# City of Hamilton
# BOARD OF HEALTH
# AGENDA

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| **Meeting #:** | 22-007 |
| **Date:** | July 6, 2022 |
| **Time:** | 9:30 a.m. |
| **Location:** | Council Chambers (BOH)<br>Council Chambers, Hamilton City Hall<br>71 Main Street West |

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

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1. CEREMONIAL ACTIVITIES

2. APPROVAL OF AGENDA

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

3. DECLARATIONS OF INTEREST

4. APPROVAL OF MINUTES OF PREVIOUS MEETING

   4.1. June 13, 2022

5. COMMUNICATIONS

   5.1. Correspondence from the Toronto Board of Health, respecting a COVID-19 Response

   Recommendation: That Item 9, respecting the Expansion of the Collection of Sociodemographic Data be endorsed, and the remainder of the correspondence be received as presented.

   5.2. Correspondence from the Sudbury District Health Unit, respecting the Healthy Babies Healthy Children Program Funding

   Recommendation: Be endorsed

5.3. Correspondence from the Grey Bruce Health Unit, respecting Support for the South West Tobacco Control Area Network

Recommendation: Be received

5.4. Correspondence from Anita Dubeau, Board Chair for the Simcoe Muskoka District Health Unit respecting their 2020/2021 Annual Report

Recommendation: Be Received

Note: Within the correspondence, there is a link to the Annual Report

5.5. Correspondence from R. Cooper, respecting Natural Science (referred from the General Issues Committee, June 15, 2022)

Recommendation: Be received.

## 6. DELEGATION REQUESTS

6.1. Robert Cooper, respecting Support for Correspondence referred from the General Issues Committee (June 15, 2022) regarding Natural Science (for today's meeting)

## 7. CONSENT ITEMS

7.1. Board of Health Governance Follow-Up (BOH21006(b)) (City Wide)

## 8. STAFF PRESENTATIONS

## 9. PUBLIC HEARINGS / DELEGATIONS

## 10. DISCUSSION ITEMS

10.1. Scarsin COVID-19 Forecasting Technology Procurement (BOH22013) (City Wide)

Discussion of Appendix "A" to Report BOH22013 must be conducted in Closed Session, Pursuant to Section 9.1, Sub-sections (i) of the City's Procedural By-law 21-02, as amended, and Section 239(2), Sub-sections (i) of the Ontario Municipal Act, 2001, as amended, as the subject matter pertains to a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the City or local board, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization

10.2. 2022 Public Health Services Organizational Risk Management Plan (BOH22014) (City Wide)

## 11. MOTIONS

## 12. NOTICES OF MOTION

## 13. GENERAL INFORMATION / OTHER BUSINESS

13.1. Outstanding Business List

13.1.a. Items to be Removed

13.1.a.a. 2015-A: Review of the City of Hamilton's Pest Control By-law (November 16, 2015, Item 9.1)

Note: Item is now on the Planning Committee Outstanding Business List

13.1.a.b. 2016-A : Hamilton Airshed Modelling System (BOH18016) (City Wide) (April 16, 2018, Item 7.1)

Note: Item now on the Planning Committee Outstanding Business List

13.1.a.c. 2019-H: Hamilton Millennial Survey Study – Employment Precarity (April 15, 2019, Item 8.1)

Addressed at Emergency & Community Services Committee, 22-004, City of Hamilton Youth Strategy (CES15056(d)) (City Wide) (Item 8.2)

13.1.a.d. 2021-F: Ottawa and Toronto Board of Health Governance Models (September 20, 2021, Item 11.1)

Addressed in Item 7.1 of this Agenda

13.1.a.e. 2022-A: Public Beach Signage (BOH22004) (City Wide) (March 21, 2022, Item 7.1)

Addressed at Board of Health, June 13, 2022, in Item 7.1, Green Millen Trail Waterfront Assessment (BOH22004(a)) (City Wide)

## 14. PRIVATE AND CONFIDENTIAL

14.1. Appendix "A" to Scarsin COVID-19 Forecasting Technology Procurement (BOH22013) (City Wide)

Pursuant to Section 9.1, Sub-sections (i) of the City's Procedural By-law 21-02, as amended, and Section 239(2), Sub-sections (i) of the *Ontario Municipal Act, 2001*, as amended, as the subject matter pertains to a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the City or local board, which, if disclosed, could reasonably be expected to prejudice significantly the competitive position or interfere significantly with the contractual or other negotiations of a person, group of persons, or organization

## 15. ADJOURNMENT

TORONTO

John D. Elvidge
City Clerk

City Clerk's Office

Secretariat
Julie Amoroso, Board Secretary
Toronto Board of Health
Toronto City Hall, 10th Floor, West Tower
100 Queen Street West
Toronto, Ontario M5H 2N2

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June 9, 2022

SENT VIA E-MAIL

**To:** Boards of Health in Ontario and the Association of Local Public Health Agencies

**Subject:** Response to COVID-19 - April 2022 Update (Item HL36.1) (see Part 10 of the Toronto Board of Health's decision on page 2 which is addressed to all Boards of Health in Ontario and the Association of Local Public Health Agencies)

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**The Toronto Board of Health, during its meeting on April 11, 2022, adopted Item HL36.1, as amended, and:**

1. Expressed its full support to the Medical Officer of Health to implement additional measures to address the harm of COVID-19, as needed.

2. Requested the Medical Officer of Health, in partnership with Ontario Health and the City's community and health sector partners, to accelerate the integration of the delivery of on-site COVID-19 vaccination, testing, treatment, and health and social services.

3. Requested the Medical Officer of Health to continue using the VaxTO program for the COVID-19 3rd- and 4th-dose campaign, and to scale up live calling in support of vaccine booster dose uptake.

4. Requested the Province of Ontario to re-enable local Medical Officers of Health to issue letters of instruction as part of the local toolkit to reduce the impact of COVID-19 and help keep people safe.

5. Requested the Medical Officer of Health to implement a public health promotion campaign to inform the public of COVID-19 risks and provide guidance for risk mitigation.

6. Requested the Medical Officer of Health and the Province of Ontario to provide additional focused guidance to help the public discern how best to employ layers of protection against COVID-19 and to provide support to those at greatest risk for severe outcomes from COVID-19, including priority access to testing, personal protective equipment, and other resources to support safer public interactions.

7. Requested the Medical Officer of Health to explore innovative and accessible ways to use data to communicate with the public to enable informed decisions about how best to mitigate the risk of COVID-19.

8. Requested the Ministry of Health and Ontario Health to work with Toronto Public Health, primary care, pharmacies, other health care practitioners, and any other relevant stakeholders, to facilitate access to and increase appropriate uptake of COVID-19 treatments, incorporating core elements such as:

    a. an information campaign to raise awareness among health care providers and the public of the availability of this effective treatment;

    b. resources to support health care providers and the public to use available COVID-19 treatments; and

    c. a strategy to leverage existing community vaccine distribution infrastructure to ensure effective, equitable access to COVID-19 treatment.

9. Requested the Province of Ontario to work with relevant stakeholders and communities to expand the collection of sociodemographic data in the health system (which may include, for example, optimizing the linkage of existing Census data with health data) to ensure that resources are deployed to the populations with the greatest need and to ensure equitable and culturally-safe access to health and social services.

10. Forwarded Part 9 above, concerning the collection of sociodemographic data, to all Boards of Health in Ontario and the Association of Local Public Health Agencies.

11. Requested the Medical Officer of Health to provide public reporting on, and consider for potential inclusion in dashboard changes, the following:

    a. COVID-19 related hospitalizations among school-aged children and youth;

    b. transmission of COVID-19 in schools; and

    c. health workforce absentee data.

To view this item and background information online, please visit: http://app.toronto.ca/tmmis/viewAgendaItemHistory.do?item=2022.HL36.1.

Yours sincerely,

JAAmoroso

Julie Amoroso
Board Secretary
Toronto Board of Health

Sent (via e-mail) to the following Boards of Health in Ontario and the Association of Local Public Health Agencies:

- Algoma Public Health Board of Health, c/o Mayor Sally Hagman, Chair
- Brant County Board of Health, c/o Councillor John Bell, Chair
- Chatham-Kent Board of Health, c/o Councillor Joe Faas, Chair
- City of Hamilton Board of Health, c/o Mayor Fred Eisenberger, Chair
- Durham Region Board of Health (Health and Social Services Committee), c/o John Henry, Durham Regional Chair
- Eastern Ontario Health Unit Board of Health, c/o Councillor Syd Gardiner, Chair
- Grey Bruce Health Unit Board of Health, c/o Mayor Sue Paterson, Chair
- Haldimand-Norfolk Health Unit Board of Health, c/o Mayor Kristal Chopp, Chair
- Haliburton, Kawartha, Pine Ridge District Health Unit Board of Health, c/o Councillor Doug Elmslie, Chair
- Halton Region Board of Health (Regional Council), c/o Gary Carr, Halton Regional Chair
- Hastings Prince Edward Public Health Board of Health, c/o Mayor Jo-Anne Albert, Chair
- Huron Perth Public Health Board of Health, c/o Councillor Kathy Vassilakos, Chair
- Kingston, Frontenac, Lennox & Addington Public Health Board of Health, c/o Deputy Warden and Mayor, Denis Doyle, Chair
- Lambton County Board of Health (County Council), c/o County Warden and Mayor, Kevin Marriott, Chair
- Leeds, Grenville & Lanark District Health Unit Board of Health, c/o Mayor Doug Malanka, Chair
- Middlesex-London Health Unit Board of Health, c/o Councillor Maureen Cassidy, Chair
- Niagara Region Board of Health (Regional Council), c/o Jim Bradley, Regional Chair
- North Bay Parry Sound District Health Unit Board of Health, c/o Nancy Jacko, Chair
- Northwestern Health Unit Board of Health, c/o Mayor Doug Lawrance, Chair
- Ottawa Board of Health, c/o Councillor Keith Egli, Chair
- Peterborough Public Health Board of Health, c/o Deputy Warden and Mayor Andy Mitchell, Chair
- Porcupine Health Unit Board of Health, c/o Mayor Sue Perras, Chair
- Public Health Sudbury & Districts Board of Health, c/o Councillor René Lapierre, Chair
- Region of Peel Board of Health (Regional Council), c/o Nando Iannicca, Regional Chair and Chief Executive Officer
- Region of Waterloo Board of Health (Region of Waterloo Council), c/o Karen Redman, Regional Chair
- Renfrew County and District Health Unit Board of Health, c/o Ann Aikens, Chair
- Simcoe Muskoka District Health Unit Board of Health, c/o Deputy Mayor and Councillor Anita Dubeau, Chair
- Southwestern Public Health Board of Health (Oxford, Elgin and St. Thomas), c/o Warden Larry Martin, Chair
- Thunder Bay District Health Unit Board of Health, c/o Councillor James McPherson, Chair
- Timiskaming Health Unit Board of Health, c/o Mayor Carman Kidd, Chair

- Wellington-Dufferin-Guelph Public Health Board of Health, c/o Mayor and Councillor George Bridge, Chair
- Windsor-Essex County Health Unit Board of Health, c/o Warden and Mayor Gary McNamara, Chair
- York Region Board of Health (York Regional Council), c/o Wayne Emmerson, York Region Chairman and Chief Executive Officer
- Dr. Paul Roumeliotis, Association of Local Public Health Agencies, President, COMOH Representative, East Region

cc (via e-mail):
- Dr. Eileen de Villa, Medical Officer of Health, Toronto Public Health

Public Health
Santé publique
SUDBURY & DISTRICTS

June 21, 2022

*VIA ELECTRONIC MAIL*

Ministry of Children, Community and Social Services
Government of Ontario
438 University Avenue, 7th Floor
Toronto, ON M5G 2K8

Dear Honourable Minister:

**Re: Healthy Babies Healthy Children Funding**

The Board of Health for Public Health Sudbury & Districts remains wholly committed to the critical Healthy Babies Healthy Children program, however, has longstanding and increasing concerns about the Board's ability to meet clients' growing needs with current program funding. Please be advised that at it's meeting on June 16, 2022, the Board of Health for Public Health Sudbury & Districts carried the following resolution #19-22:

> *THAT the Board of Health for Public Health Sudbury & Districts request the Ministry of Children, Community and Social Services (MCCSS) to review base-funding needs for the Healthy Babies Healthy Children Program to ensure this essential program is sufficiently resourced to meet the current and growing needs of children and a healthy start in life.*

The Board of Health recognizes that the Healthy Babies Healthy Children (HBHC) program provides a critical prevention/early intervention program and is designed to ensure that all Ontario families with children (prenatal to age six) who are at risk of physical, cognitive, communicative, and/or psychosocial problems have access to effective, consistent, early intervention services. Since 1997 the province has committed to resourcing the Healthy Babies Healthy Children program at 100%. Unfortunately, the HBHC budget has not been increased since 2015, resulting in significant erosion in capacity due to fixed cost increases such as collective agreement commitments and steps on salary grids, travel and accommodation costs, and operational and administrative costs.

