# City of Hamilton
# BOARD OF HEALTH
# AGENDA

| | |
|---|---|
| **Meeting #:** | 21-011 |
| **Date:** | November 15, 2021 |
| **Time:** | 9:30 a.m. |
| **Location:** | Due to the COVID-19 and the Closure of City Hall (CC)<br>All electronic meetings can be viewed at:<br>City's Website: https://www.hamilton.ca/council-committee/council-committee-meetings/meetings-and-agendas<br>City's YouTube Channel: https://www.youtube.com/user/InsideCityofHamilton or Cable 14 |

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

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## 1. CEREMONIAL ACTIVITIES

## 2. APPROVAL OF AGENDA

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

## 3. DECLARATIONS OF INTEREST

## 4. APPROVAL OF MINUTES OF PREVIOUS MEETING

4.1. October 18, 2021

## 5. COMMUNICATIONS

5.1. Correspondence from Huron Perth Public Health respecting the Variation in Vaccination Policies for the Home and Community Care Sector

Recommendation: To be received

5.2. Correspondence from the Minister of Health respecting Additional One-Time Funding for 2021-2022

Recommendation: To be received

5.3. Correspondence from the North Bay Parry Sound District Health Unit respecting the Government's Financial Commitment to Public Health

Recommendation: Be received

## 6. DELEGATION REQUESTS

## 7. CONSENT ITEMS

7.1. PHS Organizational Risk Management Plan: 2021 Progress Report (BOH21003(a)) (City Wide)

## 8. STAFF PRESENTATIONS

8.1. Overview of COVID-19 Activity in the City of Hamilton 11 Mar 2020 to Present (to be distributed)

## 9. PUBLIC HEARINGS / DELEGATIONS

## 10. DISCUSSION ITEMS

10.1. Child & Adolescent Services 2021-2022 Budget and Base Funding Increase of Five Percent (BOH 21010) (City Wide)

10.2. Budget Request for Food Advisory Committee 2022 (BOH21011) (City Wide)

## 11. MOTIONS

## 12. NOTICES OF MOTION

## 13. GENERAL INFORMATION / OTHER BUSINESS

## 14. PRIVATE AND CONFIDENTIAL

## 15. ADJOURNMENT

# BOARD OF HEALTH
# MINUTES 21-010

**9:30 a.m.**
**Monday, October 18, 2021**
**Due to COVID-19 and the closure of City Hall, this meeting was held virtually**

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

**Absent with Regrets:** Councillor T. Whitehead – Leave of Absence
Councillor B. Johnson - Personal

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

**1. Support for the Application to the Province respecting a Second Consumption Treatment Services (CTS) Site Located in Ward 3 (Item 9.1)**

**(Nann/Eisenberger)**
That the application being submitted to the Ministry of Health by the AIDS Network, for the City of Hamilton's Second Consumption Treatment Services (CTS) site located in Ward 3, be supported.

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

| | | | |
|---|---|---|---|
| YES | - | Mayor Fred Eisenberger | |
| YES | - | Ward 1 | Councillor Maureen Wilson |
| ABSENT | - | Ward 2 | Councillor Jason Farr |
| YES | - | Ward 3 | Councillor Nrinder Nann |
| YES | - | Ward 4 | Councillor Sam Merulla |
| VACANT | - | Ward 5 | |
| YES | - | Ward 6 | Councillor Tom Jackson |
| YES | - | Ward 7 | Councillor Esther Pauls |
| YES | - | Ward 8 | Councillor J. P. Danko |
| YES | - | Ward 9 | Councillor Brad Clark |
| YES | - | Ward 10 | Councillor Maria Pearson |
| ABSENT | - | Ward 11 | Councillor Brenda Johnson |
| YES | - | Ward 12 | Councillor Lloyd Ferguson |
| YES | - | Ward 13 | Councillor Arlene VanderBeek |

| | | | |
|---|---|---|---|
| ABSENT | - | Ward 14 | Councillor Terry Whitehead |
| YES | - | Ward 15 | Councillor Judy Partridge |

**2. Alcohol, Drug & Gambling Services and Community Mental Health Promotion Program Budget 2021-2022 (BOH21008) (City Wide) (Item 10.1)**

**(Partridge/Pauls)**

(a) That the 2021-2022 Alcohol, Drug & Gambling Services and Community Mental Health Promotion Program budgets, funded by the Hamilton, Niagara, Haldimand, Brant Local Health Integration Network, be approved, including the net increase of 0.1 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 2021-2022 Alcohol, Drug and Gambling Services and Community Mental Health Promotion Program budget; and,

(b) That the 2021-2022 Alcohol, Drug & Gambling Services', Choices and Changes program budget, funded by the Ministry of Children, Community and Social Services be approved, 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 2021-2022 Alcohol, Drug and Gambling Services Choices and Changes program budget; and,

(c) That the 2021-2022 Alcohol, Drug and Gambling Services' Other Funding Grants program budget be approved, including a net decrease of 0.1 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 2021-2022 Alcohol, Drug and Gambling Services Other Funding Grants programs budget.

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

| | | | |
|---|---|---|---|
| YES | - | Mayor Fred Eisenberger | |
| YES | - | Ward 1 | Councillor Maureen Wilson |
| YES | - | Ward 2 | Councillor Jason Farr |
| YES | - | Ward 3 | Councillor Nrinder Nann |
| YES | - | Ward 4 | Councillor Sam Merulla |
| VACANT | - | Ward 5 | |
| YES | - | Ward 6 | Councillor Tom Jackson |
| YES | - | Ward 7 | Councillor Esther Pauls |
| ABSENT | - | Ward 8 | Councillor J. P. Danko |
| YES | - | Ward 9 | Councillor Brad Clark |
| YES | - | Ward 10 | Councillor Maria Pearson |
| ABSENT | - | Ward 11 | Councillor Brenda Johnson |

| | | | |
|---|---|---|---|
| YES | - | Ward 12 | Councillor Lloyd Ferguson |
| YES | - | Ward 13 | Councillor Arlene VanderBeek |
| ABSENT | - | Ward 14 | Councillor Terry Whitehead |
| YES | - | Ward 15 | Councillor Judy Partridge |

**3. Comprehensive Opioid Response (BOH21009) (City Wide) (Item 10.2)**

**(Nann/VanderBeek)**
That the Report BOH21009, respecting a Comprehensive Opioid Response, be received.

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

| | | | |
|---|---|---|---|
| YES | - | Mayor Fred Eisenberger | |
| YES | - | Ward 1 | Councillor Maureen Wilson |
| YES | - | Ward 2 | Councillor Jason Farr |
| YES | - | Ward 3 | Councillor Nrinder Nann |
| ABSENT | - | Ward 4 | Councillor Sam Merulla |
| VACANT | - | Ward 5 | |
| YES | - | Ward 6 | Councillor Tom Jackson |
| YES | - | Ward 7 | Councillor Esther Pauls |
| YES | - | Ward 8 | Councillor J. P. Danko |
| YES | - | Ward 9 | Councillor Brad Clark |
| YES | - | Ward 10 | Councillor Maria Pearson |
| ABSENT | - | Ward 11 | Councillor Brenda Johnson |
| ABSENT | - | Ward 12 | Councillor Lloyd Ferguson |
| YES | - | Ward 13 | Councillor Arlene VanderBeek |
| ABSENT | - | Ward 14 | Councillor Terry Whitehead |
| YES | - | Ward 15 | Councillor Judy Partridge |

**4. Healthy Babies Healthy Children Program Budget 2021-2022 (BOH21012) (City Wide) (Item 10.3)**

**(Pearson/Jackson)**

(a) That the 2021-2022 Healthy Babies, Healthy Children program budget, funded by the Ministry of Children, Community and Social Services, be approved; and,

(b) That the Medical Officer of Health or delegate be authorized and directed to receive, utilize, report on and execute all Service agreements and contracts, in a form satisfactory to the City Solicitor, required to give effect to the 2021-2022 Healthy Babies, Healthy Children program budget.

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

YES - Mayor Fred Eisenberger

| | | | |
|---|---|---|---|
| YES | - | Ward 1 | Councillor Maureen Wilson |
| YES | - | Ward 2 | Councillor Jason Farr |
| YES | - | Ward 3 | Councillor Nrinder Nann |
| ABSENT | - | Ward 4 | Councillor Sam Merulla |
| VACANT | - | Ward 5 | |
| YES | - | Ward 6 | Councillor Tom Jackson |
| YES | - | Ward 7 | Councillor Esther Pauls |
| YES | - | Ward 8 | Councillor J. P. Danko |
| YES | - | Ward 9 | Councillor Brad Clark |
| YES | - | Ward 10 | Councillor Maria Pearson |
| ABSENT | - | Ward 11 | Councillor Brenda Johnson |
| ABSENT | - | Ward 12 | Councillor Lloyd Ferguson |
| YES | - | Ward 13 | Councillor Arlene VanderBeek |
| ABSENT | - | Ward 14 | Councillor Terry Whitehead |
| YES | - | Ward 15 | Councillor Judy Partridge |

**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.

**(Pearson/Ferguson)**
That the agenda for the October 18, 2021 Board of Health be approved, as presented.

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

| | | | |
|---|---|---|---|
| YES | - | Mayor Fred Eisenberger | |
| YES | - | Ward 1 | Councillor Maureen Wilson |
| YES | - | Ward 2 | Councillor Jason Farr |
| YES | - | Ward 3 | Councillor Nrinder Nann |
| ABSENT | - | Ward 4 | Councillor Sam Merulla |
| VACANT | - | Ward 5 | |
| ABSENT | - | Ward 6 | Councillor Tom Jackson |
| ABSENT | - | Ward 7 | Councillor Esther Pauls |
| YES | - | Ward 8 | Councillor J. P. Danko |
| YES | - | Ward 9 | Councillor Brad Clark |
| YES | - | Ward 10 | Councillor Maria Pearson |
| ABSENT | - | Ward 11 | Councillor Brenda Johnson |
| YES | - | Ward 12 | Councillor Lloyd Ferguson |
| YES | - | Ward 13 | Councillor Arlene VanderBeek |
| ABSENT | - | Ward 14 | Councillor Terry Whitehead |

ABSENT - Ward 15 Councillor Judy Partridge

**(c) DECLARATIONS OF INTEREST (Item 3)**

None

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

**(i) September 20, 2021 (Item 4.1)**

**(Clark/Pearson)**
That the Minutes of September 20, 2021, be approved, as presented.

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

| | | | |
|---|---|---|---|
| YES | - | Mayor Fred Eisenberger | |
| YES | - | Ward 1 | Councillor Maureen Wilson |
| YES | - | Ward 2 | Councillor Jason Farr |
| YES | - | Ward 3 | Councillor Nrinder Nann |
| YES | - | Ward 4 | Councillor Sam Merulla |
| VACANT | - | Ward 5 | |
| ABSENT | - | Ward 6 | Councillor Tom Jackson |
| ABSENT | - | Ward 7 | Councillor Esther Pauls |
| YES | - | Ward 8 | Councillor J. P. Danko |
| YES | - | Ward 9 | Councillor Brad Clark |
| YES | - | Ward 10 | Councillor Maria Pearson |
| ABSENT | - | Ward 11 | Councillor Brenda Johnson |
| YES | - | Ward 12 | Councillor Lloyd Ferguson |
| YES | - | Ward 13 | Councillor Arlene VanderBeek |
| ABSENT | - | Ward 14 | Councillor Terry Whitehead |
| ABSENT | - | Ward 15 | Councillor Judy Partridge |

**(e) DELEGATION REQUESTS (Item 6)**

**(i) Delegation Requests (Items 6.1 and 6.2)**

**(Farr/VanderBeek)**
That the following Delegation Requests be approved for today's meeting:

(i) Rebecca Ganann, McMaster University, respecting the EMBOLDEN study which to enhance physical and community mobility of older adults who experience difficulties participating in community programs and reside in areas of high health inequity (For today's meeting) (Item 6.1)

(ii) Devyani Bakshi, McMaster University, respecting Climate Changes and its impacts on the healthcare system (for today's meeting) (Item 6.2)

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

| | | | |
|---|---|---|---|
| YES | - | Mayor Fred Eisenberger | |
| YES | - | Ward 1 | Councillor Maureen Wilson |
| YES | - | Ward 2 | Councillor Jason Farr |
| YES | - | Ward 3 | Councillor Nrinder Nann |
| YES | - | Ward 4 | Councillor Sam Merulla |
| VACANT | - | Ward 5 | |
| YES | - | Ward 6 | Councillor Tom Jackson |
| YES | - | Ward 7 | Councillor Esther Pauls |
| YES | - | Ward 8 | Councillor J. P. Danko |
| YES | - | Ward 9 | Councillor Brad Clark |
| YES | - | Ward 10 | Councillor Maria Pearson |
| ABSENT | - | Ward 11 | Councillor Brenda Johnson |
| YES | - | Ward 12 | Councillor Lloyd Ferguson |
| YES | - | Ward 13 | Councillor Arlene VanderBeek |
| ABSENT | - | Ward 14 | Councillor Terry Whitehead |
| YES | - | Ward 15 | Councillor Judy Partridge |

## (f) STAFF PRESENTATIONS (Item 8)

### (i) Overview of COVID-19 Activity in the City of Hamilton 11 Mar 2020 to Present (Item 8.2)

Dr. E. Richardson, Medical Officer of Health; Michelle Baird, Director, Healthy and Safe Communities and Stephanie Hughes, Epidemiologist, Healthy and Safe Communities, addressed the Board with an Overview of COVID-19 Activity in the City of Hamilton 11 Mar 2020 to present, with the aid of a PowerPoint presentation.

**(Partridge/Pearson)**
That the Presentation respecting an Overview of COVID-19 Activity in the City of Hamilton 11 Mar 2020 to present, be received.

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

| | | | |
|---|---|---|---|
| YES | - | Mayor Fred Eisenberger | |
| YES | - | Ward 1 | Councillor Maureen Wilson |
| ABSENT | - | Ward 2 | Councillor Jason Farr |
| YES | - | Ward 3 | Councillor Nrinder Nann |
| YES | - | Ward 4 | Councillor Sam Merulla |
| VACANT | - | Ward 5 | |
| YES | - | Ward 6 | Councillor Tom Jackson |

| | | | |
|---|---|---|---|
| YES | - | Ward 7 | Councillor Esther Pauls |
| YES | - | Ward 8 | Councillor J. P. Danko |
| YES | - | Ward 9 | Councillor Brad Clark |
| YES | - | Ward 10 | Councillor Maria Pearson |
| ABSENT | - | Ward 11 | Councillor Brenda Johnson |
| YES | - | Ward 12 | Councillor Lloyd Ferguson |
| ABSENT | - | Ward 13 | Councillor Arlene VanderBeek |
| ABSENT | - | Ward 14 | Councillor Terry Whitehead |
| YES | - | Ward 15 | Councillor Judy Partridge |

**(h) DELEGATIONS (Item 9)**

**(i) Tim McClemont, AIDS Network respecting a Second Consumption Treatment Services (CTS) site located in Ward 3 (Item 9.1)**

Tim McClemont of the AIDS Network addressed the Board respecting a Second Consumption Treatment Services (CTS) site located in Ward 3.

**(Nann/Wilson)**
That the Delegation from Tim McClemont, AIDS Network respecting a Second Consumption Treatment Services (CTS) site located in Ward 3, be received.

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

| | | | |
|---|---|---|---|
| YES | - | Mayor Fred Eisenberger | |
| YES | - | Ward 1 | Councillor Maureen Wilson |
| ABSENT | - | Ward 2 | Councillor Jason Farr |
| YES | - | Ward 3 | Councillor Nrinder Nann |
| YES | - | Ward 4 | Councillor Sam Merulla |
| VACANT | - | Ward 5 | |
| YES | - | Ward 6 | Councillor Tom Jackson |
| YES | - | Ward 7 | Councillor Esther Pauls |
| YES | - | Ward 8 | Councillor J. P. Danko |
| YES | - | Ward 9 | Councillor Brad Clark |
| YES | - | Ward 10 | Councillor Maria Pearson |
| ABSENT | - | Ward 11 | Councillor Brenda Johnson |
| YES | - | Ward 12 | Councillor Lloyd Ferguson |
| YES | - | Ward 13 | Councillor Arlene VanderBeek |
| ABSENT | - | Ward 14 | Councillor Terry Whitehead |
| YES | - | Ward 15 | Councillor Judy Partridge |

For further disposition of this matter, refer to Item 1.

**(ii) Rebecca Ganann, McMaster University respecting the EMBOLDEN study to enhance physical and community mobility of older adults who experience difficulties participating in community programs and reside in areas of high health inequity (Added Item 9.1)**

Rebecca Ganann, McMaster University addressed the Board respecting the EMBOLDEN study to enhance physical and community mobility of older adults who experience difficulties participating in community programs and reside in areas of high health inequity, with the aid of a PowerPoint Presentation.

**(Wilson/Danko)**
That the Delegation from Rebecca Ganann, McMaster University respecting the EMBOLDEN study to enhance physical and community mobility of older adults who experience difficulties participating in community programs and reside in areas of high health inequity, be received.

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

| | | | |
|---|---|---|---|
| YES | - | Mayor Fred Eisenberger | |
| YES | - | Ward 1 | Councillor Maureen Wilson |
| ABSENT | - | Ward 2 | Councillor Jason Farr |
| YES | - | Ward 3 | Councillor Nrinder Nann |
| YES | - | Ward 4 | Councillor Sam Merulla |
| VACANT | - | Ward 5 | |
| YES | - | Ward 6 | Councillor Tom Jackson |
| YES | - | Ward 7 | Councillor Esther Pauls |
| YES | - | Ward 8 | Councillor J. P. Danko |
| YES | - | Ward 9 | Councillor Brad Clark |
| YES | - | Ward 10 | Councillor Maria Pearson |
| ABSENT | - | Ward 11 | Councillor Brenda Johnson |
| YES | - | Ward 12 | Councillor Lloyd Ferguson |
| YES | - | Ward 13 | Councillor Arlene VanderBeek |
| ABSENT | - | Ward 14 | Councillor Terry Whitehead |
| YES | - | Ward 15 | Councillor Judy Partridge |

**(iii) Devyani Bakshi, McMaster University, respecting Climate Changes and its impacts on the healthcare system (Added Item 9.2)**

The delegate was not present when called upon and will be rescheduled for a future Board of Health meeting.

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

**(Pearson/Partridge)**

That, there being no further business, the Board of Health be adjourned at 12:45 p.m.

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

| | | | |
|---|---|---|---|
| YES | - | Mayor Fred Eisenberger | |
| YES | - | Ward 1 | Councillor Maureen Wilson |
| ABSENT | - | Ward 2 | Councillor Jason Farr |
| YES | - | Ward 3 | Councillor Nrinder Nann |
| ABSENT | - | Ward 4 | Councillor Sam Merulla |
| VACANT | - | Ward 5 | |
| YES | - | Ward 6 | Councillor Tom Jackson |
| YES | - | Ward 7 | Councillor Esther Pauls |
| YES | - | Ward 8 | Councillor J. P. Danko |
| YES | - | Ward 9 | Councillor Brad Clark |
| YES | - | Ward 10 | Councillor Maria Pearson |
| ABSENT | - | Ward 11 | Councillor Brenda Johnson |
| YES | - | Ward 12 | Councillor Lloyd Ferguson |
| YES | - | Ward 13 | Councillor Arlene VanderBeek |
| ABSENT | - | Ward 14 | Councillor Terry Whitehead |
| YES | - | Ward 15 | Councillor Judy Partridge |

Respectfully submitted,

Mayor F. Eisenberger
Chair, Board of Health

Loren Kolar
Legislative Coordinator
Office of the City Clerk

October 19, 2021

Hon. Christine Elliott
Ministry of Health
College Park, 5th Floor
777 Bay Street
Toronto, ON M7A 2J3

Sent via email: christine.elliott@ontario.ca

Dear Hon. Christine Elliott,

On behalf of the Board of Health for Huron Perth Public Health, we wish to express our great concern for the variation in vaccination policies for the Home and Community Care sector and the risk this presents to those who are trying to stay in their homes.

It is our understanding that home and community care in Huron and Perth is made up of multiple partners and classified as follows:

Home and Community Support Services (HCSS) – have care coordinators in the field and are direct deliverers of some specialized services.

Home Care Service –agencies that have contracts to deliver home care through agreements with Home and Community Support Services.

Community Support Services (CSS) – agencies that provide a range of services including assisted living, adult day programs, transportation, meals on wheels and friendly visiting.

Private agencies – agencies that provide home and community care with no direct provincial funding.

Members of the public, as well as Primary Care stakeholders, are aware that allowing unvaccinated home and community workers to enter a client's home poses additional and avoidable risk to vulnerable clients in whom an exposure to Covid-19 could do irreparable damage and cost them their independence or even their lives. We have received reports from clients who have requested, and have been unable to access, vaccinated workers; these clients have chosen to decline services, meaning they are not receiving appropriate levels of care.

It is our understanding that most agencies that fall under Home Care Services in Huron and Perth have mandatory vaccination policies with only exemptions due to medical purposes. We are grateful that these organizations have embraced this direction and are supporting the safety of their clients. However, some agencies under HCSS and CSS, in compliance with Directive# 6, allow for staff to opt out of vaccination with regular testing allowances. We know that the sensitivity of Rapid Antigen Tests is limited, and particularly if only performed once weekly. Clients do not have the choice to request a fully vaccinated worker and must choose if they are willing to take that risk.

