City of Hamilton
BOARD OF HEALTH
REVISED

Meeting #: 23-001
Date: January 16, 2023
Time: 9:30 a.m.
Location: Council Chambers (BOH)
Hamilton City Hall
71 Main Street West

Matt Gauthier, Legislative Coordinator (905) 546-2424 ext. 6437

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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 November 28, 2022

5. COMMUNICATIONS

5.1 Correspondence from Loretta Ryan, Executive Director, Association of Local Public Health Agencies (alPHa), respecting Governance Toolkit for Ontario Boards of Health

Recommendation: Be received.

5.2 Correspondence from Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer, Public Health Sudbury & Districts, respecting Physical Literacy for Healthy Active Children

Recommendation: Be received.

*5.3 Correspondence from Loretta Ryan, Executive Director, Association of Local Public Health Agencies (alPHa), respecting 2023 Budget Consultations

Recommendation: Be received.

6. DELEGATION REQUESTS

*6.1 Delegations respecting Item 8.1 - Report BOH23002, Board of Health Orientation Part 2: Population Health Assessment and Public Health Priorities (for today's meeting)

*a. Kojo Damptey, Executive Director, Hamilton Centre for Civic Inclusion

*b. Lyndon George, Hamilton Anti-Racism Resource Centre

7. DELEGATIONS

8. STAFF PRESENTATIONS

8.1 Board of Health Orientation Part 2: Population Health Assessment and Public Health Priorities (BOH23002) (City Wide)

8.2 Respiratory Disease Update

9. CONSENT ITEMS

9.1 Pharmacies and Spatial Mapping: Influenza and COVID-19 Vaccinations (BOH23004) (City Wide)

9.2 Cold Alert Thresholds and Response Process (BOH23005) (City Wide)

10. DISCUSSION ITEMS

10.1 Ministry of Health Funding and Accountability Report: 2021 Annual Report and Attestation (BOH23001) (City Wide)

11. MOTIONS

12. NOTICES OF MOTION

13. GENERAL INFORMATION / OTHER BUSINESS

14. PRIVATE AND CONFIDENTIAL

14.1 Appointment of an Associate Medical Officer of Health (BOH23003) (City Wide)

Pursuant to Section 9.3, Sub-sections (b) and (d) of the City's Procedural By-law 21-021, as amended, and Section 239(2), Sub-sections (b) and (d) of the *Ontario Municipal Act*, 2001, as amended, as the subject matters pertain to personal matters about an identifiable individual, including municipal or local board employees; and, labour relations or employee negotiations.

15. ADJOURNMENT

BOARD OF HEALTH
MINUTES 22-010

9:30 a.m.

Monday, November 28, 2022

Council Chambers, City Hall, 2nd Floor
71 Main Street West, Hamilton, Ontario

Present: Mayor A. Horwath
Councillors J. Beattie, C. Cassar, B. Clark, M. Francis, T. Hwang, C. Kroetsch, N. Nann, T. McMeekin, E. Pauls, M. Spadafora, M. Tadeson, A. Wilson, M. Wilson

Absent with Regrets: Councillors J.P. Danko and T. Jackson – Personal

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THE FOLLOWING ITEMS WERE REFERRED TO COUNCIL FOR CONSIDERATION:

1. APPOINTMENT OF THE VICE-CHAIR TO THE BOARD OF HEALTH FOR THE 2022 - 2026 TERM (Item 1)

(Kroetsch/Nann)
That Councillor M. Wilson be appointed as the Vice-Chair of the Board of Health for the 2022-2026 Term.

Result: Motion CARRIED by a vote of 14 to 0, as follows:

YES	-	Mayor Andrea Horwath	
YES	-	Beattie, Jeff	Ward 10
YES	-	Cassar, Craig	Ward 12
YES	-	Clark, Brad	Ward 9
ABSENT	-	Danko, J.P.	Ward 8
YES	-	Francis, Matt	Ward 5
YES	-	Hwang, Tammy	Ward 4
YES	-	Kroetsch, Cameron	Ward 2
ABSENT	-	Jackson, Tom	Ward 6
YES	-	Nann, Nrinder	Ward 3
YES	-	McMeekin, Ted	Ward 15
YES	-	Pauls, Esther	Ward 7
YES	-	Spadafora, Mike	Ward 14
YES	-	Tadeson, Mark	Ward 11
YES	-	Wilson, Alex	Ward 13

YES	-	Wilson, Maureen	Ward 1

2. Board of Health Orientation 2022-2023 (BOH22018) (City Wide)

(Nann/M. Wilson)
That Report BOH22018, respecting the Board of Health Orientation 2022-2023, be received.

Result: Motion CARRIED by a vote of 14 to 0, as follows:

YES	-	Mayor Andrea Horwath	
YES	-	Beattie, Jeff	Ward 10
YES	-	Cassar, Craig	Ward 12
YES	-	Clark, Brad	Ward 9
ABSENT	-	Danko, J.P.	Ward 8
YES	-	Francis, Matt	Ward 5
YES	-	Hwang, Tammy	Ward 4
YES	-	Kroetsch, Cameron	Ward 2
ABSENT	-	Jackson, Tom	Ward 6
YES	-	Nann, Nrinder	Ward 3
YES	-	McMeekin, Ted	Ward 15
YES	-	Pauls, Esther	Ward 7
YES	-	Spadafora, Mike	Ward 14
YES	-	Tadeson, Mark	Ward 11
YES	-	Wilson, Alex	Ward 13
YES	-	Wilson, Maureen	Ward 1

3. 2023 Food Advisory Committee Budget Request (BOH22019) (City Wide) (Item 10.1)

(Hwang/A. Wilson)
(a) That the Food Advisory Committee 2023 base budget submission attached as Appendix “A” to Report BOH22019 in the amount of $1,500, be approved and referred to the 2023 budget process for consideration; and,

(b) That, in addition to the $1,500 base funding approval, a one-time budget allocation for 2023 of $2,987.84 from Department ID 112212, be used for broader community engagement such as community event/workshop(s) and/or research on the Food Strategy to be funded by the Food Advisory Committee Reserve Account 29100, be approved and referred to the 2023 budget process for consideration.

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

YES	-	Mayor Andrea Horwath	
YES	-	Beattie, Jeff	Ward 10

YES	-	Cassar, Craig	Ward 12
YES	-	Clark, Brad	Ward 9
ABSENT	-	Danko, J.P.	Ward 8
YES	-	Francis, Matt	Ward 5
YES	-	Hwang, Tammy	Ward 4
YES	-	Kroetsch, Cameron	Ward 2
ABSENT	-	Jackson, Tom	Ward 6
YES	-	Nann, Nrinder	Ward 3
ABSENT	-	McMeekin, Ted	Ward 15
YES	-	Pauls, Esther	Ward 7
YES	-	Spadafora, Mike	Ward 14
YES	-	Tadeson, Mark	Ward 11
YES	-	Wilson, Alex	Ward 13
YES	-	Wilson, Maureen	Ward 1

4. Follow-up: Alcohol, Drug, & Gambling Services and Community Mental Health Promotion Budget 2022-2023 (BOH22012(b)) (City Wide)

(Pauls/Tadeson)

(a) That the 2022-2023 Alcohol, Drug, & Gambling Services and Community Mental Health Promotion Program budgets, funded by Ontario Health, be approved including the items below; and,

(i) The net 0.6 FTE reduction for Alcohol, Drug & Gambling Services; and,

(ii) The 0.65 FTE reduction for the Community Mental Health Promotion Program budgets;

(b) That the Medical Officer of Health or delegate be authorized and directed to receive, utilize, report on, and execute all service agreements and contracts, in a form satisfactory to the City Solicitor, required to give effect to the 2022-2023 Alcohol, Drug & Gambling Services and Community Mental Health Promotion Program budgets, funded by Ontario Health.

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

YES	-	Mayor Andrea Horwath	
YES	-	Beattie, Jeff	Ward 10
YES	-	Cassar, Craig	Ward 12
YES	-	Clark, Brad	Ward 9
ABSENT	-	Danko, J.P.	Ward 8
YES	-	Francis, Matt	Ward 5
YES	-	Hwang, Tammy	Ward 4
YES	-	Kroetsch, Cameron	Ward 2
ABSENT	-	Jackson, Tom	Ward 6
YES	-	Nann, Nrinder	Ward 3

ABSENT	-	McMeekin, Ted	Ward 15
YES	-	Pauls, Esther	Ward 7
YES	-	Spadafora, Mike	Ward 14
YES	-	Tadeson, Mark	Ward 11
YES	-	Wilson, Alex	Ward 13
YES	-	Wilson, Maureen	Ward 1

FOR INFORMATION:

(a) APPOINTMENT OF THE VICE-CHAIR TO THE BOARD OF HEALTH FOR THE 2022 - 2026 TERM (Item 1)

Councillor C. Kroetsch nominated Councillor M. Wilson as Vice-Chair to the Board of Health for the 2022-2026 Term.

