition, medication, contagious diseases, medical and mental health conditions, community resources, the Residential Tenancies Act, 2006, etc.

- Employees shall be trained in how to give first aid treatment.

- A nurse inspector may ask that the operator or an employee take education in specific areas where there is a need to do so, for example, when the facility has started a new medication system and employees need to learn more about it.

- The Residential Care Facilities Education Committee (RCFEC) plans education sessions for employees of residential care facilities. The RCFEC is made up of members from the Public Health Services Department, Community Services Department, residential care facilities, St. Joseph's Hospital Mountain Site Education Services and the Canadian Mental Health Association. If you are interested in becoming an RCFEC member or would like information on the Committee, please contact Public Health Services at (905) 546-2063 during business hours (Monday to Friday, 8:30 a.m. to 4:30 p.m.).

- The RCFEC plans monthly sessions on topics related to issues that Committee members and residential care facilities employees have identified. Notices are sent out prior to the session with all the details. Employees of residential care facilities are encouraged to attend these sessions.

- Continuing education hours may be earned by:

  1. reading material; for example, a professional article

  2. watching or listening to information; for example, watching an educational video or listening to educational cassettes or CDs. You can obtain such material from community agencies, libraries, and pharmacies, etc.

  3. attending workshops, education sessions or professional conferences, etc.

  4. attending education sessions planned by the RCFEC

- An up-to-date record of an employee's continuing education hours, including date, topic and time of education, shall be kept and signed by the operator and the employee. If an employee has proof of continuing education, for example, a certificate, then the operator shall include a copy in the record.

## Section 17 – Operation of Residential Care Facility and Supervision of Tenants

***The operator shall ensure that, at all times, a qualified employee has been designated as the person responsible for the operation of the facility and either the operator or a qualified employee is present at the facility with the primary duty of supervising the tenants.***

- The operator or at least one employee over the age of eighteen shall be on duty at all times.

- Enough employees shall be on duty to meet all tenants' care needs. Recommendations may be made by a nurse inspector about the number of hours worked in a row by an employee and the number of employees on duty each shift. For example, it may be recommended that no employee work more than 12 hours in a row and that 2 employees be on duty for the night shift. The recommendations made by a nurse inspector shall be followed.

- All employees whose primary duty is the supervision of the tenants shall be familiar with Schedule 20 and the Guidelines.

- The name of the operator or employee who has the primary duty of supervising the tenants shall be posted for tenants to see during his/her shift.

## PART IV: ADMISSION OF TENANTS

### Sections 33 and 34 - Assessment

***Prior to admitting an individual as a tenant of a facility, the operator shall obtain an up-to-date assessment from a physician or other member of a regulated health profession employed by a referring agency designated in the Guidelines..***

***An operator shall determine on the basis of the assessment and the criteria for admission set forth in the Guidelines, whether the level of care services which is provided in the home is adequate to meet the individual's needs in relation to the activities of daily living.***

***An operator shall not admit an individual as a tenant who is not ambulatory who for the protection or themselves or others requires placement in a locked unit or who requires a level of care services which the operator is not authorized to provide in the facility, except in accordance with the Guidelines.***

- A "regulated health profession" means a discipline under the Regulated Health Professions Act, 1991.

- The up-to-date assessment shall be obtained from member of one of the following disciplines regulated under the Regulated Health Professions Act, 1991: medicine, nursing, physiotherapy, or occupational therapy.

- In the case of the individual being referred on an emergency basis by an emergency service - for example, by the Crisis Outreach and Support Team (COAST) - the up-to-date assessment shall be obtained within one week of placement.

- A "referring agency" includes, but is not limited to, a hospital, a community agency, or a private clinic.

- The regulated health professional employed by a referring agency or the physician completing the assessment shall have specific knowledge of the individual's care needs.

An assessment shall be completed not more than thirty days before the tenant is accepted into the facility. It shall include information on the mental and physical function of the individual in regards to activities of daily living. In Schedule 20, “activities of daily living” means activities of an individual that maintain his/her sufficient nutrition, hygiene, warmth, rest and safety. See Appendix “B” for a sample assessment form.

- The assessment referred to in subsection 33(1) shall be reviewed to determine if it is appropriate to place an individual the residential care facility.

- In addition to reviewing the assessment, the following criteria for admission shall be considered:

    1. Will the individual receive the necessary care services? In Schedule 20, “care services” means providing advice, information, or supervision to tenants in activities of daily living. This includes giving help at times with medications, bathing, feeding, dressing, incontinence care, mobility, and personal emergency care. A tenant may also need to have housekeeping, laundry services and assistance with transportation.

    2. Is the individual ambulatory? In Schedule 20, “ambulatory” means that an individual is independently mobile, by mechanical or any other means, or with the minimal assistance of another person. For example, an individual in a wheelchair must be able to move in the wheel chair on his/her own and must be able to move from a bed to a wheelchair on his/her own or with little help.

- An individual who is admitted to a residential care facility for the purpose of receiving respite care, is deemed to be a tenant for the purposes of Schedule 20 and is subject to the admission criteria.

- An individual who has episodes of confusion causing him/her to wander shall not be admitted. Instead, the individual shall be referred to a facility offering a higher level of care.