We know that current risk of COVID-19 spread is highest among those who are not vaccinated and that unfortunately, it can be passed to fully vaccinated individuals, including those who are trying, with the aid of home and community services, to stay in their homes. We commend the Ministry of Health for making staff vaccinations mandatory in Long Term Care Homes and are calling for direction to make vaccination mandatory for all staff working and caring for vulnerable clients such as Long Term Care, Retirement Homes and agencies across the Home and Community Care sector.

Thank you for your attention to this important matter.

Regards,

Kathy Vassilakos
Board of Health Chair

Copy: Premier of Ontario, Hon. Doug Ford
Association of Municipalities of Ontario
alPHa
Randy Pettapiece, MPP
Perth Wellington Lisa Thompson, MPP Huron Bruce
Home and Community Care Support Services - South West

**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

eApprove-72-2021-312

November 2, 2021

Mayor Fred Eisenberger
Chair, Board of Health
City of Hamilton, Public Health Services
71 Main Street West
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 $8,931,100 in additional one-time funding for the 2021-22 funding year to support extraordinary costs associated with preventing, monitoring, detecting, and containing COVID-19 in the province.

Ontario recognizes the considerable time and resources necessary for public health units to continue to effectively respond to COVID-19, including leading the roll-out of the COVID-19 Vaccine Program at the local level. In recognition of these unique circumstances, public health units will have continued opportunities to request reimbursement of COVID-19 extraordinary costs, including vaccine related expenses, for the 2021 and 2022 funding years.

Dr. Kieran Moore, 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 the important service that your public health unit provides to Ontarians, and your ongoing dedication and commitment to addressing the public health needs of Ontarians.

Sincerely,

Christine Elliott

Christine Elliott
Deputy Premier and Minister of Health

…/2

Mayor Fred Eisenberger

c: Dr. Elizabeth Richardson, Medical Officer of Health, City of Hamilton, Public Health Services
Dr. Kieran Moore, Chief Medical Officer of Health
Alison Blair, Associate Deputy Minister, Pandemic Response and Recovery

Ontario

**Ministry of Health**

Office of Chief Medical Officer of Health, Public Health
Box 12,
Toronto, ON M7A 1N3

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

**Ministère de la Santé**

Bureau du médecin hygiéniste en chef, santé publique
Boîte à lettres 12
Toronto, ON M7A 1N3

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

eApprove-72-2021-312

November 3rd, 2021

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")**

This letter is further to the recent letter from the Honourable Christine Elliott, Deputy Premier and Minister of Health, in which she informed your organization that the Ministry of Health (the "ministry") will provide the Board of Health with up to $8,931,100 in additional one-time funding for the 2021-22 funding year to support extraordinary costs associated with preventing, monitoring, detecting, and containing COVID-19 in the province.

This will bring the total maximum funding available under the Agreement for the 2021-22 funding year to up to $62,881,900 ($29,141,500 in base funding and $33,740,400 in one-time funding). Please find attached to this letter a new Schedule A (Grants and Budget), Schedule B (Related Program Policies and Guidelines), Schedule C (Reporting Requirements), and Schedule D (Board of Health Financial Controls) that, pursuant to section 3.4 of the Agreement, shall replace the existing schedules. All terms and conditions contained in the Agreement remain in full force and effect.

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

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

…/2

Dr. Elizabeth Richardson

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

Yours truly,

Kieran Michael Moore, MD, CCFP(EM), FCFP, MPH, DTM&H, FRCPC, FCAHS
Chief Medical Officer of Health

Attachments

c: Mayor Fred Eisenberger, Chair, Board of Health, City of Hamilton, Public Health Services
Emma Sydney, Business Administrator, City of Hamilton, Public Health Services
David Trevisani, Manager, City of Hamilton, Public Health Services
Alison Blair, Associate Deputy Minister, Pandemic Response and Recovery, MOH
Jim Yuill, Director, Financial Management Branch, MOH
Jeffrey Graham, Director, Fiscal Oversight and Performance Branch, MOH
Ronnie Gavsie, Executive Lead, Pandemic Response and Recovery, MOH
Elizabeth Walker, Director, Accountability and Liaison Branch, MOH
Jodi Melnychuk, Director (A), Vaccine Planning and Engagement Branch, MOH
Brent Feeney, Manager, Accountability and Liaison Branch, MOH

# New Schedules to the Public Health Funding and Accountability Agreement

**BETWEEN THE PROVINCE AND THE BOARD OF HEALTH**

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

**EFFECTIVE AS OF THE 1ST DAY OF JANUARY 2021**

Issued November 2021

## SCHEDULE "A"
## GRANTS AND BUDGET

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

| DETAILED BUDGET - MAXIMUM BASE FUNDS (FOR THE PERIOD OF JANUARY 1, 2021 TO DECEMBER 31, 2021, UNLESS OTHERWISE NOTED) | |
|---|---|
| **Programs/Sources of Funding** | **2021 Approved Allocation ($)** |
| Mandatory Programs (70%) | 26,725,400 |
| Medical Officer of Health (MOH) / Associate Medical Officer of Health (AMOH) Compensation Initiative (100%)[1] | 168,000 |
| Ontario Seniors Dental Care Program (100%) | 2,248,100 |
| **Total Maximum Base Funds[2]** | **29,141,500** |

| DETAILED BUDGET - MAXIMUM ONE-TIME FUNDS (FOR THE PERIOD OF APRIL 1, 2021 TO MARCH 31, 2022, UNLESS OTHERWISE NOTED) | | | |
|---|---|---|---|
| **Projects / Initiatives** | | | **2021-22 Approved Allocation ($)** |
| Mitigation (100%)[3] | | | 2,215,800 |
| Mandatory Programs: Racoon Rabies Outbreak Response (100%) | | | 54,300 |
| Mandatory Programs: New Purpose-Built Vaccine Refrigerators (100%) | | | 188,600 |
| Mandatory Programs: Public Health Inspector Practicum Program (100%) | | | 30,000 |
| COVID-19: General Program (100%)[3] | | | 4,990,000 |
| COVID-19: Vaccine Program (100%)[3] | | | 23,921,700 |
| Ontario Seniors Dental Care Program Capital: Mobile Dental Clinic Bus (100%) | | | 40,000 |
| School-Focused Nurses Initiative (100%) | # of FTEs | 23.0 | 2,300,000 |
| **Total Maximum One-Time Funds[2]** | | | **33,740,400** |

| MAXIMUM TOTAL FUNDS | 2021-22 Approved Allocation ($) |
|---|---|
| **Base and One-Time Funding** | **62,881,900** |

| DETAILED BUDGET - MAXIMUM ONE-TIME FUNDS (FOR THE PERIOD OF APRIL 1, 2022 to MARCH 31, 2023, UNLESS OTHERWISE NOTED) | | | |
|---|---|---|---|
| **Projects / Initiatives** | | | **2022-23 Approved Allocation ($)** |
| School-Focused Nurses Initiative (100%)[4] | # of FTEs | 23.0 | 759,000 |
| **Total Maximum One-Time Funds[2]** | | | **759,000** |

**NOTES:**

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

(2) 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".

(3) Approved one-time funding is for the period of January 1, 2021 to December 31, 2021.

(4) Approved one-time funding is for the period of April 1, 2022 to July 31, 2022.

## SCHEDULE “B”

## RELATED PROGRAM POLICIES AND GUIDELINES

| Type of Funding | ***BASE FUNDING*** |
|---|---|

*Provincial base funding is provided to the Board of Health for the purposes of delivering public health programs and services in accordance with the Health Protection and Promotion Act (HPPA), Regulations under the HPPA, Ontario Public Health Standards, and the Agreement. Provincial base funding is also provided to the Board of Health for the purposes of delivering related public health programs and initiatives in accordance with Schedule B.*

***Mandatory Programs: Harm Reduction Program Enhancement***

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.

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.

<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:

| Type of Funding | ***BASE FUNDING*** |
| --- | --- |

- Order 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 Province.
- Comply with the quarterly reporting requirements established by the Province.
- 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 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 naloxone (NARCAN® Nasal Spray and injectable naloxone formulations)*

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

- Its use of naloxone 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 naloxone.
- The Province takes no responsibility for any unauthorized use of naloxone 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.
    - Comply with the terms and conditions as it relates to the use and administration of naloxone as specified in all applicable federal and provincial laws.
    - Provide training to persons who will be administering naloxone. 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 naloxone.
    - Follow all provincial written instructions relating to the proper use, administration, training and/or distribution of naloxone.

- Immediately return any naloxone in its custody or control at the written request of the Province at the Board of Health's own cost or expense, and that the Province does not guarantee supply of naloxone, nor that naloxone 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.

***Mandatory Programs: Healthy Smiles Ontario Program***

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.

In addition to the program requirements under the Ontario Public Health Standards, the Board of Health must ensure that the following requirements are met:

- 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.
- The Board of Health is required to bill back relevant programs for services provided to non-HSO clients. 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., must be reported as income in financial reports as per Schedule C of the Agreement.
- 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.

## SCHEDULE "B"

## RELATED PROGRAM POLICIES AND GUIDELINES

| Type of Funding | ***BASE FUNDING*** |
|---|---|

    - 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.

***Mandatory Programs: Nursing Positions***

Base funding may be utilized to support Chief Nursing Officer, Infection Prevention and Control, and Social Determinants of Health Nursing positions, as well as other nursing positions at the Board of Health.

The Board of Health shall only employ a Chief Nursing Officer with the following qualifications:
- 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 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.).

The Chief Nursing Officer role must be implemented at a management level within the Board of Health, reporting directly to the Medical Officer of Health or Chief Executive Officer and, in that context, will contribute to organizational effectiveness.

The Board of Health shall only employ an Infection Prevention and Control Nurse with the following qualifications:
- The position 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 years of beginning of employment.

| Type of Funding | ***BASE FUNDING*** |
|---|---|

The Board of Health shall only employ a Social Determinants of Health Nurse with the following qualifications:

- The position is required to be to be a Registered Nurse; and,
- The position is required to have or be committed to obtaining the qualifications of a public health nurse as specified in section 71(3) of the HPPA and section 6 of Ontario Regulation 566 under the HPPA.

***Mandatory Programs: Smoke-Free Ontario***

Smoke-Free Ontario is a comprehensive approach that combines programs, policies, social marketing, and legislation to reduce the use of tobacco and vapour products and lower health risks by protecting Ontarians from second-hand smoke and vapour, and to keep harmful products out of the hands of children and youth.

In addition to the program requirements under the Ontario Public Health Standards, the Board of Health must ensure that it complies with any written directions provided by the Province on the interpretation and enforcement of the *Smoke-Free Ontario Act, 2017*.

***Medical Officer of Health / Associate Medical Officer of Health Compensation Initiative (100%)***

The Province provides the Board 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 funding 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, including requirements related to minimum salaries.

***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 is being implemented through a phased approach.

| Type of Funding | ***BASE FUNDING*** |
| --- | --- |

The government announced the launch and staged implementation of the OSDCP on November 20, 2019. During the first stage of implementation, dental services were available for eligible seniors through Boards of Health, participating Community Health Centres and Aboriginal Health Access Centres. Through Stage 1, dental care was initiated and provided to eligible low-income seniors through Boards of Health, participating Community Health Centres, and Aboriginal Health Access Centres based on increasing Board of Health operational funding and leveraging existing infrastructure.

The second stage of the program, which began in winter 2020, expanded the program by investing in new dental clinics to provide care to more seniors in need. This included new dental services in underserviced areas, including through mobile dental buses and an increased number of dental suites in Boards of Health, participating Community Health Centres, and Aboriginal Health Access Centres. The second stage of the program will continue throughout 2021, with consideration being given to the ongoing implementation challenges presented by the COVID-19 response.

Program Enrolment

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

In cases where eligible seniors present with acute pain and urgent need, and are not already enrolled in the program, OSDCP providers, at the clinical discretion of the attending dental care provider, may support timely access to emergency dental treatment by providing immediate services following the seniors' signing of an emergency need and eligibility attestation. This attestation and enrollment process is to be administered at the local level. Following the delivery of emergency treatment, all seniors will need to submit an OSDCP application, be determined eligible, and be enrolled to receive any further non-emergency dental care through the OSDCP.

Program Delivery

The OSDCP is delivered through Boards of Health, participating Community Health Centres, and Aboriginal Health Access Centres across the province. 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 Board of Health service delivery under the OSDCP, the Board of Health may enter into partnership contracts 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 Schedules of Services for Dentist and Non-Dentist Providers on behalf of the Public Health Unit.

Base funding for the OSDCP must be used in accordance with the OSDCP-related requirements of the *Oral Health Protocol, 2018* (or as current), including specified requirements for service delivery, oral health navigation, and data collection and analysis. The Board of Health can allocate base funding for this Program across the program expense categories, with every effort made to maximize clinical service delivery and minimize administrative costs.

**SCHEDULE "B"**

**RELATED PROGRAM POLICIES AND GUIDELINES**

| Type of Funding | ***BASE FUNDING*** |
|---|---|

Planning for delivery of the OSDCP began when the program was announced in April 2019 with clinical service delivery beginning with the program launch in November 2019.

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 Board of Health 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 Board of Health 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).
  - 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).
  - 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.
  - Client transportation costs in order to address accessibility issues and support effective program delivery based on local need, such as where the enrolled OSDCP client would otherwise not be able to access dental services. Boards of Health will be asked to provide information on client transportation expenditures through in-year reporting and should track these expenditures and the number of clients accessing these services accordingly.

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

- Staff recruitment incentives;
- Billing incentives; 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.

**SCHEDULE "B"**

**RELATED PROGRAM POLICIES AND GUIDELINES**

| Type of Funding | ***BASE FUNDING*** |
|---|---|

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, HSO 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.
- A client co-payment is required on new denture services. Co-payment amounts are specified by the Province in Appendix A of the OSDCP Denture Services Factsheet for Providers (Factsheet), which applies to both dentists and denturists. It is the Board of Health's responsibility to collect the client co-payment for the codes outlined in Appendix A of the Factsheet. The Board of Health may determine the best mechanism for collecting co-payments, using existing payment and administration processes at the local level, in collaboration with OSDCP service delivery partners (e.g., Community Health Centre, Aboriginal Health Access Centre), as needed. The remaining cost of the service, after co-payment, is to be absorbed by the Board of Health through its operating base funding for the OSDCP. The revenue received from client co-payments for OSDCP service(s) is to be used to offset OSDCP program expenditures. Co-payment revenues are to be reported as part of the financial reporting requirements 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 (e.g., 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.
- 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.

**SCHEDULE "B"**

**RELATED PROGRAM POLICIES AND GUIDELINES**

| Type of Funding | ***ONE-TIME FUNDING*** |
|---|---|

***Mitigation (100%)***

One-time mitigation funding must be used to offset the increased costs of municipalities as a result of the 70% (provincial) / 30% (municipal) cost-sharing change for mandatory programs.

***Mandatory Programs: New Purpose-Built Vaccine Refrigerators (100%)***

One-time funding must be used for the purchase of two (2) 25 cu. ft. and seven (7) 55 cu. ft. new purpose-built vaccine refrigerators used to store publicly funded vaccines. The purpose-built refrigerators must meet the following specifications:

a. Interior
   - Fully adjustable, full extension stainless steel roll-out drawers;
   - Optional fixed stainless-steel shelving;
   - Resistant to cleaning solutions;
   - Ongoing positive forced fan air circulation to ensure temperature uniformity at all shelf levels;
   - Fan is either encased or removed from the chamber. Fan auto shut-off when door is opened; and,
   - Walls are smooth, scratch and corrosion resistant painted interior and exterior surfaces.

b. Refrigeration System
   - Heavy duty, hermetically sealed compressors;
   - Refrigerant material should be R400 or equivalent;
   - Advanced defrost sensor(s) to manage the defrost cycle and minimize trace amounts of frost build-up; and,
   - Evaporator operates at +2°C, preventing vaccine from freezing.

c. Doors
   - Full view non-condensing, glass door(s), at least double pane construction;
   - Spring-loaded closures include ≥90º stay open feature and <90º self-closing feature;
   - Door locking provision;
   - Option of left-hand or right-hand opening; and,
   - Interior cabinet lights with door activated on/off switch, as well as, an independent external on/off.

d. Tamper Resistant Thermostat
   - The thermostat should be set at the factory to +5ºC with a control range between +2ºC to +8ºC but this could be done at the time of delivery/installation at no additional cost.

e. Thermometer
   - An automatic temperature recording and monitoring device with battery backup;
   - An external built-in visual digital display thermometer independent of the temperature recording and monitoring device which has a digital temperature display in Celsius and temperature increment readings of 0.1ºC;

| Type of Funding | ***ONE-TIME FUNDING*** |
|---|---|

- The external built-in digital thermometer must also be able to record and display the maximum, minimum and current temperatures and allow the user to easily check and reset these recordings as required; and,
- The automatic temperature recording and monitoring device and digital display thermometer must be calibrated/accurate within +/- 0.5ºC or better.

f. Alarm Condition Indicator
- Audible and visual warnings for over-temperature, under-temperature and power failure;
- Remote alarm contacts;
- Door ajar enunciator; and,
- Alarm testing system.

g. Top or Bottom Mounted Compressors/Condensers
- Compressor mounted at top or bottom but not in rear.

h. Noise Levels
- The noise produced by the operation of the refrigerator shall not exceed 85 decibels at one metre. Specifications of the refrigerator must include the noise level measured in decibels of sound at one metre from the refrigerator.

i. Locking Plug
- Power supply must have a locking plug.

j. Castors
- Heavy duty locking castors either installed at the factory or upon delivery.

k. Voltage Safeguard
- Voltage safeguard device capable of protecting against power surges related to the resumption of power to the refrigerator.

l. Warranty
- The warranty should include, from date of acceptance, a five-year comprehensive parts and labour warranty with the stipulation that a qualified service representative shall be on-site no later than 12 hours after the service call was made. Software upgrades provided free of charge during the warranty period.

m. Electrical Equipment
- All electrically operated equipment must be UL, CSA and/or Electrical Safety Authority approved and bear a corresponding label. The equipment should specify the electrical plug type, voltage and wattage rating, and the recommended breaker size for the circuit connection.

## SCHEDULE "B"

## RELATED PROGRAM POLICIES AND GUIDELINES

| Type of Funding | ***ONE-TIME FUNDING*** |
|---|---|

***Mandatory Programs: 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.

***Mandatory Programs: Racoon Rabies Outbreak Response (100%)***

One-time funding must be used to support the Board of Health's response to the racoon rabies outbreak in the community. Eligible costs include salary and benefits for Public Health Inspector position(s).

***COVID-19: General Program (100%)***

One-time funding must be used to offset extraordinary costs associated with preventing, monitoring, detecting, and containing COVID-19 in the province (excluding costs associated with the delivery of the COVID-19 vaccine program). Extraordinary costs refer to the costs incurred over and above the Board of Health's existing funding/approved budget for mandatory programs in organized and unorganized areas (where applicable).

Eligible costs include, but are not limited to:
- Staffing – Salaries and benefits, inclusive of overtime for existing or redeployed Board of Health staff (including management staff directly engaged in COVID-19 activities); staff redeployed from associated regional governments; new temporary or casual staff; salaries and benefits associated with overtime worked by indirect staff (e.g., finance, HR, legal, communications, etc.) and management staff (where local board of health policies permit such arrangements) that have not been redeployed directly to COVID-19, but have incurred overtime due to working on COVID-19 related activities.
- Travel and Accommodation – for staff delivering COVID-19 service away from their home office location, or for staff to conduct infectious disease surveillance activities (swab pick-ups and laboratory deliveries).
- Supplies and Equipment – small equipment and consumable supplies (including laboratory testing supplies and personal protective equipment) not already provided by the ministry, and information and information technology upgrades related to tracking COVID-19 not already approved by the ministry.
- Purchased Services – service level agreements for services/staffing with community providers and/or municipal organizations, professional services, security services, cleaning services, hazardous waste disposal, transportation services including courier services and rental cars, data entry or information technology services for reporting COVID-19 data to the ministry (from centres in the community that are not operated by the Board of Health) or increased services required to meet pandemic reporting demands, outside legal services, and additional premises rented by the Board of Health.

## SCHEDULE "B"

## RELATED PROGRAM POLICIES AND GUIDELINES

| Type of Funding | ***ONE-TIME FUNDING*** |
|---|---|

- Communications – language interpretation/translation services, media announcements, public and provider awareness, signage, and education materials regarding COVID-19.
- Other Operating – recruitment activities, staff training.

Other requirements of this one-time funding include:
- The Board of Health must ensure that any goods and services acquired with this one-time funding are 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 enter into a Memorandum of Understanding / Service Level Agreement (or other similar arrangement) with any partner organization delivering services under this program (this includes services provided by a municipality of which a public health unit is a part of). The Memorandum of Understanding / 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 the funds (value for money). Funding included as part of a Memorandum of Understanding / Service Level Agreement must NOT exceed those that would have been paid if the transaction was at "arm's length" (and is subject to provincial audit or assessment). Copies of these agreements must be provided to the Province upon request.