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

(b) CHANGES TO THE AGENDA (Item 2)

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

(Hwang/Pauls)
That the agenda for the November 28, 2022 Board of Health be approved, as presented.

Result: Motion CARRIED by a vote of 14 to 0, as follows:

YES	-	Mayor Andrea Horwath	
YES	-	Beattie, Jeff	Ward 10
YES	-	Cassar, Craig	Ward 12
YES	-	Clark, Brad	Ward 9
ABSENT	-	Danko, J.P.	Ward 8
YES	-	Francis, Matt	Ward 5
YES	-	Hwang, Tammy	Ward 4
YES	-	Kroetsch, Cameron	Ward 2
ABSENT	-	Jackson, Tom	Ward 6
YES	-	Nann, Nrinder	Ward 3
YES	-	McMeekin, Ted	Ward 15
YES	-	Pauls, Esther	Ward 7
YES	-	Spadafora, Mike	Ward 14
YES	-	Tadeson, Mark	Ward 11
YES	-	Wilson, Alex	Ward 13
YES	-	Wilson, Maureen	Ward 1

(c) DECLARATIONS OF INTEREST (Item 3)

None

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

(i) September 26, 2022 (Item 4.1)

(Pauls/M. Wilson)
That the Minutes of September 26, 2022 be approved, as presented.

Result: Motion CARRIED by a vote of 14 to 0, as follows:

YES	-	Mayor Andrea Horwath	
YES	-	Beattie, Jeff	Ward 10
YES	-	Cassar, Craig	Ward 12
YES	-	Clark, Brad	Ward 9
ABSENT	-	Danko, J.P.	Ward 8
YES	-	Francis, Matt	Ward 5
YES	-	Hwang, Tammy	Ward 4
YES	-	Kroetsch, Cameron	Ward 2
ABSENT	-	Jackson, Tom	Ward 6
YES	-	Nann, Nrinder	Ward 3
YES	-	McMeekin, Ted	Ward 15
YES	-	Pauls, Esther	Ward 7
YES	-	Spadafora, Mike	Ward 14
YES	-	Tadeson, Mark	Ward 11
YES	-	Wilson, Alex	Ward 13
YES	-	Wilson, Maureen	Ward 1

(e) COMMUNICATIONS (Item 5)

(Spadafora/Beattie)
That the following items be approved, as presented:

(i) Correspondence from the Minister of Health respecting Provincial Supports for COVID-19 Response and Recovery (Item 5.1)

Recommendation: Be received

(ii) Correspondence from Windsor-Essex County Health Unit Board of Health respecting a Resolution regarding the Inclusion of Language Interpretation and Translation Services to the Healthy Smiles Ontario Fee Guide (Item 5.2)

Recommendation: Be endorsed

(iii) Correspondence from Jane Riddell and Tracy Matthews, President and Vice President, GoodLife Fitness, respecting Health Concerns in the Upcoming Flu Season (Item 5.3)

Recommendation: Be received, and referred to the Medical Officer of Health for consideration

Result: Motion CARRIED by a vote of 14 to 0, as follows:

YES	-	Mayor Andrea Horwath	
YES	-	Beattie, Jeff	Ward 10
YES	-	Cassar, Craig	Ward 12
YES	-	Clark, Brad	Ward 9
ABSENT	-	Danko, J.P.	Ward 8
YES	-	Francis, Matt	Ward 5
YES	-	Hwang, Tammy	Ward 4
YES	-	Kroetsch, Cameron	Ward 2
ABSENT	-	Jackson, Tom	Ward 6
YES	-	Nann, Nrinder	Ward 3
YES	-	McMeekin, Ted	Ward 15
YES	-	Pauls, Esther	Ward 7
YES	-	Spadafora, Mike	Ward 14
YES	-	Tadeson, Mark	Ward 11
YES	-	Wilson, Alex	Ward 13
YES	-	Wilson, Maureen	Ward 1

(f) STAFF PRESENTATIONS (Item 8)

(i) Board of Health Orientation 2022-2023 (BOH22018) (City Wide) (Item 8.1)

Carolyn Hureau, Manager, Planning & Competency Development Program, addressed the Board with a presentation respecting Board of Health Orientation 2022-2023 (BOH22018).

(Kroetsch/Hwang)
That the Presentation respecting Board of Health Orientation 2022-2023 (BOH22018), be received.

Result: Motion CARRIED by a vote of 14 to 0, as follows:

YES	-	Mayor Andrea Horwath	
YES	-	Beattie, Jeff	Ward 10
YES	-	Cassar, Craig	Ward 12

YES	-	Clark, Brad	Ward 9
ABSENT	-	Danko, J.P.	Ward 8
YES	-	Francis, Matt	Ward 5
YES	-	Hwang, Tammy	Ward 4
YES	-	Kroetsch, Cameron	Ward 2
ABSENT	-	Jackson, Tom	Ward 6
YES	-	Nann, Nrinder	Ward 3
YES	-	McMeekin, Ted	Ward 15
YES	-	Pauls, Esther	Ward 7
YES	-	Spadafora, Mike	Ward 14
YES	-	Tadeson, Mark	Ward 11
YES	-	Wilson, Alex	Ward 13
YES	-	Wilson, Maureen	Ward 1

(ii) Respiratory Diseases Update (Item 8.2)

Jen Vickers-Manzin, Director, Healthy Families Division, Erin Rodenburg, Epidemiologist, and Dr. Brendan Lew, Senior Management Resident, addressed the Board with a presentation respecting a Respiratory Diseases Update.

(A. Wilson/Nann)
That the Respiratory Diseases Update be received.

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

YES	-	Mayor Andrea Horwath
YES	-	Beattie, Jeff Ward 10
YES	-	Cassar, Craig Ward 12
YES	-	Clark, Brad Ward 9
ABSENT	-	Danko, J.P. Ward 8
YES	-	Francis, Matt Ward 5
YES	-	Hwang, Tammy Ward 4
YES	-	Kroetsch, Cameron Ward 2
ABSENT	-	Jackson, Tom Ward 6
YES	-	Nann, Nrinder Ward 3
ABSENT	-	McMeekin, Ted Ward 15
YES	-	Pauls, Esther Ward 7
YES	-	Spadafora, Mike Ward 14
YES	-	Tadeson, Mark Ward 11
YES	-	Wilson, Alex Ward 13
YES	-	Wilson, Maureen Ward 1

(a) (Kroetsch/A. Wilson)
That staff be directed to report back to the Board of Health at the January 16, 2023 meeting, on pharmacies that are, or are not administering Influenza and COVID-19 vaccinations including geo-data.

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

YES	-	Mayor Andrea Horwath
YES	-	Beattie, Jeff Ward 10
YES	-	Cassar, Craig Ward 12
YES	-	Clark, Brad Ward 9
ABSENT	-	Danko, J.P. Ward 8
YES	-	Francis, Matt Ward 5
YES	-	Hwang, Tammy Ward 4
YES	-	Kroetsch, Cameron Ward 2
ABSENT	-	Jackson, Tom Ward 6
YES	-	Nann, Nrinder Ward 3
ABSENT	-	McMeekin, Ted Ward 15
YES	-	Pauls, Esther Ward 7
YES	-	Spadafora, Mike Ward 14
YES	-	Tadeson, Mark Ward 11
YES	-	Wilson, Alex Ward 13
YES	-	Wilson, Maureen Ward 1

(b) (A. Wilson/Nann)

(i) That staff of Hamilton Public Health be directed to issue a public media release on measures, actions, and steps Hamiltonians can use to stay healthy and mitigate the spread of COVID-19, Influenza, and other respiratory health conditions, including specifically the use of masks indoors; and

(ii) That staff be directed to utilize all communications channels, including the City's social media, be used to promote masking and other recommended measures for the public at this time.

Result: Motion CARRIED by a vote of 10 to 3, as follows:

YES	-	Mayor Andrea Horwath	
YES	-	Beattie, Jeff	Ward 10
YES	-	Cassar, Craig	Ward 12
YES	-	Clark, Brad	Ward 9
ABSENT	-	Danko, J.P.	Ward 8
NO	-	Francis, Matt	Ward 5
YES	-	Hwang, Tammy	Ward 4
YES	-	Kroetsch, Cameron	Ward 2

ABSENT	-	Jackson, Tom	Ward 6
YES	-	Nann, Nrinder	Ward 3
ABSENT	-	McMeekin, Ted	Ward 15
NO	-	Pauls, Esther	Ward 7
NO	-	Spadafora, Mike	Ward 14
YES	-	Tadeson, Mark	Ward 11
YES	-	Wilson, Alex	Ward 13
YES	-	Wilson, Maureen	Ward 1

(g) ADJOURNMENT (Item 15)

(Tadeson/Hwang)
That, there being no further business, the Board of Health be adjourned at 12:21 p.m.