## Section 35 - Consent for Admission

***An individual shall not be admitted as a tenant in a facility without:***

***(a) his/her consent; or***

***(b) the consent in writing of his/her next-of-kin, or attorney for personal care, as the case may be, if the person has been declared mentally or physically incapable of giving consent.***

- An individual must chose to move into a facility of his/her own free will.

- If the individual has been declared mentally or physically incapable of giving consent or the operator believes that the individual is not able to consent to the admission, then the next of kin or attorney for personal care shall consent in writing to the individual being admitted.

- The consent shall be signed, dated and placed on the tenant's file.

## Section 36 - Tenancy Agreement

***The operator shall enter into a written tenancy agreement with each individual who is admitted as a tenant of the facility and shall give each such individual a residential care facility information package prior to entering into the tenancy agreement.***

- The tenancy agreement shall include:
  - all ongoing care services and meals that the tenant agrees to pay for and the cost of each;
  - a statement that the tenant has the right to cancel the agreement within five days and to discuss the agreement with anyone;
  - how much the tenant will pay in rent and how often the payments will occur, for example, weekly, monthly or otherwise;
  - the term of agreement which may be fixed term or monthly/weekly/etc.;
  - the cost of optional services; and
  - a residential care facility information package.

- The tenancy agreement may include anything else the tenant and operator agree to, for example:

  - house rules;
  - limits on roommates or subletting; and
  - permission for the operator to enter to clean, make repairs, or check on the tenant's condition.

- The tenant's permission for the operator to enter to check on his/her condition, may be revoked at any time on written notice to the operator.

- Either the tenant or the operator may terminate the tenancy in accordance with the Residential Tenancy Act, 2006 and each has the rights and obligations set out in that Act and any other relevant legislation.

- The tenant shall be made aware that he/she has the right to consult with someone about the tenancy agreement.

- Each tenant shall be given a residential care facility information package. A residential care facility information package tells the tenant:

  - what kind of rental units are available and how much each costs;

  - the kinds of care, services and meals that are available and how much each costs;

  - the lowest number of employees that must work in the facility at any one time;

  - the qualifications of the employees;

  - what optional services are available, and how much they cost;

  - whether there is a personal emergency response system such as a call bell, and how it works; and

  - whether or not complaints can be made to the operator and if they can be made then how to do so.

  - That complaints about the operation of the facility may be made by telephoning the City of Hamilton Public Health Services at 905-546-2063.

## PART V: Care Services

### Section 37 - Care Services

***The operator shall provide care services to each tenant in a facility in accordance with the Guidelines issued by the Medical Officer of Health.***

- In Schedule 20, “care services” means advice, information, or supervision provided to tenants in the activities of daily living and may also include:

  (i) periodic personal care, as required, such as the giving of medications, bathing assistance, assistance with feeding, incontinence care, dressing assistance, assistance with personal hygiene, and ambulatory assistance;

  (ii) provision of recreational or social activities, housekeeping, laundry services, and assistance with transportation;

  (iii) personal emergency response services, including assistance in evacuating under emergency conditions due to mental limitations and/or developmental handicaps and limitations of the tenants.

- A nurse inspector may review a tenant’s physical and mental health condition and care services provided to the tenant. This includes discussions with the operator, employees and/or the tenant in addition to an assessment of the tenant’s s. 49(2) file.

- A nurse inspector shall be consulted for suggestions for follow up with care if needed.

- Sufficient care services shall be provided to meet the care needs of a tenant, with consideration being given to input from the tenant .

- Enough appropriately trained employees shall be on duty to provide care services to tenants.

- Recreational activities shall be provided for tenants with a list of activities posted for each tenant to see. Recreational activities may include a variety of planned activities such as movie nights, card or board games, crafts and offsite activities like swimming, picnics, walks, etc.

- Tenants shall be encouraged to take part in activities and a note shall be made on the tenant's file about any activities in which the tenant is involved in. If a tenant refuses to take part in any activities, a note shall be made on the tenant's including the reason why.

- A plan shall be in place to deal with tenant's physical or mental health emergencies and crises that occur in the facility.

- All employees shall know how to deal with physical or mental health emergencies and crises in the facility; for example, by calling 911, contacting the Crisis Outreach and Support Team (COAST) or reporting communicable diseases. The operator shall make sure all employees receive appropriate training with respect to the facility's emergency/crisis plan.

- Employees shall keep a daily written record of important information about a tenant to be passed on to other employees, such as a change in physical or mental health, a medication change, a tenant's absence from the facility, a referral to COAST, etc.

## Section 38 - Storage and Availability of Prescription Drugs

***The operator shall make sure that all prescription drugs:***

***(a) are kept in one or more locked drug cabinets, unless the drug requires refrigeration, or must be kept with the tenant for immediate use;***
***(b) are made available only:***
***(i) to those tenants for whom they have been prescribed, as directed by a physician;***
***(ii) in a unit-dose medication dispensing system as described in the Guidelines.***

- A safe medication system, developed in consultation with a tenant's pharmacist(s), shall be used ensuring a tenant receives his/her medication(s) as ordered by his/her physician(s). The operator or employee responsible for the medication shall know how the medication system works.

- All prescription medications must be made available in a unit-dose medication dispensing system. A unit-dose medication dispensing system allows each dose of medication to be available as a single dose only to the tenant for whom it is prescribed. A dosette box is not an acceptable unit-dose system.

- All prescription drugs shall be kept in one or more locked cabinets.

- Medications that need to be kept in a refrigerator - for example, insulin- shall be kept in a locked box in the refrigerator.