The following are examples of non-admissible expenditures:
- Costs associated with delivering other public health programs and services.
- Lost revenues for public health programs and services not considered a direct COVID-19 cost.
- Any COVID-19 costs directly incurred by other organizations and/or third parties (i.e., long-term care homes, hospitals, municipalities). However, if a Board of Health is entering into an agreement with another organization and/or third party, then those costs would be admissible if a Memorandum of Understanding / Service Level Agreement is in place that sets out clear performance expectations and ensures accountability for the funds, as noted above.
- Sick time and vacation accruals, or banked overtime (funding of these items will be considered only when these amounts are paid).
- Costs that are reimbursable from other sources.
- Costs associated with COVID-19 case and contact management self-isolation sites.
- Costs associated with municipal by-law enforcement.
- Electronic Medical Record systems.

The Board of Health is required to track COVID-19 spending separately and retain records of COVID-19 spending.

***COVID-19: Vaccine Program (100%)***

One-time funding must be used to offset extraordinary costs associated with organizing and overseeing the COVID-19 immunization campaign within local communities, including the development of local COVID-19 vaccination campaign plans. Extraordinary costs refer to the costs incurred over and above the Board of Health's existing funding/approved budget for mandatory programs in organized and unorganized areas (where applicable).

**SCHEDULE “B”**

**RELATED PROGRAM POLICIES AND GUIDELINES**

| Type of Funding | ***ONE-TIME FUNDING*** |
|---|---|

Eligible costs include, but are not limited to:

- Staffing – salaries and benefits, inclusive of overtime, for existing staff or redeployed Board of Health staff (including management staff directly engaged in COVID-19 activities); staff redeployed from associated regional governments; new temporary or casual staff; and, salaries and benefits associated with overtime worked by indirect staff (e.g., finance, HR, legal, communications, etc.) and management staff (where local board of health policies permit such arrangements) that have not been redeployed directly to COVID-19, but have incurred overtime due to working on COVID-19 related activities. Activities include providing assistance with meeting provincial and local requirements for COVID-19 surveillance and monitoring (including vaccine safety surveillance, adverse events and number of people vaccinated), administering the COVID-19 vaccine, managing COVID-19 Vaccine Program reporting requirements, and planning and deployment of immunization/ vaccine clinics.
- Travel and Accommodation – for staff delivering COVID-19 Vaccine Program services away from their home office location, including transporting vaccines, and transportation/accommodation for staff of mobile vaccine units.
- Supplies and Equipment – supplies and equipment associated with the storage and handling of the COVID-19 vaccines (including vaccine refrigerators, freezers, coolers, etc.), small equipment and consumable supplies (including personal protective equipment) not already provided by the Province, supplies necessary to administer the COVID-19 vaccine (including needles/syringes and disposal, sterile gauze, alcohol, bandages, etc.) not already provided by the Province, information and information technology upgrades related to tracking COVID-19 immunization not already approved by the ministry.
- Purchased Services – service level agreements for services/staffing with community providers and/or municipal organizations, professional services, security services, cleaning services, hazardous waste disposal, transportation services (e.g., courier services, transporting clients to vaccination clinics), data entry or information technology services for reporting COVID-19 data related to the Vaccine Program to the Province from centres in the community that are not operated by the Board of Health or increased services required to meet pandemic reporting demands, outside legal services, and additional premises leased or rented by the Board of Health.
- Communications – language interpretation/translation services, media announcements, public and provider awareness, signage, and education materials regarding COVID-19 immunization outreach.
- Other Operating – recruitment activities, staff training.

Other requirements of this one-time funding include:

- The Board of Health must ensure that any goods and services acquired with this one-time funding are 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 enter into a Memorandum of Understanding / Service Level Agreement (or other similar arrangement) with any partner organization delivering services under this program (this includes services provided by a municipality of which a public health unit is a part of). The Memorandum of Understanding / 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 the funds (value for money). Funding included as part of a Memorandum of Understanding / Service Level Agreement must NOT exceed those that would

| Type of Funding | ***ONE-TIME FUNDING*** |
|---|---|

have been paid if the transaction was at "arm's length" (and is subject to provincial audit or assessment). Copies of these agreements must be provided to the Province upon request.

The following are examples of non-admissible expenditures:

- Costs associated with delivering other public health programs and services.
- Lost revenues for public health programs and services not considered a direct COVID-19 cost.
- Any COVID-19 costs directly incurred by other organizations and/or third parties (i.e., long-term care homes, hospitals, municipalities). However, if a Board of Health is entering into an agreement with another organization and/or third party, then those costs would be admissible if a Memorandum of Understanding / Service Level Agreement is in place that sets out clear performance expectations and ensures accountability for the funds, as noted above.
- Sick time and vacation accruals, or banked overtime (funding of these items will be considered only when these amounts are paid).
- Costs that are reimbursable from other sources.

The Board of Health is required to track COVID-19 spending separately and retain records of COVID-19 spending.

***Ontario Seniors Dental Care Program Capital: 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 to expand the 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:

- 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.

**SCHEDULE "B"**

**RELATED PROGRAM POLICIES AND GUIDELINES**

| Type of Funding | ***ONE-TIME FUNDING*** |
|---|---|

***School-Focused Nurses Initiative (100%)***

The School-Focused Nurses Initiative was created for the 2020-21 school year to support additional nursing FTE capacity in every board of health to provide rapid-response support to school boards and schools in facilitating public health and preventative measures related to the COVID-19 pandemic. One-time funding for this initiative is being renewed for the 2021-22 school year.

The school-focused nurses contribute to the following activities in support of school boards and schools:
- Providing support in the development and implementation of COVID-19 health and safety plans;
- Providing sector specific support for infection prevention; surveillance, screening and testing; outbreak management; case and contact management; and COVID-19 vaccinations; and,
- Supporting communication and engagement with local school communities, as well as the broader health care sector.

While the priority focus is on the COVID-19 response, the additional nurses may also support the fulfilment of board of health requirements to improve the health of school-aged children and youth as per the School Health Program Standard and related guidelines and protocols under the Ontario Public Health Standards. The additional FTEs may also support childcare centres, home childcare premises and other priority settings relating to the health of school-aged children and youth.

The initiative is being implemented with the following considerations:
- Recruitment of Registered Nurses to the extent possible;
- French language and Indigenous (First Nation, Métis, Inuit) service needs;
- Capacity for both in-person and virtual delivery;
- Consistency with existing collective agreements; and,
- Leveraging the Chief Nursing Officer role as applicable in implementing this initiative, as well as coordinating with existing school health, nursing, and related programs and structures within the Board of Health (e.g., School Health Teams, Social Determinants of Health Nurses, Infection Prevention and Control Nurses, and school-based programs such as immunization, oral and vision screening, reproductive health, etc.).

Qualifications required for these positions are:
- Current registration with the College of Nurses of Ontario (i.e., Registered Nurse, Registered Practical Nurse, or Registered Nurse in the Extended Class).

One-time funding must be used to continue the new temporary FTEs for school-focused nurses as specified in Schedule A of the Agreement. Funding is for nursing salaries, wages, and benefits only and cannot be used to support other operating costs. Additional costs incurred by the Board of Health to support school re-opening initiatives that cannot be managed within the existing budget of the Board of Health, are admissible through the COVID-19 extraordinary costs process.

**SCHEDULE "B"**

**RELATED PROGRAM POLICIES AND GUIDELINES**

| Type of Funding | ***OTHER*** |
|---|---|

***Infectious Diseases Programs Reimbursement***

Funding for Infectious Diseases Programs will be provided on a case-by-case basis through direct reimbursement. These funds are provided to offset the costs of treatment medications not made available through the Ontario Government Pharmaceutical and Medical Supply Service (OGPMSS).

To be reimbursed, original receipts and client identification information needs to be submitted to the Infectious Diseases Section of the Health Protection and Surveillance Policy and Programs Branch (Office of Chief Medical Officer of Health, Public Health). Clients will not be directly reimbursed.

Questions about the reimbursement process and expense eligibility can be submitted to the following email: IDPP@ontario.ca.

Leprosy

The Board of Health may submit claims on a case-by-case basis for medication costs related to the treatment of Leprosy. As per Chapter A: Leprosy, of the *Infectious Diseases Protocol, 2018* (or as current), treatment should be under the direction of an infectious disease specialist and should refer to World Health Organization (WHO) treatment recommendations.

Tuberculosis

The Board of Health may submit claims on a case-by-case basis for second-line and select adjunct medications related to the treatment of active tuberculosis and latent tuberculosis infection. For more information on the reimbursement process, see section 9 of the *Tuberculosis Program Guideline, 2018* (or as current).

***Vaccine Programs Reimbursement***

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 the Board of Health to individuals aged 6 months or older who live, work or attend school in Ontario.

**SCHEDULE "B"**

**RELATED PROGRAM POLICIES AND GUIDELINES**

| Type of Funding | ***OTHER*** |
| --- | --- |

Meningococcal

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

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

Human Papillomavirus (HPV)

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

**SCHEDULE "C"**

**REPORTING REQUIREMENTS**

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

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

| Name of Report | Reporting Period | Due Date |
|---|---|---|
| **1. Annual Service Plan and Budget Submission** | For the entire Board of Health Funding Year | April 1 of the current Board of Health Funding Year |
| **2. Quarterly Standards Activity Reports** | | |
| Q2 Standards Activity Report | For Q1 and Q2 | July 31 of the current Board of Health Funding Year |
| Q3 Standards Activity Report | For Q3 | October 31 of the current Board of Health Funding Year |
| Q4 Standards Activity Report | For Q4 | January 31 of the following Board of Health Funding Year |
| **3. Annual Report and Attestation** | For the entire Board of Health Funding Year | April 30 of the following Board of Health Funding Year |
| **4. Annual Reconciliation Report** | For the entire Board of Health Funding Year | April 30 of the following Board of Health Funding Year |
| **5. COVID-19 Expense Form** | For the entire Board of Health Funding Year | As directed by the Province |
| **6. MOH / AMOH Compensation Initiative Application** | For the entire Board of Health Funding Year | As directed by the Province |
| **7. Other Reports and Submissions** | As directed by the Province | As directed by the Province |

## Definitions

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

**“Q1”** means the period commencing on January 1st and ending on the following March 31st.

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

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

**“Q4”** means the period commencing on October1st and ending on the following December 31st.

## Report Details

Annual Service Plan and Budget Submission

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

Quarterly Standards Activity Reports

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

Annual Report and Attestation

- The Annual Report and Attestation will provide a year-end summary report on achievements on all programs governed under the Agreement, in all accountability domains under the Organizational Requirements, and identification of any major changes in planned activities due to local events.
- The Annual Report will include a narrative report on the delivery of programs and services, fiduciary requirements, good governance and management, public health practice, and other issues, year-end report on indicators, and a board of health attestation on required items.
- The Annual Report and Attestation shall be signed on behalf of the Board of Health by an authorized signing officer.

Annual Reconciliation Report

- The Board of Health shall provide to the Province an Annual Reconciliation Report for

funding provided for public health programs governed under the Accountability Agreement.

- The Annual Reconciliation Report must contain: Audited Financial Statements; and, Auditor's Attestation Report in the Province's prescribed format.
- The Annual Reconciliation Report shall be signed on behalf of the Board of Health by an authorized signing officer.
- Specific to Temporary Pandemic Pay Initiative, the Board of Health shall provide the following as part of the Annual Reconciliation Report:
  - Accounting for the reporting of both the revenue and expenditures for the Temporary Pandemic Pay Initiative should appear as separate and distinct items within the Annual Reconciliation Report.
  - The Audited Financial Statement must include appropriate disclosure regarding the Board of Health's revenue and expenditures related to the Temporary Pandemic Pay Initiative.

COVID-19 Expense Form

- The Board of Health shall complete and submit actual and forecasted expenditures associated with COVID-19 extraordinary costs (for both the COVID-19 Vaccine Program and the COVID-19 General Program) through the submission of a COVID-19 Expense Form.
- The COVID-19 Expense Form shall be signed on behalf of the Board of Health by an authorized signing officer.

Medical Officer of Health (MOH) / Associate Medical Officer of Health (AMOH) Compensation Initiative Application

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

## SCHEDULE “D”

## BOARD OF HEALTH FINANCIAL CONTROLS

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

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

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

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

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

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

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

   Examples of potential controls to support this objective include, but are not limited to:
   - Independent review of an aging accounts receivable report to ensure timely clearance of accounts receivable balances.
   - Separate accounts receivable function from the cash receipts function.
   - Accounts receivable sub-ledger is reconciled to the general ledger control account on a regular and timely basis.
   - Original source documents are maintained and secured to support all receipts and expenditures.

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

   Examples of potential controls to support this objective include, but are not limited to:
   - Policies are implemented to govern procurement of goods and services and expense reimbursement for employees and board members.
   - Use appropriate procurement method to acquire goods and services in accordance with applicable policies and directives.
   - Segregation of duties is used to apply the three (3) way matching process (i.e., matching 1) purchase orders, with 2) packing slips, and with 3) invoices).
   - Separate roles for setting up a vendor, approving payment, and receiving goods.
   - Separate roles for approving purchases and approving payment for purchases.
   - Processes in place to take advantage of offered discounts.
   - Monitoring of breaking down large dollar purchases into smaller invoices in an attempt to bypass approval limits.
   - Accounts payable sub-ledger is reconciled to the general ledger control account on a regular and timely basis.
   - Employee and Board member expenses are approved by appropriate individuals for reimbursement and are supported by itemized receipts.
   - Original source documents are maintained and secured to support all receipts and expenditures.
   - Regular monitoring to ensure compliance with applicable directives.
   - Establish controls to prevent and detect duplicate payments.
   - Policies are in place to govern the issue and use of credit cards, such as corporate, purchasing or travel cards, to employees and board members.
   - All credit card expenses are supported by original receipts, reviewed and approved by appropriate individuals in a timely manner.
   - Separate payroll preparation, disbursement and distribution functions.

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

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

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

November 1, 2021

The Honourable Christine Elliott
Minister of Health
Ministry of Health
777 Bay Street
College Park 5th Floor
Toronto, ON M7A 2J3

Dear Minister Elliott:

**RE: Public Health Funding for 2022**

The Board of Health for the North Bay Parry Sound District Health Unit (Board) commends the government's financial commitment to public health throughout the pandemic. This trust has enabled public health programs and services, critical to the pandemic response, to continue. There is still much to be accomplished as the pandemic evolves. Vital to achieving future successes is the ability to strategically plan for 2022.

Pursuant to the Health Unit's correspondence of June 24, 2021, the Board is again respectfully requesting the Ministry to urgently establish funding expectations for 2022. This is critical for planning purposes for both the Health Unit and the municipalities we serve.

The Board is urging the Ministry of Health to commit in writing to:

1. Extend COVID-19 funding in 2022 for:
    a. COVID-19 Extraordinary Costs; and
    b. COVID-19 Vaccination Extraordinary Costs
2. Establish funding in 2022 for public health recovery efforts
3. Increase provincial funding for public health base budgets with the proportional municipal levy increase needed in 2022 to maintain public health unit capacity

Health units have had only one base funding increase in the past five years; however, wage and benefit increases and general increases to operating costs due to inflation continue. In addition, two public health union contracts are to be negotiated in 2022 with workforces experiencing recruitment and retention issues. A zero percent increase in base funding for 2022 is untenable if health units are to fulfill the requirements for programs, services, and accountability as delineated in the Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (Standards).

As per the Standards:

.../2

*"Boards of health are responsible for programs and services in all core function areas, demonstrating accountability to the ministry, and monitoring and measuring the effectiveness, impact and success of their programs and services."*

Requisite to realizing Ministry expectations to deliver mandated public health programs is a highly skilled and experienced workforce. They are essential to ensuring the future success of entrusted programs such as healthy growth and development, school health, chronic disease prevention and well-being, substance misuse and injury prevention, healthy environments, food safety, infectious and communicable diseases prevention and control, and immunization.

The COVID-19 pandemic has taught us that an able-bodied, prepared public health system is more important than ever. Without a base funding increase, public health's capacity will be diminished, with even harder choices having to be made regarding where we can assist in pandemic recovery and building healthier and sustainable communities. A base funding increase for 2022 is necessary to maintain public health services at status quo.

Your assistance and attention to this pressing matter is greatly appreciated.

Sincerely yours,

James Chirico, H.BSc., M.D., F.R.C.P. (C), MPH
Medical Officer of Health/Executive Officer

Nancy Jacko
Chairperson, Board of Health

/sb

Copy to: Premier Doug Ford
Hon. Helen Angus, Deputy Minister of Health
Chief Medical Officer of Health
Elizabeth Walker, Director, Public Health Accountability and Liaison Branch
Collen Kiel, Director, Public Health Strategy and Planning Branch
Vic Fedeli, MPP, Nipissing
Norm Miller, MPP, Parry Sound-Muskoka
John Vanthof, MPP, Timiskaming-Cochrane
Ontario Boards of Health
Member Municipalities (31)
Association of Municipalities Ontario (AMO)
Association of Local Public Health Agencies (alPHa)
Council of Medical Officers of Health (COMOH)
Andrea Horwath, New Democratic Party of Ontario, Leader, Official Opposition
Steven Del Duca, Ontario Liberal Party
Mike Schreiner, Green Party of Ontario
Jim Karahalios, New Blue Party of Ontario

# INFORMATION REPORT

| TO: | Mayor and Members<br>Board of Health |
|---|---|
| COMMITTEE DATE: | November 15, 2021 |
| SUBJECT/REPORT NO: | PHS Organizational Risk Management Plan: 2021 Progress Report (BOH21003(a)) (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 |

**COUNCIL DIRECTION**

Not Applicable.

**INFORMATION**

**Background:**
There are two types of risk that boards of health regularly encounter:
1. Issues that may be creating a risk to the public's health; and,
2. Issues that place the organization at risk of not meeting established business objectives.

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

mitigate risks, and submit an annual risk management report to the Ministry of Health (Ministry).

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

The PHS Organizational Risk Management Framework supports the Board of Health in identifying and mitigating issues that place PHS at risk of not meeting established business objectives. A total of 29 risks were identified for 2021. Of these, 13 fell into the high-risk category – more than ever before – as they had the highest likelihood of occurring and greatest potential impact on operations. Most of these high-risk items were associated with the impact, uncertainty and persistence of the COVID-19 pandemic and were related to two types of risk: people/human resources and operational/service delivery. The risk ratings for several of these high-risk items have remained unchanged despite the successful implementation of the 2021 risk management plans. This was not surprising given that the risk posed by COVID-19 was external to the organization and beyond PHS' control. There was, however, a reduction in the risk ratings (from high to medium) for two previously identified risks:

- The Board of Health may have financial management risk due to financial forecasting gaps; and,
- The Board of Health is at risk of changing priorities due to COVID-19 recovery.

Further details about the progress made throughout 2021 in implementing risk reduction strategies are outlined in Appendix "A" to Report BOH21003(a). This information will be submitted to the Ministry as part of the Q3 Standards Activity Report.

### Next Steps

In Q4 2021, the PHS leadership team will continue to use the Ontario Public Service Risk Management Framework (Appendix "B" to BOH21003(a)) to identify new organizational risks and reassess existing risks to inform the 2022 PHS Risk Management Plan. Action plans for mitigation and monitoring will be developed for those risks that have the highest likelihood of occurring and greatest potential impact on operations. The 2022 PHS Risk Management Plan will come forward to the Board of Health for approval in Q1 2022.