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

YES	-	Mayor Andrea Horwath
YES	-	Beattie, Jeff Ward 10
YES	-	Cassar, Craig Ward 12
YES	-	Clark, Brad Ward 9
ABSENT	-	Danko, J.P. Ward 8
YES	-	Francis, Matt Ward 5
YES	-	Hwang, Tammy Ward 4
YES	-	Kroetsch, Cameron Ward 2
ABSENT	-	Jackson, Tom Ward 6
YES	-	Nann, Nrinder Ward 3
ABSENT	-	McMeekin, Ted Ward 15
YES	-	Pauls, Esther Ward 7
YES	-	Spadafora, Mike Ward 14
YES	-	Tadeson, Mark Ward 11
YES	-	Wilson, Alex Ward 13
YES	-	Wilson, Maureen Ward 1

Respectfully submitted,

Mayor Horwath,
Chair, Board of Health

Loren Kolar
Legislative Coordinator
Office of the City Clerk

From:	allhealthunits on behalf of Loretta Ryan
To:	"All Health Units"
Cc:	Board
Subject:	[allhealthunits] Governance Toolkit for Ontario Boards of Health
Date:	Tuesday, November 29, 2022 12:12:30 PM
Attachments:	image001.jpg

PLEASE ROUTE TO:
All Board of Health Members

Dear Board of Health Members,

alPHa is pleased to release the updated *Governance Toolkit for Ontario Boards of Health*. The toolkit provides practical tools to help Boards of Health govern more effectively. Please note, this document does **not** replace but complements alPHa's current *alPHa Orientation Manual for Boards of Health* and is included the *BOH: Shared Resources* area of the alPHa website. Whereas the Manual provides an overview of the public health sector and the board of health's role within it, this toolkit focuses on giving boards of health practical tools and information.

We hope you find the toolkit useful. It is a living document that alPHa plans to update periodically. If you have any comments, suggestions, or tools and examples for possible inclusion, please let us know by sending an email to info@alphaweb.org.

Take Care,

Loretta

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Loretta Ryan, CAE, RPP
Executive Director
Association of Local Public Health Agencies (alPHa)
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BOH GOVERNANCE TOOLKIT

For Ontario Boards of Health

alPHa
Association of Local
PUBLIC HEALTH
Agencies

Updated: November 28, 2022

BOH GOVERNANCE TOOLKIT

The Association of Local Public Health Agencies (alPHa) represents Ontario's public health units and their boards of health. alPHa is committed to helping those who sit on provincial boards of health better understand their roles and responsibilities as public health officials and keeping them updated on the latest public health initiatives.

This toolkit is an effort to support board of health members and the important work they do. It is intended for use by boards of health in Ontario. However, alPHa recognizes that some of these materials may need to be adapted to meet the needs of specific boards. Boards of health are therefore encouraged to customize the tools to meet their unique needs and circumstances.

It should be further noted that the Toolkit does **not** replace but complements alPHa's current *2022 alPHa Orientation Manual for Boards of Health* or the *BOH: Shared Resources* area of the alPHa website. Whereas the Manual provides an overview of the public health sector and the board of health's role within it, this toolkit focuses on giving boards of health practical tools and information to help them govern more effectively.

This document is not intended as, nor should it be considered, legal advice. Boards of health are advised to seek legal or professional advice if they are concerned about the applicability of specific governance practices to their circumstances. The contents of this toolkit should not be considered a definitive list of resources and references on governance.

Toolkit Content

What is Governance?

In general terms, governance can be thought of as the stewardship or oversight of the affairs—particularly the *strategic direction*—of an organization.

Definitions of Governance include:

"While governance includes oversight, it is a broader concept. Governance refers to the structures, systems, and practices an organization has in place to:

- *assign decision-making authorities, define how decisions are to be made, and establish the organization's strategic direction;*
- *oversee the delivery of its services; the implementation of its policies, plans, programs, and projects; and the monitoring and mitigation of its key risks; and*
- *report on its performance in achieving intended results and use performance information to drive ongoing improvements and corrective actions."*

Canadian Audit and Accountability Foundation

Governance has been defined to refer to structures and processes that are designed to ensure accountability, transparency, responsiveness, rule of law, stability, equity and inclusiveness, empowerment, and broad-based participation. Governance also represents the norms, values and rules of the game through which public affairs are managed in a manner that is transparent, participatory, inclusive and responsive.

UNESCO International Bureau of Education

The board, acting in its governance role, sets the desired goals for an organization and establishes the systems and processes to support achievement of those goals. A key role of the board is to determine and oversee the governance of the organization. The chart below illustrates some of the key responsibilities for each governance area for boards of health (BOHs).

Governance Area	BOH Key Responsibilities
Strategic	• Providing strategic leadership and direction by setting the vision, mission and values. • Assessing and approving the strategic plan. • Determining organizational priorities. • Ensuring compliance with legislation, regulations, provincial policies and directives. • Developing intersectoral alliances and/or partnerships with other stakeholders. • Establishing policies and procedures for the management and operation of the board of health (BOH). • Ensuring the planning and delivery of services and programs. • Ensuring operational plans are executed within the approved budget.
Fiscal Management and Reporting	• Reporting on organizational activities to stakeholders and government. • Safeguarding and allocating organization's resources through sound fiscal policies and internal controls. • Setting and approving the budget.

	• Commissioning independent financial audit.
Relationships	• Establishing processes for effective communications with stakeholders. • Developing effective working relationship with stakeholders and partners. • Developing effective working relationship with the MOH/CEO.
Quality Management	• Ensuring quality assurance processes are in place. • Identifying and assessing risks to the health unit and board of health, and developing risk management policies. • Meeting expectations of the Accountability Agreements with the Ministry of Health. • Undergoing a business process audit (accreditation) by an accredited agency. • Performing a governance review on a regular basis.
Monitoring, Reporting and Evaluation	• Monitoring, assessing and reporting on progress of the strategic plan. • Assessing and reporting on BOH's performance in achieving strategic outcomes. • Ensuring processes are in place to monitor, evaluate and improve outcomes. • Ensuring health status and health needs of the population are monitored, reported on and assessed regularly. • Monitoring, reporting and assessing outcomes with respect to the Ontario Public Health Standards and Organizational Standards requirements.
Management	• Establishing policies and procedures for BOH affairs. • Conducting business with openness and transparency. • Ensure ongoing education of BOH members. • Establishing sound processes for recruitment and appointment of the MOH/CEO. • Hiring the MOH/CEO • Evaluating performance of the MOH/CEO on a regular basis. • Assessing performance of the BOH and its members. • Reviewing BOH bylaws, policies and procedures on a regular basis.

It is important to note that while the board of health (BOH) works closely with the Medical Officer of Health—who is also the Chief Executive Officer (MOH/CEO), or the Medical Officer of Health and the Chief Executive Officer (CEO)—if the BOH has chosen the split management model, it is the MOH/CEO's responsibility to lead the health unit in achieving board-approved directions. *Therefore, the responsibility for the day-to-day management and operations of the health unit lies with the MOH/CEO or the CEO, if using that model.*

Governance also involves trust and confidence. This fiduciary role is another important function for BOHs. By fulfilling its oversight and fiduciary role, the BOH cultivates respect, confidence, support and unity within the health unit while acting in its best interest.

Fiduciary Responsibilities of the BOH

- *Acting in the best interest of the health unit.*
- *Avoiding conflict of interest.*
- *Corporate obedience – BOH solidarity, speaking with one voice, operating within legal requirements.*
- *Maintaining confidentiality*

Good Governance

Good governance occurs when a BOH carries out their trust or fiduciary responsibility to achieve the health unit's goals. Foundations for good governance rest on:

Board Quality - The quality of the people at the BOH table and their collective skills
Board Role - What the BOH does
Board Structure & Processes - How the BOH does its work

A BOH applying good governance exercises its legal authority to conduct the health unit's affairs; shows leadership by reflecting the values and priorities of the health unit and developing positive relationships with stakeholders; manages the health unit's financial resources effectively and efficiently; and is accountable for its actions and responsibilities.

A BOH practicing good governance:

- ☑ is clear on its roles and responsibilities
- ☑ maintains effective communications with external stakeholders
- ☑ has appropriate processes in place for decision-making
- ☑ sets policies for the health unit
- ☑ understands the budgeting process and financial reporting responsibilities
- ☑ develops the health unit's strategic plan and is accountable for outcomes
- ☑ evaluates the performance of the MOH/CEO, individual Board members and the Board itself

Board of Health Effectiveness

In general, there are six elements that are necessary for a BOH to be effective:

1. **Commitment** — BOH members should be committed individually and as a group to the health unit's mission, mandate, goals and processes to achieve them. They should have the necessary knowledge, abilities and commitment to fulfil their duties.