- Medications kept with the tenant for immediate use shall be kept where the tenant can easily reach them but away from other tenants.

- Employees shall be well-trained in giving medications safely and properly, what the medication is used for, and how the medication is to be stored. Pharmacists shall be consulted with as required for direction.

- All medications shall be made available to a tenant only under the direction of the his/her physician.

- The operator or an employee shall watch to make sure that a tenant has taken his/her medication. If a tenant does not take his/her medication, a note shall be made in the tenant's file, or on a medication record sheet. The reason for the tenant not taking his/her medication should also be noted.

- The tenant's physician shall be notified if the tenant does not take his/her medication.

- A tenant may need medication by needle, for example, insulin. The operator shall make sure that a registered nurse determines that the operator or non-professional employee is allowed to be trained to give the insulin.

## Section 39 - Self-Medication

***The operator shall allow self-medication by the tenants of a facility under specified conditions set forth in the Guidelines issued by the Medical Officer of Health.***

- If a tenant asks to take, order, and/or store his/her own medications:

1. A note shall be requested from the tenant's physician that says that the tenant is able to take his/her own medications. This note should be updated if there is a change in a tenant's physical or mental health affecting the tenant's ability to take his/her own medications.

2. The tenant shall keep the medication in a locked box in his/her room. A tenant with a private room may choose not to keep his/her medications in a locked box, but they shall be kept where the tenant can easily reach them but away from other tenants. The tenant shall keep his/her room door locked at all times if not present in the room.

3. The tenant's ability shall be monitored to ensure that the tenant is taking his/her medications**.**

## Section 40 – Controlled Substances Prescribed on an "as needed"/PRN Basis

***If a tenant is prescribed a drug that is a controlled substance as defined in the Controlled Drugs and Substances Act (Canada) on an "as needed"/PRN basis and the operator has not completed a medication course as described in the Guidelines within the preceding twelve months, then they shall complete such a medication course no more than thirty days after the drug has been prescribed.***

☐ If prescribed medications include controlled substances as defined in the Controlled Drugs and Substances Act (Canada), prescribed on an "as needed"/PRN basis the operator must complete a medication course.

☐ The medication course shall contain information such as: information about the Controlled Drugs and Substances Act, the addictive nature of narcotics, side effects of narcotics, any Inventory requirement for controlled drugs and substances, what to do in the event of missing narcotics, storage requirements, requirements for documentation and disposal of narcotics, record keeping, common narcotics and review of safe medication administration. The operator must maintain documentation of course completion.

## Section 41 - Nutrition

***The operator shall ensure that the tenants of a facility are served daily sufficient food of good quality and adequate nutritional and caloric value as described in the Guidelines issued by the Medical Officer of Health.***

- Three meals (breakfast, lunch, and dinner) shall be served to tenants daily.

- Snacks and fluids shall be available between meals and in the evening.

- The total amount of food served during meals and snacks shall provide each tenant with at least the minimum number of servings from each of the four food groups of Canada's Food Guide (Appendix "C").

- Meals and snacks shall provide an appropriate energy intake to maintain each tenant's weight within a healthy weight range.

- Menus shall be written, dated and posted in advance of the current week for tenants to see and kept on file for at least one month after being served. The total number of servings of each food group served daily shall be included.

- Changes to a meal shall be marked on the posted menu prior to the meal being served.

- Menus shall reflect the recommendations of Canada's Food Guide regarding serving sizes, the age appropriate number of Food Guide Servings per day from each food group, and how to make each Food Guide Serving count.

- Tenants shall be consulted when menus are planned to ensure acceptability. Alternative healthy food choices should be made available. All food served should be culturally appropriate.

- The operator shall provide special diets and nutritional supplements upon direction of a tenant's physician or registered dietitian and menus and meals shall be adapted as required.

- Tenants requiring dietary guidelines/intervention - for example, special diets to address food allergies, significant weight loss, etc. - shall have access to a registered dietitian for nutrition counseling through Community Care Access Centre (CCAC), local hospital outpatient clinics or other resources.

- A copy of Canada's Food Guide shall be posted in the kitchen.

□ Canada's Food Guide and additional nutrition and menu planning information are available from Public Health Services, Nutrition and Physical Activity Consumer Advice Line at (905) 546-3630.

- A facility shall have an adequate supply of perishable foods to meet the needs of the tenants for at least a 24-hour period and an adequate supply of non-perishable foods to meet the needs of the tenants for at least a three-day period.

- All food shall be stored in accordance to the requirements of Ontario Regulation 562 as amended by Ontario Regulation 586/99 under the Health Protection and Promotion Act. Additional information is available from Public Health Services, Health Protection Division at (905) 546-2063.

- The operator shall participate in an annual menu planning session offered by the Residential Care Facilities Education Committee.