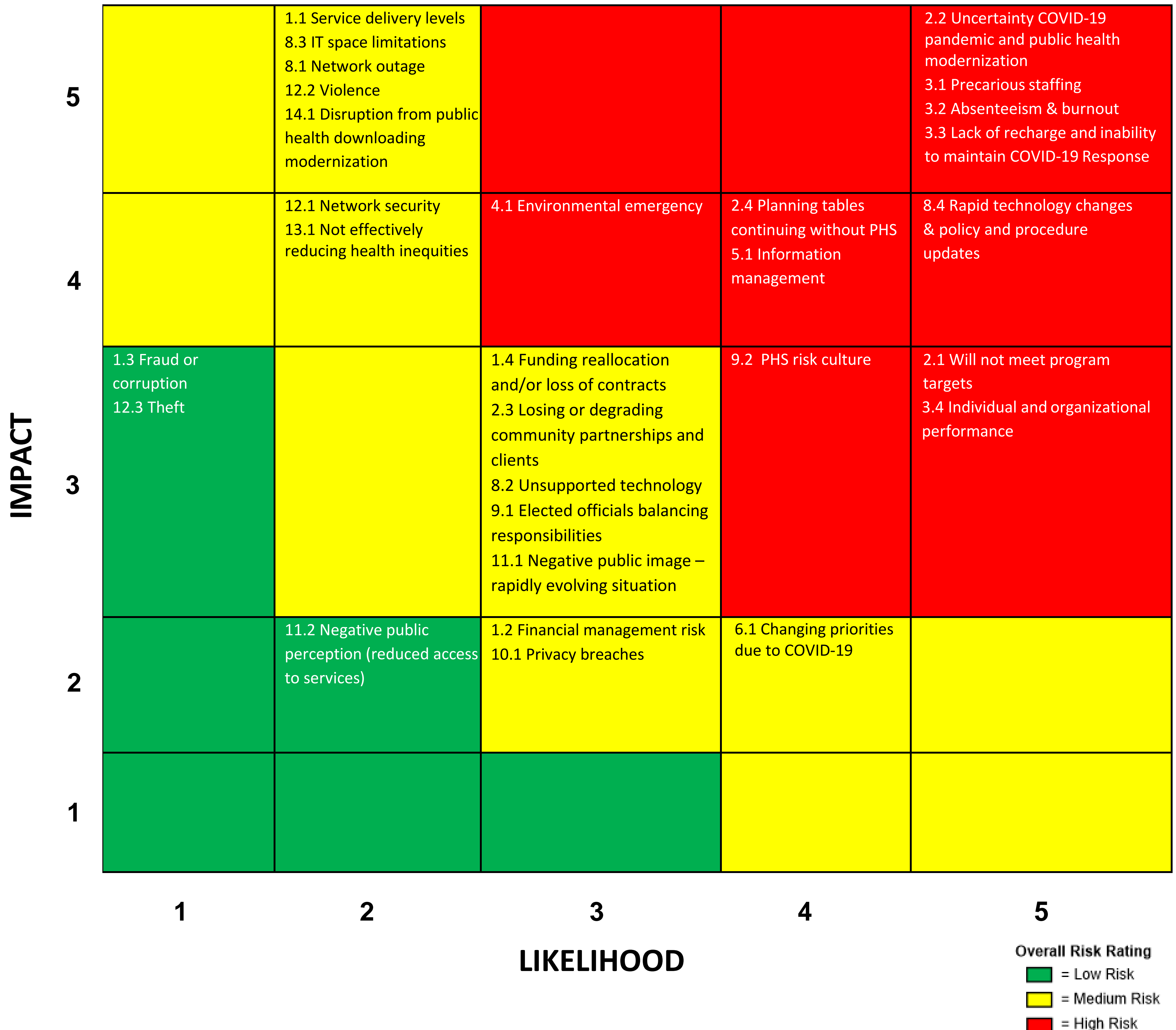
## APPENDICES AND SCHEDULES ATTACHED

Appendix "A" to BOH21003(a): 2021 PHS Organizational Risk Management Progress Report

Appendix "B" to BOH21003(a): Ontario Public Service Risk Management Strategy & Process Toolkit

## 2021 Public Health Services Organizational Risk Management Plan

The chart below shows the **current ratings** for 2021 risks categorized by low, medium, high.



**City of Hamilton Public Health Services Organizational Risk Framework**

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

## Progress Update for High-Risk Items

| RISK IDENTIFICATION | | | | RISK ASSESSMENT | | | RISK REDUCTION | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **ID #** | **Risk Exposure** | **Description of Risk** | **Cause/Source of Risk** | **Current Mitigation Strategies (what are we doing)** | **Initial Rating - Jan 2021** Likelihoood (L) x Impact (I) | **Current Risk Rating - Nov 2021** (L x I) | **Planned Actions** | **Timelines** | **Progress to Date** | **Anticipated Residual Risk** (once action plan fully implemented) (L x I) |
| **1. Financial Risks** | | | | | | | | | | |
| **1.2** | The Board of Health may have financial management risk due to financial forecasting gaps. | Accurate financial forecasting may be challenging given the uncertainty and lack of timely provincial information for financial forecasting with the additional uncertainty of COVID-19 costs and costs that will extend beyond COVID-19 (e.g. technology asset leases), budget approval through the City and province is delayed relative to expenditures. | COVID-19 costs, City budget not approved until March/April, Provincial funding approval in Fall. | 1. Using past, current and projected financial conditions to increase forecast accuracy.<br>2. Utilize the fee for service and free platforms where possible<br>3. Reallocation of funds (e.g., mileage and parking costs may further decrease if more services are offered virtually) | L4, I4 | L3, I2 | 1. Using past, current and projected financial conditions to increase forecast accuracy.<br>2. Using the fee for service and free platforms where possible.<br>3. Reallocation of funds (e.g., mileage and parking costs may further decrease if more services are offered virtually). | 1. Ongoing<br>2. Ongoing<br>3. Ongoing | 1. Full forecasts were completed in June and August. To increase accuracy of forecasts the following was included: actual cost to date, a complete review of cost down to each employee, estimation of amount of time temp employees would be required, and Scarsin COVID-19 Forecasting.<br>2. DARTS services were used for transportation at no cost. Full cost recovery of "It's your Shot" T shirts sold to non-PHS staff.<br>3. All saving in Mandatory programs in 2021 including employee relates cost and operations costs were applied against COVID-19 costs. HBHC unspent budget up to March 31, 2021 was reallocated to the support COVID-19. Child Services and Neighborhood Development was able to use some funding to support COVID-19 by providing additional staff at no additional cost to PHS. | L3, I2 |
| **2. Operational or Service Delivery Risks** | | | | | | | | | | |
| **2.1** | The Board of Health will not meet program targets due to the lack of capacity for regular programming during the COVID-19 response. | Lack of capacity due to COVID-19 response has resulted in resources being unavailable for programs to run as planned and meet targets. | Lack of capacity due to COVID-19 response. | 1. Continue to provide services as capacity allows<br>2. Clear communication regarding current limitations to public and funders<br>3. Seize opportunities as they arise to provide new service delivery models to increase reach during COVID-19 restrictions<br>4. Continue to evaluate risk ratings to balance risks across programs | L5, I4 | L5, I3 | 1. Continue implementing change management strategies to support staff and maintain adapted service delivery levels as capacity allows.<br>2. Clear communication regarding current limitations to public and funders.<br>3. Seize opportunities as they arise to provide new service delivery models to increase reach during COVID-19 restrictions. | 1. Ongoing<br>2. Ongoing<br>3. Ongoing | 1. Service delivery levels have been maintained and capacity to reopen additional services is re-evaluated on an ongoing basis by PHLT. Change management strategies have been implemented to support staff as capacity is re-evaluated.<br>2. Continue to communicate the public and have ongoing discussions with partners regarding limited capacity and resources for COVID-19 response and vaccination.<br>3. Continue to use new service delivery models (e.g. virtual care) | L5, I3 |
| **2.2** | The Board of Health will need to manage the risks of uncertainties of how COVID-19 will play out, how work is being done, and public health modernization (including broader legislation and frameworks) | Uncertainties due to the COVID-19 response, changes in how organizations work, and changes related to public health modernization. | Unknown impact of COVID-19 on organizations and regulatory frameworks/policy | 1. Continue to work with the corporation on how we manage the workplace going forward<br>2. Continue to re-evaluate risk ratings and resources needed for program re-opening for both COVID-19 Response and Business Continuity<br>3. Continue to participate in provincial discussions on future of health services | L5, I5 | L5, I5 | 1. Intelligence gathering and monitoring regarding system changes related to COVID and public health modernization<br>2. Advanced planning for reopening based on gathered intelligence<br>3. Provide regular updates to Council on status of recovery/re-opening post-COVID and public health modernization | 1. Ongoing<br>2. Ongoing<br>3. Ongoing | 1. Continue to gather intelligence and monitor system changes related to COVID-19 and PH modernization.<br>Monthly updates provided to BOH and staff.<br>2. Advanced plans have been developed and implemented including: PHS Recovery Plan (internal/organizational), Equitable Recovery Plan, COVID Vaccine & Disease Control transition plans for Summer and Fall 2021.<br>3. Continue to provide regular updates to BOH and Council including: transition plans, status of program reopening BOH Governance Education Session and PH modernization (as available). | L4, I4 |
| **2.4** | The Board of Health is at risk of significant community planning tables moving ahead without PHS involvement (e.g., GHHN, Hamilton Community Safety & Well-Being Plan) | The longer programs are closed the longer time the tables go without PHS input, expertise, and intelligence support. | Resources shifted to focus on COVID-19 response. | 1. Engage when with community planning tables when capacity allows<br>2. Regular communication with partners regarding where PHS is at and what our capacity is, keeping us engaged and included in communications.<br>3. Share information about why PHS is not currently engaged and what work we are currently doing (i.e. staff are deployed to COVID-19) | L4, I5 | L4, I4 | 1. Regular communication with partners regarding PHS limited capacity and reaffirm commitment to engage when capacity allows<br>2. Re-engage with community planning tables as capacity allows | 1. Ongoing<br>2. Ongoing | 1. Continue to communicate with partners regarding limited capacity and resources for COVID-19 response and vaccination.<br>2. Relationships with partners have been cultivated and strengthened through the Hamilton COVID-19 Response Table. In Q4, PHS started to re-engage with community planning tables (e.g., GHHN, Safe Transitions, Drug Strategy, Climate Change, etc.) and will continue to re-engage in 2022 as capacity allows . | L4, I4 |
| **3. People / Human Resources** | | | | | | | | | | |
| **3.1** | The Board of Health may be at risk of precarious staffing. | Due to COVID-19, recruitment is difficult with more competition for certain core PH positions (PHN, PHI, etc.), more retirements are expected to continue through 2021 (similar to 2020), decreased work satisfaction during the COVID-19 response. | COVID-19 response has impacted staffing levels across business continuity and COVID-19 response. | 1. Succession and workforce planning<br>2. Regular assessment of program risk ratings in relation to current vacancies across the department<br>3. Change management strategies including open and transparent communication about staff capacity | L5, I5 | L5, I5 | 1. Regular assessment of program risk ratings in relation to current vacancies across the department to proactively identify staffing needs<br>2. Complete succession planning and ensure sequencing when staff onboarding to transfer knowledge for all program areas<br>3. Identify opportunities for new work allies (e.g. co-op students) to build capacity<br>4. Ensure contracts are as long as possible (e.g. min 1 year) to retain staff | 1. Ongoing<br>2. Ongoing<br>3. Ongoing<br>4. Ongoing | 1. Reviewed program risk ratings and FTEs in relation to current vacancies as part of Summer and Fall transition planning. These continue to be reviewed regularly as part of recovery/re-opening planning.<br>2. PHLT met with HR to discuss challenges with succession planning based on the COVID-19 context.<br>3. Leveraged student nurses for COVID vaccine (total of 113) as well as Ministry case and contact management staff through the COVID-19 response to increase capacity.<br>4. All recent temporary new hires (PHNs, Contact Tracers, Data Entry, Vaccine Couriers) have an end date of May 31, 2022. Where required, temp contracts have also been extended. | L4, I3 |

| RISK IDENTIFICATION | | | | RISK ASSESSMENT | | | RISK REDUCTION | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| ID # | Risk Exposure | Description of Risk | Cause/Source of Risk | Current Mitigation Strategies (what are we doing) | Initial Rating - Jan 2021 Likelihoood (L) x Impact (I) | Current Risk Rating - Nov 2021 (L x I) | Planned Actions | Timelines | Progress to Date | Anticipated Residual Risk (once action plan fully implemented) (L x I) |
| 3.2 | The Board of Health may be at risk of higher employee absenteeism and burnout resulting from increased stress and decreased work satisfaction during the COVID-19 response. | The longer we remain in COVID-19 response, the more staff are likely to experience negative impacts to their health and well-being. Significant impact to staffing capacity with increased/longer staff absences. Difficult to mitigate with lack of staffing capacity. Some staff have identified that they are experiencing monotony in their jobs, lack of control over their roles, and heavy workloads. | Change fatigue, personal stress, uncertainty related to COVID-19 response | 1. Continued focus on health & wellness<br>2. Ensure staff take vacation<br>3. Ensure adequate staffing (including backup / coverage for critical staff in both business continuity and COVID-19)<br>4. Succession planning<br>5. Leadership role modeling healthy work habits<br>6. Increase opportunities for choice/control<br>7. Supportive approach to 7 days/week schedules (e.g. sent out well ahead of time)<br>8. Explore opportunities to hire more staff for key positions | L5, I5 | L5, I5 | 1. Ensure execution on strategies to manage workload and ongoing demands related to COVID-19 Response<br>2. Where feasible and possible turn over some sense of control/choice/ownership to staff (e.g. job assignment, supportive work schedule, diversify work plan)<br>3. Ensure adequate staffing and explore opportunities to hire more staff in key positions (including backup / coverage for critical staff in both business continuity and COVID-19)<br>4. Continue to review guidelines in clinical areas to streamline workload (e.g. case management guidelines in sexual health)<br>5. Participate in cross-sectoral working group for Health and Community Care Worker Wellness | 1. Ongoing<br>2. Ongoing<br>3. Q1 2021<br>4. Q1 2021<br>5. Ongoing | 1. Brought on more resources and not decreasing resource over Summer / Fall to allow for vacation time.<br>2. Limited ability to implement due to current demands, will continue to re-evaluate feasibility.<br>3. Additional staff have been hired to support COVID-19; however, health and human resources continue to be stretched due to the length of the emergency response.<br>4. Case management work instructions for Chlamydia, Gonorrhea and Syphilis follow-up, low risk enteric diseases were revised in order to streamline processes and reduce workload.<br>5. Continue to participate in cross-sectoral working group for Health and Community Care Worker Wellness. PHS staff also participated in a Health Care Worker Wellness survey in Q2 2021. Results have been shared with staff and are being used to identify strategies to support staff and their well-being. | L5, I3 |
| 3.3 | Board of Health may be at risk of lack of recharge and inability to maintain intensity and level of COVID-19 response. | Lack of respite and recharge due to the intensity of the COVID-19 response may result in degrading of effective leadership capabilities. | Intensity and unrelenting nature of the COVID-19 response. | 1. Ensure vacations and time off are taken with appropriate back up support in place<br>2. Build up capacity for leadership within COVID Response | L5, I5 | L5, I5 | 1. Ensure vacations and time off are taken with appropriate back up support in place<br>2. PHLT to monitor vacation balances monthly<br>3. Ensure sufficient leadership and key personnel capacity within COVID Response to share the workload | 1. Ongoing<br>2. Ongoing<br>3. Q1 & Ongoing | 1. All staff have been encouraged to take vacation and time off. Leaders ensured sufficient capacity and back-up support within programs to allow staff time off.<br>2. PHLT continues to monitor vacation balances on a monthly basis.<br>3. PHLT has regularly reviewed the FTE requirements for both COVID-19 and Business Continuity (i.e., Summer 2021, Fall 2021, Winter 2022) and made adjustments as required to ensure sufficient leadership and key personnel capacity. Capacity of management resources remain strained due to lack of staffing, degree of change and length of emergency response. | L5, I3 |
| 3.4 | Board of Health may be at risk of performance at the individual and organizational level being impacted by reasons above [3.1 - 3.3] including transition back to post COVID-19 work environment. | In addition to risks due to recruitment, retention, and job stress, adjustment to post-COVID reality may be difficult for staff who may need to move to different roles or may need to develop further competencies for new roles. | Unknow impact of COVID-19 on capacity and work environment. | 1. Advanced planning and open and transparent discussions of where PHS is headed as we move into reopening, change management, and assess and develop competencies. | L5, I5 | L5, I3 | 1. Undertake advanced planning as PHS transitions to reopening (including aligning staff to roles that match new skills gained during pandemic response)<br>2. Open and transparent change management as PHS transitions to reopening<br>3. Assess and develop competencies of new PHS staff to set up for success in other roles | 1. Ongoing<br>2. Ongoing<br>3. Q1 & Q2 | 1. Advanced planning is ongoing. Priority areas within the PHS Recovery Plan have been identified and work will commence in Q4 2021.<br>2. Staff are developing open and transparent change management strategies as part of the reopening and transition planning. These will be implemented as the reopening plan rolls out.<br>3. Several staff have been cross-trained to assume different roles in order to increase capacity as needed (e.g., PHIs cross-trained in Outbreak Management and Infection Prevention & Control, and PHNs trained in outbreak management). | L5, I3 |
| **4. Environmental Risks** | | | | | | | | **4. Q1 2021** | | |
| 4.1 | The Board of Health may be at risk from a natural, technological or human-caused emergency impacting the environment. | An environmental emergency could lead to risk exposure in terms of loss or reallocation of resources leading to potential legislative non-compliance and/or negative public image | Natural hazards (e.g., climate change, extreme weather). | 1. Emergency Response Plan, Business Continuity Planning, hazard specific plans, participation in Corporate Climate Change Task Force, Building Adaptive & Resilient Communities work. | L3, I4 | L3, I4 | 1. Adapt emergency management plan and response structure in the event of a natural hazard. | 1. As needed | 1. There has been no need to adapt the emergency management plan and response structure thus far in 2021. | L3, I2 |
| **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 as well as time pressures to manage the pandemic. | 1. Internal Privacy, Security and Information Management work group at public health to address information management concerns. | L4, I4 | L4, I4 | 1. Create and rollout policies to support Records and Information Management Framework<br>2. Coordinated clean up of staff personal drives (m-drive) and shared drives<br>3. Establish and implement consistent practices for information management on shared drives<br>4. Explore implementation of Document & Records Management Software | 1. Q1 / Q2 2022<br>2. Q3 / Q4 2022<br>3. Q3 / Q4 2022<br>4. 2022 | 1. On-hold. Timeline has been revised to Q4 2022 as staff still demobilized to COVID-19.<br>2. On-hold. Timeline has been revised to 2023 as staff still demobilized to COVID-19.<br>3. On-hold. Timeline has been revised to 2023 as staff still demobilized to COVID-19.<br>4. On-hold. Timeline has been revised to 2023 as staff still demobilized to COVID-19. | L3, I2 |
| **6. Strategic / Policy Risks** | | | | | | | | | | |
| 6.1 | The Board of Health is at risk of changing priorities due to COVID-19 recovery. | Potential for provincial strategic priorities to shift as a result of COVID-19 recovery and the forthcoming provincial election.<br>New priorities may not align with those of the City of Hamilton. This may impact the programs and services delivered by public health. | Pandemic response, unintended consequences, post COVID-19 recovery and 2022 provincial election. | 1. Advance planning for COVID-19 recovery.<br>2. Continue advocacy and provide input on issues/priorities related to public health. | L5, I5 | L4, I2 | 1. Advanced planning to adapt PHS priorities to align with emerging provincial and regional priorities and address the disproportionate impacts of COVID-19<br>2. Share emerging provincial and regional priorities with other City of Hamilton departments as appropriate to determine alignment | 1. Ongoing<br>2. Ongoing | 1. Priorities have been identified. Work on these priorities will commence Q4 2021 and continue through 2022.<br>2. Priorities were shared with BOH in September 2021 and will be shared with other City of Hamilton departments in 2022 as appropriate to ensure alignment. | L4, I2 |
| **8. Technology Risks** | | | | | | | | | | |

| RISK IDENTIFICATION | | | | RISK ASSESSMENT | | | RISK REDUCTION | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **ID #** | **Risk Exposure** | **Description of Risk** | **Cause/Source of Risk** | **Current Mitigation Strategies (what are we doing)** | **Initial Rating - Jan 2021** Likelihoood (L) x Impact (I) | **Current Risk Rating - Nov 2021** (L x I) | **Planned Actions** | **Timelines** | **Progress to Date** | **Anticipated Residual Risk** (once action plan fully implemented) (L x I) |
| **8.4** | The Board of health may be at risk of not updating policies and procedures quickly enough to keep up with rapidly changing new technology nor having capacity to review and align with data management best practice. | With rapid implementation of new technology and processes (e.g. COVAX), staff may not understand their responsibilities and accountability related to data management best practices. | Rapid changes and implementation of new processes and provincial direction due to nature of the COVID-19 response. | 1. Optimize current state processes used for COVID response deployments /redeployments and offboarding)<br>2. Negotiate, collaborate with the province in the development, piloting, and implementation of new systems<br>3.Work with legal to develop appropriate agreements with other outside agencies where applicable (e.g. PHS/ SJHH COVAX Agreement) | **L5, I4** | **L5, I4** | 1. Rely on provincial guidelines for new technology as applicable<br>2. Streamline and communicate regularly updated work instructions<br>3. Involve privacy and legal in review of guidelines and policies as needed<br>4. Resume centralization of onboarding<br>5. Resume centralization of offboarding<br>6. Approval and implementation of new/updated data management policies and procedures. | 1. Ongoing<br>2. Ongoing<br>3. Ongoing<br>4. TBD<br>5. TBD<br>6. TBD | 1. Continuing to rely on provincial guidelines for new technology as applicable (i.e. CCM, COVAX)<br>2. Continuing to streamline and communicate updated work instructions regularly (i.e. CCM, COVAX) with staff and relevant community partners<br>3. Continuing to involve privacy and legal in review of guidelines and policies as needed (i.e. CCM, COVAX)<br>4. Currently on-hold<br>5. Currently on-hold<br>6. Currently on hold | **L5, I3** |
| **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. | 1. Continue using the PHS Risk Management Framework to identify and assess organizational risks. | **L4, I3** | **L4, I3** | 1. Incorporate the PHS Risk Management Framework into program and project planning. | 1. Q4 2021 | 1. On-hold. Plan to look at how the PHS Risk Management Framework can be incorporated into reopening and transition planning. Aim to incorporate into annual program planning process in Q4 2022, recognizing this will be a cultural shift and may take longer to normalize. | **L3, I2** |