2. **Acceptance** — BOH members must accept their responsibilities of their governance role. This means reading and making efforts to understand applicable background documents (legislation, policies, etc.), asking informed questions, and knowing the health unit's business and performance.

3. **Planning** — The board of health focuses on strategic issues by engaging in the strategic planning process and avoids involvement in operational management affairs of the health unit.

4.	**Communication**	The board of health has internal and external communications processes that ensure access to relevant timely information, advice and resources.
5.	**Outcomes**	The board of health evaluates its impact in the community by systematically reviewing its policies, monitoring progress in achieving strategic goals, and undertaking evaluations of the Board itself, its members, and MOH/CEO or the MOH and the CEO.
6.	**Reporting**	The board of health should report on its activities and outcomes to various stakeholders and in accordance with any legislative requirements.

Governance as Leadership

Boards need to frequently look at how they think about and carry out their governance responsibilities. The Governance as Leadership Model (Chait, Ryan & Taylor, 2004) provides BOHs an enduring framework to understand governance and practice it effectively.

It enables boards to reframe their work under three governance "modes": **fiduciary**, **strategic**, and **generative**.

Fiduciary
In this mode, boards are concerned mostly with the basic, traditional activities of stewardship and oversight—mission fulfillment, financial oversight, accountability, legal compliance and corporate obedience. Work is focused on conformance to established board policies and procedures to act in the best interest of the public health unit.

Strategic
In the strategic mode, boards establish organizational priorities and develop strategic directions for staff to action. They engage in strategic planning, strategic decision-making, policy making, and problem solving. Work is focused on monitoring performance as reported back to the BOH by staff against the strategic plan.

Generative
The generative mode sees boards framing organizational issues and problems and making sense of ambiguous situations. This involves boards positioning themselves differently; exploring issues from multiple, sometimes conflicting, perspectives; and looking to the past to uncover patterns, new ways to frame old issues, and new sources of ideas. Work is focused on active learning and organizational robustness.

Boards that are able to govern in these three modes are said to be truly governing, according to the Governance as Leadership Model. Using all three modes can lead to greater board engagement, stronger governance, and organizational excellence.

Effective Board of Health Habits

Effective BOHs work together as a team focusing on strategic issues within the context of the health unit's strategic plan. Building effective, collective work habits can be difficult. It requires focused agreement on behavior and a shared will to improve and build team competence. It has been observed that effective boards adopt a recurring pattern of six healthy habits.

Focus on Strategic Oversight
An effective board defines its own work area by focusing on strategic issues, such as the development and monitoring of the health unit's strategic plan, rather than staff management affairs. This is often difficult. Most board members are frequently experts at addressing operational issues in their respective health units and naturally gravitate to that arena. To avoid this, it may be helpful for the board and its MOH/CEO to be clear on the board's responsibilities and duties, i.e. the health unit's strategic agenda and the information required to carry it out.

Know the Business
Effective board members know the health unit's structure, strategy, population being served, programs, services, performance as well as the governing legislation and the *Ontario Public Health Standards*. They also know the sector and are familiar with stakeholders' activities. Boards cannot assume that their members maintain expert knowledge in all subject areas. Effective boards are quick to enlist outside experts to deliver fresh perspectives or new knowledge on topics where they lack experience.

Are Committed
Boards should expect and demand that each member identifies with the health unit's mission, has a well-defined team role, prepares for meetings, avoids conflicts of interest, attends meetings regularly and participates constructively and effectively in those meetings.

Adapt Knowledge to the Health Unit
Board members have a wealth of experience that must be adapted to the unique circumstances of the health unit and evidence-based community needs. They may wish to adopt what has been done elsewhere but should critically evaluate its appropriateness to the current health unit's environment before doing so.

Constructive Participation
Every board member brings valuable experience, expertise and judgment to the board. Without the participation of each member, the effort is substantially diminished. An effective board is one where every voice is encouraged and respected. Interpersonal conflicts among board members should be addressed in a timely fashion and may be addressed through board development programs.

Evaluate Performance
The effective board evaluates its performance periodically. Performance assessment leads to a culture of accountability, which, in turn may lead the board to hold itself, individual members, and the MOH/CEO, or the MOH and the CEO, to higher performance standards and expectations.

Tips for Productive Board Meetings

The Meeting Agenda
Most board work is conducted at regularly scheduled meetings, so careful attention must be paid to preparing the meeting agenda and developing the background and other materials submitted to the board for its pre-meeting review. The board agenda should be accompanied by the reports, memos, plans, and other materials to be discussed at the meeting and should be delivered to the board in advance (e.g., a week before) to allow members adequate time to prepare for an informed discussion of the materials and management's recommendations and proposals.

Board Materials
The board packages prepared by management and sent to board members before the meeting provide important information regarding the health unit's activities to help members evaluate management's proposals and directions to enable the members to make informed judgments. Agenda materials should avoid information overload, be clear about which items needs a board decision or is for information purposes, and that the agenda notes the time allocation for each item.

The topics for discussion should relate to the health unit's overall strategic agenda, goals, and objectives. These strategic matters require serious, timely discussion by board members, so appropriate time must be allotted at meetings to cover them adequately and consideration should be given to the timing of their discussion during meetings (the beginning of the meeting is better than the end of the meeting).

Frequency of Board Meetings
The board should meet at least quarterly to review the health unit's activities and performance. The length of the meeting may help determine how many regular meetings are held. Additional special meetings are held as needed, particularly when there is need to discuss important or urgent matters prior to the next regular board meeting. Of course, consideration by the members of major issues affecting the health unit will require more frequent meetings.

Committee meetings should generally be scheduled to coincide with board meetings if in person to minimize travel and allow the committees to report promptly to the board on their deliberations and proposals. The board's procedural bylaw should outline the different types of board meetings available—in person, virtual or hybrid—and when they will be used by the board.

Open and Closed Meetings
A Board of Health must follow the requirements under s. 239 of the **Municipal Act** with respect to when a closed meeting can occur. An extract of the Act is noted below as board members need to fully understand these provisions. If a member of the public is concerned that the board has met in **a** closed meeting inappropriately, they can file a complaint with the Municipal Investigator if there is one named, or with the Ontario Ombudsman.

The Ontario Ombudsman has created a thorough **Open Meetings-Guide for Municipalities,** which is informative and instructive for municipal councils and municipal boards, such as a Board of Health.

Meetings open to public
239 (1) Except as provided in this section, all meetings shall be open to the public. 2001, c. 25, s. 239 (1).

Exceptions
(2) A meeting or part of a meeting may be closed to the public if the subject matter being considered is,
(a) the security of the property of the municipality or local board;
(b) personal matters about an identifiable individual, including municipal or local board employees;
(c) a proposed or pending acquisition or disposition of land by the municipality or local board;
(d) labour relations or employee negotiations;
(e) litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board;
(f) advice that is subject to solicitor-client privilege, including communications necessary for that purpose;
(g) a matter in respect of which a council, board, committee or other body may hold a closed meeting under another Act;
(h) information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them;
(i) a trade secret or scientific, technical, commercial, financial or labour relations information, supplied in confidence to the municipality 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;
(j) a trade secret or scientific, technical, commercial or financial information that belongs to the municipality or local board and has monetary value or potential monetary value; or
(k) a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board. 2001, c. 25, s. 239 (2); 2017, c. 10, Sched. 1, s. 26.

Other criteria
(3) A meeting or part of a meeting shall be closed to the public if the subject matter being considered is,
(a) a request under the *Municipal Freedom of Information and Protection of Privacy Act*, if the council, board, commission or other body is the head of an institution for the purposes of that Act; or
(b) an ongoing investigation respecting the municipality, a local board or a municipally-controlled corporation by the Ombudsman appointed under the *Ombudsman Act*, an Ombudsman referred to in subsection 223.13 (1) of this Act, or the investigator referred to in subsection 239.2 (1). 2014, c. 13, Sched. 9, s. 22.

Educational or training sessions
(3.1) A meeting of a council or local board or of a committee of either of them may be closed to the public if the following conditions are both satisfied:
1. The meeting is held for the purpose of educating or training the members.
2. At the meeting, no member discusses or otherwise deals with any matter in a way that materially advances the business or decision-making of the council, local board or committee. 2006, c. 32, Sched. A, s. 103 (1).

Depending on the nature of the closed meeting item, senior management staff including the MOH/CEO, may need to be included with the obvious exception being when it is an item that bears on them directly (such as performance appraisal, employment contract negotiations, etc.).