## Section 42 – Infection Control

***The operator shall ensure that all requirements for the control of infectious diseases that are set forth in the Guidelines issued by the Medical Officer of Health are complied with, including recommendations for tuberculosis screening, immunization programs, reporting requirements, and outbreak control measures.***

TUBERCULOSIS SCREENING REQUIREMENTS

- **Regarding tuberculosis screening for employees and volunteers:**
  - All current employees/volunteers- current employees/volunteers that have not previously had a documented two-step Tuberculin skin test (TST) upon starting employment shall have this done. If an employee/volunteer has a documented previous positive TST, then he/she shall be referred to a physician.
  - For new employees/volunteers – each new employee/volunteer shall receive and provide documentation of a two-step TST or single-step TST (for individuals who have never had a TST before, a two-step TST is required, for those who have had a two-step previously, a single TST is required) within one month of starting employment. If an employee/volunteer has a documented previous positive TST, then he/she shall be referred to a physician.
  - The TST results are recorded in writing in millimetres of induration.
  - An employee/volunteer is referred to a physician for chest x-ray to rule out active disease if:
    1. The TST is positive (see Appendix “I”);
    2. The employee/volunteer has a previous documented positive TST; or
    3. The employee/volunteer has a history of TB disease.
  - Yearly skin testing is not necessary.
  - Testing thereafter shall occur as required by the Medical Officer of Health - for example, in the event of an active case of TB in the facility or increasing rates of TB in the community.

- **Regarding tuberculosis screening of tenants:**

- Each tenant upon admission shall receive a TST. IF tenant has a documented positive TST, he/she is to be referred to a physician.
- The TST shall be a two-step or one-step test as indicated (see section above).
- The TST shall be given within two (2) weeks of admission unless a tenant is to reside in the RCF for a period less than two weeks.
- The tenant shall be referred to a physician to rule out active disease if:
  1. The TST is positive (see Appendix “I”),
  2. The tenant has a previous documented positive TST, or
  3. The tenant has a history of TB disease
- A TST is not needed for:
  1. Tenants with a documented TST within one year prior to admission.
  2. Tenants who move from place to place but have a documented TST within one year prior to admission.
- Yearly testing is not necessary.
  - - Testing thereafter shall occur as required by the Medical Officer of Health (for example, in the event of an active case of TB in the facility or increasing rates of TB in the community).

Note: Please refer to Appendix “I” for additional TB information

- **Immunizations:**
  - All employees and tenants should have an annual influenza vaccination.
  - Tenants 65 years of age and over should strongly consider having a pneumococcal vaccination once only. If a tenant thinks that he/she may have already had a pneumococcal vaccination but there is no record thereof, it is recommended that the tenant be immunized again (once only) as long as at least two years have elapsed.
  - All employees and tenants should be up to date regarding immunizations according to the Canadian Immunization schedule (for example, tetanus, diphtheria)

- **Reporting requirements and outbreak control measures, operators and employees shall:**

  - Be familiar with the diseases that must be reported- see attached list (Appendix “D”).

  - Immediately report any suspected or diagnosed communicable diseases to Public Health Services, Infectious Disease Control Program, at (905)546-2063.

References:

1. Ministry of Health. (1998). Ontario Ministry of Health Tuberculosis Protocol

2. Health Canada. (2006). Canadian Immunization Guide, 7th Ed.

## Section 43 - Medical Care

***Each tenant of a facility or his/her next-of-kin, or attorney for personal care, as the case may be, shall retain a physician to attend to the tenant.***

***Where the tenant, his/her next-of-kin, or attorney for personal care is unable to do so, the operator shall make arrangements for a physician to provide emergency medical care to the tenant.***

- Each tenant shall have a physician.

- The physician's name and telephone number shall be placed in the tenant's section 49(2) file.

- The operator shall arrange for the physician to give emergency medical care if the tenant, next of kin, or legal representative is not able to do so. For immediate, life threatening situations, 911 shall be called. Calling a tenant's physician will cause unnecessary delay in the provision of emergency care.

**Section 44 – Medical Care (continued)**

***The operator shall allow a tenant's physician or a member of a regulated health professional who is providing care or treatment to a tenant to enter the facility at any reasonable time for the purpose of attending to the health of the tenant.***

- A tenant's physician or a regulated health professional shall be allowed into a facility to give him/her health care.

- What is a "reasonable time" shall be interpreted in accordance with the importance of the health care to be given – the more important the health care, the more expansive the interpretation.

- The arrangements of a tenant's physician for "after hours" care shall be known and shall be used when the tenant's physician is not available.

**Section 45 - Additional Care**

***Wherever the tenant's physician, the operator, the Medical Officer of Health, or a member of a regulated health profession who is employed by a referring agency designated in the Guidelines, determines that a tenant requires additional care services for their special needs and the tenant, their next-of-kin, or attorney for personal care has not arranged for such additional care, the operator shall ensure that such additional care is made available to the tenant while the tenant continues to reside in the facility.***

***In ensuring that additional care services are provided,the operator shall:***

***(a) consult with the tenant, their next-of-kin, attorney for personal care and/or a community worker, and prepare a plan which shall include a description of the health issue and the services being provided to address that health issue. The plan may include additional care services, such as additional personal care services and/or rehabilitative services;***

***(b) ensure that additional personal care services are provided through a referral to a community care access centre or to a private community agency;***

***(c) where the tenant requires rehabilitative services, support the tenant's rehabilitative goals in the facility and in the community, which may include assisting tenant with meal preparation, laundry, household duties and self-medication.***

- Extra care shall be given to the tenant if the physician, the operator, the Medical Officer of Health, or a regulated health professional employed by a referring agency is of the opinion that it is needed and the tenant, their next-of-kin**,** or attorney for personal care has not arranged for such additional care.

- When a tenant has special needs, these shall be discussed with the tenant, the tenant's next of kin, and the tenant's community worker (social worker from a psychiatric agency, a nurse from CCAC) about what needs are to be included in the tenant's care plan to meet the special needs.