# RISK MANAGEMENT STRATEGY & PROCESS TOOLKIT

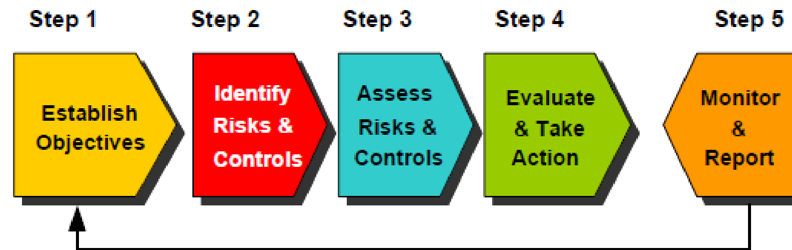
### Step 1: Establish objectives

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

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

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

### The risk management process




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

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

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

### Step 2: Identify risks & controls

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

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

### 14 categories of risk

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

# RISK MANAGEMENT STRATEGY & PROCESS TOOLKIT

## Step 3: Assess Risks & Controls

Assess inherent risks

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

Assess controls

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

Reassess residual risks

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

**Key Risk Indicators (KRI)**

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

**Risk Tolerance**

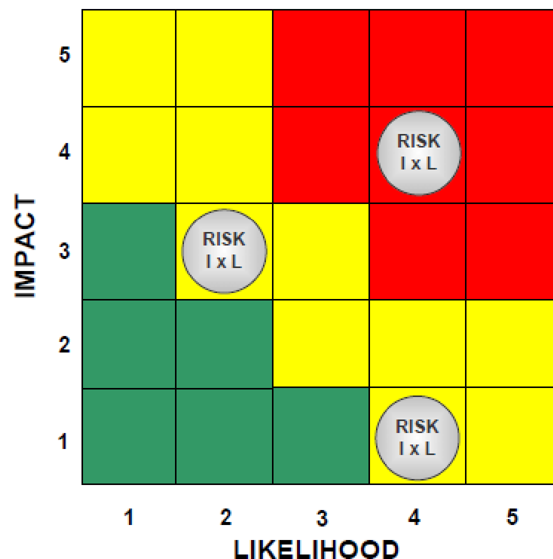
- The amount of risk that the area being assessed can manage

**Risk Appetite**

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

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

## RISK PRIORITIZATION MATRIX




## Step 4: Evaluate & Take Action

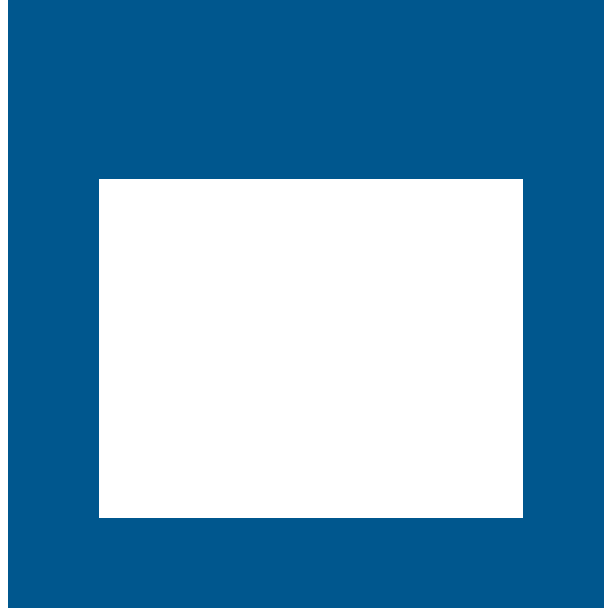
- Identify risk owners.
- Identify control owners.
- Have mitigation strategies reduced the risk rating (Impact x Likelihood) enough that the risk is below approved risk tolerance levels?
- Do you need to implement further mitigation strategies?
- Develop SMART (Specific, Measurable, Achievable, Realistic,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

## Step 5: Monitor & Report

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

## Definitions

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



# Public Health Services COVID-19 Situation Report & Organizational Update

Board of Health

November 15, 2021

Dr. Elizabeth Richardson

Public Health Services
Office of the Medical Officer of Health

# Overview

1. Overall Status
2. COVID-19 Situation Report
3. Scarsin Forecast
4. COVID-19 Vaccine
5. Current Public Health Services Priorities

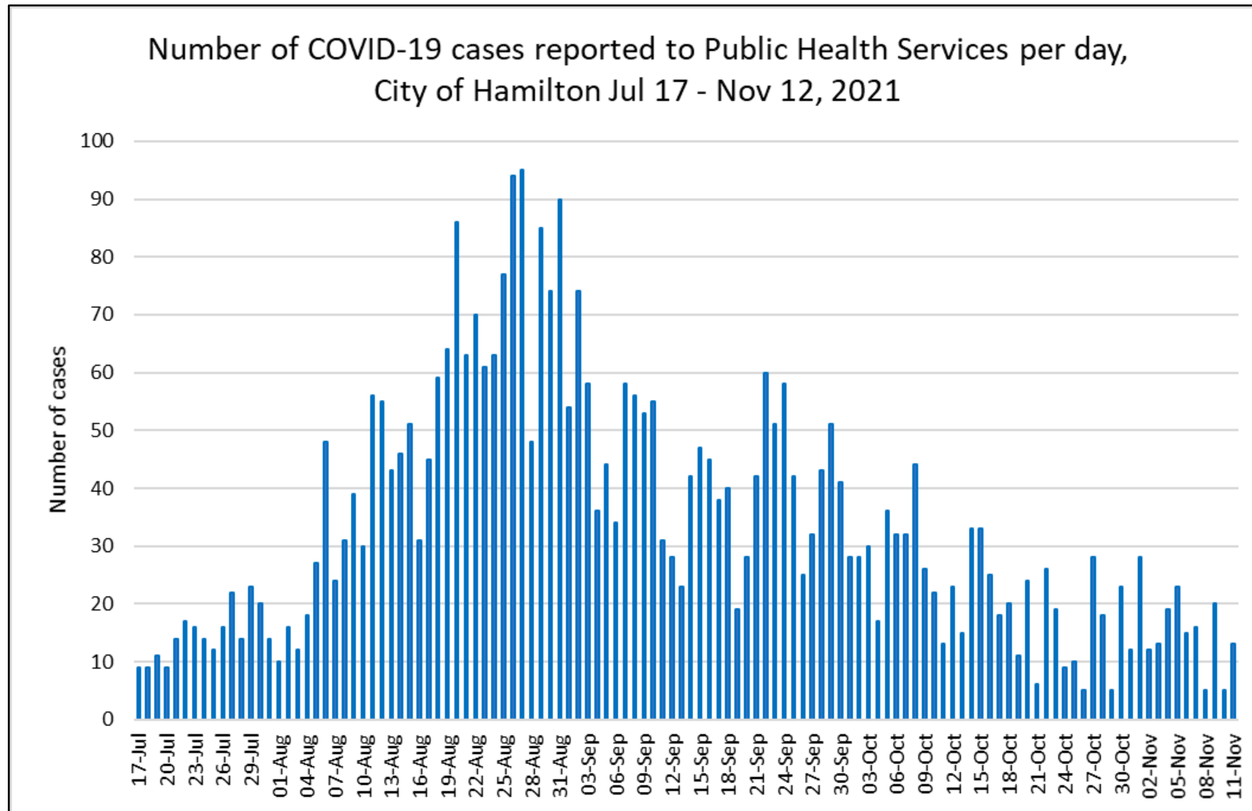
# Overall Status

- Case and outbreak activity in Hamilton has been maintaining at current levels for several weeks
- Provincial pause in reopening due to increase in case activity.
- As of November 11, 2021: 871,132 doses given; 85.6% of Hamiltonians 12yrs+ vaccinated with one dose and 82.2% with both doses
- Updated Scarsin forecast indicates that Hamilton can anticipate an increase in cases with increased transmission risk due to increased indoor activities and reopening, however severe outcomes such as hospitalization should be modest
- Control of COVID-19 remains dependent on both vaccination and the practice of public health measures

# Situation Report

Stephanie Hughes, Epidemiologist

# Reported Cases




## Key Messages

- Hamilton is in Wave 4 of COVID-19 and maintaining at current activity levels
- As of November 12, 2021 there were 15 cases of COVID-19 reported to Hamilton Public Health per day on average

Hamilton

Public Health Services
Office of the Medical Officer of Health

# Phases of COVID-19 in Hamilton – Wave 4

**Phase 1: Pre-peak**
Jul 17 – Aug 16, 2021
(1 month)

- 757 cases reported
- 14 outbreaks
- 47 hospitalizations and 4 deaths
- Outbreaks occurring in workplace, child care, communal living settings
- Stage 3 – Provincial Roadmap to Reopen
- Vaccine doses administered decreased

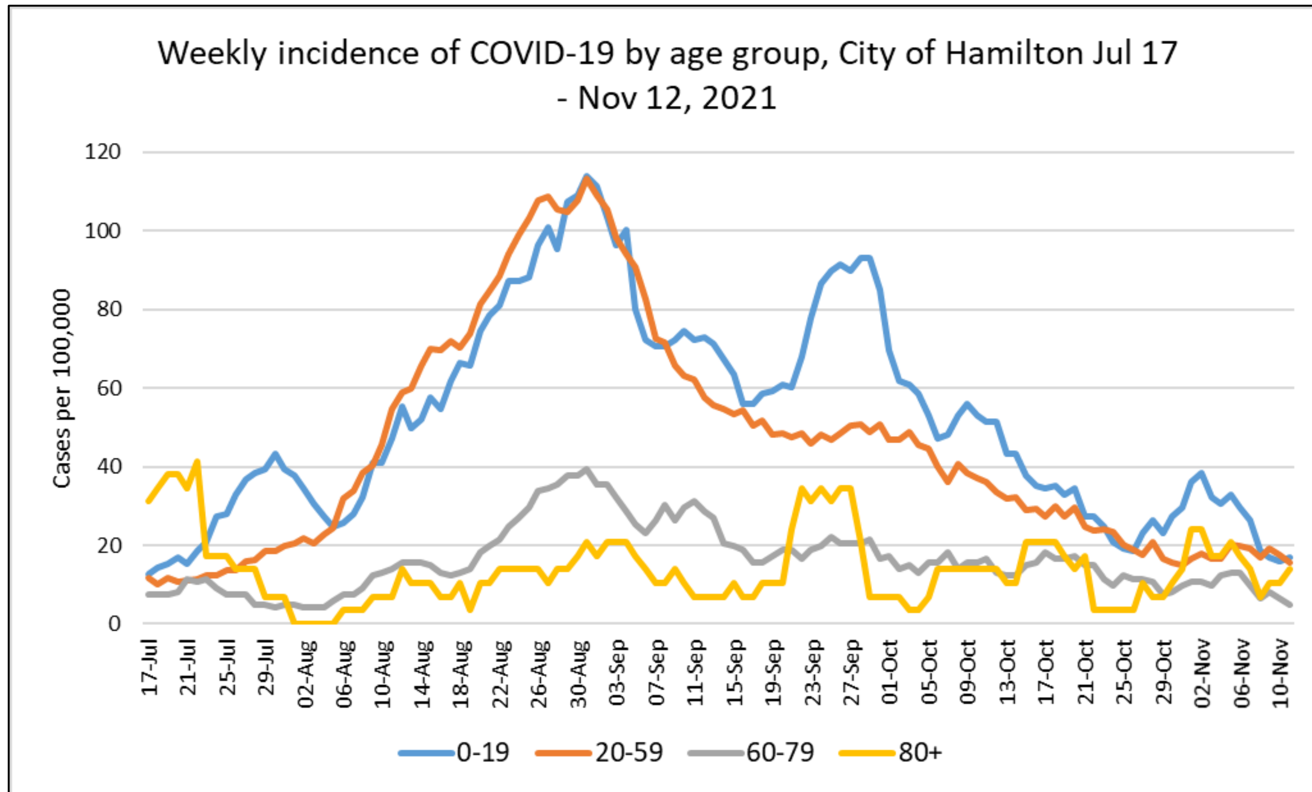
**Phase 2: Peak**
Aug 17 – Sept 1, 2021
(0.5 month)

- 1,128 cases reported
- 22 outbreaks
- 67 hospitalizations and 3 deaths
- Outbreaks occurring in workplace, child care, athletic settings
- Provincial reopening stages paused, maintenance of public health measures
- Introduction of hyper-local vaccine clinics to areas of Hamilton with lower vaccine coverage

**Phase 3: Post-peak**
Sept 2 – Nov 12, 2021
(2.5 months)

- 2,094 cases reported
- 76 outbreaks
- 124 hospitalizations and 13 deaths
- Outbreaks occurring in workplace, child care, school, athletic, banquet hall, communal living settings
- Increase in indoor activity
- Vaccine passports implemented (ON)
- Increase in provincial cases

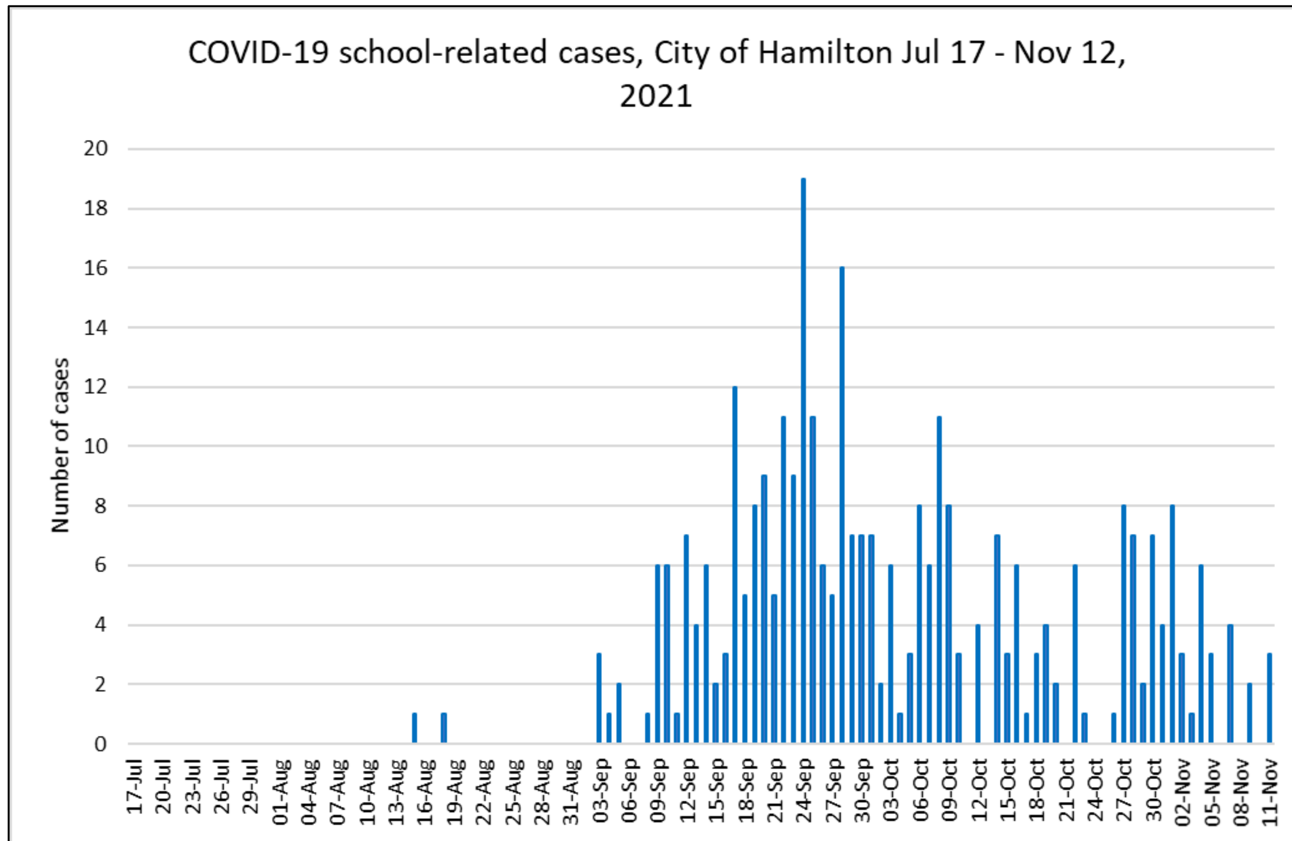
# Affected Age Groups




## Key Messages

- Wave 4 COVID-19 cases in Hamilton have been predominantly younger/middle-aged individuals (0-59 years)
- There have been recent increases in young individuals (0-19 years), which align with increases in school activity

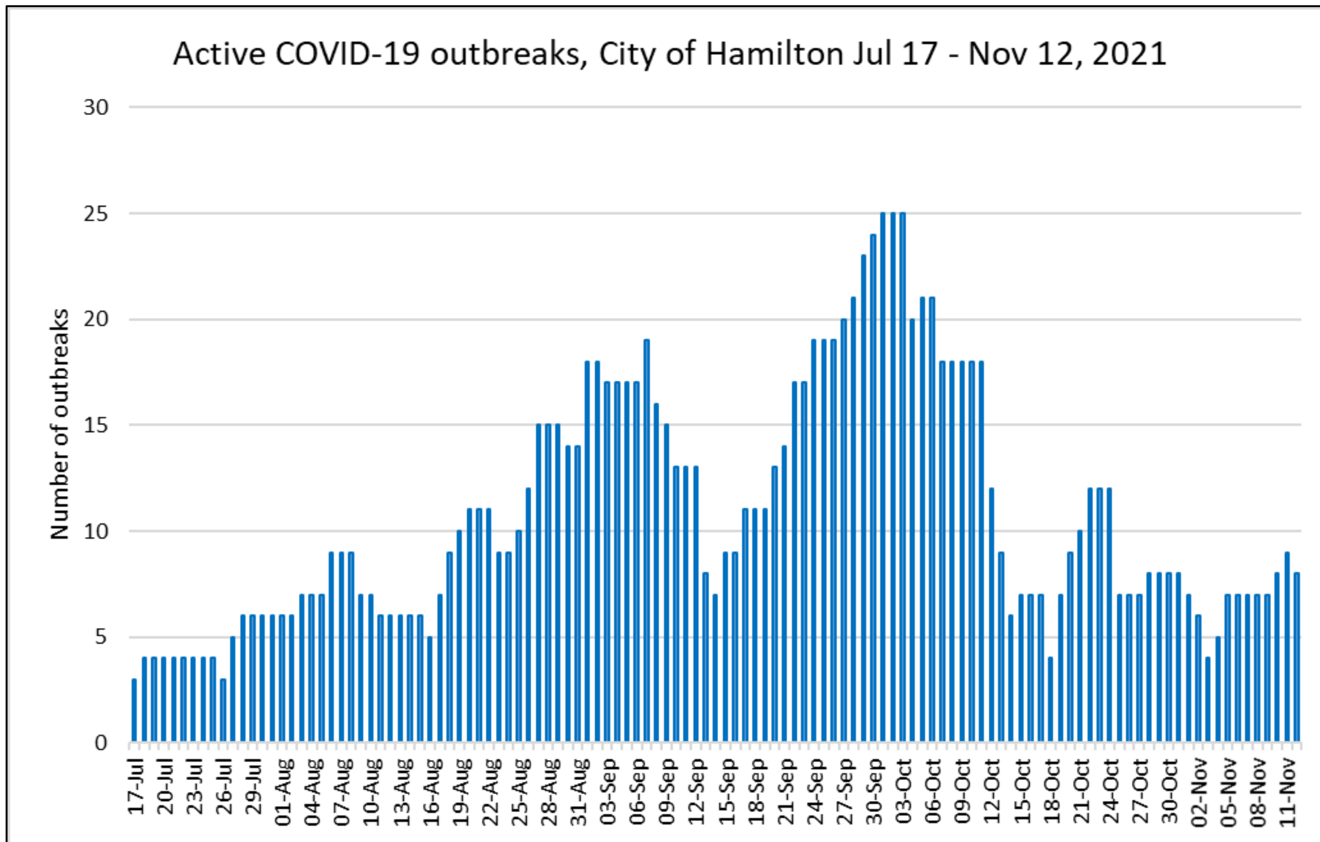
# Reported School-Related Cases




## Key Messages

- School-related COVID-19 case activity in Hamilton hit a peak near the end of September 2021
- As of November 12, 2021 school-related case activity was decreasing

# Active Outbreaks




## Key Messages

- COVID-19 outbreak activity in Wave 4 peaked around late September 2021
- The number of active COVID-19 outbreaks in recent weeks has been maintaining