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This has been further compounded by the increased intensity of need in our communities pre-dating but further exacerbated by the COVID-19 pandemic.

The HBHC program has made every effort to mitigate the effects of the funding shortfalls over the years and to protect programming. The program, however, is not sustainable and significant service reductions will be required without increased to base funding.

It remains our priority to ensure that the HBHC program can effectively identify and support children and families most in need throughout the Sudbury/Manitoulin District. To this effect, we are submitting a revised 2022/23 HBHC program budget based on current needs and requesting consideration by the Ministry staff.

The Board of Health for Public Health Sudbury & Districts is respectfully requesting the Minister's commitment to carefully review base-funding needs for the HBHC program to ensure this essential program is sufficiently resourced to meet the current and growing needs of children and a healthy start in life.

Thank you for your attention to this important public health issue.

Sincerely,

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

cc: Dr. Kieran Moore, Chief Medical Officer of Health, Ministry of Health
Loretta Ryan, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health
Dr. Jackie Schleifer Taylor, Chair, Governing Council of Provincial Council for Maternal and Child Health
Sanober Diaz, Executive Director of Provincial Council for Maternal and Child Health

June 15, 2022

Manager, Legislative Review
Office of Policy and Strategic Planning
Tobacco Control Directorate
Controlled Substances and Cannabis Branch, Health Canada
0301A-150 Tunney's Pasture Driveway
Ottawa, ON K1A 0K9
Email: legislativereviewtvpa.revisionlegislativeltpv@hs-sc.gc.ca

**Re: <u>Support for South West Tobacco Control Area Network</u>**

On May 27, 2022, at a regular meeting of the Board for the Grey Bruce Health Unit, the Board of Health reviewed the Southwest T-CAN's submission to the Tobacco Control Directorate of Health Canada on ways to strengthen the Tobacco and Vaping Products Act. The submission, presented to the Board of Health for their endorsement, is part of a mandated three-year review of the Act and has a focus on the vaping regulation sections of the Act and their ability to protect young people from the harms of vapour products.

The Board endorses the submission and strongly supports the recommendations to Health Canada, including a ban on all vapour and e-product flavours, implementing a framework to strictly regulate the advertising of vapour products, and restricting the availability of high-concentration vapour products.

Motion No: 2022-41

**Moved by: Brian Milne** **Seconded by: Luke Charbonneau**

**"THAT, the Board of Health endorse the report South West Tobacco Control Area Network (Ontario) Submission to the Legislative Review of the Tobacco and Vaping Products Act."**

**Carried.**

Sincerely,

Sue Paterson
Chair, Board of Health
Grey Bruce Health Unit

cc: Honourable Alex Ruff, MP for Bruce-Grey-Owen Sound
Warden for Bruce, Warden Janice Jackson
Warden for Grey, Warden Selwyn Hicks
Ontario Boards of Health

Encl.
/mh

SOUTH WEST TOBACCO CONTROL AREA NETWORK

**Appendix B to Report No. XX-22**

Manager, Legislative Review
Office of Policy and Strategic Planning
Tobacco Control Directorate
Controlled Substances and Cannabis Branch, Health Canada
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## Southwest Tobacco Control Area Network (Ontario) Submission to the Legislative Review of the *Tobacco and Vaping Products Act*

The Southwest Tobacco Control Area Network (SWTCAN) commends Health Canada for the steps taken to prevent the initiation of vaping by youth, young adults and non-smokers. Since March 2019, the member public health units of the SWTCAN have made submissions providing comments and feedback on the *Tobacco and Vaping Products Act* (*TVPA*) and Regulations. The SWTCAN is pleased to submit further comments to the Department's mandated 3-year review of the *Act* focusing on its vaping regulation sections and their ability to protect young persons from the harms of vapour products.

### ***SECTION 1***
### *PROTECT YOUNG PERSONS AND NON-USERS OF TOBACCO PRODUCTS FROM INDUCEMENTS TO USE VAPING PRODUCTS*

*Q.1 Are the current restrictions on advertising and promotional activities adequately protecting youth?*

*Q.2 Are the restrictions within the Act and its regulations sufficient to address potential inducements to use these products by youth and non-users of tobacco products?*

*Q.3 Are there other measures the Government could employ to protect youth and non-users from inducements to use tobacco products?*

*Q.4 Does the TVPA contain the appropriate authorities to effectively address a rapidly evolving product market and emerging issues such as the observed increase in youth vaping?*

*Q.5 Has scientific evidence emerged in this area since the legislation was enacted in 2018 that points to the need for additional action or further restrictions?*

### Health Canada Messaging about Vapour Products

Vaping prevalence rates have skyrocketed in recent years, particularly among youth and young adults. The nation-wide prevalence of vaping among students (grades 7-12) has doubled, rising from 10% in 2016-2017 to 20.2% in 2018-2019. (Health Canada, 2018;2019).

Since the 2018 publication of the assessment of vaping ("Public Health Consequences of E-Cigarettes") by the US National Academy of Science, Engineering and Medicine (NASEM), scientific understanding of the various harms now known to be associated with e-cigarette use by young people has significantly increased. As noted by colleagues at Physicians for a Smoke-Free Canada (PSC), the NASEM assessment was based on only one-third of the evidence available today (PSC, 2022). PSC's blogpost on the current status of Health Canada's messaging on vaping and its impact on younger users reads, in part, as follows:

*"In its 2018 assessment, the NASEM panel of experts explored the scientific evidence behind 47 conclusions finding that there was conclusive or substantial scientific evidence for only 18, moderate evidence for 8, and limited or no evidence for 21 of the conclusions. Fifteen of the 18 conclusions for which there was strong or substantial level of confidence confirmed potential harms from these products and only two conclusions related to potential benefits of vaping" (PSC, 2022). The NASEM panel of experts concluded that e-cigarette users who entirely quit using tobacco products and transition to vapour products were exposed to fewer of the chemicals found in cigarette smoke and they experienced short-term health consequences in some organ systems (PSC, 2022).*

The amount of available scientific evidence regarding the safety and dangers of vapour products is growing, and since 2018 other governments have tasked scientists to conduct reviews. There is a scientific consensus that is building that warns that vaping is dangerous and not particularly useful as a cessation method, especially when purchased and regulated as a consumer product (PSC, 2022). At present, there is no updated authoritative document that has brought together available systematic reviews, meta-analyses and reports from researchers and pertinent health/government agencies; however, according to Physicians for a Smoke-Free Canada (2022), some conclusions can be drawn that warrant significant consideration when considering public health messaging and government legislation:

1. *"E-cigarettes have increased the number of young nicotine users in some countries;*
2. *Young people who use e-cigarettes are more likely to smoke conventional cigarettes;*
3. *Dual use is common and harmful;*
4. *When purchased as consumer products, e-cigarettes are not effective cessation aids;*
5. *E-cigarettes cause damage to respiratory and circulatory systems;*
6. *Other governments have provided more recent scientific assessments." (PSC, 2022)*

**The Southwest Tobacco Control Area Network recommends that Health Canada's messaging on vaping and the safety of vapour products be reviewed, revised and updated to reflect all available evidence.**

## Vapour Product Flavouring and Additives

The plethora of flavours in vapour products has posed significant challenges in public health efforts to halt vapour product uptake, especially by young people. Youth consider the flavour of vaping products to be the most important factor when trying e-cigarettes, and vaping initiation is more likely to occur with fruit, sweet, menthol and cherry flavoured products (Zare et al. 2018). Additionally, when non-traditional flavours are restricted and mint and menthol remain on the market, young people shift their purchasing and consumption preferences toward mint and menthol flavour (Morean et al., 2018; Diaz et al., 2020). The exclusion of menthol and mint flavours from the pending ban on flavours under the *Tobacco and Vaping Products Act* and regulations needs to be revisited. According to Al-Hamdani, Hopkins, and Davidson (2021) and the 2020-2021 Youth and Young Adult Vaping Project, almost all vapour product users consumed a flavoured vape juice both at initiation (91.9%) and at present (90.3%). In addition, in most provinces, berry, mango and mint/menthol were the most reported flavours being used (Al-Hamdani, et al., 2021).

**The Southwest Tobacco Control Area Network highly recommends Health Canada to adopt the regulation to ban all vapour product and e-substance flavours, including mint and menthol or a combination of mint/menthol, except for tobacco flavoured products, without delay.**

## Vapour Product Promotion and Advertising

The current restrictions on advertising and promotional activities do not adequately protect youth. Vaping products should be brought under the same advertising and promotion control framework as tobacco. Advertising at such places as recreational facilities, restaurants, places of entertainment, post-secondary institutions, broadcast media, in print publications and online/social media should be prohibited given the potential for youth exposure. Vapour product advertising should only be information advertising or brand preference advertising, which would align the vaping product promotional framework with the approach applied to tobacco products. A 2019 national Leger poll found that 86% of Canadians believe that the government should apply the same advertising restrictions to vaping products with nicotine as it does to tobacco products in order to protect youth (Leger, 2019). Additionally, there should be a complete ban on offering free or discounted vaping

products. There is a substantial body of evidence that supports price control measures and strong taxation regimes for reducing youth and young adult smoking initiation, as they are more sensitive to price increases (Public Health Ontario, 2017). According to Huang, Tauras and Chaloupka (2013) and research conducted by Corrigan and colleagues (2021), policies increasing the price of vapour products, either through a taxation regime or limiting rebates, discount pricing, and coupons/bulk buying incentives could dissuade relatively few older adult cigarette smokers from switching to e-cigarettes while at the same time, be highly effective at preventing youth and young adults from initiating the use of vapour products.

**The Southwest Tobacco Control Area Network highly recommends that Health Canada implement a comprehensive framework that strictly regulates advertising and promotional activities in alignment with current controls in place for tobacco products. Further, the inclusion of product pricing measures and prohibitions on incentive and bulk buying programs are required.**

**On-Screen Impressions of Smoking and Vaping**

For over a decade, staff members from the Southwest Tobacco Control Area Network have been active members of the Ontario Coalition for Smoke-Free Movies (OCSFM) and have closely followed emerging evidence about the impact on youth when they observe tobacco and vapour product use on screen.

OCSFM's extensive experience on this issue, including frequent interactions with colleagues and researchers from the United States has led to the conclusion that frequent exposure of youth to both smoking and vaping on theatre screens, on television and on-line continuously encourages youth to try or continue using both tobacco and vapour products (Truth Initiative, 2021; Bennett et al., 2022; US Surgeon General, 2012).