- The tenant's care plan shall include a description of the health issue and the services being provided to address that health issue. The plan may include additional care services, such as additional personal care services and/or

rehabilitative services. This includes the care provided by external care providers.

- Enough employees shall be on duty to provide additional care services arranged for by the operator and the employees shall be trained to provide these care services.

- If a tenant appears to need more care services than what the operator is allowed to give:
  1. The tenant's physician shall be requested to provide an updated assessment.
  2. The tenant, next of kin, or attorney for personal care, as the case may be, shall be consulted about contacting the Community Care Access Center (CCAC) for extra help with care and/or to have an assessment for placement into another type of facility.
  3. The tenancy agreement shall be amended to include any additional care services.

- In Schedule 20, "rehabilitative services" means services for an individual with a physical, mental, or developmental handicap, and includes:

  (a) homemaker services;
  (b) day care;
  (c) training and rehabilitation;
  (d) casework and counseling; and
  (e) training in life skills.

- Where rehabilitative services from part of a tenant's care plan, the plan shall include goals for rehabilitation and the tenant shall be helped to meet these goals – for example, helped to get meals ready, do laundry, carry out household chores or taking his/her medication(s).

**Sections 46 and 48 - Tenant Moving Out of Residential Care Facility**

***The operator or the employee designated under paragraph 17(2)(a), shall inform the tenant, as soon as possible, of the provisions of section 148 of the Residential Tenancies Act, 2006 and may arrange for the transfer of the tenant:***

***(a) to a long term care facility or other appropriate living arrangement, with the agreement of the tenant, where an operator is informed by:***

***(i) a community care access centre that a tenant of a facility is eligible for admission to a long term care facility;***

***(ii) the tenant's physician or the Medical Officer of Health, that the tenant no longer requires the level of care services which the facility is authorized to provide; or***

***(iii)the tenant's physician or the Medical Officer of Health, that the tenant requires a level of care services that the operator is not authorized to provide; or***

***(b)to a long term care facility, with the agreement of the tenant, where a tenant requires placement in a locked unit for the protection of themselves or others.***

***.***

***Where a tenant is transferred from a residential care facility to a long term care facility, hospital or to another facility licensed under this By-law, the operator shall request the tenant, or, if they are unable to act, their next-of-kin or attorney for personal care, to complete an authorization in Form 1 for the release of information pertaining to the tenant to the long term care facility, hospital or other licensed residential care facility.***

***Where a tenant is transferred from a residential care facility to another facility licensed under this By-law, or to a long-term care home or hospital, the operator shall complete a transfer in Form 2.***

- A tenant may no longer need to live in a residential care facility because he/she can live on his/her own. Alternatively, because of changes in physical or mental health, a tenant may need to go to a facility that provides a higher level of care such as a nursing home.

- If the tenant needs to move to a facility that provides a higher level of care, the tenant, the next of kin or attorney for personal care, as the case may be, shall be consulted regarding a referral to CCAC.

- If a tenant who needs to move is not willing to, under the Residential Tenancy Act, 2006 the operator may apply for an order to terminate the tenancy agreement from the Landlord and Tenant Board. The operator would have to prove to the Board that other appropriate accommodation is available for the tenant, and that the operator is not able to meet the tenant's care needs in the facility, even with additional care services.

- When an operator is told that a tenant will be moving out of the facility, the operator shall, as soon as possible, to the tenant about the provisions of Residential Tenancy Act, 2006. The operator may arrange for the move if the tenant agrees.

- Where a tenant is transferred from a residential care facility to a long term care facility or to another facility licenced under this By-law, the tenant, or the next of kin or attorney for personal care, as the case may be, shall sign a "Release of Information Form" (Form 1, Appendix "H").

- Where a tenant is transferred from a residential care facility to another facility licensed under this By-law, or to a hospital, or a long-term care home, a "Transfer Sheet" (Form 2, Appendix "G") shall be be completed. the operator shall complete a transfer in Form 2.

- Forms 1 and 2 should be used when a tenant is sent to a Long Term Care Facility, to another Residential Care Facility, or to a hospital.

- Completed Forms 1 and 2 shall be placed in a tenant's s. 49(2) file.

## PART VI: RECORDS AND REPORTS

### Section 49 - Alphabetical List and Tenant's File;

***The operator shall maintain an up-to-date, alphabetical list of the current tenants of a facility which includes the name, sex, date of birth, age and date of admission of each tenant.***

***The operator shall maintain a separate file for each tenant, which contains the following information:***

***(a) sex, date of birth, age, date of admission, and date of discharge or death;***
***(b) name, address, and telephone number of next-of-kin;***
***(c) name and telephone number of the tenant's attorney for personal care, if any;***
***(d) the name and telephone number of the tenant's physicians;***
***(e) completed assessment;***
***(f) the name, address and telephone number of any community agency which is providing support to the tenant;***
***(g) tuberculin or chest x-ray testing results, and the dates thereof;***
***(h) a brief medical history of the tenant in respect of the care services provided by the operator under the tenancy agreement (section 36) or any additional care services made available by the operator (subsection 45(1)) from the date of their admission, including medication information, laboratory results, physicians' orders as available and staff notes;***
***(i) a residential care facility information package; and***
***(j) particulars of each accident suffered by the tenant or death of a tenant while in the facility;***
***(k) Forms 1, 2 and 3 (where used).***

- Each tenant shall be informed that his/her records will be reviewed by a nurse inspector employed by the City of Hamilton's Public Health Services Department.