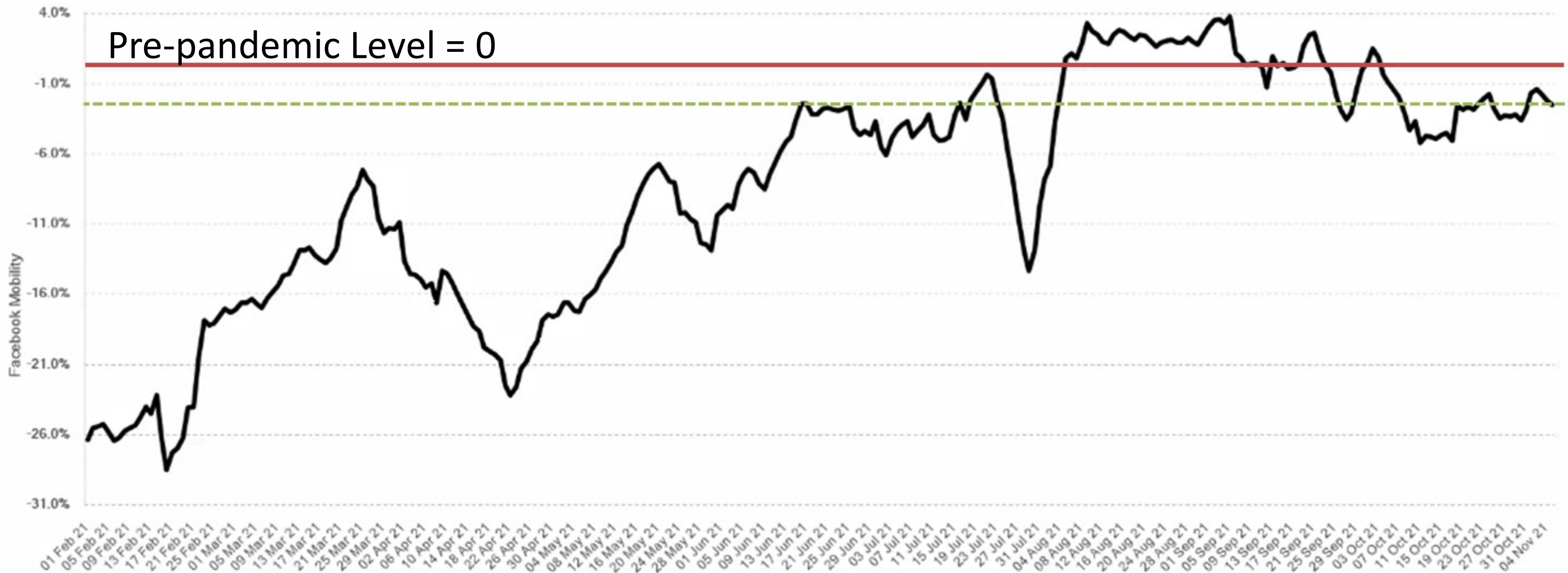
# SCARSIN FORECAST

Ruth Sanderson, Epidemiologist

# Scarsin Forecast

- Hamilton continues to navigate the delicate balance with reopening and control of COVID-19
- Sharing publicly for the first time forecasts that are extended out to the end of Jan 2022:
  - The forecasts continue to indicate that the use of public health measures will balance the increased transmission with increased indoor activities and reopening
  - The updated reopening forecast indicates that, while Hamilton can anticipate an increase in cases this year, severe outcomes, such as hospitalization, are forecast to be modest

# Overall Mobility, Hamilton

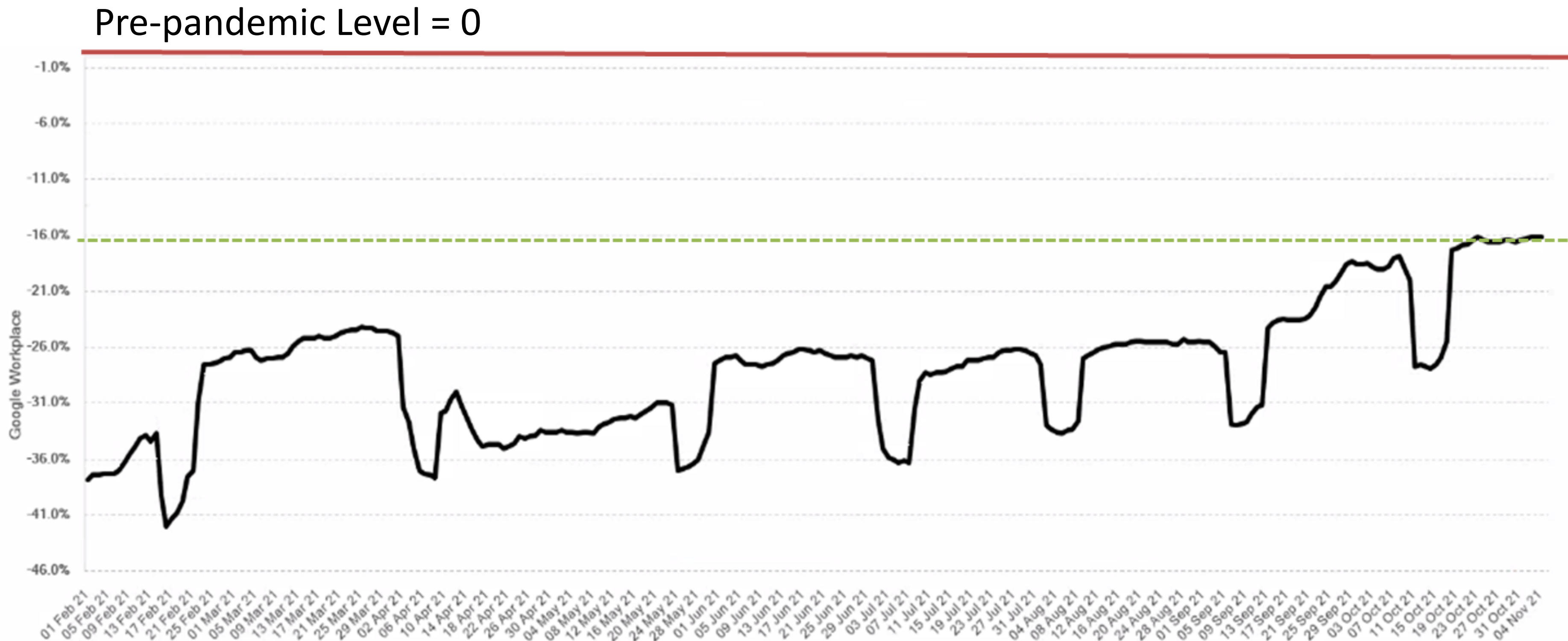



Data Source: Scarsin Decision Support System retrieved Nov 8, 2021

**Key Messages:**

Hamilton's community mobility levels remain just below pre-pandemic levels; now at -2% as of Nov 4, 2021.

# Workplace Mobility, Hamilton




Data Source: Scarsin Decision Support System retrieved Nov 8, 2021

**Key Messages:**

Workplace mobility has levelled off at 16% below pre-pandemic levels. Levels have not been this high in Hamilton since Mar 2020.

# Scarsin Forecast – Overview of Scenarios

**Scenario 1 – Maintained Public Health Measures (PHM)**
–Maintained public health measures (e.g., 70% masking to Jan 31, 2022)

**Scenario 2 – Reopening**
Reduced avoidance and physical distancing starting Nov 15, 2021, down to 0% by Feb 15, 2022, in community, workplaces, university & school settings. Masking at 60% to end of year then gradually declines to 0% by end of Mar 2022.

**Scenario 3 – Child Vaccination & Reopening**
Vaccination of 5–11-year-olds starting Dec 6, 2021; achieves 40% first dose vaccination by end of year, sets 8-week interval between.

**Scenarios Assume:**

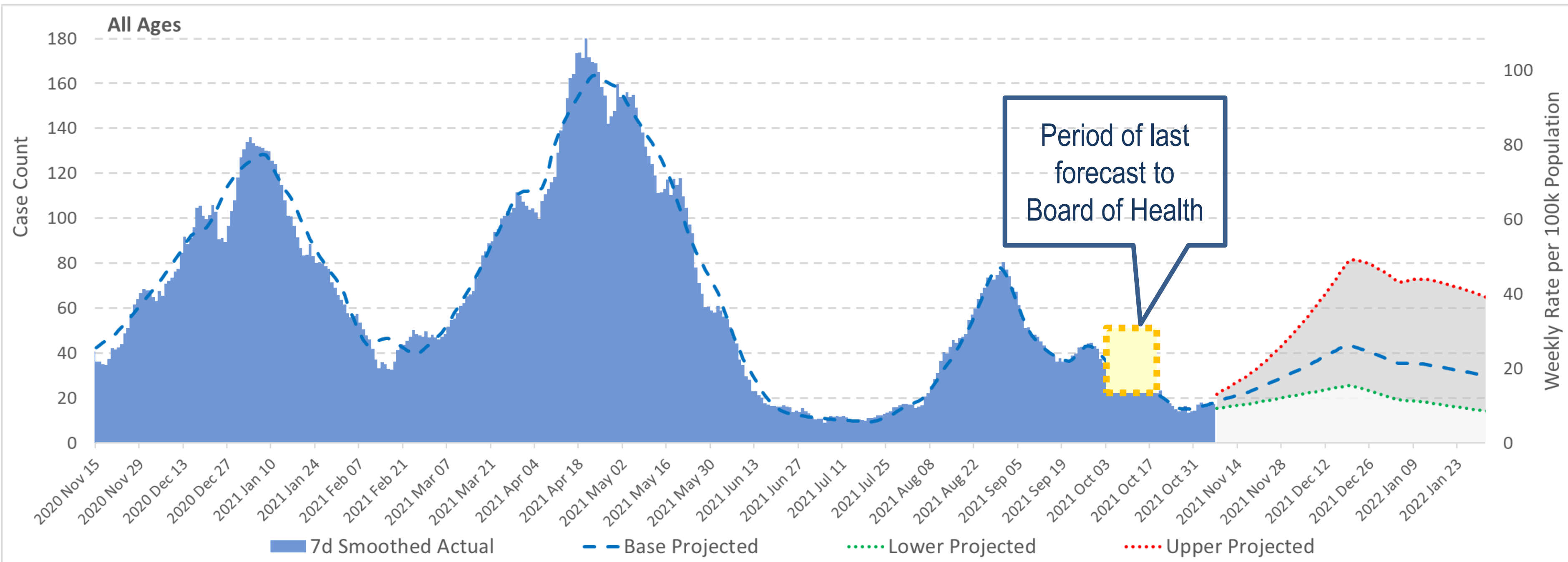
-- Increased transmission risk with increased activity
- indoors due to cooler weather and "reopening" activities
-- 80% vaccination in eligible population by late Oct 2021
- with continued vaccination
-- Maintained workplace mobility after Oct 2, 2021, so that
- it decreases to 12% below pre-pandemic levels by Jan 9,
- 2022; community mobility at 0% by Dec 31, 2021
-- Delta circulating at 99.5% of cases as of Sep 20, 2021
-- Immunity curves adjusted for vaccine type
-- First dose immunity adjusted for Delta
-- Reduced dosing interval to four weeks in Jul 2021
-- Fall in-class learning schools/ universities

**-Updated Data:**

**- Case data retrieved Nov 8, 2021**
**- Updated mobility data**
**- Vaccination data retrieved Nov 8, 2021**

# Scarsin Forecast

## Scenario 2 Reopening: COVID-19 Cases Among Hamiltonians



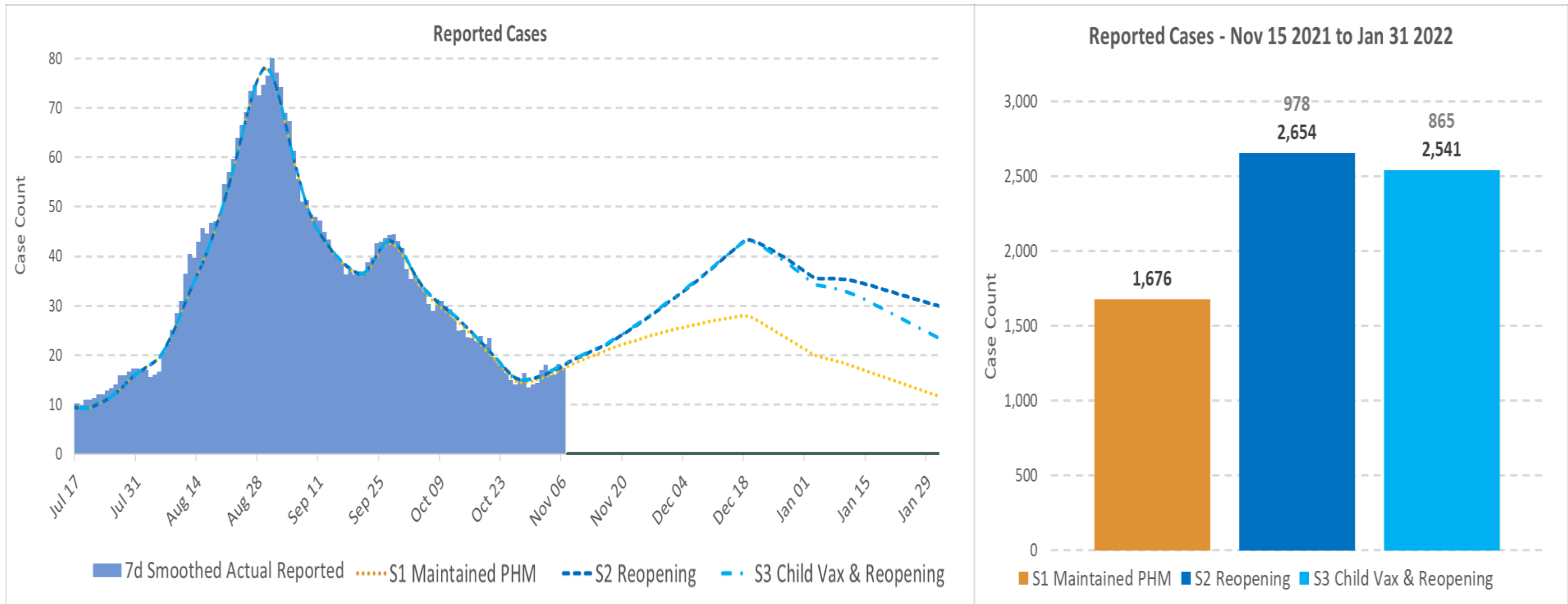

Data Source: Scarsin Decision Support System retrieved Nov 10, 2021

**Key Messages:**

Compared to this time last year, Hamilton is in a much better position due to continued public health measures and vaccination. A modest increase in cases is predicted in late Nov with "reopening" and added transmission risk from increased indoor activity (including reduced avoidance/ distancing after Nov 15, 2021). Cases may peak at 40 per day.

# Scarsin Forecast

## Scenario Comparisons, COVID-19 Cases Among Hamiltonians



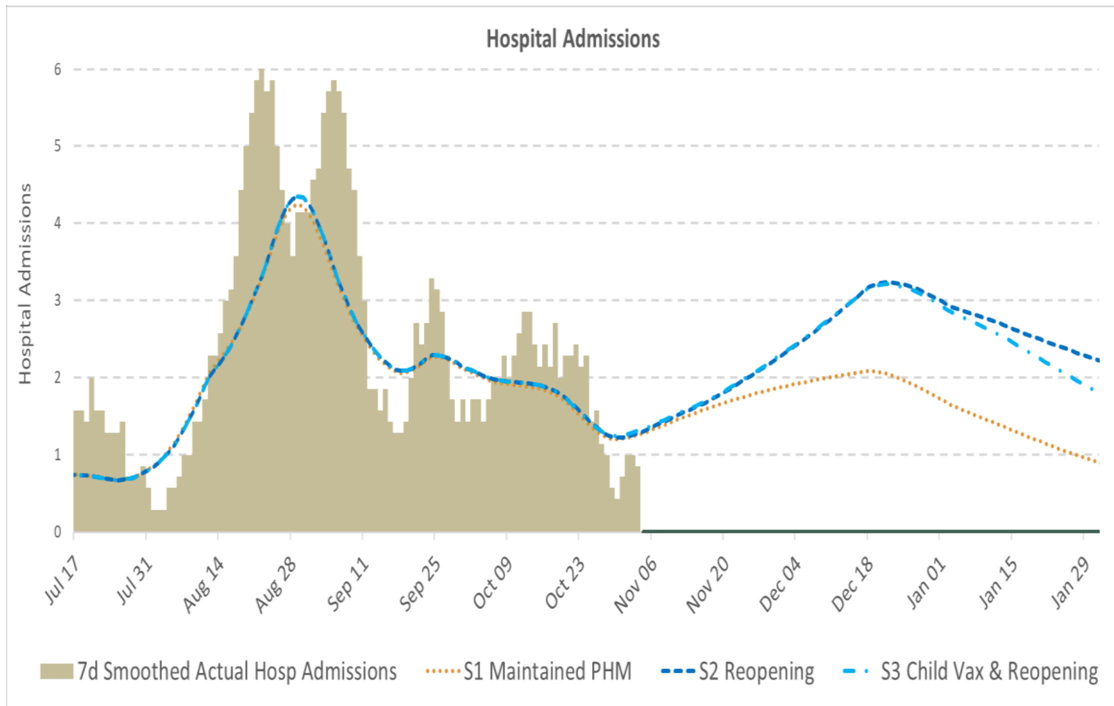

Data Source: Scarsin Decision Support System retrieved Nov 10, 2021

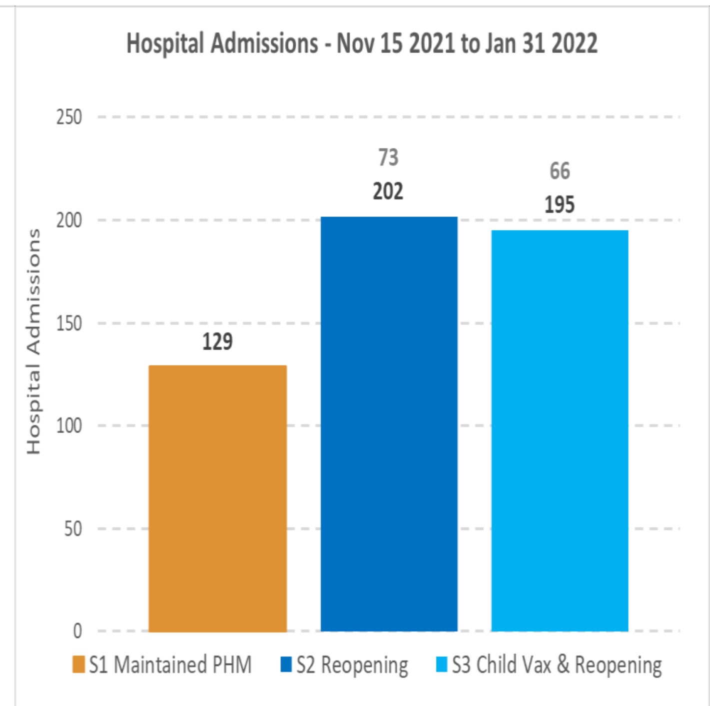
**Key Messages:**

Scenario 2 Reopening predicts 978 additional cases from Nov 15, 2021 – Jan 31, 2022, compared to Scenario 1 the previous base of maintaining all public health measures (PHM) in place to the end-of-the-year. Cases will primarily be among those aged 0-19yrs (32%) and 20-59yrs (57%). Vaccination of children aged 5-11yrs, starting in Dec 2021, will prevent 113 cases in the new year compared with the reopening scenario (Scenario 2).

# Scenario Comparisons, COVID-19 Hospital Admissions Among Hamiltonians

# Scarsin Forecast




Data Source: Scarsin Decision Support System retrieved Nov 10, 2021

## Key Messages:

Scenario 2-Reopening scenario predicts 73 additional hospital admission from Nov 15, 2021 – Jan 31, 2022, compared to Scenario 1 Maintained Public Health Measures. Admissions will primarily be among those aged 20-59yrs (75%) and 60-79yrs (17%). Vaccination of children 5-11yrs in Dec 2021 (Scenario 3), will prevent 7 additional hospitalizations in Jan 2022 compared with Scenario 2. Anticipate 13 deaths in Scenario 2 between Nov 15, 2021, and Jan 31, 2022; primarily in those over 60yrs (77%).