Prior to the introduction of multiple viewing platforms and ubiquitous streaming services for both movies and episodic series, the on-screen presence of tobacco products was largely limited to combustibles, usually cigarettes, and usually seen in movies in theatres. Smoking impressions and tobacco imagery within movies in North America has very rarely been the subject of a "restricted" movie rating. Internationally replicated research that began in the early 2000s demonstrated that youth were often influenced to start smoking by seeing movie characters smoking on screen (Dalton et al., 2003). The American film industry has significant global influence, and the influence that tobacco imagery within movies has on youth should not be underestimated (Polansky, Driscoll and Glantz, 2019).

By 2016, researchers had confirmed and replicated their conclusions to the point that the World Health Organization called on signatories of the Framework Convention on Tobacco Control (FCTC), of which Canada is one, to implement the following policy measures, in line with the guidelines of article 13, to reduce the impact that smoking in the movies is having on youth tobacco use initiation:

- Require adult ratings for films with tobacco imagery to reduce overall exposure of youth to tobacco imagery in films;
- Certify within movie credits that film producers received nothing of value for using or displaying tobacco products in a film;
- Prohibit the display and identification of tobacco brands in films;
- Make media production companies ineligible for public subsidies and grants if they show smoking or tobacco brands, or identify a relationship with the tobacco industry; and,
- Require strong anti-smoking advertisements to be shown prior to showing films that contain tobacco imagery through all distribution channels (cinemas, televisions, online, etc) (World Health Organization, 2015).

The platforms on which youth can access movies, episodic series and other content today have multiplied since the 2000s. Streamed films and episodic series are readily accessible in the home, in theatres and on various portable media devices. While these products are often preceded by advisories about violence, drug use, explicit sexual content, or mature themes, only Netflix and Disney+ make any mention of smoking. The WHO's policies noted above are entirely disregarded. This disregard takes on even greater importance as new research from the United States shows that when youth see tobacco smoking on-screen, many youth respond by initiating the use of vapour products (Bennett et al., 2022). According to the US Truth Initiative, "…research shows **on-screen exposure to tobacco imagery makes young people more likely to start vaping**. A landmark 2020 study published in Preventive Medicine, found that exposure to smoking images through episodic programming can triple a young person's odds of starting to vape nicotine*"* (Truth Initiative, 2022). The Truth Initiative's

2021 report, *While You were Streaming: Nicotine on Demand* shows that 60% of young people's top 15 favorite streaming and broadcast season shows released in 2020 featured smoking, exposing an estimated 27 million youth to tobacco imagery (Truth Initiative, 2021). The report also highlights the poor performance of Netflix, one of the most popular on-line streaming platforms with viewers of all ages. Despite efforts by the US National Association of Attorneys General to urge US streaming services and creative guilds to limit tobacco depictions in programming appealing to youth, Netflix "remains the worst offender four years in a row based on its new 2020 season releases and popular binge-worthy shows" (Truth Initiative, 2022). Canadian youth watch much the same media content as their counterparts in the United States; therefore, the latest findings should be cause for alarm as there is no evidence-based reason to conclude that Canadian youth are less-susceptible to the influence of frequent exposure to on-screen smoking and (increasingly) vaping.

At present, there are no provincial restrictions in place to prevent – or reduce the likelihood of - youth exposure to on-screen smoking or vaping. While Ontario did at one time have a legislated requirement that film advertising had to contain an advisory of tobacco use if warranted, recent legislation removed that requirement. The 2020 *Ontario Film Content Information Act* cancelled the province's previous film rating system, and now asks "exhibitors" to advise moviegoers about film content, but without prescribed regulations specifying how this requirement should be achieved.

**In light of the increasing evidence about the pervasiveness of on-screen smoking and its effect on the initiation of youth smoking and vaping, the Southwest Tobacco Control Area Network recommends that Health Canada explores the enactment of WHO's policy options to address on-screen tobacco and vaping imagery.**

## ***SECTION 2***
## ***PROTECT THE HEALTH OF YOUNG PERSONS AND NON-USERS OF TOBACCO PRODUCTS FROM EXPOSURE TO AND DEPENDENCE ON NICOTINE THAT COULD RESULT FROM THE USE OF VAPING PRODUCTS***

*Q.1 Are the current restrictions in the Act and its regulations sufficient to protect the health of young persons from exposure to and dependence on nicotine that could result from the use of vaping products?*

*Q.2 Are the new restrictions on nicotine concentration levels sufficient to protect youth and non-users of tobacco products from nicotine exposure? If not, what additional measures are needed?*

*Q.3 Are there other measures that the Government could employ to protect the health of young persons from exposure to and dependence on nicotine from vaping products?*

*Q.4 Has scientific evidence emerged in this area since the legislation was enacted in 2018 that points to the need for additional action or further restrictions?*

### Nicotine Concentration and Uniform Dosing Levels

Data from the 2018-19 Canadian Student Tobacco Alcohol and Drugs (CSTADS) survey showed that 20.2% of Canadian students (approximately 418,000) had used an e-cigarette (with or without nicotine) in the past 30 days (Health Canada, 2019). Students that reported vaping (with or without nicotine) in the past 30 days were vaping regularly, with approximately 40% reporting daily or almost daily use (Health Canada, 2019). CSTADS also showed that vaping had led to an overall increase in nicotine use by youth, which suggested that vaping had not replaced smoking behaviours among young people. In fact, the total prevalence of vaping and smoking among young people was much higher than the prevalence of smoking in that population a decade ago. By far, most of the youth in Canada who vaped were using devices that contained nicotine, with 87.6% of all current grade 7 – 12 students vaping nicotine (Health Canada, 2019). In addition, according to the 2020-2021 Youth and Young Adult Vaping project, of the 3000 individuals between the ages of 16 and 24 who were interviewed, 64.3% reported using vape juice containing the highest possible concentrations of nicotine (50-60 mg/ml) (Al-Hamdani et al., 2021).

Nicotine is a highly addictive substance that poses significant risk, especially to young people. The brain continues to develop until an individual reaches the approximate age of 25. Exposure to nicotine during brain development can result in nicotine addiction, mood disorders, permanent lowering of impulse control, and changes to attention and learning (NASEM, 2018). Other health impacts include increased blood pressure, increasing risk of heart disease and stroke (Gonzalez and Cooke, 2021), and the potential for increased risk of the spread of breast cancer to the lungs (Huynh et al., 2020). The

adverse effects from the use of high concentrations of nicotine include vomiting, headaches, dizziness, nausea and in extreme cases, fainting and nicotine poisoning (NASEM, 2018).

Federal regulation of nicotine levels offers consistent protection from nicotine addiction for youth across Canada, by bringing the current patchwork of provincial regulations into alignment across Canada. The federal regulation to limit nicotine concentration in vaping products to a maximum of 20 mg/ml has been supported by many public health agencies across Canada and is in alignment with the European Union Commission. Nicotine is a highly addictive substance and reported youth preferences for products with the highest levels of nicotine (Al-Hamdani et al., 2021) justifies the requirement for Health Canada to monitor the scientific evidence on an ongoing basis and adjust product limits accordingly.

Another important factor related to nicotine concentration levels is the application of vapour product design standards to ensure the consistent and uniform dosing of nicotine to vapour product users. According to the European Union's (EU) Commission investigating the latest available evidence on vapour products, at present, vapour products are not held to design and manufacturing standards that ensure that the device delivers the same amount of nicotine per puff by the user (European Union SHEER, 2021). Given that cigarettes are engineered to deliver consistent doses of nicotine, it appears logical that e-cigarettes should do the same if they are to effectively replace nicotine delivered from cigarettes.

**The Southwest Tobacco Control Area Network supports the immediate enactment of the 20 mg/ml nicotine concentration level maximum for vapour products, along with the development of an annual review of available scientific evidence which would allow for downward adjustments if necessary. Further, it is recommended that Health Canada impose product engineering standards to ensure uniform nicotine dosing so that users know how much nicotine they are inhaling.**

## SECTION 3
## *PROTECT THE HEALTH OF YOUNG PERSONS BY RESTRICTING ACCESS TO VAPING PRODUCTS.*

*Q.1 Are measures in the Act sufficient to prevent youth from accessing vaping products? If not, what more could be done to restrict youth access to vaping products?*

*Q.2 Are there other measures that the Government could employ to protect youth from accessing vaping products?*

*Q.3 Has scientific evidence emerged in this area since the legislation was enacted in 2018 that points to the need for additional action or further restrictions?*

### Retailer Prohibitions of Sales of Tobacco and Vaping Products

The Middlesex-London Health Unit (MLHU), a member public health unit of the SWTCAN, reported that between 2020 and 2022, they observed an increase in the number of tobacco youth access test shopping failures, as well as an all-time high rate of vapour product youth access test shopping failures. Prior to 2020, MLHU's tobacco and vapour product youth access compliance rates were ~99.9%. Tobacco Enforcement Officers (TEOs) within Middlesex-London are noting an alarming trend. Since October 2021, TEOs and youth test shoppers have completed 200 youth access checks for vapour products that have resulted in 21 failures (89.5% compliance rate), with more retailers yet to be inspected. The majority of the youth access failures were at non-specialty vape stores, including convenience stores and gas stations, using youth test shoppers who are between 15 and 16 years of age -- well below the legal age of 19 years in Ontario.

Under the *Smoke-Free Ontario Act, 2017 (SFOA, 2017)*, only vapour products flavoured with mint, menthol and tobacco can be sold in non-specialty vape stores (e.g. convenience stores, gas station kiosks, grocery stores, etc.); whereas, vapour products that contain other flavours must only be sold in age-restricted specialty vape stores. Furthermore, under the *SFOA, 2017*, vapour products that have a nicotine concentration of greater than 20 mg/ml can only be sold in age-restricted specialty vape stores. In the Middlesex-London area, during this latest round of youth access inspections, many of the vapour products that were sold to youth test shoppers from non-specialty vape stores were flavoured with fruit and candy-flavoured additives, and had a nicotine concentration of greater than 20 mg/ml, despite the provincial legislation. The illegal sale of these products has resulted in the issuance of charges for the sale of prescribed vapour products in a prohibited place and the seizure of these products. Between June 2021 and March 2022, tobacco enforcement officers (TEOs) for MLHU have conducted a total of 5 vapour product seizures, with estimated values ranging from $200 - $25,000 from each establishment. In addition to the loss of merchandise, fines under the *SFOA, 2017* are also applied for each offence;

however, it has become apparent that the fines and seizures of vapour products are an insufficient deterrent.

Under the *SFOA, 2017*, routine non-compliance with tobacco sales offences results in the issuance of an automatic prohibition order under Section 22. At present, there is no automatic prohibition lever that can be applied to retailers who continue to sell vapour products to persons under the age of 19 years, nor for non-specialty vape stores that continue to sell vapour products that should only be available for sale in age-restricted stores in Ontario. Operators have shared with MLHU TEOs that the total revenue from sales of vapour products alone far exceeds both the fine amounts and the risk of product seizures and is viewed as a cost of doing business. Based on the current compliance rate and reported retailer behaviors, current vapour product regulations are insufficient.