Board of Health Orientation

Every BOH in Ontario is responsible for orienting its new members to their roles and responsibilities following initial appointment. The orientation should be a positive team-building experience that results in new members' understanding of their role and the expectations for them.

A model orientation session will include the following:

- **Appropriate background materials** such as:
  - mission/values statement
  - bylaws and policies
  - relevant legislation
  - past meeting minutes
  - current and past financial statements
  - strategic plan
  - information on the population being served in the health unit's area
  - organizational chart for the health unit
  - list of BOH members and senior staff
  - annual calendar of events and meetings

- **Facilitated session –** An appropriate person should facilitate the orientation session. The best time and place to hold the session should be chosen, i.e. as part of the regular board meeting or as a separate meeting.

- **Review of key topics** such as:
  - BOH manual
  - mission/vision and values of the health unit.
  - history of the health unit
  - roles and responsibilities of the BOH, its individual members, and staff.
  - relevant legislation and provincial standards, including *Ontario Public Health Standards: 2021*.
  - operational overview of the health unit.
  - review of major events and activities the BOH members will be involved in.
  - identification of current legal matters and their status.
  - review of committees the BOH members may be involved in.
  - processes for BOH meetings and attendance, communications with stakeholders, policy development, budgeting and finance, decision-making, strategic planning, and evaluation of board and MOH/CEO, or MOH and CEO.
  - role of the Association of Local Public Health Agencies (alPHa).

- **Question and answer period -** Time should be set aside for questions from members.

- **Immediate involvement of new board members -** New BOH members may be paired with current members during the orientation process.

alPHa Orientation Manual

Following each municipal election, alPHa updates the *2022 alPHa Orientation Manual for Boards of Health*. It was developed to assist boards of health in their efforts to educate and orient their new members on their roles and responsibilities as board of health officials.

Boards of Health: Shared Resources

The Boards of Health: Shared Resources area of alPHa's website was created for alPHa's Boards of Health members to facilitate the sharing of and access to orientation materials, best practices, by-laws, resolutions and other resources to support their work. Boards of health use various approaches to protect and promote health in the communities they serve, informed by their characteristics and prioritized based on ongoing assessments.

If you are a member of an Ontario board of health and have a best practice, by-law or any other resource that you would like to make available to other Ontario boards of health, please send a file or a link with a brief description to gordon@alphaweb.org and it will be posted in the appropriate library.

Please note that links to materials not produced by the Association of Local Public Health Agencies (alPHa) are provided as a convenience and for informational purposes only and do not constitute an endorsement or an approval by alPHa.

Board of Health Legislative Requirements

- Health Protection and Promotion Act and HPPA Associated Regulations
- Accessibility for Ontarians with Disabilities Act (AODA)
- French Language Services Act
- Municipal Act
- Municipal Conflict of Interest Act
- Municipal Freedom of Information and Protection of Privacy Act
- Occupational Health and Safety Act
- Personal Health Information Protection Act

alPHa's legal counsel, James LeNoury, prepared a paper on *the Obligations of a BOH under the Municipal Act* that was revised in November 2021.

Bylaws vs. Policies vs. Procedures

Bylaw	The overall framework for governing affairs of the organization; does not deal with day-to-day operations; once in place, policies and procedures may be developed.
Policy	An expression of the will of the board that is: - a governing principle - a framework for carrying out work of the board. - a way for the board to delegate authority. - a definition of what is to be done.
Procedure	Step-by-step instructions that bring a policy to life; details the method for implementing a policy.
Source:	Charity Central's Office in a Box (resource for small and rural Canadian charities), Governing Documents: Policies & Procedures, Section 6.2, Legal Resource Centre, 2010, Edmonton AB

Board of Health Bylaws, Policies and Procedures

The *Ontario Public Health Standards: 2021*, *Requirements for Programs, Services and Accountability* (OPHS) require that all BOHs in the province have local bylaws and policies on the following (this is not a complete list—see the *Good Governance and Management Practices Domain* section for detailed list):

- rules of order and frequency of meetings.
- selection of officers
- selection of board of health members based on skills, knowledge, competencies, where possible.
- conflict of interest
- confidentiality
- medical officer of health selection process, remuneration and performance review.
- procurement of external advisors to the board (e.g. lawyers, auditors) if applicable.

It is also required that "the board of health shall ensure that by-laws, policies and procedures are reviewed, and revised as necessary, and at least every two years."

In addition to the above, it is strongly suggested that BOHs have by-laws or policies on other necessary administrative or management matters concerning BOH affairs (e.g. procedural by-law, property management, banking and finances, provision of auditor, Code of Conduct). A list of potential BOH by-laws and policies can be found at the end of this document.

Unlike the previous OPHS, the 2018 (2021) Organizational Requirements, no distinctions have been made between policies and by-laws.

Accountability

Accountability vs. Responsibility vs. Answerability	
Responsibility	An obligation to act or decide.
Accountability	A formal relationship that happens when a responsibility is conferred and accepted, and with it, an obligation to report back on the discharge of that responsibility.
Answerability	An obligation to simply provide information or an explanation to another party.

Source: Guide to Corporate Governance, Saskatchewan Ministry of Health.

Accountability is a relationship based on the obligation to demonstrate and take responsibility for performance in light of agreed expectations. It requires that BOHs understand who is responsible for what, what outcomes are to be achieved and what information needs to be shared to ensure appropriate decision-making.

Ontario BOHs are ultimately accountable for the actions of their health units to the provincial Ministry of Health.

Provincial Accountability Framework

Following the first Public Health Accountability Agreements in 2011 with boards of health, the province of Ontario released the Public Health Accountability Framework within the Ontario Public Health Standards 2021. It was first effective as of 2018 and then updated in 2021. The relevant pages are 59-71. The Framework "outlines the parameters and requirements to hold boards of health accountable for the work they do, how they do it, and the results achieved. It articulates the expectations of the ministry of boards of health to promote a transparent and effective accountability relationship."

The Framework spells out the Organizational Requirements against which boards of health need to demonstrate accountability to the Ministry. The requirements fall into four "domains":

- Delivery of Programs and Services
- Fiduciary Requirements
- Good Governance and Management Practices; and
- Public Health Practice

The Organizational Requirements incorporate one or more of the following functions:

- **Monitoring and reporting** (to measure and assess activities).
- **Continuous quality improvement** (to improve efficiency and effectiveness).
- **Performance improvement** (to ensure best results are achieved).
- **Financial management** (to ensure resources are used efficiently).

- **Compliance** (to ensure ministry expectations are met).

The BOH *Public Health Accountability Framework Domains* requirements that are *Common to All* are:

1. The BOH shall submit an Annual Service Plan and Budget Submission to include all programs and services delivered by boards of health and program costing for ministry-funded programs.
2. The BOH shall submit action plans as requested to address any compliance or performance issues.
3. The BOH shall submit all reports as requested by the ministry.
4. The BOH shall have a formal risk management framework in place that identifies, assesses, and addresses risks.
5. The BOH shall produce an annual financial and performance report to the general public.
6. The BOH shall comply with all legal and statutory requirements.

Boards of health are expected to demonstrate accountability through Ministry-Board of Health Accountability Agreements; Board of Health Strategic Plan; Board of Health Annual Service Plan and Budget Submission; performance reports; and an annual report.

Ontario Public Health Standards

The *Ontario Public Health Standards 2021* provides the province's minimum expectations for the local planning and delivery of public health programs and services by BOHs. They are published by the Minister of Health under the authority of Section 7 of the *Health Protection and Promotion Act*, which also obliges BOHs to comply with them. Boards of health are accountable for implementing the Standards including the protocols and guidelines that are referenced therein.

The Standards consist of three sections:

- **Defining the work that public health does** (including the Foundational and Program Standards).
- **Strengthened accountability** (including the Public Health Accountability Framework and Organizational Standards) as outlined in the section above; and
- **Transparency and demonstrating impact** (including the Public Health Indicator Framework for Program Outcomes and Contributions to Population Health Outcomes, Transparency Framework: Disclosure and Reporting Requirements).

Strategic Oversight and Planning

The BOH's role is primarily one of strategic oversight. Strategic oversight consists of:

- setting the mission, vision and values of the BOH.
- setting strategic directions in a plan (i.e. future plan + measurable actions over a time period).
- approving major decisions that impact the direction of the health unit.

Mission, Vision, Values	
Mission	A concise statement of health unit's purpose, who it serves and why.
Vision	A statement describing the health unit's strategic direction (future plan) over a period of time.
Values	Statements of fundamental principles on which health unit operates.
Source:	Guide to Corporate Governance, Saskatchewan Ministry of Health

In approving major decisions, the BOH must be aware of the big picture and understand how decisions affect the big picture over a long-time horizon. Rather than getting involved in day-to-day decision-making or operational issues, the BOH should have confidence in the MOH/CEO's ability to make sound decisions that serve the health unit's goals and objectives. The BOH is responsible for ensuring that the MOH/CEO understand the strategic direction of the health unit.