- Any known allergies suffered by the tenant should be clearly written on a tenant's file.

- Written results and the date of TB tests/chest x-rays should be placed in a tenant's file.

## Section 50 - Occurrence Report (Form 3)

***The operator shall make a record in Form 3 of every occurrence with respect to a tenant of assault, injury or of death that has been reported to coroner, and shall place the completed Form 3 in the tenant's file and keep it available for inspection by the Medical Officer of Health.***

- A "Report of Occurrence of Assault or Injury" (Form 3, Appendix "H") shall be completed for any assault or injury to a tenant or death or a tenant reported to the coroner that happens on the facility property.

- For an assault between or amongst tenants, a Form 3 (Appendix "H") shall be completed for each for the tenant, including assaulting and assaulted tenants.

- A Form 3 (Appendix "H") shall be completed for any death resulting from an accident or unknown reasons, or due to a contagious disease that has been reported to the Office of the Coroner.

- Completed Form 3s shall be placed in a tenant's s. 49(2) file.

## APPENDIX "A"

## ADDITIONAL GUIDELINES FOR PREPARING A "SINGLE FACILITY INCIDENT PLAN"

- A single facility incident plan shall be a plan like the fire protocol that the operator follows for a fire in the facility.

- A copy of an up-to-date premises plan shall be included with the single facility incident plan.

- All operators and employees shall be familiar with the details of the single facility incident plan.

- Alternative housing and transportation for tenants to such alternative housing shall be arranged ahead of time by the operator and/or the person responsible for the operation of the facility in case tenants need to be removed. The operator and/or person in charge may call the Public Health Services Department at (905) 546-2063 for available supports.

- All paper records that are important for the active care of the tenant shall be easy to move in the case of an evacuation. Examples of information that should be kept on paper record are: name of tenant, date of birth, personal physician, brief medical history, allergies, list of current medications, next of kin/power of attorney for personal care, and special physical and health needs. If a facility keeps electronic records, they should be copied on an ongoing basis and stored away from the facility in either electronic or paper copy in order to facilitate access..

- Emergency packs containing items for person care, such as a toothbrush, deodorant, a comb, soap, etc., shall be prepared ahead of time for each tenant and removed with the tenants.

- When the operator and/or the person responsible for the operation of the facility becomes aware that an evacuation is needed, he/she shall make sure that all employees and tenants know that they must leave.

- Operators and employees shall know if tenants need extra help with special needs during their removal from the facility.

- All employees on duty shall help tenants to leave the facility, providing extra help with special needs as required.

- Next of kin shall be informed about the removal of a tenant from the facility and the name and address of the location to which the tenant has been moved.

- The operator and/or the person responsible for the operation of the facility shall call the Public Health Services Department, at (905) 546-2063 during business hours and at (905) 546-CITY ext. 2489 after business hours, to report any single facility incident.

- After a single facility incident, the Health Protection Division of the Public Health Services Department (public health inspectors) will assess the facility to determine if it is safe for the tenants to return.

**APPENDIX "B": Assessment Form**

Name of Tenant _____

Address _____ Phone _____ Date of Birth _____

Allergies _____ Language Spoken _____

Personal Physician _____ Telephone _____

Brief Medical History:
_____
_____
_____

Diagnoses:
_____
_____
_____

Medications Currently Prescribed:
_____
_____
____

Significant recent mental or physical changes/incidents/hospitalizations:
_____
_____
____

TB skin test (must be completed within 14 days of admission)
Date 1st _____ 2nd _____ Results: 1st _____ 2nd _____

If TB test positive, result of chest x-ray and doctor's assessment:
_____
_____
____
Date of Chest x-ray : _____

Requires Additional Care: Yes _____ No _____
If yes Please Describe:
_____
_____
____

Tenant is able to self-medicate Yes _____ No _____

CITY OF HAMILTON LICENSING CODE –
SCHEDULE 20 – RESIDENTIAL CARE FACILITIES
GUIDELINES

**Please complete the following with respect to this client:**

| | Yes | No |
|---|---|---|
| Does the tenant wander?<br>If YES the client is not appropriate for admission into an RCF | | |
| Does the client fully ambulate or independently ambulate with aids?<br>If NO the client is not appropriate for admission into an RCF. | | |
| Does the client have bladder incontinence?<br>If YES the client must be able to manage incontinence independently or with PERIODIC ASSISTANCE otherwise is inappropriate for admission into an RCF. | | |
| Does the client have bowel incontinence?<br>If YES the client must be able to manage incontinence independently or with PERIODIC ASSISTANCE otherwise is inappropriate for admission into an RCF. | | |
| Is the client able to eat independently with PERIODIC assistance?<br>If NO client is not appropriate for admission into an RCF. | | |
| Is the client able to maintain personal hygiene independently with PERIODIC assistance?<br>If NO client is not appropriate for admission into an RCF. | | |
| Is the client able to dress independently or with PERIODIC assistance?<br>If NO client is not appropriate for admission into an RCF. | | |
| Does the client <u>currently</u> experience episodes of aggression?<br>If YES client is not appropriate for admission into an RCF. | | |