**The Southwest Tobacco Control Area Network recommends that Health Canada implement an automatic prohibition regime for both tobacco and vaping products under the TVPA modelled after Section 22 of the *Smoke-Free Ontario Act, 2017,* for repeated convictions against retailers including those who:**

- **sell tobacco and/or vaping products to persons under the legal age;**
- **sell flavoured tobacco and vaping products prohibited by law; and,**
- **sell vaping products with nicotine concentration levels that exceed 20 mg/ml.**

## Reciprocal Relationships and Cooperation Between Federal and Provincial Inspectors

In Ontario, the display, promotion and sale of tobacco and vaping products at retail are regulated by both provincial and federal legislation. The *TVPA* is enforced by Health Canada Inspectors exclusively, who are responsible for monitoring and ensuring compliance with the *Act* and the Regulations. In Ontario, public health unit staff are designated by the authority outlined under the *Smoke-Free Ontario Act, 2017,* to enforce the requirements and restrictions at retail under provincial legislation exclusively, with no authority under the *TVPA.*

This means that if non-compliance with the *TVPA* and/or Regulations are observed by the local public health inspectors, the only recourse available is to refer the non-compliance and possible infraction to the Health Canada Inspectorate. Given the size and scope of jurisdiction that falls to the Health Canada Inspectorate, it is difficult for their Inspectors to respond to the referral in a timely matter. This means that in many cases, vapour products, prescribed by federal law to be "illegal" and subject to federal seizure, remains within the store for continued sale. There is significant consumer demand for this product; therefore, despite warnings issued by provincial inspectors, product will remain on store shelves available for sale or for distribution through other illegal means. In Ontario, there has been some success with reciprocal relationships and collaboration between Ontario Ministry of Finance Inspectors (enforcement of the *Tobacco Tax Act*) and public health staff (enforcement of the *SFOA, 2017*). For example, if illegal tobacco products (under the *Tobacco Tax Act*) are found within a retailer, and a Ministry of Finance Inspector is not within the jurisdiction, under direction of the Ministry of Finance Inspector, the Health Unit Inspector will safely secure the product off site until the Ministry of Finance Inspector can attend to seize the product for their investigation. Not only does this reciprocal and collaborative relationship help to remove illegal products from the marketplace, but it also increases public and retailer perception of a greater enforcement presence, which contributes to greater compliance overall. It is recommended that a similar arrangement be explored between federal and provincial enforcement agencies given the continued availability of flavoured and high nicotine concentration products. Alternatively, the cross designation of provincial and federal inspectorate for sections of the *TVPA* and Regulations that pertain to retail could also be explored.

**The Southwest Tobacco Control Area Network recommends that Health Canada engage with provincial Ministries of Health and representatives from local public health enforcement to explore the options that exist to support more timely enforcement action.**

## Tighten Restrictions for Online Retail Marketing

Besides the availability of vapour products at retail outlets such as convenience stores, gas stations, grocery stores, and specialty vape stores, vapour products are widely available for sale through websites and social media (Hammond, et al., 2015). While many online vendors use age-verification measures during online purchase, people under the age of 18 years are still able to purchase vapour products online (Hammond et al., 2015). In 2017, the Canadian Tobacco and Drug Survey

(CTADS) indicated that more than 75% of youth age 15-19 years who tried a vaping product borrowed, shared or bought it from a friend or relative (Health Canada, 2018). In 2019, the Canadian Tobacco and Nicotine Survey showed that social access of vaping products among those aged 15-19 years had dropped to 58%, and 43% of this age group purchase from retail sources, including online vendors (Health Canada, 2019).

Underage youth who purchase vaping products online either falsely claim to be of legal age when they access the website, or they are not required to show proof of age. A content analysis of internet e-cigarette vendor practices discovered that most vape vendors (over 60%) did not require age verification or relied on ineffective strategies such as checking a box to verify legal age (Williams et al., 2018). Similarly, Gaiha and colleagues (2020) found that more than a quarter of underage e-cigarette users surveyed were not required to verify their age when purchasing e-cigarettes online.

The local experience within the Middlesex-London jurisdiction is in congruence with the evidence. Since resuming in-person learning within Middlesex-London schools in the fall of 2021, approximately 80% of youth are telling TEOs they buy vapour products online. Young people are reporting that they find it easy to get vaping products through online sources. One youth stated that the vapour products are delivered to their mailbox and that he can easily conceal the purchase from his parents because it is his responsibility to pick up the mail after school.

Some specialty vape stores that formerly operated a brick and mortar store within the Middlesex-London jurisdiction have shifted to manufacturing and wholesale, and/or to online-based operation to continue to sell flavoured and high nicotine concentration products to all ages, with less enforcement scrutiny. These products are shipped directly to customers' houses or offered through curbside pickup. This process applies the obligation of age verification to the agents/agencies used for delivery. Enforcement agencies, both at the federal and provincial levels are challenged to be able to effectively monitor retailer compliance with youth access provisions.

Industry brand-incentive programs, like the "Vuse – Click and Collect" program, are also operating within southwestern Ontario. This program allows customers to place their orders online and then pick up the vapour products, including all flavours and nicotine concentrations, at select convenience stores. Programs like this appear to have been able to find legislative loopholes and they contribute to the erosion of progress that had been made to prohibit youth access to tobacco and vapour products and to restrict access to flavoured and high nicotine concentration vapour products.

The *TVPA* prohibits youth access to vaping products in a public place or in a place to which the public has access, which includes online retailing. The *Act* specifies that a person, including a retailer, must verify the age of a person purchasing vaping products, however it does not specify how age verification is to be implemented. The current system on many websites of clicking a box to attest to being of age has obvious pitfalls.

**The Southwest Tobacco Control Area Network recommends that Health Canada works with provincial Ministries of Health to implement consistent and strict requirements to regulate online sales, including the following measures:**

- **Require online retailers to post information advising prospective customers that the sale of vaping and tobacco products are restricted to persons of legal age;**
- **Require two-step age verification for online retailing - the two-step process should involve two authentication methods performed one after the other to verify identity;**
- **Require online retailers to utilize third-party verification services;**
- **Require tobacco and vapour products to contain a label that states that age verification is required at delivery;**
- **Upon delivery, require that a signature be obtained from the person who ordered the package, confirming they are of legal age, and packages must not be left on doorsteps;**
- **Require that delivery be restricted to prescribed carriers.**

## Enactment of a Tax and Vapour Product Pricing Regime

There is unequivocal evidence documented in the tobacco control literature that price increases result in decreased demand and use of cigarettes, and increased intentions to quit smoking (SFO-SAC, 2017). Many provinces have proposed or passed

legislation to tax vapour products, including British Columbia, Alberta, Prince Edward Island, Saskatchewan and Newfoundland Labrador. There exists the opportunity to enact a national tax regime on vapour products to reduce the consumption of vapour products by youth and young adults as they tend to be more price sensitive than adults (U.S. Department of Health and Human Services, 2000). The revenue from taxes from tobacco products along with the revenue from the taxation regime applied to vapour products could be used to fund comprehensive tobacco and vapour product control programming, including prevention and cessation efforts, increased compliance monitoring and enforcement, and ongoing research. A complementary measure to increase the retail price of tobacco and vapour products is to mandate a minimum pre-tax set price minimum (Feighery, et al., 2005). Setting minimum price limits inhibits the manufacturers' ability to use discount pricing and the retail sale of low-cost brands or devices to offset the price increases from taxation (SFO-SAC, 2010). Minimum price polices are effective and widely used to reduce alcohol consumption and harms (Anderson, et al., 2009). The taxation level and the set price minimums for vapour products should be set independently from tobacco products, with careful consideration being given to ensure that e-cigarettes do not become more expensive than cigarettes but set high enough to deter youth and young adult initiation. The 2021 federal budget announced the Government of Canada's intention to introduce a new taxation framework for vaping products in 2022.

**The Southwest Tobacco Control Area Network recommends that Health Canada enact a comprehensive, national vapour product taxation and pricing regime without delay, to reduce youth and young adult consumption and associated harms from vapour product use.**

## SECTION 4
## *PREVENT THE PUBLIC FROM BEING DECEIVED OR MISLED WITH RESPECT TO THE HEALTH HAZARDS OF USING VAPING PRODUCTS*

*Q.1 Are the current measures in place sufficient to prevent the public from being deceived or misled about the health hazards of vaping products?*

*Q.2 What additional measures would help reduce the misconceptions about the health hazards of vaping products?*

*Q.3 Has scientific evidence emerged in this area since the legislation was enacted in 2018 that points to the need for additional action or further restrictions?*

### Appealing Vapour Product Marketing and Unsubstantiated Health Claims

Websites selling vapour products online are ubiquitous and use marketing tactics that are appealing to youth. In 2019, the Ontario Tobacco Research Unit (OTRU) collected samples of flavoured vaping products from online Canadian vape stores and found several examples of flavoured vaping products with attractive packaging, design elements, names and descriptors with youth-appeal (O'Connor, et al., 2019). Furthermore, researchers who conducted a systematic content and legal analysis of the claims made by e-cigarette manufacturers and retailers on their websites concluded that the vast majority of websites made at least one health-related claim, focusing on potential health benefits while minimizing or eliminating information about possible harmful effects of vaping products (Klein, et al., 2016). Grana and Ling's (2014) content analysis of e-cigarette retail websites also discovered that health claims and cessation messages that are unsupported by current scientific evidence are frequently used by vapour product retailers to sell vaping products (Grana and Ling, 2014). Vaping products have not been approved by Health Canada as a smoking cessation aid because they are not currently tested, manufactured, and regulated as such in Canada. Therefore, claims about vapour product efficacy as a cessation tool should be strictly prohibited.

Enforcement reports from Health Canada inspectors reinforce the lack of compliance by online retailers with current promotion and advertising restrictions under the *TVPA*. Between July 2020 and March 2021, Health Canada inspectors conducted inspections of Instagram social media accounts to assess vapour product industry compliance, with a focus on publicly accessible online promotions. Inspectors reviewed 304 accounts on Instagram and observed non-compliance on 53% of the accounts, resulting in the issuance of a warning letter (Health Canada, 2021) Increased enforcement (issuance of fines) and stricter prohibitions on vapour product advertising are required.

**The Southwest Tobacco Control Area Network recommends Health Canada to prohibit online vapour product retailers from making health claims, using celebrity and medical professional endorsements, and promoting e-cigarettes as a cessation aid. Increased compliance monitoring and the use of progressive enforcement measures (Part I charges and Part III summonses) are required.**

## Vapour Product Appearance and Packaging Design

In November 2019, Canada implemented plain and standardized tobacco product packaging regulations. With strict promotion and advertising rules in effect for tobacco products across Canada, the tobacco package became an important marketing tool, using colours, images, logos and distinctive fonts, finishes and sizing. According to Moodie, Mackintosh, Hastings and Ford, (2011), studies have determined that the colour, shape and size of a package can influence consumer behaviour and contributes to consumer perceptions of the product. Package design can make its contents appear safe to use, undermining the visibility, credibility and effectiveness of health warnings. The same body of evidence can be applied to the regulation of vapour products and packaging. Devices are being manufactured to look like small, discrete everyday objects, so that youth can vape discretely, hiding their nicotine addiction from parents, employers and teachers. Across southwestern Ontario, the ability to "stealth vape" in school washrooms and classrooms undermine the efforts that school staff and public health unit staff are taking to promote and enforce the *Smoke-Free Ontario Act, 2017* on school property. The devices can be customized, which complements the lifestyle messaging that youth are receiving from the internet and on social media.

**The Southwest Tobacco Control Area Network recommends that Health Canada apply a similar plain and standardized packaging regime to vapour products that Health Canada has already applied to commercial tobacco and cannabis products.**

## SECTION 5
## *ENHANCE PUBLIC AWARENESS OF HEALTH HAZARDS*

*Q.1 Have public awareness efforts been effective at educating Canadians about the health risks of vaping products?*

*Q. 2 What more could be done to educate Canadians about the health risks of vaping products?*

*Q.3 Are there still knowledge gaps to fill with regard to the health risks of vaping products? If so, what areas should research focus on?*

*Q.4 What approach should be taken to close the gap between scientific evidence and public perception so that youth and non-users of tobacco products are aware of the health risks of using vaping products, while adults who smoke are aware that they are a less harmful alternative to tobacco if they switch completely to vaping?*

## Comprehensive Review of Available Scientific Evidence Required

There has been a concerted effort to increase the body of scientific evidence available to assess the potential harms and potential benefits associated with vapour products, in an attempt to keep up with the ever-expanding vapour product market. According to a 2022 published report from Grandview Research, the global vapour product market size was valued at $18.13 billion USD in 2021 and is expected to expand at a compound annual growth rate of 30% between 2022 to 2030; North America dominated the global market with a share of over 40% in 2021 (Grandview Research, 2022). They note that the projected market growth expansion is due to the "rising awareness about e-cigarettes being safer than traditional cigarettes, especially among young people". They go on to explain that the growing online retail market amid the COVID-19 pandemic is also projected to factor into the market growth (Grandview Research 2022). The increase in the availability of vapour products by youth and young adults combined with the apparent belief and pervasive messaging found online that "less harmful" means that vapour products are safe is a significant public health concern.