Under the OPHS Organizational Requirements (#8), BOHs must have a strategic plan in place:

The board of health shall have a strategic plan that establishes strategic priorities over 3 to 5 years, includes input from staff, clients, and community partners, and is reviewed at least every other year.

Strategic planning is a continuous and systematic process in which a BOH identifies, monitors and measures its future outcomes over a specified timeframe. It includes defining specific goals and success for the health unit, and developing policies, framework and approach for achieving those goals.

This table shows the different roles played by the BOH and MOH/CEO in the strategic planning process:

The Strategic Planning Process	
Board of Health Role & Responsibilities	**MOH/CEO Role & Responsibilities**
• Ensures strategic planning process is conducted.	• Conducts strategic planning process
• Approves strategic planning process	• Conducts research, develops policies, writes strategic plan.
• Reviews and approves strategic plan.	• Implements strategic plan
• Monitor plan's implementation, annually review plan & recommend adjustments.	• Executes board of health's recommended actions following review of plan.

There are two generally accepted approaches to strategic planning: goals-based and issues-based. According to Management Help, goals-based (or vision-based) planning works from the future to the present. A time in the future is chosen and the strategic plan identifies goals to be achieved by that time. Goals-based planning is therefore usually based on the long-range such as three to five years from the present. Issues-based planning, however, begins at the present and works to the future. Major issues faced by the organization at the moment are identified and actions to address the issues are laid out. Issue based plans are usually for the short-range; one year is typical.

Which approach a BOH uses—goals-based or issues-based—depends on the board's situation. Issues-based planning is done when a board has very limited funding and human resources or if there are many current issues that need to be dealt with sooner rather than later. This kind of planning is often done for organizations that are new, i.e. one to two years old. Although there are other types of strategic planning–such as Balanced Scorecard, PEST Model (Political, economic, sociocultural + technological) and Needs Assessment–they tend to start with a goals-based approach.

Most of the time, BOHs will undertake a goals-based strategic planning process. This is a cycle comprised of nine steps:

1. Planning the process
2. Conducting an environmental or SWOT (Strengths, Weaknesses, Opportunities + Risks) review.
3. Writing/reviewing the health unit's vision, values and mission.
4. Identifying and confirming programs and services delivered.
5. Establishing goals
6. Developing operational plan(s) and completing performance measurement (i.e. for staff to manage).
7. Writing a draft strategic plan
8. Reviewing and approving the strategic plan.
9. Implementing, monitoring and reporting

Strategic planning processes can be led by external consultants who can provide additional objective expertise to the board. The links below will lead you to a sample of consultants' commercial open-data websites that offer free tools and information on strategic planning. These tools and information may be of assistance if opened/used with discretion.

Framework for a Basic Strategic Plan Document (by Authenticity Consulting, LLC)

Strategic Planning Toolkit (by Conscious Governance)

Risk Management and Assessment

Under the provincial *Public Health Accountability Framework* (2018), BOHs are required to have a "formal risk management framework in place that identifies, assesses and addresses risks." A risk management plan can incorporate the following three components: Preparation, Prevention, Protection.

Preparation	Prevention	Protection
• Identify risk	• Policies and procedures	• Insurance
• Assess risk	• Staff competence/ training	• Contracts
• Determine response	• Organization Culture	• Contingency Plans

Preparation involves identifying and assessing potential risks and determining the BOH's response to each risk. It often includes agreeing on a common definition for understanding risk within the health unit and determining what constitutes a high risk, medium risk, and a low risk. In defining risk, it might be useful to spell out the impact of consequence of each risk level (e.g. financial impact on the health unit is likely to exceed $X) and the degree/potential of occurrence of each risk level (e.g. likely to occur each year or more than 25% chance of occurrence).

In assessing risk, the health unit may want to further identify the following:

- scope of risk
- nature of risk
- stakeholders/partners, population(s) who could be affected.
- quantification of risk, and
- the BOH's/health unit's level of tolerance and appetite for that risk.

Determining the response means analyzing options for managing risk such as avoiding, accepting, reducing, eliminating or sharing a risk. Strategies for preventing loss or risk include establishing policies and procedures, ensuring staff competence, and building an organizational culture that promotes results while identifying and assessing risks. Protection includes reducing risk by having insurance, contracts and contingency plans in place. Understanding the potential liability for the health unit in various situations is also essential.

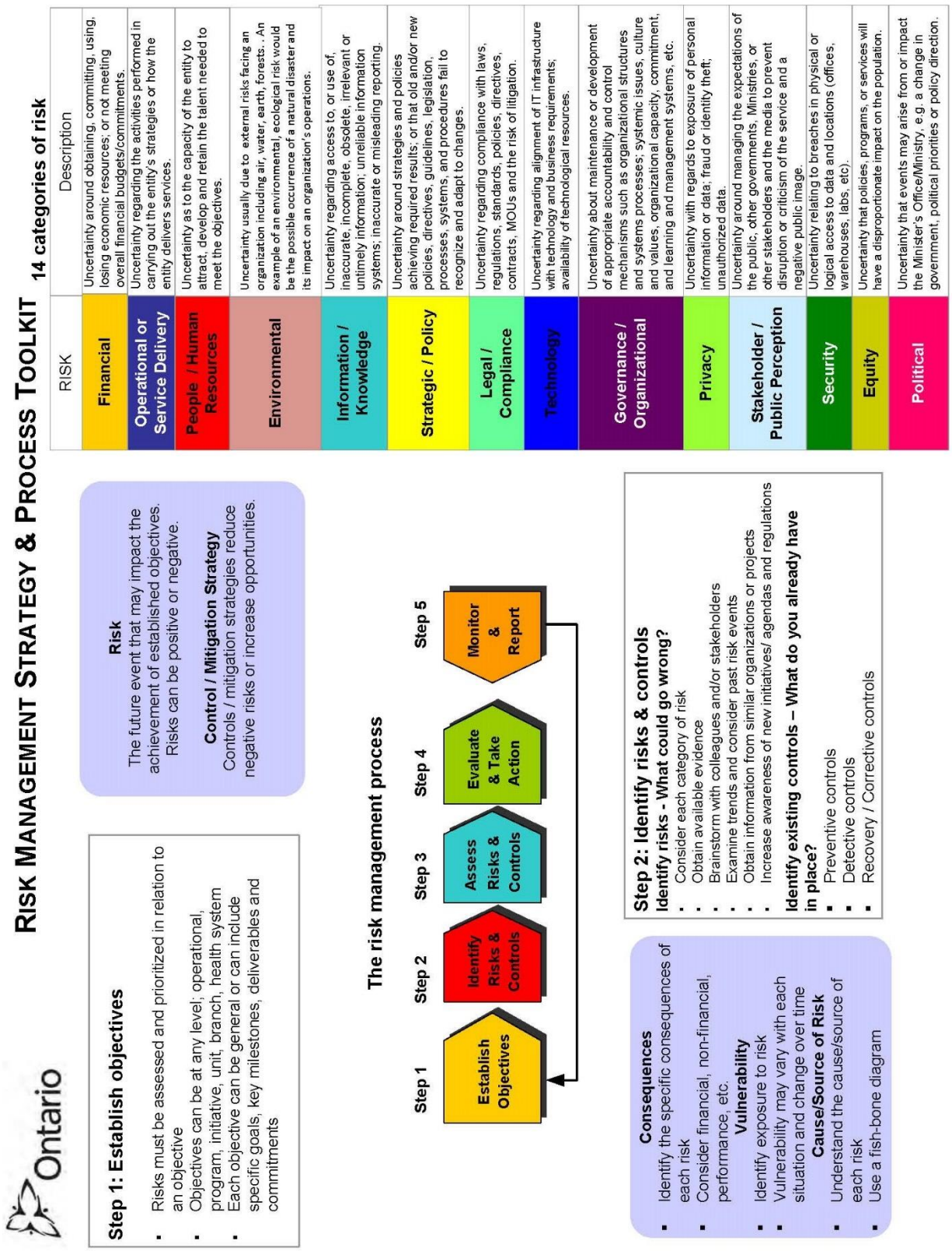
Given that the risk management perspective has evolved while dealing with COVID-19, the resilience and nimbleness of the health unit also needs to be factored into the board's discussion and analysis on risk. Without becoming directly involved in managing risk, boards can fulfill their role in risk oversight by developing policies and procedures around risk that are consistent with the organization's strategy and risk tolerance and appetite.

The BOH should monitor and evaluate its risk management strategy on a regular basis. The Ontario Internal Audit Division developed the following *Risk Management Strategy & Process Toolkit* that was

presented to Ontario Boards of Health in 2016 for their use and adaptation.