Date Completed _____

Physician/Health care Professional's name_____

Signature _____

**RCF Operator:**
**If the healthcare provider who completed this form selected any options above that indicate the client is inappropriate for placement in a residential care facility you are not authorized to admit the client to your facility.**

**APPENDIX "C"**

**CANADA'S FOOD GUIDE (obtain directly from Public Health Services staff)**

**APPENDIX "D"**

**REPORTABLE DISEASES (obtain directly from Public Health Services Staff)**

**APPENDIX "F"**

## FORM 1: RELEASE OF INFORMATION FORM

**CITY OF HAMILTON**
**CITY OF HAMILTON LICENSING CODE, 2001**
**Schedule 20**

**RESIDENTIAL CARE FACILITIES**
**FORM 1**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, _____,
(print name of tenant, or next-of-kin, or attorney for personal care)

give permission to

_____
(print name of residential care facility or operator))

to release information concerning the tenant named below, including medical records and other personal information, which is in the custody of the above-named residential care facility or of the operator of such facility, to:

_____
(print name of long term care facility or other licensed residential care facility to which the tenant is being transferred)

I understand that this information is being released for the purpose of enabling_____

_____to obtain
(print name of tenant)
admission to the long term care facility or other licensed residential care facility indicated above.

_____ _____
(Signature of Witness) (Signature of tenant, next-of-kin, or Attorney for Personal Care)

_____ _____
(Date) (State relationship to Tenant, if next-of-kin)

**CITY OF HAMILTON**

**CITY OF HAMILTON LICENSING CODE, 2001**

**Schedule 20**

# RESIDENTIAL CARE FACILITIES
# FORM 1

## AUTHORIZATION FOR RELEASE OF INFORMATION

## INSTRUCTIONAL POLICY & PROCEDURES

---

Purpose

The purpose of the authorization for release of information is to ensure that the tenant is in agreement to the release of his/her medical records and/or information in the event of a transfer. This information would be provided to another home care operator and/or other health care facility in liaison with the appropriate Health and Social Service Agencies.

A Form 14 is the designated consistent form for the release of records from a psychiatric facility as provided in the regulations of the Mental Health Act and would pertain to any residents whose primary diagnosis is psychiatric.

Completion Procedure

a) The operator/employee must complete the form and ensure that among the information to be included, the identity of the facility in possession of the clinical records and also to whom and/or what facility the information is made available.

b) The operator/employee will advise the tenant of the purpose of the form and request his/her signature.

c) In the event that another individual (i.e., substitute decision-maker or public guardian or trustee) signs on behalf of the tenant, he/she must do so in accordance with the wishes of the tenant.

d) The witness who signs must not be the owner/operator of the facility - must be witnessed by another person (i.e., guardian, legal representatives,. or employee).

## APPENDIX "G"

## TRANSFER SHEET

**CITY OF HAMILTON**
**CITY OF HAMILTON LICENSING CODE, 2001**
**Schedule 20**

**RESIDENTIAL CARE FACILITIES**
**Form 2**

## TRANSFER SHEET

**RESIDENTIAL CARE FACILITY INFORMATION:**

Name: _____

Address: _____

Telephone: _____

**TENANT INFORMATION:**

Name: _____

Health Card Number: _____

Family Dr.: _____ Telephone: _____

Specialist: _____ Telephone: _____

**BRIEF MEDICAL HISTORY:**

_____

_____

_____

**NEXT OF KIN:**

Name: _____

Relationship:_____

Address: _____

Telephone: _____

**COMMUNITY WORKER:**

Name: _____

Agency: _____ Telephone# _____

**TRANSFER INFORMATION:**

Transfer To:_____ Transfer From: _____

Date & Time: _____ Date & Time: _____

Reason for Transfer:

CITY OF HAMILTON LICENSING CODE –
SCHEDULE 20 – RESIDENTIAL CARE FACILITIES
GUIDELINES

Physical Functioning: Independent ☐ Requires assistance ☐

Specify: _____

_____

Mental Health:

Oriented to person, place, time: ____yes ____no Specify:

Confusion: never ☐ sometimes ☐ frequently ☐

Aggression/Agitation: never ☐ sometimes ☐ frequently ☐

Diet

Date and result of most recent TB skin test or chest x-ray:

TB Test Date: 1st 2nd TB test result: 1st 2nd

Chest X-ray Date: _____Chest X-ray Result: _____

**ADDITIONAL INFORMATION:** (Pertinent to follow-up care of tenant e.g., medication changes, lab tests, diagnoses, follow-up plan, etc.)

Medication List attached: Yes _____ No _____

**ALLERGIES:**

**SIGNATURE OF OPERATOR/MANAGER:** _____

NOTES:

1. Sending facility to keep original form.
2. Receiving facility to keep copy of form.

**APPENDIX "H"**

**REPORT OF OCCURRENCE OF ASSAULT OR INJURY OR DEATH**

**CITY OF HAMILTON**
**CITY OF HAMILTON LICENSING CODE, 2001**
**Schedule 20**

**RESIDENTIAL CARE FACILITIES**
**Form 3**

**REPORT OF OCCURRENCE OF ASSAULT , INJURY or DEATH**

1. Name of Residential Care Facility: _____

2. Address: _____

3. Date of Occurrence: _____

4. Time of Occurrence: _____ a.m. _____ p.m.

5. Name of tenant: _____

   Date of Birth (yyyy/mm/dd): _____ Male _____ Female _____

   Date of Admission: _____

6. Name of Person/s who discovered or observed occurrence: _____

7. Brief description of occurrence: _____
   _____
   _____

8. Type of injury sustained, if any:
   _____
   _____
   _____

9. Was first aid given? yes _____ no _____ describe_____
   _____
   _____

10. Was 911 called? yes _____ no _____ Time 911 called _____

11. Was tenant sent to hospital? yes _____ no _____

12. Name of hospital: _____

13. Was physician notified? yes _____ no _____

14. Time when physician notified: _____ a.m. _____p.m.

15. Name of physician: _____

16. Physician Notified By: _____

**For Physician Use Only**

17. Attending physician's name: _____
Comments:_____
_____
_____
_____
_____
_____

18. Signature of attending physician:_____

19. Were relatives or friends of tenant notified? yes _____ no _____

20. What action have you taken to prevent this occurrence from happening again? _____
_____
_____
_____

**If tenant died:**

21. Was coroner notified? yes_____ no_____

22. Date coroner notified_____

23. Time coroner notified _____a.m. _____ p.m.

24. Signature of Person Completing Form: _____

25. Signature of Operator/Manager: _____

NOTES:

1. Place original form in Tenant's File.
2. Give copy to Physician.

**APPENDIX "I"**

**ADDITIONAL TB INFORMATION**

- Tuberculosis (TB) screening is a method used to identify people who may have TB infection and/or disease. At present, the TB skin test (TST) is the most reliable screening tool. A two-step TST is given to people who have never had a TST in order to obtain an accurate baseline reading. A two-step TST means giving one TST followed by another TST 7 to 28 days later. Future TST done following the documented two-step TST should only be a single TST. If a person has a documented previous positive result then no TST is needed; these individuals must be assessed by a physician.
- Positive TST:

| TST Reaction Size (mm induration) | Situation in Which Reaction is Considered Positive |
|---|---|
| 0-4 | HIV infection with immune suppression AND the expected likelihood of TB infection is high (e.g. patient is from a population with a high prevalence of TB infection, is a close contact of an active contagious case, or has an abnormal chest x-ray) |
| 5-9 | HIV infection<br>Close contact of active contagious case<br>Children suspected of having TB disease<br>Abnormal chest x-ray with fibronodular disease<br>Other immune suppression: TNF-alpha inhibitors, chemotherapy |
| ≥10 | All others |
| Taken from Canadian TB Standards, 6th Edition | |

- A chest x-ray should not be used as a substitute for a TST. Research shows that a chest x-ray is not a useful method of detecting tuberculosis infection. Chest x-rays do not guarantee early identification of tuberculosis. In some cases, an infected individual will develop a cough and produce infectious sputum before infection is seen on an x-ray.
- **Why is the TB skin test needed?** Doing a skin test is important for two reasons: it provides a baseline, which is needed to guide post-exposure case management; and, it helps to make sure that new employees/tenants do not put colleagues or tenants at risk in the event that he/she has TB disease.

# CITY OF HAMILTON
## NOTICE OF M OT I O N

**BOARD OF HEALTH DATE: January 13, 2020**

**MOVED BY COUNCILLOR T. JACKSON …..……..……...**

**Public Health Services' Procurement and Purchase of a Dental Services Bus**

WHEREAS, in April 2019, the Provincial government announced the Ontario Seniors Dental Care Program for low-income seniors;

WHEREAS, in June 2019, the Board of Health received a letter from the Ministry of Health (the Ministry) announcing Hamilton's annual base funding increase of $2,248,100.00 to support the new dental program that is 100% provincially funded (i.e., not cost shared with municipalities);

WHEREAS, in August 2019, Public Health Services (PHS) submitted a capital funds application to the Ministry for one-time funding that supports implementation of the locally developed seniors dental care service delivery plan;

WHEREAS, in October of 2019, the Board of Health reviewed the plan for a Senior's Oral Health Program in Hamilton including the prioritized capital investments submitted to the province;

WHEREAS, in December 2019, Public Health received approval from the Ministry that the Board of Health will be provided up to $687,700 in one-time funding to fund a subset of Hamilton's capital investment recommendations including: a Dental Bus and Dental Clinics at Centre de Santé Communautaire;

WHEREAS, the estimated cost of a new Dental Bus is greater than $500,000;

WHEREAS, ADI Mobile Health was previously contracted for Hamilton's current Dental Health Bus and has been contracted by other Health Units that have Dental Health Buses; and,

WHEREAS, the Ministry aims to have approved expenditure for a dental bus spent by the end of March 2020.

THEREFORE BE IT RESOLVED:

(a) That the single source procurement, pursuant to Procurement Policy #11 – Non-competitive Procurements, for the purchase of a Dental Health bus by Public Health Services, at the upset limit of $550,000, be approved;

(b) That the Medical Officer of Health, Public Health Services, Healthy and Safe Communities Department, or their designate be authorized and directed to negotiate, enter into and execute a contract and any ancillary documents required to give effect thereto with ADI Mobile Health, in a form satisfactory to the City Solicitor for the purchase of a Dental Health bus; and,

(c) That Public Health Services report back to the Board of Health by June 15, 2020 on the implications of the Ministry's approval of a subset of the capital investment plan and outline alternatives for consideration for implementation of the Ontario Seniors Dental Care Program in Hamilton.