# Scarsin Forecast Summary

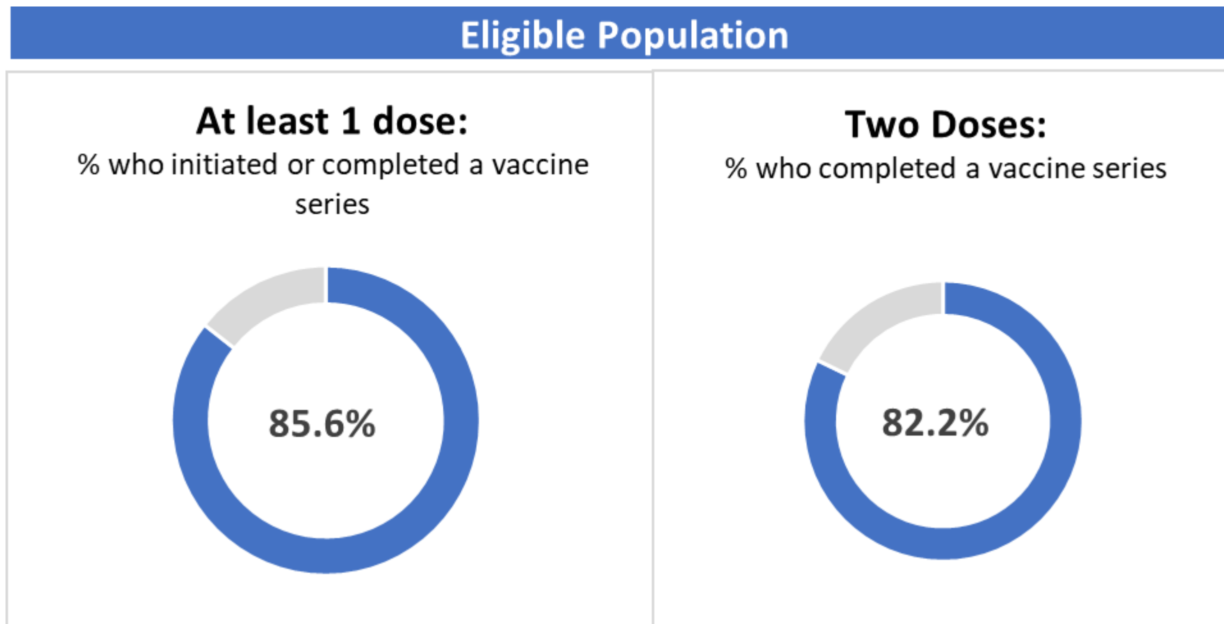
- Cases/ hospitalizations and deaths continue to be predicted to be lower out to the end of Jan 2022 than in Wave 3 and will likely remain below the levels previously reached in Wave 4
- A modest increase in cases (primarily in younger age groups) is expected in Nov/ Dec 2021 due to the increased risk of transmission as Hamiltonians move indoors and reopening continues
  - Continued use of public health measures can balance the anticipated increase in transmission
  - Vaccinating children aged 5-11yrs, starting in Dec 2021, is predicted to prevent 113 cases and 7 hospitalizations by the end of Jan 2022

# COVID VACCINE UPDATE

Melissa Biksa, Manager – COVID-19 Vaccine

# COVID-19 Vaccine – Overall Coverage

## Estimated as of End Of Day November 11, 2021




Note: Includes Hamilton residents and individuals vaccinated in Hamilton who cannot be assigned to a health unit region.
Eligible population includes individuals born in 2009 or earlier.
Sources: IntelliHealth (COVAXon Data Load); IntelliHealth (Population Projections, 2020).

# COVID-19 Vaccine – Coverage by First and Second Doses

## Estimated as of End Of Day November 11, 2021

| | Previous (Oct 29) | Previous (Nov 5) | CURRENT (Nov 12) | Trend |
|---|---|---|---|---|
| % change in first-dose coverage among Hamilton's eligible population in the past week | 85.1% (+0.3%) | 85.4% (+0.3%) | **85.6% (+0.2%)** | ↓ |
| % change in second-dose coverage among Hamilton's eligible population in the past week | 81.0% (+0.7%) | 81.6% (+0.6%) | **82.2% (+0.6%)** | ↓ |
| # of first- and second-doses administered to Hamilton residents in the past week | 4,926 | 4,171 | **3,786** | ↓ |
| ▪ % of first- and second-doses administered to Hamilton residents in Hamilton | 88.2% | 88.8% | **89.8%** | -- |
| ▪ % of first- and second-doses administered to Hamilton residents outside of Hamilton | 11.8% | 11.2% | **10.2%** | -- |

First doses remaining to achieve 90% vaccine coverage: **22,747**

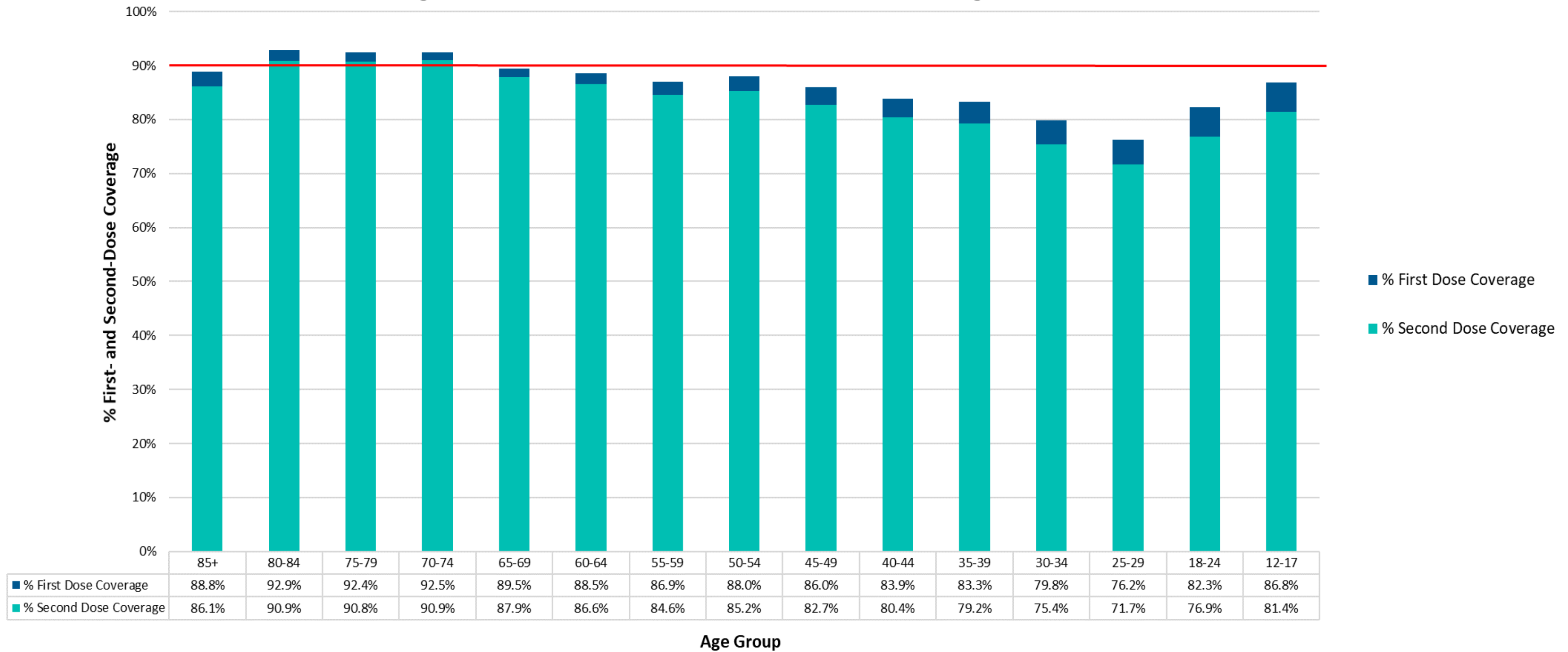
29,209 | 22,747

37,308 | 40,626

Sources: IntelliHealth (COVAXon Data Load); IntelliHealth (Population Projections, 2020).

# COVID-19 Vaccine – Coverage by Age

## Estimated as of End Of Day November 11, 2021

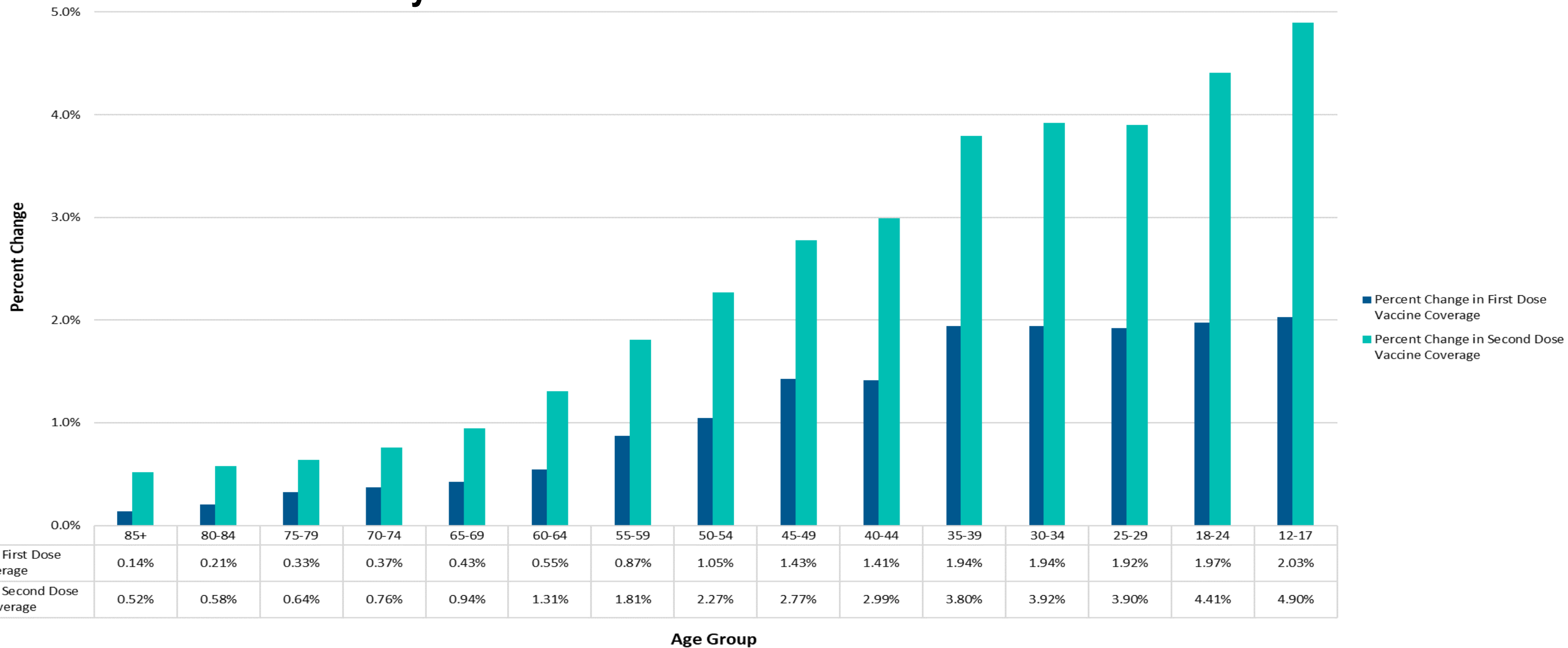



| | 85+ | 80-84 | 75-79 | 70-74 | 65-69 | 60-64 | 55-59 | 50-54 | 45-49 | 40-44 | 35-39 | 30-34 | 25-29 | 18-24 | 12-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % First Dose Coverage | 88.8% | 92.9% | 92.4% | 92.5% | 89.5% | 88.5% | 86.9% | 88.0% | 86.0% | 83.9% | 83.3% | 79.8% | 76.2% | 82.3% | 86.8% |
| % Second Dose Coverage | 86.1% | 90.9% | 90.8% | 90.9% | 87.9% | 86.6% | 84.6% | 85.2% | 82.7% | 80.4% | 79.2% | 75.4% | 71.7% | 76.9% | 81.4% |

Sources: IntelliHealth (COVAXon Data Load); IntelliHealth (Population Projections, 2020).

# COVID-19 Vaccine – Coverage by Age

## Estimated as of End Of Day November 11, 2021

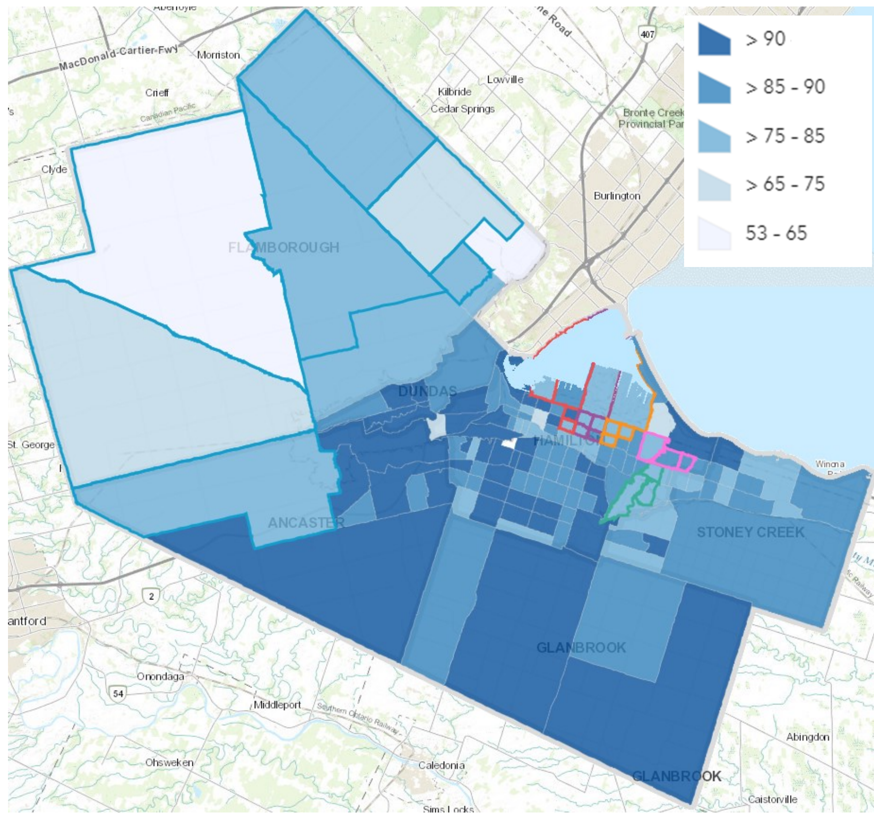



| | 85+ | 80-84 | 75-79 | 70-74 | 65-69 | 60-64 | 55-59 | 50-54 | 45-49 | 40-44 | 35-39 | 30-34 | 25-29 | 18-24 | 12-17 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Percent Change in First Dose Vaccine Coverage | 0.14% | 0.21% | 0.33% | 0.37% | 0.43% | 0.55% | 0.87% | 1.05% | 1.43% | 1.41% | 1.94% | 1.94% | 1.92% | 1.97% | 2.03% |
| Percent Change in Second Dose Vaccine Coverage | 0.52% | 0.58% | 0.64% | 0.76% | 0.94% | 1.31% | 1.81% | 2.27% | 2.77% | 2.99% | 3.80% | 3.92% | 3.90% | 4.41% | 4.90% |

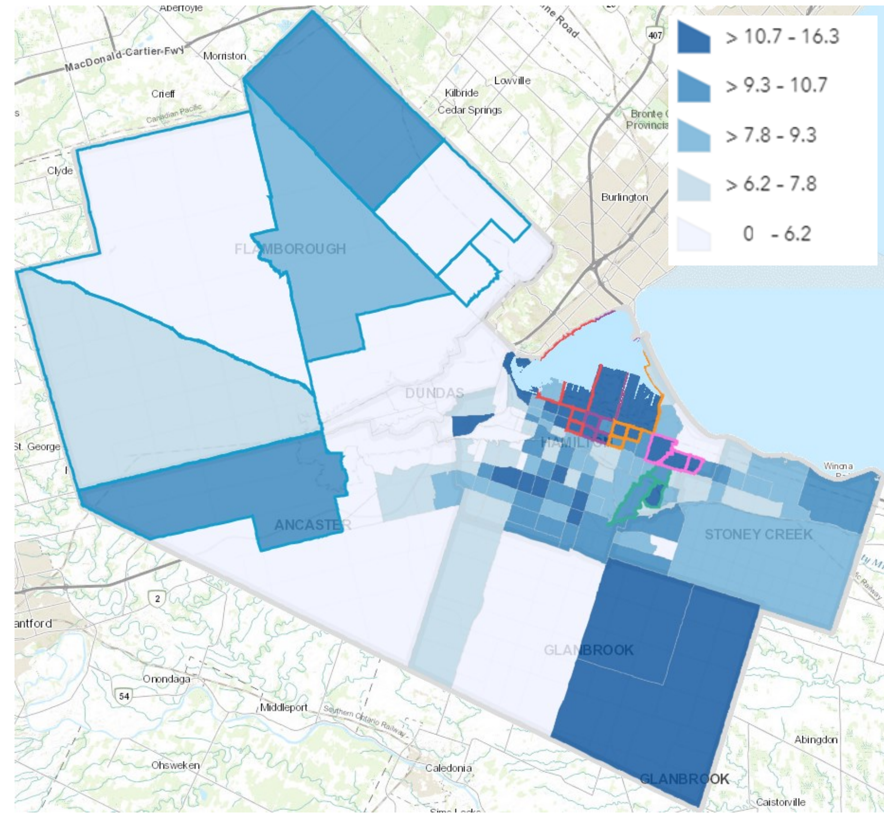
Sources: IntelliHealth (COVAXon Data Load); IntelliHealth (Population Projections, 2020).