Risk Management Strategy & Process Toolkit

Source: Ontario Internal Audit Division, Treasury Board Secretariat presentation to alPHa, Feb. 24, 2016



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?

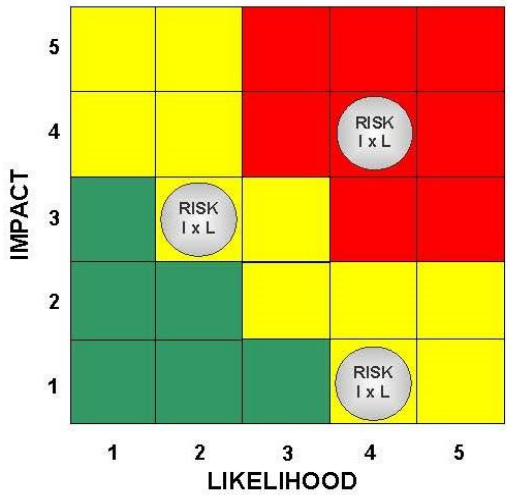
Key Risk Indicators (KRI)
- Leading Indicators - Early or leading indicators that measure sources or causes to help prevent risk occurrences
- Lagging Indicators - Detection and performance indicators that help monitor risks as they occur.

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*

The 2016 Risk Management Strategy and Process Toolkit stands the test of time for its usability; however, boards will need to apply a 2022/23 lens as they consider any updates of their previous risk management framework.

New, emerging and heightened risks for public health employers include:

- New, mutating or multiple infectious diseases and pandemics.
- IT disruption, cybersecurity including data theft and fraud.
- Professional/human resources shortages.
- Climate change and its impact on vector-borne diseases, water security, etc.
- HR challenges that need updated policies dealing with harassment and sexual harassment in the workplace, toxic workplaces, as well as changing workplace environments (e.g., hybrid).

BOH Governance Learnings (2015 Algoma Assessment)

In February 2015, the Minister of Health and Long-Term Care appointed Mr. Graham Scott as an Assessor under the authority of the HPPA to conduct an assessment of the District of Algoma Health Unit Board of Health. Mr. Scott had conducted previous health unit assessments for Ontario. His Assessor's Report was completed by June 2015.

He found that there were shortfalls with respect to the governance and oversight provided by the Algoma BOH. Although many of Mr. Scott's recommendations were contentious, there are a number of his observations that are worth noting to highlight the importance of strong, informed board governance and conduct. These included:

- Active (i.e., not passive), informed questions to senior management at board meetings.
- That the board expects clear accountability from senior management in critical areas such as department restructuring, financial matters and overall outcomes of the health unit.
- That there is appropriate public transparency at BOH meetings and that in-camera sessions are used in accordance to legislative provisions and best practices.
- That there is adequate BOH training.
- That there is a strong conflict of interest understanding and practice at the board.

Board of Health Liability

In partnership with its legal counsel, alPHa produced a still timely *Board of Health Liability Paper, 2018* that reviews BOH members' liabilities as members of a board as well as their specific public health liabilities related to their role on the BOH. Appendix A in this paper includes potential questions for Board self-evaluation.

Accreditation and Quality

While it is not mandatory for a public health unit to be accredited, a good number choose to participate in an accreditation process. Accreditation is an ongoing, voluntary process used by organizations to assess and improve the quality of its services to stakeholders. It helps the public health unit strive for excellence by setting benchmarks of consistent standards for programs and services that should be met by the public health unit.

Accreditation also provides a process for quality assurance by identifying areas for improvements in efficiency and performance related to the leadership, management and delivery of services. Some health units have developed their own internal approaches for continuous quality improvement.

Public health units may choose from a number of different accreditation organizations in the country. The scope of the accreditation standards differs across the various accreditation bodies. The following are a just a few of the Canadian accreditation organizations and their areas of emphasis:

Accreditation Canada	(health quality)
Canadian Centre for Accreditation	(community health and social services)
Canadian Accreditation Council	(broad range of human services)
Excellence Canada	(broad range of corporate and non-profits)

Evaluation

Evaluations are an important component to ensure the maintenance and improvement of the governance process. To assess board effectiveness, evaluation of the BOH as a whole, individual BOH members, and the MOH/CEO, or MOH and CEO if model used, should be undertaken. After deciding what it will do with the results, the board should ensure there is a process to allow the evaluation results to be acted upon.

The evaluation process for BOHs may consider the following questions:

- What is the purpose of the evaluation?
- Who should complete the evaluation?
- What is the process?
- How will results be shared?
- What is the process to ensure the results are acted upon?

Any of these aspects may be subject to evaluation (there may be others not listed below):

- individual BOH member's performance
- collective board performance
- board chair performance
- board meeting evaluation
- board strategic planning evaluation
- committee chair performance
- committee member's performance
- orientation session evaluation

Evaluation of the Board of Health

Evaluating the BOH's effectiveness, it should be noted, is not the same as evaluating the effectiveness of the health unit. This distinction is important because it means the BOH must be clear on its desired outcomes and that it has objective measures to evaluate the board's unique contribution.

When assessing board effectiveness, the review should encompass, but not be limited to:

- whether specific outcomes were achieved, including strategic goals.
- whether legislative requirements have been met and to what degree.
- whether committees of the board are functional and effective.
- fiduciary and budgetary responsibilities were exercised.
- flow and timeliness of information.
- liaisons with stakeholders
- conduct of meetings
- agenda setting process
- decision-making and follow-up processes
- management of sensitive and/or legal matters.

It is expected that board leadership requires openness to self-evaluation and board evaluation. The chair should also be open to evaluation of his or her performance and to acting upon constructive criticism.

A board self-assessment or evaluation is completed by all board members and provides a process to evaluate and improve board performance, board processes and individual member performance. It is important that the questions are relevant to areas of board role and performance.

Questions are usually asked in the following categories:

- Board Role and Responsibility
- Board Composition and Quality
- Board Structures and Processes
- Board Efficiency and Performance
- Member Self-Assessment

The usual format asks a member to rate the board's performance, and the member's own performance, on a sliding scale. It is also common to allow an opportunity for the board member to answer open-ended questions or offer narrative comments.

Evaluation of the Individual Board of Health Member

An evaluation of an individual BOH members' performance can either be a self-assessment evaluation (done as part of the annual board evaluation), or it can be a peer evaluation. The more common approach is the self-evaluation by board members. Peer evaluations would involve every board member evaluating the performance of every other board member, and must be undertaken with care.

Feedback on individual BOH members' performance should be a regular process provided by the chair or through resources that are external to the BOH.

Areas to ask questions on a BOH member's self-evaluation survey may include:

- preparation for board and committee meetings.
- regular attendance at meetings
- participation in discussions at board and committee meetings.
- understanding the board's governance role and responsibilities.
- decision-making based on evidence and research.
- application and contribution of the individual BOH member's expertise.
- behavior both inside and outside the board meeting.
- adherence to board policies, particularly conflict of interest and the Code of Conduct.
- respect for harmonious board relations and principle of board solidarity.

It should be noted that commitment and buy-in from individual BOH members to the evaluation process is crucial.

Evaluation of the Medical Officer of Health (MOH)

An essential part of determining health unit's performance is assessment of the Medical Officer of Health (MOH) whether they are also the CEO or not. The MOH/CEO is accountable to the BOH for leading the health unit and for implementing its decisions. The MOH/CEO leads and manages all aspects of the health unit's operations, including: directing executive staff; preparing, monitoring and complying with the annual budgets; and overseeing the efficient operation of the health unit's programs and services. If the MOH/CEO is to be accountable and to achieve predefined outcomes then he or she must be free to decide who does what, when, why and under what circumstances.

The evaluation will often emphasize how the MOH/CEO has met desired outcomes, but it is important to also emphasize how well they were achieved. In other words, the assessment also needs to emphasize how the MOH's performance reflects the health unit's values, vision, mission, mandate and policies and contributed to the achievement of strategic goals. A component of the MOH/CEO's evaluation may involve interviews and discussions with and/or surveys of feedback from employees and other stakeholders.

A process for the MOH/CEO's or MOH's evaluation should be clearly defined and mutually agreed in advance. The BOH identifies in advance the areas for which the MOH will be held accountable. The evaluation should be completed by the health board as a whole. Alternatively, the MOH evaluation could also be done by a sub-committee chaired by the chair of the board with input from the rest of the board members with the subcommittee then reporting to the full board of the evaluation and the subcommittee's recommendations.

Aspects of the MOH/CEO or MOH's performance that may be reviewed include:

- relations with and reporting to the BOH.
- strategic and operational planning, including implementation of board policies.
- overall administration, including development and implementation of human resource policies.
- fulfilment of statutory requirements (Health Protection and Promotion Act, Ontario Public Health Standards, Ontario Public Health Organizational Standards etc.).
- communications within health unit and external stakeholders.
- relations within health unit and external stakeholders.