As noted by Physicians for a Smoke-Free Canada (2022), the 2018 NASEM assessment of evidence on e-cigarette and vapour products relied on only one-third of the evidence that is available today. Since the release of the publication, researchers have developed a greater understanding of the potential harms associated with e-cigarette use, including health harms from dual use of vapour products and cigarettes and the potential for vapour products to aid in smoking cessation. Messaging available on Health Canada web pages require review and revision to incorporate findings from the growing body of scientific evidence.

- ***Dual use of combustible cigarettes and e-cigarettes is common and harmful.***

  Health Canada's webpage on Vaping and Quitting Smoking (2020) states that if individuals switch completely from

smoking cigarettes to using vapour products, individuals will experience short-term general health improvements. The challenge with this messaging is that research has shown that in Canada, 38% of Canadian vapers are people who both smoke cigarettes and vape (PSC, 2021). In addition, the 2020 Canadian Tobacco and Nicotine Survey results showed that although youth and young adults between the ages of 15 and 24 made up only 15% of the surveyed population, they represented 40% of those who reported that they vape. The emphasis on the harm reduction approach clouds the fact that there is scientific consensus that using both vapour products and conventional cigarettes is likely more harmful than only smoking or only using vapour products (PSC, 2022), and youth and young adults are then more susceptible to trying vapour products because 'they aren't as bad as smoking'.

- ***E-cigarettes cause damage to respiratory and circulatory systems.***

  The available scientific evidence regarding the impact of vapour product use on respiratory and circulatory systems has increased substantially, with hundreds of studies examining the health harms in laboratory studies of both animals and humans.

  - Researchers have concluded that the damage caused by vapour products leads to lung and heart disease and stroke (Keith and Bhatnagar, 2021). Vapour product use may also compromise the ability to remove microbial pathogens, increasing the risk of infection from viruses, fungi and bacteria (Keith and Bhatnagar, 2021).
  - In another comprehensive review of cardiovascular effects, findings from Buchanan and colleagues (2020) suggest that vapour product use is associated with inflammation, oxidative stress and haemodynamic imbalance increasing risk of cardiovascular disease (Buchanan et al., 2020).
  - In a review of 38 studies measuring cardiovascular effects of e-cigarettes, "most studies suggest potential for cardiovascular harm from electronic cigarette use, through mechanisms that increase risk of thrombosis and atherosclerosis" (Kennedy et al, 2019).
  - A 2020 review and meta-analyses of vapour product impact on lung health showed that e-cigarette use was associated with a 39% increase in the risk of asthma and a 51% increase in the risk of developing chronic obstructive pulmonary disease; studies conducted within laboratories showed influence on biological processes that contribute to respiratory harm and illness (Wills et al., 2020).
  - According to Lauren Davis and colleagues (2022), based upon a review of the pulmonary effects of long-term vaping product use, they conclude that e-cigarette use is "…likely to result in irreversible parenchymal lung tissue damage and impaired gas exchange, contributing to chronic lung conditions in long-term vapers".

- ***There is insufficient evidence to support/promote vapour products as a cessation tool when sold and regulated as a consumer product.***

  Health Canada's web page on Vaping and Quitting Smoking reads that "quitting smoking can be difficult, but it is possible. Vaping products and e-cigarettes deliver nicotine in a less harmful way than smoking cigarettes". The web page further states that "while evidence is still emerging, some evidence suggests that using e-cigarettes is linked to improved rates of success" (Health Canada, 2020). There has been a growing body of scientific evidence to evaluate the effectiveness of vapour products to help those addicted to tobacco to quit, with mixed results. Physicians for a Smoke-Free Canada (2021) compiled a summary of scientific reports published after both the release of NASEM (2018) and the release of European Union's scientific advisors "Final Opinion on Electronic Cigarettes" (2021). The following conclusions were drawn that warrant further investigation by Health Canada:

  - Published studies to date, including longitudinal data analysis, randomized control trials and meta-analysis of e-cigarettes as consumer products (i.e. not regulated or monitored in a clinical setting), when dual use of smoking and vaping was assessed, found high levels of dual use. Further, those that successfully quit smoking had a high prevalence of sustained use of e-cigarettes (PSC, 2021).
  - Vapour products may be helpful as smoking cessation aids, but the available evidence indicates that this is only observed in clinical settings with strict product oversight. Vapour products may have the potential to be as effective as other approved methods for cessation (e.g. nicotine replacement therapy, varenicline, buproprion, etc.); however, they do not meet minimum threshold levels for safety for widespread use. In Canada, vapour products are regulated, marketed and sold as a consumer product (not a drug). Due to the high risk of dual use, sustained addiction to vapour products, growing scientific consensus regarding respiratory and cardiovascular

harms associated with use, and the high risk of uptake of vapour products by never smokers, a precautionary approach remains prudent (PSC, 2021).

At present, vaping products have not been approved by Health Canada as a smoking cessation aid because they are not currently tested, manufactured, and regulated as such in Canada. Therefore, until an intensive review of the latest evidence is completed, Health Canada's messaging is confusing and contributing to misperceptions of perceived product safety.

**The Southwest Tobacco Control Area Network recommends that Health Canada's messaging on vaping and the safety of vapour products be reviewed, revised and updated to incorporate all available evidence for public consumption and comprehension. Any legislated health warnings on vapour products or product promotional materials should be reviewed to ensure congruence with the growing body of scientific evidence available for vapour products.**

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**From:** allhealthunits on behalf of Miller, Christine
**To:** All Health Units
**Subject:** [allhealthunits] Simcoe Muskoka District Health Unit (SMDHU) 2020 & 2021 Annual Report
**Date:** Tuesday, June 21, 2022 11:48:55 AM

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**Attention Ontario Boards of Health**

*Sending on behalf of Anita Dubeau, Board Chair for the Simcoe Muskoka District Health Unit*

Hello,

I am pleased to provide you with a link to Simcoe Muskoka District Health Unit's ***2020 & 2021 Annual Report***. This report highlights the health unit's work and accomplishments in 2020 and 2021. Most of this work over these two years was concentrated on the agency's response to the COVID-19 pandemic. This focus had a significant impact on the delivery of SMDHU's regular public health services and programs; however, priority programs were maintained with restricted capacity, which are also highlighted in this report.

As Chair of the SMDHU Board of Health, I am proud of what this agency has accomplished over the past two years to protect and promote the health and well-being of those who live, work and play in Simcoe Muskoka, particularly our staff's unwavering dedication to preventing the transmission of COVID-19 in our communities.

I would also like to take a moment to recognize all our community partners who played critically important roles in their respective ways in the response to the pandemic. Together as a community we accomplished much, and our collaborative efforts not only helped to safeguard the health of our residents through measures to help prevent the transmission of the virus, but also contributed to less severe illness and many lives saved through assessment, testing, case management, vaccination, treatment, and compliance and enforcement of public health measures and mandates. Although the pandemic is not over and we will be dealing with COVID-19 for some time to come, I would like to thank you, on behalf of the Board of Health, Dr. Charles Gardner and the entire staff of the health unit, for your invaluable partnership and your exemplary work in response to the pandemic.

I request that you share our 2020 & 2021 Annual Report with others inside and outside of your organization. If you have any questions, comments or concerns about public health issues in your community, please contact Health Connection at 705-721-7520, or 1-877-721-7520 or through the online contact form on our website.

Sincerely,
Anita Dubeau
Chair, Board of Health

**From:** Robert Cooper
**Sent:** Sunday, June 5, 2022 10:47 PM
**To:** Holland, Andrea <Andrea.Holland@hamilton.ca>; Pilon, Janet <Janet.Pilon@hamilton.ca>
**Subject:** Natural Science

Dear Councillors & Mayor;

CC Local Media

Please find attached other organizations that are following the natural science and ending COVID mandates while 5 Councillors and Mayor choose to follow their own skewed political science by bullying and firing hard working City Employees.

I am not including the four Councillors who missed the vote among the hard working City Employees referenced above.

And still I wait to have a cost disclosed on the termination of these employees.....Council couldn't even provide a date for the costs to be reported back.....just more toxic cultural leadership from this Council enforcing the lack of accountability and transparency at City Hall

Robert Cooper

https://www.cbc.ca/news/canada/toronto/toronto-police-vaccine-mandate-ending-1.6474624

https://www.theglobeandmail.com/business/article-bay-street-backs-away-from-vaccine-mandates/

https://www.cbc.ca/news/canada/newfoundland-labrador/nl-ends-vaccine-mandate-1.6466874

**From:** clerk@hamilton.ca
**To:** Kolar, Loren
**Cc:** Vernem, Christine
**Subject:** Delegation to BOH Cooper re Natural Science
**Date:** Tuesday, June 21, 2022 2:10:55 PM

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-----Original Message-----
From: City of Hamilton, Ontario, Canada via City of Hamilton, Ontario, Canada <no-reply@hamilton.ca>
Sent: Tuesday, June 21, 2022 1:39 PM
To: clerk@hamilton.ca
Subject: Form submission from: Request to Speak to Committee of Council Form

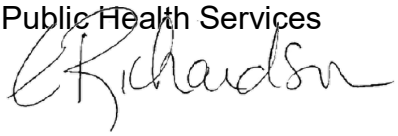
Submitted on Tuesday, June 21, 2022 - 1:38pm Submitted by anonymous user: 108.162.216.217 Submitted values are:

==Committee Requested==
Committee: Board of Health
Will you be delegating in person or virtually? In person (as of May 30, 2022)
Will you be delegating via a pre-recorded video? No

==Requestor Information==
Name of Organization (if applicable): None
Name of Individual: Robert Cooper
Preferred Pronoun:
Contact Number: [redacted]
Email Address: [redacted]
Mailing Address: [redacted]
Reason(s) for delegation request: Follow-up on my letter regarding science
Will you be requesting funds from the City? No
Will you be submitting a formal presentation? No

The results of this submission may be viewed at:
https://www.hamilton.ca/node/286/submission/627496

# INFORMATION REPORT

| | |
|---|---|
| **TO:** | Mayor and Members<br>Board of Health |
| **COMMITTEE DATE:** | July 6, 2022 |
| **SUBJECT/REPORT NO:** | Board of Health Governance Follow-Up (BOH21006(b)) (City Wide)<br>**(Outstanding Business List Item)** |
| **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<br>  |

## COUNCIL DIRECTION

At the Board of Health meeting on September 20, 2021, the following motion was passed as a result of the Board of Health Governance Education Session (Report BOH21006(a)):

> "That the Mayor and Medical Officer of Health correspond with the Ottawa and Toronto Board of Health Chairs and Medical Officers of Health to request information regarding their semi-autonomous board structures, lessons learned and outcomes that have resulted from changes in their structure and governance, with a presentation back to a future Board of Health meeting".

## INFORMATION

The purpose of this report is to provide an overview of the information shared by these public health units. It should be noted that staff previously shared a report with the Board of Health on June 14, 2021 that outlined the historical development of Hamilton's current Board of Health structure and Board of Health governance models used in other jurisdictions (Report BOH21006). The Board of Health requested this information following several delegations at the March 22, 2021 Board of Health meeting advocating for reform to Hamilton's current Board of Health to include health experts and diverse community leaders. One of the recommendations included within Report BOH21006

and approved by the Board of Health was to engage an external vendor to facilitate a governance education session. Following this session, the Board of Health passed a motion to request information from Toronto and Ottawa Public Health regarding their semi-autonomous Board of Health governance structure.