# COVID-19 Vaccine – Coverage by Census Tracts ("neighbourhoods")

## Estimated ≥ One Dose Coverage Among Eligible Population (up to November 8, 2021)

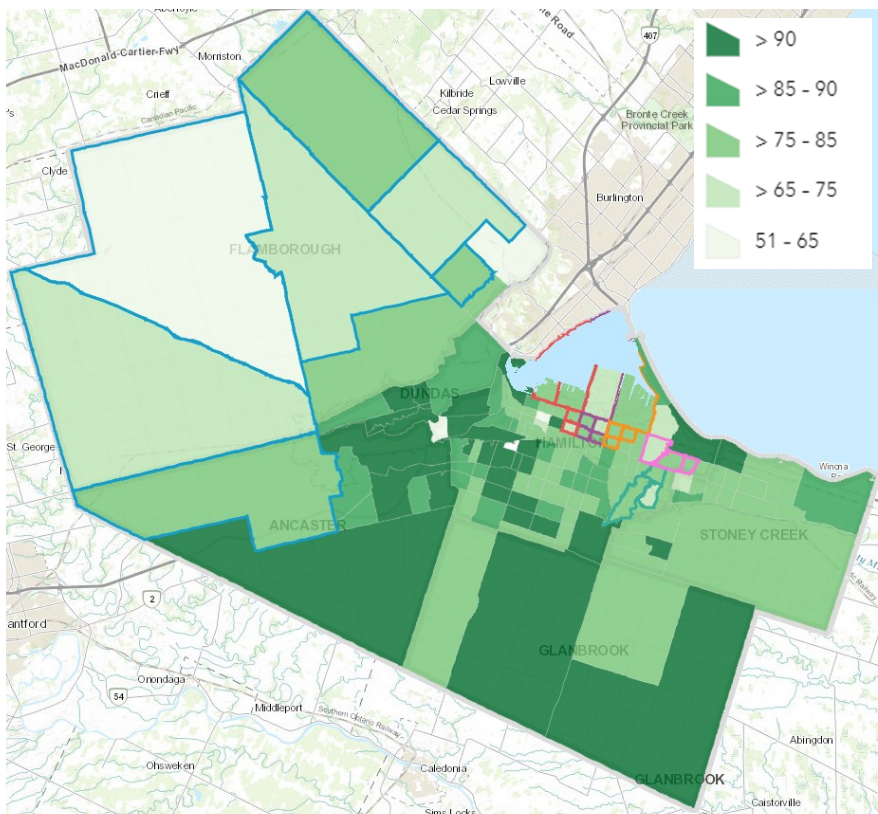



## Change in ≥ One Dose Coverage Among Eligible Population (August 5 – November 8, 2021)

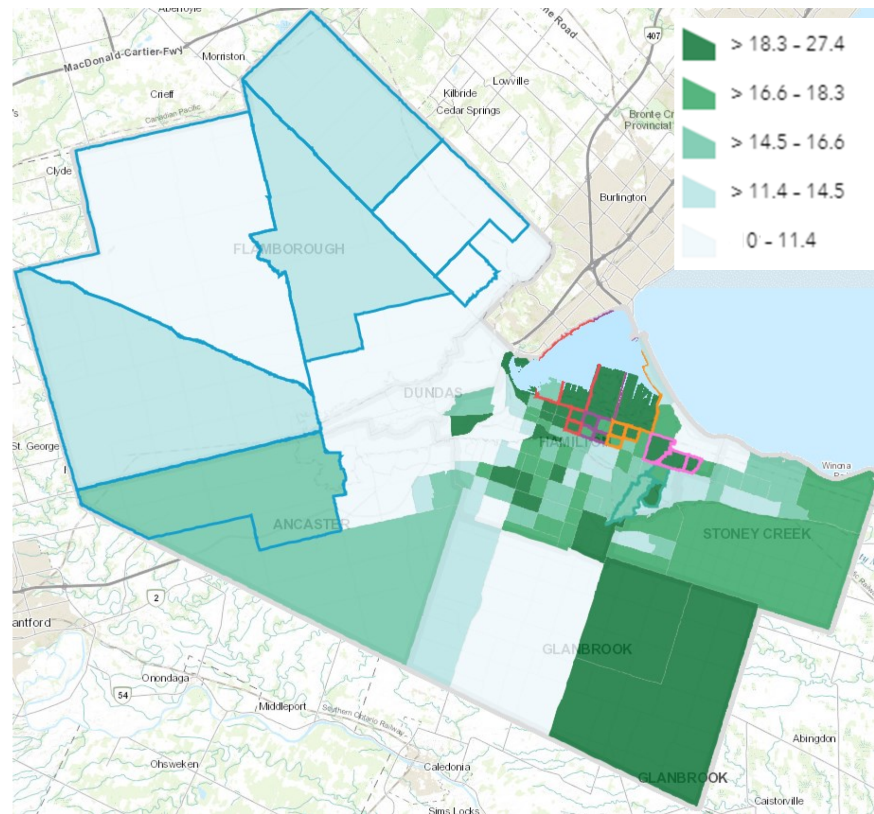


# COVID-19 Vaccine – Coverage by Census Tracts ("neighbourhoods")

**Estimated Two Dose Coverage Among Eligible Population (up to November 8, 2021)**

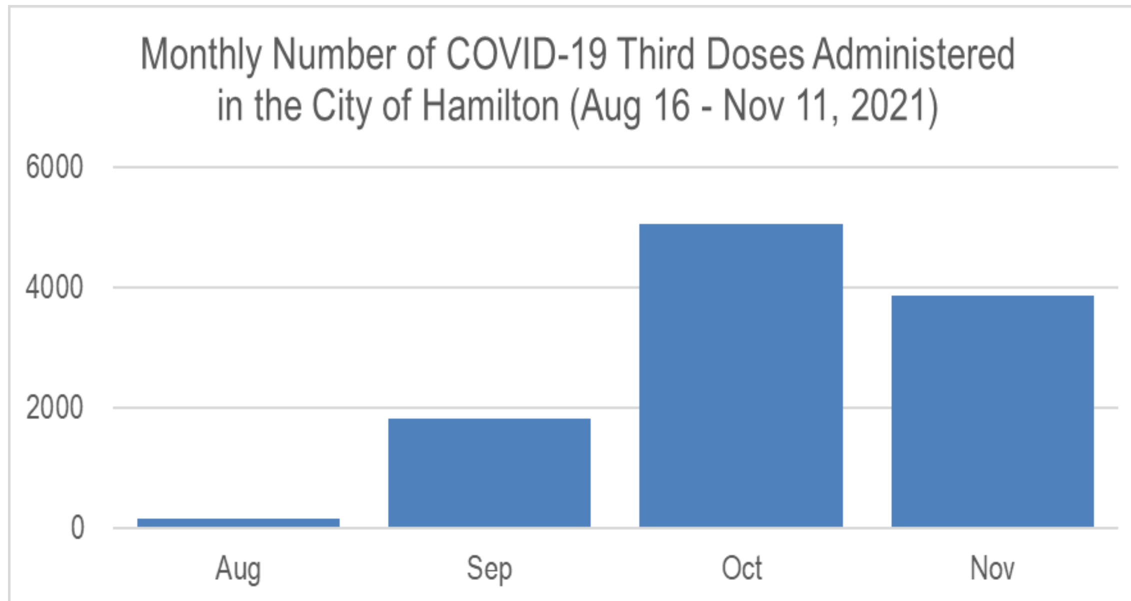



**Change in Two Dose Coverage Among Eligible Population (August 5 – November 8, 2021)**



# COVID-19 Vaccine – Third Doses

## Estimated as of End Of Day November 11, 2021



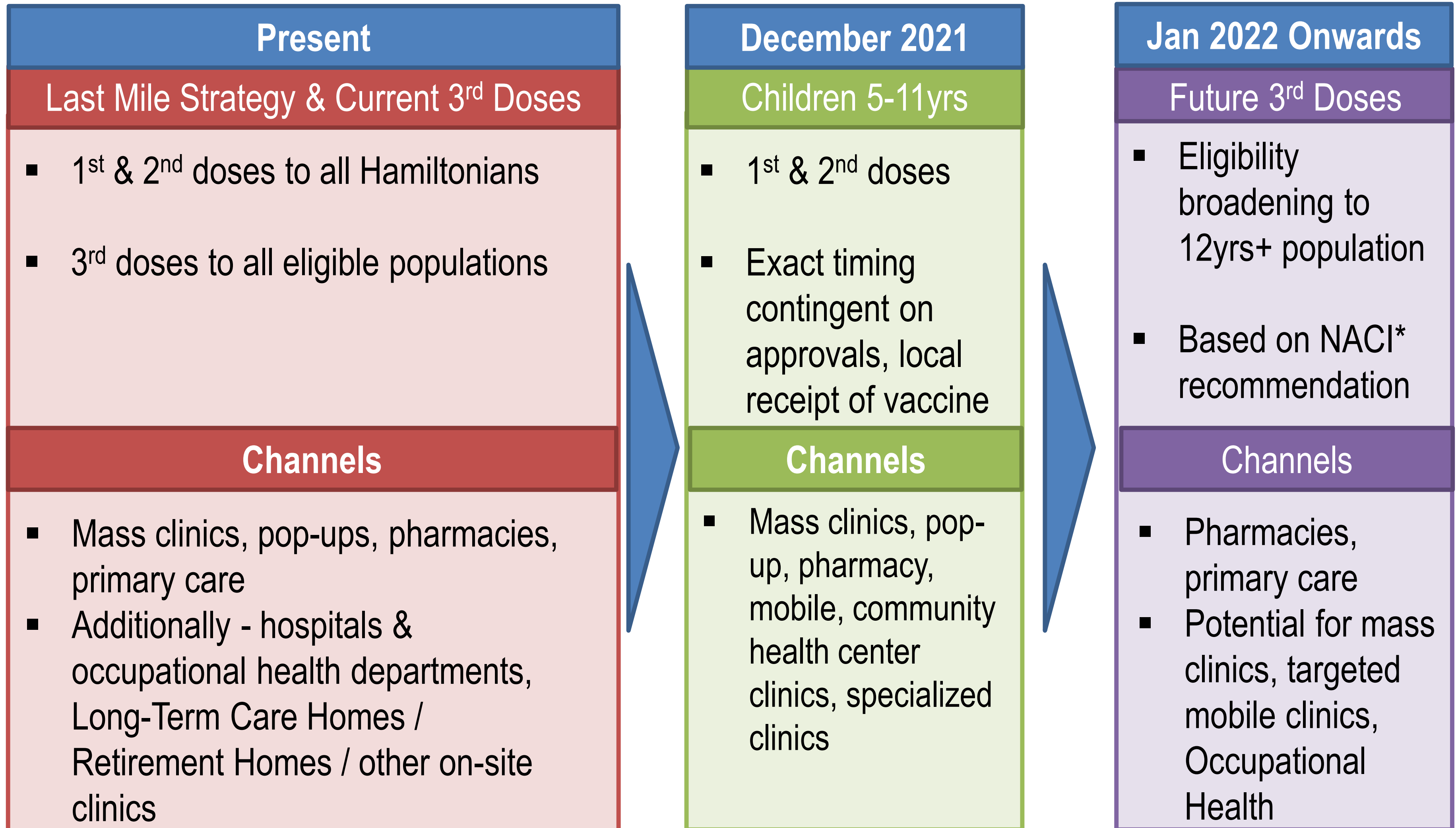

Nearly **11,000** third doses administered in the City of Hamilton

So far, majority administered in October 2021 and in long-term care and retirement homes

Rate of administration increasing in November 2021

Sources: IntelliHealth (COVAXon Data Load)

# COVID-19 Vaccine – Rollout Placemat




*NACI = National Advisory Committee on Immunization

# COVID-19 Vaccine – Operational Priorities

As we move through new eligibility for 1st, 2nd and 3rd doses, the priority for administration is:

1. 1st and 2nd doses (including 5-11 year olds)
2. Booster (3rd) doses

Online scheduling will be configured to prioritize appointments for 5-11 year old population and 12 year old+ 1st and 2nd doses will be able to walk-in.

# COVID-19 Vaccine - 3rd Doses

Two doses of vaccine offer **robust and persistent protection against severe disease from COVID-19**

Third doses are **recommended** and **not mandatory**

**Currently Eligible**

- Moderately-to-Severely Immunocompromised
- Older Adults in Congregate Settings
- Community Dwelling Older Adults 70yrs+
- Health Care Workers, including Essential Caregivers
- Indigenous Adults
- Viral Vector Vaccine Recipients

# COVID-19 Vaccine: Mass Clinics Update

- Locations
  - CF Lime Ridge: Opened November 3, 2021
  - The Centre on Barton: New mass clinic will open week of November 15, 2021
  - Hamilton Health Sciences West End Clinic: Health Care Workers Only

- Booking
  - $1^{st}$ & $2^{nd}$ Doses 12yrs+ Population: Walk-in & VERTO
  - $1^{st}$ & $2^{nd}$ Doses 5-11yrs Population: VERTO Only
  - $3^{rd}$ Doses: VERTO Only

# COVID-19 Vaccine – Mobile Clinics Update

| Pop-Up Clinic Schedule (Nov. 15th - 28th) | | | |
|---|---|---|---|
| **Monday** | Waterdown Library | **Thursday** | Barton Library |
| | Central Library | | Bennetto Rec |
| | East End Clinic | | Red Hill Library |
| **Tuesday** | Red Hill Library | **Friday** | Ancaster Library/ Bernie Morelli |
| | Bernie Morelli/ Pinky Lewis | | East End Clinic |
| | School Clinic | **Saturday** | Sackville Hill Rec |
| **Wednesday** | Huntington Park Rec | | Stoney Creek Rec |
| | East End Clinic | **Sunday** | Mountain Clinic |
| | Bennetto Rec | | Stoney Creek Rec |

- 5-11yrs specific clinics will be operated once the vaccine is approved

# CURRENT PUBLIC HEALTH SERVICES PRIORITIES

Dr. Elizabeth Richardson, Medical Officer of Health

# Current Public Health Services Priorities

## COVID Response

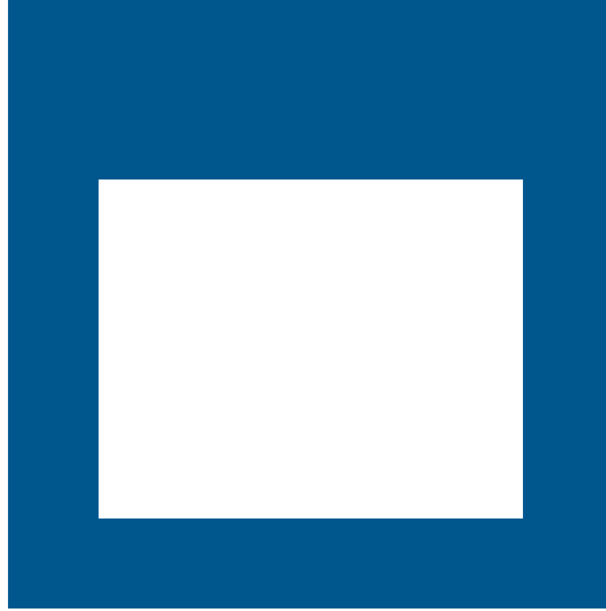
- Ongoing COVID-19 disease control program and expanding COVID-19 vaccination program

## Deficits of Care

- Identify most urgent deficits of care that need to be addressed first
- Use a "Build Back Better" approach when reopening programs to apply lessons learned through COVID-19

## Staff Wellness

- Develop and implement strategies to support and retain public health staff, considering the significant impact on mental health and wellness due to the length of emergency response and deployment



# QUESTIONS?

# CITY OF HAMILTON
## PUBLIC HEALTH SERVICES
### Healthy Families Division

| | |
|---|---|
| **TO:** | Mayor and Members<br>Board of Health |
| **COMMITTEE DATE:** | November 15, 2021 |
| **SUBJECT/REPORT NO:** | Child & Adolescent Services 2021-2022 Budget and Base Funding Increase of Five Percent (BOH 21010) (City Wide) |
| **WARD(S) AFFECTED:** | City Wide |
| **PREPARED BY:** | Lynn Foye (905) 546-2424 Ext. 3697 |
| **SUBMITTED BY:**<br><br>**SIGNATURE:** | Jennifer Vickers-Manzin, CNO<br>Director, Healthy Families Division<br>Public Health Services |

## RECOMMENDATION

a) That the 2021-2022 Child & Adolescent Services Program budget funded by the Ministry of Health be approved; and, that the Medical Officer of Health be authorized and directed to receive, utilize, report on and execute all service agreements and contracts, in a form satisfactory to the City Solicitor, required to give effect to the 2021-2022 Child & Adolescent Services Program budget; and,

b) That the Board of Health approve the increase of a permanent 0.61 FTE Clinical Therapist.

## EXECUTIVE SUMMARY

Child and Adolescent Services (C&AS) provides outpatient children's mental health services. C&AS serves Hamilton children, youth and families from birth to 18 years of age presenting with mental health concerns including social, emotional and/or behavioural problems. Services are community based and delivered by a

multidisciplinary team comprised of registered social workers, psychotherapists, family therapists, an occupational therapist and a psychological associate.

Local and Provincial data indicates increases in suicide, mental illness, and substance use overdoses, especially among youth and young adults. Emerging evidence suggests this trend has been exacerbated by COVID-19 and will result in increased need for mental health services. This trend has been evident at C&AS where referrals for some programs have peaked at two times the pre-pandemic level. In recognition of the importance and increased demand for mental health services, the Ministry of Health is providing a five percent increase to the C&AS 2021-2022 base budget.

We have continued throughout the pandemic to provide high quality mental health services through both in-person and virtual care. High referral volume and public health measures have however significantly impacted service duration and wait times across all programs and wait times currently range from three weeks to eight months. The recent allocation of a five percent base increase to the C&AS operating budget allows us to maintain our current clinical therapist FTE and add a permanent 0.61 FTE clinical therapist. Increasing clinical therapist FTE will enable C&AS to support broader community efforts underway to strengthen existing services, reduce wait times, and respond to the negative impacts of COVID-19 in our community.

**Alternatives for Consideration – Not Applicable**

**FINANCIAL – STAFFING – LEGAL IMPLICATIONS**

Financial: The 2021-2022 budget allocation and increase to base funding will add a permanent 0.61 FTE clinical therapist ($65,324) to the 100% MOH funded budget. The remaining funds ($44,176) from the five percent base increase will be used to offset cost of living, step increases, and to maintain current clinical therapist FTE.

| Ministry of Health (MOH) Funding | | | | | | |
|---|---|---|---|---|---|---|
| | 2019-2020 | | 2020-2021 | | 2021-2022 | |
| | Annual Budget | FTE | Annual Budget | FTE | Annual Budget | FTE |
| C&AS Children and Youth Mental Health Services | $2,190,518 | 17.39 | $2,190,518 | 17.39 | $2,300,020* | 18.00** |

* This amount reflects the additional annualized 5% increase to the 100% MOH funded operating budget.

** 0.61 FTE permanent clinical therapist added using 100% MOH funded dollars

Staffing: The addition of a permanent 0.61FTE clinical therapist will increase the overall complement at C&AS from 17.39 FTE to 18.0 FTE. The FTE will assist in reducing wait times for service.

Legal: C&AS is contracted with the Ministry of Health to provide programs and services to children and youth, aged birth to 18 years old.

## HISTORICAL BACKGROUND

To stay within budget cap over the past five years C&AS has made the following FTE changes:

- **2016-2017**
  A 0.60 FTE receptionist and 0.24 FTE clinical therapist reduction (BOH16025); and,
- **2017-2018**
  A 0.22 FTE clinical therapist reduction (BOH17014); and,
- **2018-2019**
  A five percent base funding increase enabled the program to maintain clinical therapist FTE and increase 0.46 FTE clinical therapist (BOH18024); and,
- **2019-2020**
  A decrease of 0.17 clinical therapist FTE (BOH19036); and,
- **2020-2021**
  Staffing levels and permanent 17.39 FTE staff maintained.

## POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

Provincially funded child and youth mental health services are provided to children and youth under 18 years of age under the authority of the *Child, Youth and Family Services Act* (CYFSA). Services and supports that address a range of social, emotional, behavioural, psychological and/or psychiatric problems are provided to children and youth who are at risk of, or who have developed, mental health problems, illnesses, or disorders.

## RELEVANT CONSULTATION

Finance and Administration has been consulted regarding the preparation of the budget and provided review of included financial figures.

## ANALYSIS AND RATIONALE FOR RECOMMENDATION

Each year C&AS provides high quality, evidence-based mental health treatment services to approximately 800 new children, youth and their families in addition to those carried in from the previous year. Many of these clients are vulnerable children or youth dealing with serious emotional and/or behavioural problems as well as complex social problems such as the lack of sufficient housing and the experience of homelessness and poverty.

Mental health issues are a significant concern for children and youth in Hamilton. Increasing rates of hospital emergency room visits for self-harm have been well documented at both the provincial and local level. The services provided by C&AS are highly valued by families and can vastly improve the life trajectory of those served and help to turn the curve on mental health and well-being of children and youth in our community.

The number of families C&AS services each year is variable and dependent on several factors such as: the number of families referred; the length of time each family requires services; staffing levels and the length of wait for services. Continuous quality improvement (CQI) efforts enable us to achieve small gains to maintain service levels and enhance access for those who vulnerable. For example, in 2020 we implemented onsite service provision through Good Shepherd Centre to increase access to children and families experiencing homelessness. In addition, immediate access to a clinical therapist through a virtual walk-in resulted in decreased wait times. We anticipate this virtual model will further assist us in mitigating operational and system pressure by streamlining administrative process for referrals while also mitigating long wait times for mental health services for children, youth and families.

We will monitor impact of this budget allocation on service delivery with a focused priority to mitigate potential negative impact to children and youth and staff.

## ALTERNATIVES FOR CONSIDERATION

Not Applicable.

## ALIGNMENT TO THE 2016 – 2025 STRATEGIC PLAN

### Healthy and Safe Communities

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

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

## APPENDICES AND SCHEDULES ATTACHED

Not Applicable.

# CITY OF HAMILTON
## PUBLIC HEALTH SERVICES
### Healthy Environments Division

| TO: | Mayor and Members<br>Board of Health |
|---|---|
| COMMITTEE DATE: | November 15, 2021 |
| SUBJECT/REPORT NO: | Budget Request for Food Advisory Committee 2022 (BOH21011) (City Wide) |
| WARD(S) AFFECTED: | City Wide |
| PREPARED BY: | Richard MacDonald (905) 546-2424 Ext. 5818 |
| SUBMITTED BY:<br><br>SIGNATURE: | Kevin McDonald<br>Director, Healthy Environments Division<br>Public Health Services |

**RECOMMENDATION**

That the Food Advisory Committee 2022 base budget submission attached as Appendix “A” to Report BOH21011 in the amount of $1,500, be approved for submission to the 2022 budget process.

**EXECUTIVE SUMMARY**

The Food Advisory Committee requests that a total budget of $1,500 be referred to the 2022 budget process for consideration to cover basic committee expenses.

**Alternatives for Consideration – See Page 3**

**FINANCIAL – STAFFING – LEGAL IMPLICATIONS**

Financial: If the recommendation is not approved, the Food Advisory Committee would not have the budget to operate in 2022.

Staffing: Not Applicable.

Legal: Not Applicable.

## HISTORICAL BACKGROUND

The Food Advisory Committee was created as a result of the City of Hamilton's 2014 advisory committee review process and the City of Hamilton'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 City 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 the Public Health Services, 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, the Food Advisory Committee has informed and participated in two Food Strategy events and intends to continue to advise and support the implementation of Food Strategy actions in 2022.

## POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

No policy implications or legislated requirements applicable.

## RELEVANT CONSULTATION

City of Hamilton's 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 to the Food Advisory Committee.

## ANALYSIS AND RATIONALE FOR RECOMMENDATION

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.

The Food Advisory Committee budget request is attached as Appendix "A" to Report BOH21011.

The Food Advisory Committee's full mandate is outlined in their Terms of Reference, attached as Appendix "B" to Report BOH21011.

## ALTERNATIVES FOR CONSIDERATION

Council could choose not to refer the Food Advisory Committee budget request for 2022 to the budget process for Advisory Committees.

## ALIGNMENT TO THE 2016 – 2025 STRATEGIC PLAN

**Community Engagement and 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.

**Clean and Green**
Hamilton is environmentally sustainable with a healthy balance of natural and urban spaces.

**Built Environment and Infrastructure**
Hamilton is supported by state-of-the-art infrastructure, transportation options, buildings and public spaces that create a dynamic City.

**Culture and Diversity**
Hamilton is a thriving, vibrant place for arts, culture, and heritage where diversity and inclusivity are embraced and celebrated.

## APPENDICES AND SCHEDULES ATTACHED

Appendix "A" to Report BOH21011: Completed Advisory Committee Budget Template

Appendix "B" to Report BOH21011: Terms of Reference Food Advisory Committee

# CITY OF HAMILTON

## 2022

## ADVISORY COMMITTEES

## BUDGET SUBMISSION FORM

| FOOD ADVISORY COMMITTEE |
| --- |

# PART A: General Information

## ADVISORY COMMITTEE MEMBERS:

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

## 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 | 600.00 |
| Materials, supplies & printing | 400.00 |
| **SUB TOTAL** | **$1000.00** |

**SPECIAL EVENT/PROJECT COSTS:**

| | |
|---|---|
| Training/Education<br>Event(s) | 500.00 |
| **SUB TOTAL** | **$ 1500.00** |

| | |
|---|---|
| **TOTAL COSTS** | **$ 1500.00** |

| | |
|---|---|
| **Funding from Advisory Committee Reserve (only available to Advisory Committees with reserve balances)** | **$ 0** |

| | |
|---|---|
| **TOTAL 2022 BUDGET REQUEST (net of reserve funding)** | **$ 1500** |
| **PREVIOUS YEAR (2021) APPROVED BUDGET** | **$ 2500** |

**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:** **Krista D’Aoust, Chair**

**Signature:**

**Date:** **October 5, 2021**

**Telephone # :** 289-260-3973

# 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