In response to this motion, a letter of request was sent to the Ottawa and Toronto Board of Health Chairs and Medical Officers of Health on December 17, 2021 (Appendix "A" to Report BOH21006(b)). Ottawa Public Health was unable to respond due to a lack of capacity related to the ongoing COVID-19 emergency response. Although Toronto Public Health did not have capacity to present to the Board of Health or provide a written response, they met with staff to share information about their semi-autonomous board structure.

Toronto currently uses a semi-autonomous Board of Health governance structure whereby the City Council appoints members as well as citizen representatives to a separate board of health; however, City Council retains the authority for budget and staffing approvals. The Toronto Board of Health consists of 13 members[1], including:

- Six members of City Council;
- Six members of the public; and,
- One education representative.

As outlined in the Toronto Board of Health selection criteria[1], the public members should collectively meet the following qualifications:

- Interest or background in issues affecting municipal public health programs and services;
- Interest or skills in planning and policy development leading to a comprehensive municipal public health agenda that meets local community needs;
- Experience in organizational activities, such as committees, non-profit groups, voluntary societies, occupational associations;
- Skills in leadership and management and/or experience in administration and budget development;
- Demonstrated skills in conflict management, negotiation and mediation;
- Ability to make a commitment to monthly involvement in Board of Health meetings and related committee or other activities; and,
- A youthful perspective, defined as an individual in the 18-30 age range, is a desired qualification for at least one public member.

[1] Toronto Board of Health (2019). Board of Health – Selection of Candidates for Interview. https://www.toronto.ca/legdocs/mmis/2019/ca/bgrd/backgroundfile-123265.pdf

In addition to these qualifications, the selection criteria outline that "experience in such areas as community development, city building, social justice, poverty reduction and equity, diversity and reconciliation would be additional assets to the board"[1].
This aligns with the information provided by Karima Kanani, Lawyer and Partner, Miller Thompson Lawyers, during the Board of Health Governance Education Session on September 20, 2021. One of the principles of good governance she reviewed was board composition. More specifically, board members should be identified based on personal attributes and technical competencies, collectively reflecting proficiencies for a skills-based board that is inclusive of diversity and representative of the community.

During staff consultation, Toronto Public Health emphasized the importance of enabling meaningful and diverse representation in local public health planning and service delivery. Furthermore, Toronto Public Health identified that there is no one board of health structure that will guarantee representation from all diverse groups and communities across a municipality. In order to gather diverse perspectives and input from citizens, they highlighted the importance of establishing and consulting with various committees and panels.

Both Toronto Public Health and Karima Kanani specified that board structure and composition is one element of good governance. Furthermore, they both identified the need for a comprehensive approach that is inclusive of the other best practices and principles of good governance, including:

- **Board conduct and processes:**
  Use of By-laws and policies to provide rigor and clarity to Board procedures as well as effective management of Board conduct;
- **Board evaluation**:
  Commitment to continuous improvement of Board governance and effectiveness through Board evaluation of its own performance and ability to meet stated objectives;
- **Community / stakeholder engagement**:
  Systematic engagement and consideration of voices and perspectives of the community and other stakeholders in decision-making to advance the needs of the community, including equity, diversity and inclusion;
- **Enterprise risk management**:
  A systematic, holistic and integrated approach to identifying, evaluating and responding to significant risks on an enterprise wide basis;
- **Relationship of governance and management**:
  Clarity and balance between Board authority and management decision-making is key to effective operations. Boards responsible for establishing policies/procedures and risk and compliance oversight, whereas management is responsible for the implementation of policies/procedures and reporting risks and mitigation plans to the Board; and,

- **Stewardship:**
  The Board is the steward of the vision, mission and values and sets the tone, culture and accountabilities.

Within Hamilton's current Board of Health governance structure, there are several mechanisms that allow the Board of Health to hear diverse voices and experiences reflective of the Hamilton community. First, citizens can delegate to the Board of Health. This continues to be an effective way for citizens to share perspectives and recommendations to inform planning and decision-making. Second, the City of Hamilton has many Volunteer Advisory Committees to Council with Council member representation on each Volunteer Advisory Committees. These Volunteer Advisory Committees include various equity seeking groups such as:

- Aboriginal Advisory Committee;
- Accessibility Committee for Persons with Disabilities (legislated requirement);
- Committee Against Racism;
- Immigrant and Refugee Volunteer Advisory Committee;
- Lesbian, Gay, Bisexual, Transgender, and Queer Volunteer Advisory Committee;
- Seniors Advisory Committee; and,
- Status of Women Committee.

In September 2020, an Equity, Diversity, and Inclusion Steering Committee was also formed. The mandate for this committee is to collaborate and exchange information to support all staff to foster equity, diversity and inclusion by:

- Continuous education, training, and courageous conversations across the organization;
- Identification, prevention, and recommendation on the removal of barriers to full inclusion to allow all employees to reach their full potential and have a strong sense of belonging;
- Supporting the successful embedding of Equity, Diversity, and Inclusion principles and practices in our policies, programs, and services; and,
- Promoting and demonstrating the core principles and behaviours of Equity, Diversity, and Inclusion to enhance workplace culture.

Public Health Services is also committed to engaging with equity seeking groups in a meaningful and collaborative way to address public health issues within the community. A recent example of this was the Vaccine Readiness Network. The Vaccine Readiness Network was an open membership group of health, education, social service and community organizations and representatives in Hamilton. The purpose of this group was to share information on the status of COVID-19 vaccine planning and distribution and to discuss shared roles to enhance COVID-19 vaccine access and confidence,

particularly among priority populations. This work highlighted the importance of engaging representatives from diverse communities in order to advance equitable health outcomes for all Hamiltonians.

Ultimately, the decision to change the current public health governance structure in Hamilton is at the discretion of the Board of Health. Any changes would require legislative change under the *City of Hamilton Act* and may also require change to the regulation under the *Health Promotion and Protection Act*.

It is important to consider the current public health landscape and potential for broader health system transformation when deliberating changes to Hamilton's Board of Health governance structure. In April 2019, the Ontario Budget included plans to consolidate the then 35 public health units into 10 new regional Public Health Entities. In November 2019, the Ministry released a discussion paper[2] on public health modernization outlining key strengths and challenges of public health in Ontario. Hamilton provided a collective response advocating that public health's unique mandate to keep people and our communities healthy, prevent disease, and reduce health inequities be maintained (Report BOH20004). The Ministry had planned further public health consultations in 2020; however, these were put on-hold due to the COVID-19 emergency response. It is anticipated that provincial direction regarding public health structuring, including governance, at both the provincial and local levels is forthcoming.

## APPENDICES AND SCHEDULES ATTACHED

| | |
|---|---|
| Appendix "A" to Report BOH21006(b): | Letters of Request to Toronto and Ottawa Public Health |

[2] Ontario Ministry of Health (2019). Discussion Paper: Public Health Modernization. https://health.gov.on.ca/en/pro/programs/phehs_consultations/docs/dp_public_health_modernization.pdf

OFFICE OF THE MAYOR
CITY OF HAMILTON

December 17, 2021

**VIA:** Mail and Email

Dr. Eileen de Villa
Medical Officer of Health
Toronto Public Health
100 Queen Street West
Toronto, ON M5H 2N2
Eileen.deVilla@Toronto.ca

Dear Dr. de Villa

We are writing on behalf of the Board of Health for Hamilton Public Health Services (HPHS) to request information about the semi-autonomous structure of the Toronto Board of Health.

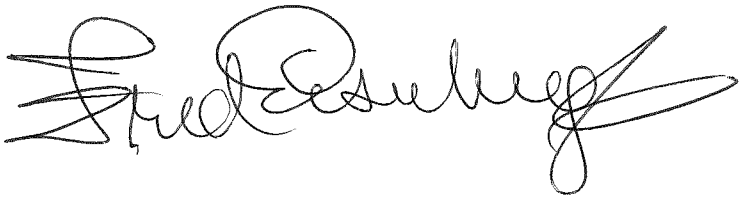
Over the past few months, the Board of Health for HPHS has endeavoured to learn more about board of health governance and structural options within the context of public health modernization. On September 20, 2021, board of health members participated in a governance education session facilitated by Karima Kanani, Lawyer and Partner, Miller Thompson Lawyers. This session provided an overview of the legal landscape of public health governance, principles of good governance, advancing diversity, equity and inclusion through governance, and alternate board of health structures.

Following that session, Board of Health members expressed interest in learning more about the semi-autonomous board of health structure. As such, we would like to request information about the Toronto Board of Health's transition to a semi-autonomous structure, including lessons learned and outcomes that have resulted from the change.



71 MAIN STREET WEST, 2ND FLOOR, HAMILTON, ONTARIO L8P 4Y5 PHONE 905.546.4200 FAX: 905.546.2340

Sincerely,



Fred Eisenberger
Mayor

Dr. Elizabeth Richardson,
Medical Officer of Health

CC: Councillor Joe Cressy, Chair, Toronto Board of Health

OFFICE OF THE MAYOR
CITY OF HAMILTON

December 17, 2021

**VIA:** Mail and Email

Dr. Vera Etches
Medical Officer of Health
Ottawa Public Health
100 Constellation Drive
Ottawa, ON K2G 6J8
Vera.Etches@Ottawa.ca

Dear Dr. Etches,

We are writing on behalf of the Board of Health for Hamilton Public Health Services (HPHS) to request information about the semi-autonomous structure of the Ottawa Board of Health.

Over the past few months, the Board of Health for HPHS has endeavoured to learn more about board of health governance and structural options within the context of public health modernization. On September 20, 2021, board of health members participated in a governance education session facilitated by Karima Kanani, Lawyer and Partner, Miller Thompson Lawyers. This session provided an overview of the legal landscape of public health governance, principles of good governance, advancing diversity, equity and inclusion through governance, and alternate board of health structures.

Following that session, Board of Health members expressed interest in learning more about the semi-autonomous board of health structure. As such, we are requesting information about the Ottawa Board of Health's transition to a semi-autonomous structure, including lessons learned and outcomes that have resulted from the change. We would also like to request that a member of the Ottawa Board of Health or staff designate attend a future HPHS Board of Health meeting to share this information.

Sincerely,

Fred Eisenberger
Mayor

Dr. Elizabeth Richardson,
Medical Officer of Health

CC: Councillor Keith Egli, Chair, Ottawa Board of Health

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

| | |
|---|---|
| **TO:** | Mayor and Members<br>Board of Health |
| **COMMITTEE DATE:** | July 6, 2022 |
| **SUBJECT/REPORT NO:** | Scarsin COVID-19 Forecasting Technology Procurement (BOH22013) (City Wide) |
| **WARD(S) AFFECTED:** | City Wide |
| **PREPARED BY:** | Ashley Vanderlaan (905) 546-2424 Ext. 4718 |
| **SUBMITTED BY:**<br><br>**SIGNATURE:** | Michelle Baird<br>Director, Epidemiology, Wellness and Communicable Disease Control Division<br>Public Health Services<br>Michelle Baird |

**RECOMMENDATION**

(a) That the Board of Health approve the single source procurement, pursuant to Procurement Policy #11 – Non-competitive Procurements, for:
   (i) Scarsin Decision Support Software platform services;
   (ii) Decision Support Software;
   (iii) Software maintenance and support until February 16, 2023, with the option to extend for up to 24 months which option may be exercised incrementally or otherwise; and,
   (iv) That the Medical Officer of Health be authorized to negotiate, enter into and execute a contract or amendment(s) to the City's existing agreement and any ancillary documents required to give effect thereto with Scarsin Corporation, in a form satisfactory to the City Solicitor; and,

(b) That the Board of Health authorize the Medical Officer of Health to execute an amendment(s) to our Collaboration Agreement with St. Joseph's Healthcare Hamilton, Hamilton Health Sciences Corporation and the Greater Hamilton Health Network to outline the continued cost sharing, use and sharing of the Scarsin Decision Support Software COVID-19 forecasting intelligence.

## EXECUTIVE SUMMARY

As per the Corporate Procurement Policy (By-Law No. 20-205, as amended) Section 4.11 (2(a)), it is recommended that Hamilton Public Health Services, through the Hamilton COVID-19 Response Table (HCRT): (1) continue to procure the Scarsin Decision Support Service platform to inform Hamilton's ongoing COVID-19 response planning and decision-making; (2) to do so by extension agreement, amendment or new agreement with Scarsin Corporation (Scarsin); and (3) to amend the Collaboration Agreement with St. Joseph's Healthcare Hamilton (SJHH), Hamilton Health Sciences Corporation (HHS) and the Greater Hamilton Health Network (GHHN). The current Scarsin contract and Collaboration Agreement are set to expire on August 16, 2022.

Per the Procurement Policy (By-Law No.20-205 as amended) Section 4.11 (2(a)), it is recognized that executing a contract or amendment to the City's existing agreement with Scarsin will exceed the Policy 11 cumulative spend threshold of $250,000, and that further engagement requires the Board of Health's approval for negotiations to enter into a single source purchase of the Scarsin Decision Support Service platform until February 16, 2023 with the option to extend for up to 24 months which option may be exercised incrementally or otherwise.

Since February 17, 2021, through the Hamilton COVID-19 Response Table (HCRT), Public Health Services, St. Joseph's Healthcare Hamilton, Hamilton Health Sciences Corporation, and the Greater Hamilton Health Network, have collectively worked with Scarsin, further to a Public Health Services acquired license to use the software. This partnership was established to perform local COVID-19 forecasting and reporting activities surrounding COVID-19 infection spread and severity in the short, medium and long-term horizons to inform our community's response. All partners have entered into a Collaboration Agreement outlining the continued cost sharing, use and sharing of the forecasting intelligence.

On both August 16, 2021 and February 15, 2022, Public Health Services entered into two six-month contract extensions with Scarsin. For the initial contract, first and second software contract extensions, and additional technical software support, as per the Procurement Policy, four Non-competitive Procurement Forms were approved by the Healthy and Safe Communities Department General Manager.

Hamilton's utilization of Scarsin's forecasting technology has helped to strengthen our community's collective response by anticipating case trajectory and severity related to COVID-19 transmission. This forecasting technology supports evidence-informed decision-making, allowing Public Health Services to take focused and collective action where it is most needed to mitigate the impacts of COVID-19, while also providing the broader Hamilton community with a line of sight into the future of evolving COVID-19 epidemiology.

**Alternatives for Consideration – Not Applicable**

## FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: Since February 17, 2021, Public Health Services, St. Joseph's Healthcare Hamilton, Hamilton Health Sciences Corporation, and the Greater Hamilton Health Network have contributed towards the cost of the software, staffing and staffing related expenses, and such contributions are outlined in Appendix "A" to Report BOH22013. Per the Scarsin Contract, the specific pricing information contained in Appendix "A" to Report BOH22013 is considered confidential and is made available in-camera.

Staffing: Dedicated staffing resources are required to manage, maintain and support the use of the Scarsin Decision Support Software. It is estimated that the current staffing model (i.e. 1.0 FTE epidemiologist; 1.0 FTE Health Analyst) would continue to be an ongoing resourcing requirement to support this platform.

Legal: Legal Services will participate in the negotiations, drafting and finalization of the extension agreement, amendment or new agreement with Scarsin.

## HISTORICAL BACKGROUND

**Table 1: Scarsin Contract Periods**

| Scarsin Contract (Software) | Timeline |
|---|---|
| Initial Contract | February 17, 2021 to August 16, 2021 |
| Additional Technical Forecasting Support | February 17, 2021 to August 16, 2021 |
| First Contract Extension | August 17, 2021 to February 15, 2022 |
| Second Contract Extension | February 16, 2022 to August 16, 2022 |
| Extension agreement, amendment or new agreement until February 16, 2023 with the option to extend up to 24 months which option may be exercised incrementally or otherwise. | August 17, 2022 to February 16, 2025 |

## POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

Based on Corporate Procurement Policy, By-Law No.20-205, as amended, Section 4.11 (2(a)), it is recognized that procurement of the Scarsin COVID-19 Decision Support Services platform software will result in a single source purchase of COVID-19 forecasting intelligence.

## RELEVANT CONSULTATION

City of Hamilton's Procurement Section has provided guidance with respect to adherence to the Procurement Policy only.

## ANALYSIS AND RATIONALE FOR RECOMMENDATION

Hamilton's utilization of Scarsin's forecasting technology has helped to strengthen our community's collective response by anticipating case trajectory and severity related to COVID-19 transmission. This forecasting supports evidence-informed decision-making, allowing Hamilton Public Health Services to take focused and collective action where it is most needed to mitigate the impacts of COVID-19, while also providing the broader Hamilton community with a line of sight into the future of evolving COVID-19 epidemiology.

Scarsin forecasting has proven value. This adaptive technology uses Hamilton's local data and sophisticated mathematical modelling to forecast the impact of different interventions, thereby informing Hamilton's key decision makers' ongoing response and recovery/post-pandemic planning.

The Scarsin model has successfully adapted to the evolving pandemic information needs and data flows. As needed, Scarsin incorporated changes in public health measures, changing transmission of variants, the impact of vaccination on the population's susceptibility, and the impacts on severe outcomes such as hospitalization and intensive care unit admissions.

The ongoing pan-sectorial collaboration of the HCRT, facilitates collective action amongst public health, health care, and primary care partners to provide a unified voice to help control the spread of COVID-19 in our community.

The intelligence generated from the forecasts is regularly shared with the Board of Health, the Public Health Leadership Team and the HCRT, informing future strategic planning based on where we are and where we are heading.

The regular public dissemination of forecasts to Hamiltonians strengthens communication transparency and supports the rationale guiding public health decision making.

## ALTERNATIVES FOR CONSIDERATION

Not Applicable.

## ALIGNMENT TO THE 2016 – 2025 STRATEGIC PLAN

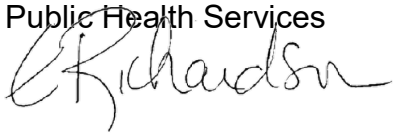
**Healthy and Safe Communities**
Hamilton is a safe and supportive City where people are active, healthy, and have a high quality of life.

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

**APPENDICES AND SCHEDULES ATTACHED**

| | |
|---|---|
| Appendix “A” to Report BOH22013 | Scarsin Software and Staffing Costs (Confidential) |

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

| | |
|---|---|
| **TO:** | Mayor and Members<br>Board of Health |
| **COMMITTEE DATE:** | July 6, 2022 |
| **SUBJECT/REPORT NO:** | 2022 Public Health Services Organizational Risk Management Plan (BOH22014) (City Wide) |
| **WARD(S) AFFECTED:** | City Wide |
| **PREPARED BY:** | Nancy Sullivan (905) 546-2424 Ext. 5752 |
| **SUBMITTED BY:**<br><br>**SIGNATURE:** | Dr. Elizabeth Richardson, MD, MHSc, FRCPC<br>Medical Officer of Health<br>Public Health Services<br>  |

**RECOMMENDATION**

That the Board of Health approve Appendix "A" to Report BOH22014, the 2022 Public Health Services Organizational Risk Management Action Plan.

**EXECUTIVE SUMMARY**

As part of the Ontario Public Health Standards (Standards), Public Health Accountability Framework and Organizational Requirements, boards of health are required to develop an organizational risk management framework, create action plans to mitigate risks, and submit an annual risk management report to the Ministry of Health.

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 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 plan relate to organizational risk.

The Public Health Leadership Team has reassessed existing risks and identified new risks to inform the 2022 PHS Organizational Risk Management Plan (Appendix "A" to Report BOH22014). The plan includes a total of 27 risks; 25 were carried over from

2021 and two are new. Of these, five have been classified as high risk as they have the highest likelihood of occurring and greatest potential impact on operations.

Action plans for mitigation and monitoring of the high risks have been developed and will be implemented by staff in 2022 (Appendix "A" to Report BOH22014). The Public Health Leadership Team will continue to review and update the action plans on a semi-annual basis.

**Alternatives for Consideration – See Page 4**

## FINANCIAL – STAFFING – LEGAL IMPLICATIONS

**Financial:** The risk assessment outlines financial risks/concerns but does not ask for new financial investments.

**Staffing:** The risk assessment outlines staffing risks/concerns but does not ask for new staffing.

**Legal:** Approval and submission of the 2022 PHS Organizational Risk Management Plan will ensure compliance with the Public Health Accountability Framework and Organizational Requirements. It also supports the Board of Health in practicing good governance and due diligence by mitigating potential organizational risks.

## HISTORICAL BACKGROUND

In 2018, the Ministry of Health introduced the Public Health Accountability Framework and Organizational Requirements (Requirements) to ensure that boards of health have the necessary foundations within the four domains of program and service delivery, financial management, governance and public health practice to successfully implement the Standards (Report BOH17010(b)). As part of the Requirements, public health units must have a formal risk management framework in place to identify, assess and address organizational risks. To demonstrate compliance with this requirement, boards of health must submit a risk management report annually to the Ministry of Health.

Accordingly, in 2018 the Public Health Leadership Team developed the first Public Health Services Risk Management Plan that identified organizational risks across 14 risk categories. This plan was based on the Ontario Public Service Risk Management Framework (Report BOH17039).

Each year, the Risk Management Plan is reviewed and updated by the Public Health Leadership Team. Action plans to mitigate the risks that have the greatest likelihood of occurring and greatest potential impact on operations are monitored and updated on a

semi-annual basis. Progress on the implementation of these action plans and risk reduction strategies is reported to the Board of Health on an annual basis.

## POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

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

## RELEVANT CONSULTATION

Following the introduction of the new Ontario Public Health Standards in 2018, a consultation on the development of the Public Health Services 2018 Risk Management Plan (Report BOH17039(a)) was conducted with Corrine Berinstein, Senior Audit Manager, Health Audit Services Team of the Ontario Internal Audit Division. Corrine Berinstein provided guidance on the interpretation and use of the Ontario Public Service Risk Management Framework. During this time, consultation was also sought from Charles Brown, Director of Audit Services, City of Hamilton, to ensure the 2018 plan was in alignment with the future direction for enterprise risk management at the City of Hamilton. The same framework used in the Public Health Services 2018 Risk Management Plan has been applied to the 2022 plan.

## ANALYSIS AND RATIONALE FOR RECOMMENDATION

The Public Health Services Organizational Risk Management Plan focuses on organizational risk and supports the Board of Health in identifying and mitigating issues that place Public Health Services at risk of not meeting established business objectives. To inform the 2022 Public Health Services Organizational Risk Management Plan, the Public Health Leadership Team reassessed risks from the 2021 plan (Report BOH21003) and identified new risks. A total of 25 risks were carried over from 2021 and two new risks were added.

The most significant organizational risks in the 2022 plan are listed below:

- **Operational or Service Delivery Risks;**
    - The Board of Health may not meet pre-pandemic program targets and service levels, or fully address service backlogs and worsening and emerging public health issues due to lack of capacity; and,
    - The Board of Health will need to identify and work through the impacts of the COVID-19 pandemic and prolonged emergency response on the organization and roles and responsibilities of Public Health Services.

- **People / Human Resources related risks;**
    - The Board of Health may be at risk of precarious staffing due to challenges with recruitment and retention, as well as staff burnout and mental health challenges due to the prolonged emergency response.

- **Information/Knowledge Risks; and,**
    - The Board of Health may be at risk due to unreliable information management systems and practices.

- **Governance / Organizational Risks**
    - The Board of Health may be at risk of incomplete risk management due to the delay in fully implementing the risk management framework into Public Health Services project and program planning.

This is a reduction from the 13 high-risk items in the 2021 Organization Risk Management Plan. The majority of the high-risk items in the 2021 plan were associated with the impact, uncertainty and persistence of the COVID-19 pandemic and no longer have the same likelihood of occurring and potential impact on operations as we transition into the early recovery stage.

Action plans were developed for all five of the high-risk items listed above as they have the highest likelihood of occurring and greatest potential impact on operations (Appendix “A” to Report BOH22014).

## ALTERNATIVES FOR CONSIDERATION

The Board of Health could choose to amend the 2022 PHS Organizational Risk Management Plan.

## ALIGNMENT TO THE 2016 – 2025 STRATEGIC PLAN

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## APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report BOH22014: 2022 Public Health Services Organizational Risk Management Action Plan

Appendix “B” to Report BOH22014: Ontario Public Service Risk Management Strategy & Process Toolkit

# 2022 Public Health Services Organizational Risk Management Action Plan

The chart below shows the **current ratings** for 2022 risks categorized by low, medium, high.

| IMPACT | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| 5 | | 1.1 Budget pressures<br>8.1 Network outage<br>8.3 IT space limitations<br>12.2 Violence | | | 3.1 Precarious staffing |
| 4 | | 6.1 Outdated policies & procedures<br>12.1 Network security<br>13.1 Health inequities | | 5.1 Information management | 2.1 Capacity to meet program targets or fully address deficits of care/worsening health issues |
| 3 | 1.3 Fraud or corruption<br>1.4 Funding reallocation and/or loss of contracts<br>12.3 Theft | | 2.3 Losing or degrading community partnerships and clients<br>2.4 Planning tables continuing without PHS<br>4.1 Enviro emergency<br>8.2 Unsupported technology<br>9.1 Elected officials' balancing responsibilities<br>11.1 Negative public perception (lack of understanding) | 9.2 Incomplete risk management | 2.2 Changes to organization and roles & responsibilities due to impacts of COVID-19 and prolonged emergency response |
| 2 | | 11.2 Negative public perception (reduced access to services) | 1.2 Financial management risk due to forecasting gaps<br>9.3 Impact of changing priorities following municipal election<br>10.1 Privacy breaches | 8.4 Capacity to support the implementation of new technologies and processes<br>14.1 Impact of changing provincial policies | |
| 1 | | | | | |

**LIKELIHOOD**

**Overall Risk Rating**

= Low Risk
= Medium Risk
= High Risk

## 2022 City of Hamilton Public Health Services Organizational Risk Management Action Plan

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

| RISK IDENTIFICATION | | | | RISK ASSESSMENT | | RISK REDUCTION | | | |
|---|---|---|---|---|---|---|---|---|---|
| **ID #** | **Risk Exposure** | **Description of Risk** | **Cause/Source of Risk** | **Current Mitigation Strategies (what are we doing)** | **Rating Scale 1 (low) - 5 (high) (Likelihood x Impact)** | **Action Plan (what else can we do?) Only for HIGH risk** | **Timelines** | **Residual Risk once action plan fully implemented (L x I)** | **Status to Date** |
| **2. Operational or Service Delivery Risks** | | | | | | | | | |
| **2.1** | The Board of Health may not meet pre-pandemic program targets and service levels, or fully address service backlogs and worsening and emerging public health issues due to lack of capacity. | Lack of capacity due to re-deployment of staff to COVID-19 response in the first 4 months of 2022 and impact of prolonged response (e.g., staff fatigue/burn-out) has resulted in resources being unavailable to resume PHS programs and services, as well as to identify and address deficits of care/service backlogs and worsening and emerging public health issues. | Lack of capacity due to continued deployment of staff to COVID-19 response in the-first 4 months of 2022, staff fatigue due to prolonged COVID-19 response, and challenges with retention & recruitment.<br>Time needed to allow for transition and recovery. | 1. Continue implementing change management strategies to support staff and maintain adapted service delivery levels as capacity allows.<br>2. Clear communication regarding service levels to public and funders.<br>3. Seize opportunities as they arise to implement lessons learned during COVID-19 response. | **L5, I4** | 1. Determine and communicate 2022 PHS priorities.<br>2. Determine and communicate priorities for addressing deficits of care and order of program re-opening.<br>3. Review program and financial data on a regular basis to demonstrate accountability and ensure effective delivery of services in an efficient and fiscally responsible manner.<br>4. Work with community partners to address community health priorities through collaborative tables and intersectoral action. | 1. Q1 2022<br>2. Q2 2022<br>3. Q4 2022<br>4. Q2-Q4 2022 | **L3, I3** | 1. PHS priorities for 2022 have been set and communicated to staff and board of health.<br>2. Priorities for addressing deficits of care and order of program re-opening has been set and communicated.<br>3. Managers and directors identifying key performance measures for recovery initiatives. |
| **2.2** | The Board of Health will need to identify and work through the impacts of the COVID-19 pandemic and prolonged emergency response on the organization and roles and responsibilities of Public Health Services. | Uncertainties related to required changes to the organizaiton and roles and responsibilities of public health services to address the impact of the COVID-19 pandemic and prolonged emergency response on the community and organization. | Worsening and emerging public health issues that were caused or exacerbated by the COVID-19 pandemic and prolonged emergency response. Lack of provincial direction on the continued role of Public Health Services in managing COVID-19. | 1. Gather intelligence and monitor system changes related to the impact of COVID-19.<br>2. Develop and implement advanced plans, including: PHS Recovery Plan, Equitable Recovery Plan, COVID Vaccine & Disease Control transition plans.<br>3. Provide regular updates to BOH and Council including: COVID-19 status updates, recovery plan, transition plans, status of program reopening, etc. | **L5, I3** | 1. Contiue to gather intelligence and monitor system changes related to the impact of COVID-19.<br>2. Continue to develop and implement advanced plans, including: PHS Recovery Plan, Equitable Recovery Plan.<br>3. Complete scenario-based planning to identify the staffing complement needed to continue meeting Provincial requirements related to COVID-19 and to respond to potential future COVID-19 situations.<br>4. Develop plan for IMS Nurse Competency Maintenance Program.<br>5. Continue to participate in provincial discussions on the roles and responsibilities of public health. | 1. On-going<br>2. On-going<br>3. Q1-Q2 2022<br>4. Q4 2022<br>5. On-going | **L4, I2** | 3. COVID-19 Scenarios-based planning for Spring/Summer complete. |
| **3. People / Human Resources** | | | | | | | | | |
| **3.1** | The Board of Health may be at risk of precarious staffing due to challenges with recruitment and retention, as well as staff burnout and mental health challenges due to the prolonged emergency response. | 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 2022, staff fatigue/burn out and decreased work satisfaction as a result of the prolonged COVID-19 emergency response. | Challenges with recruitment and retention. COVID-19 response has impacted staffing levels across business continuity and COVID-19 response. Unprecedented labour shortages as a result of both increased competition across all settings and an increasing number of staff facing burnout and mental health challenges as a result of the prolonged emergency response. | 1. Regular assessment of 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 | **L5, I5** | 1. Continue to regularly monitor vacancies and staff absences across PHS.<br>2. Implementation of strategies to improve recruitment and retention (e.g., conversion of 40 temporary FTEs to permanent positions).<br>3. Establishment of a Nursing Recruitment and Retention Working Group.<br>4. Advocate for provincial funding to build capacity in the public health system to ensure dedicated staff are available to respond to emergencies without impacting core public health programs and services. | 1. Ongoing<br>2. Ongoing<br>3. Ongoing<br>4. TBD | **L4, I3** | 1. The Public Health Leadership Team continues to monitor vacancies and absences (at least once monthly) to proactively determine staffing needs and make adjustments as required.<br>2. Recuitment of 40 permanent FTEs is complete.<br>3. The Nursing Recruitment and Retention Working Group was established in early 2022 and continues to be operational. |
| **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. | 1. Internal Privacy, Security and Information Management work group at public health to address information management concerns. | **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. Q4 2022<br>2. Q1/Q2 2023<br>3. Q1/Q2 2023<br>4. 2023 | **L3, I2** | |
| **9. Governance / Organizational Risks** | | | | | | | | | |

| RISK IDENTIFICATION | | | | RISK ASSESSMENT | | RISK REDUCTION | | | |
|---|---|---|---|---|---|---|---|---|---|
| ID # | Risk Exposure | Description of Risk | Cause/Source of Risk | Current Mitigation Strategies (what are we doing) | Rating Scale 1 (low) - 5 (high) (Likelihood x Impact) | Action Plan (what else can we do?) Only for HIGH risk | Timelines | Residual Risk once action plan fully implemented (L x I) | Status to Date |
| 9.2 | The Board of Health may be at risk of incomplete risk management due to the delay in fully implementing the risk management framework into PHS project and program planning. | 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 relatively new to public health work. | 1. Continue using the PHS Risk Management Framework to identify and assess organizational risks. | L4, I3 | 1. Incorporate the PHS Risk Management Framework into program and project planning. | 1. Q4 2022 | L3, I2 | |

Ontario

# Risk Management Strategy & Process Toolkit

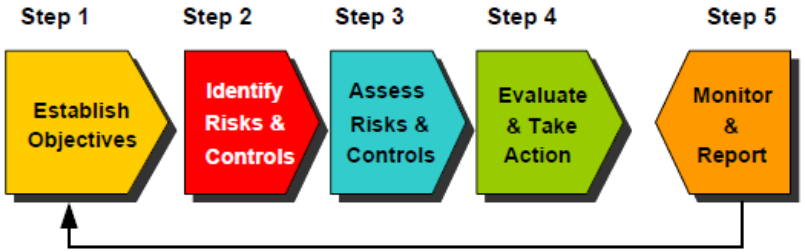
## Step 1: Establish objectives

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

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

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

## The risk management process




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

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

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

## Step 2: Identify risks & controls

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

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

## 14 categories of risk

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

Ontario

# RISK MANAGEMENT STRATEGY & PROCESS TOOLKIT

## Step 3: Assess Risks & Controls

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

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

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

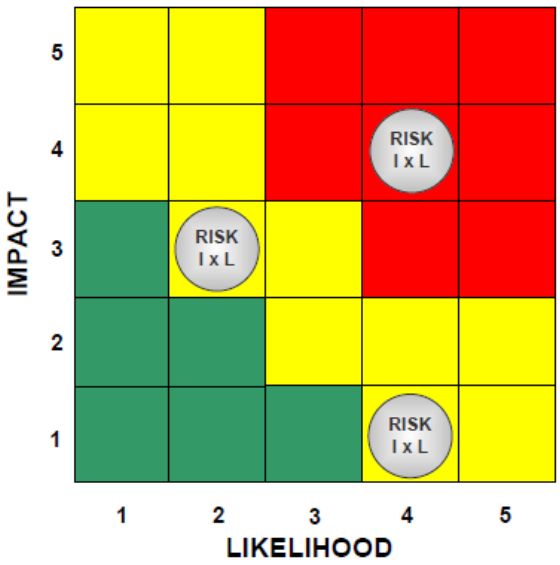
**Key Risk Indicators (KRI)**
- Leading Indicators - Early or leading indicators that measure sources or causes to help prevent risk occurrences
- Lagging Indicators - Detection and performance indicators that help monitor risks as they occur.

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

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

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

**RISK PRIORITIZATION MATRIX**




## Step 4: Evaluate & Take Action

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

## Step 5: Monitor & Report

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

## Definitions

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