It is recommended the evaluation form used to assess the MOH should be customized to the health unit's mission, strategic plan, goals and expectations agreed upon by the MOH and outlined in the MOH's contract and job description.

Evaluation of the Chief Executive Officer (CEO)

There are a number of boards of health in Ontario who have decided to separate the role of MOH and the CEO into two positions.

Aspects of the CEO's performance that may be reviewed include:

- relations with and reporting to the BOH.
- strategic and operational planning, including implementation of board policies.
- overall administration, including development and implementation of human resource policies.
- communications within health unit and external stakeholders.
- relations within health unit and external stakeholders.

It is recommended that the evaluation form used to assess the CEO should be customized to the health unit's mission, strategic plan, goals and expectations agreed upon by the CEO and outlined in the CEO's contract and job description.

Evaluation of the Evaluations

It is recommended that the BOH periodically assess the types of evaluations it performs and the appropriateness of the tools it uses. It should also evaluate its processes for sharing survey results and providing resources to ensure the results may be acted upon.

Governance Review and Best Practices

To ensure the quality of a board of a health, it is advised that a BOH conduct a governance review or audit to evaluate its own performance and practices periodically. Approaches may include forming a governance committee at larger health units or taking a more informal approach at smaller health units. Typically, the governance review process is as follows:

1. **Establish the purpose of the governance review** – The purpose is to ensure the BOH is able to fully discharge its duties in an accountable manner and that it achieves its organizational mission.

2. **Establish the scope of the review** – The scope of the review may be as limited or broad as is necessary. A limited review may only look at only a few processes and practices compared to a full review, which would cover every governance aspect.

3. **Establish the process for the review** – The process would include conducting the review (i.e. examining governance documents, process and practices), evaluating current practices, determining gaps, and assessing areas requiring change.

4. **Develop a workplan for governance improvement** – Using the results of the assessment, the BOH would develop an action plan to address gaps and make improvements.

Evergreen BOH Governance Toolkit

We hope you find this toolkit useful. It is a living document that alPHa plans to update periodically. To ensure ongoing relevancy and currency of information, alPHa's online BOH Resource Page houses the most up-to-date versions of this document and other orientation materials.

If you have any comments, suggestions, or tools and examples for possible inclusion in the toolkit, please let us know at info@alphaweb.org.

Potential BOH By-Laws and Policies

Below is a list of potential health unit by-laws and policies. It should be noted that this list is not exhaustive and each health unit needs to have, adapt or update their by-laws and policies given the requirements of the health unit and their circumstances.

As part of the board orientation, BOH members should receive a copy and/or link to all the health unit's by-laws and policies for their review and future board discussion on any revisions, updating, additions or deletions needed.

BOH by-laws – as examples

- Property Management Bylaw
- Banking and Finance Bylaw
- Procedural Bylaw (Meeting Calling, Proceedings and Recording).
    - Virtual Meeting Bylaw if separate from Procedural Bylaw.
    - Open and In-Camera Meetings Bylaw if separate from Procedural Bylaw.
- Auditor Appointment Bylaw
- Chair and Vice Chair Powers, Duties, and Term of Office of the Chairperson and Vice-Chairperson.
- Execution of Documents Bylaw
- Building Code Act – Sewage Systems Bylaw.
- Procurement of Goods and Services Procurement Bylaw.
- Conflict of Interest and Code of Conduct bylaws or policies.

Board of Health Policies - as examples

- Accessibility
- Appointments – Provincial Representatives
- Board Leadership and Committee Membership Selection.
- BOH Orientation
- CEO Appraisal
- Correspondence
- COVID Vaccination Policy for BOH Members.
- Delegation of Authority
- Donor Recognition
- Effective BOH Governance
- Human Rights and Discrimination
- Immunization
- Indigenous Land Acknowledgement
- Medical Officer of Health – Appointment, Absences, Performance Appraisal, Selection.
- Privacy legislation compliance + procedures – MFIPPA, PHIPA.
- Public Complaints
- Remuneration of Board of Health Volunteers.
- Remuneration of Members
- Remuneration Review
- Risk Management
    - Cybersecurity and IT Security policies.
    - Insurance if separate policy
- Sponsorship
- Whistleblowing Reporting Policy
- Workplace Violence and Harassment Prevention.
- Vision, Mission and Values

Sources

Much of the material in this toolkit came from, or was informed by, the following sources. If a direct reference, it was cited. These links connect directly to governance articles or 'governance' can be searched on these websites.

- alPHa Boards of Health: Shared Resources
- Canadian Society of Association Executives
- Canadian Audit and Accountability Foundation
- Capacity Canada - Resources
- Canadian Chartered Professional Accountants
- Excellence in Governance: A Handbook for Health Board Trustees
- Guide to Good Governance, Governance Centre of Excellence
- Institute on Governance
- National Council of Nonprofits
- Ontario Hospital Association
- Ontario Municipal Councillors Guide
- Ontario Not-for-Profit Network
- Ontario Ombudsman
- Ontario Public Health Standards: Requirements for Programs, Services and Accountability 2021
- UNESCO International Bureau of Education

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2022
ORIENTATION MANUAL
FOR
BOARDS OF HEALTH

Orientation Manual for Boards of Health
Revised: November 15, 2022
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Introduction

The 2022 alPHa Orientation Manual for Boards of Health has been updated to provide new Board members with summary information on public health in Ontario and on the roles and responsibilities of a board of health.

A companion document, *Governance Toolkit for Ontario Boards of Health*, currently under construction for release later in November 2022, provides boards of health with practical tools, best practices and templates to help them govern more effectively.

Orientation Manual Content:

- What is Public Health
- Legislation and Standards governing Boards of Health (BOH)
  - Health Protection and Promotion Act (HPPA)
  - Ontario Public Health Standards (OPHS)
- Roles and Responsibilities
  - Board of Health
  - Medical Officer of Health
  - Governance
  - Guidelines for BOH members
- Board of Health Members and Structures
  - BOH Members
  - BOH Structures
- Ontario Ministry of Health
  - Minister
  - Office of the Ontario Chief Medical of Health (CMOH)
  - Public Health Funding
- Association of Local Public Health Agencies (alPHa) and Key Stakeholders
- Appendixes
  - Links to Key alPHa Resources
  - Provincial Legislation of Interest
  - History of Health Units in Ontario and Key Milestones
  - alPHa Organizational Chart

Context for the November 2022 Edition

The Association of Local Public Health Agencies (alPHa) is pleased to provide the 2022 edition of the Orientation Manual for Boards of Health. The manual brings together in one place key information for board of health members. It includes information about public health and public health units; the structures, roles, and responsibilities of boards of health; and relevant legislation and the Ontario Public Standards which each Board of Health must follow.

The public health system in Ontario is characterized by a balance of local and provincial oversight that is all but unique in Canada. The importance of the local voice in the programming and delivery of public health services throughout Ontario's communities is incorporated into the structure and governance of the system itself. As a member of a board of health, you have a key role to play in keeping your community healthy, which in turn contributes to the health of the entire population.

What is Public Health?

Public health is the science and art of protecting and improving the health and well-being of people in local communities and across the country. It focuses on the health of the entire population or segments of it, such as high-risk groups/priority populations, rather than individuals (i.e. population health).

It is useful to understand the public health ethical orientation as its focus is on population health rather than the acute health care system's focus on the individual. This helps understand some of the differences in practices and approaches between the public health system and the health care system in Ontario.

Public health is the organized efforts of society to keep people healthy and prevent injury, illness, and premature death. It is a combination of programs, services and policies that protect and promote the health of all Canadians. - Last, J. (2001). Dictionary of Epidemiology (4th ed.). New York: Oxford University Press.

Public health uses strategies to protect and promote health and prevent disease and injury in the population. Because a population-based approach is employed, public health works with members of communities, community agencies and local governments to ensure long-term health for all.

Social Determinants of Health include:

- *Income and social status*
- *Housing*
- *Social support networks*
- *Access to health services*
- *Education, literacy + skills*
- *Gender*
- *Employment + working conditions*
- *Culture and race*
- *Social environments*
- *Indigenous status*
- *Physical environments*
- *Unemployment and job security*
- *Personal health practices and coping skills*
- *Social inclusion/exclusion*
- *Early childhood development*

Public health:

- *protects* health by controlling infectious diseases through regulatory inspections and enforcement, and by preventing or reducing exposure to environmental hazards;
- *promotes* health by educating the public on healthy lifestyles, working with community partners, and advocating for public policy that promotes a healthy population; and
- *prevents* disease and injury by the surveillance of outbreaks, screening for cancer, immunization to control infectious disease, and conducting research on injury prevention.

Since the implementation of the *Ontario Public Health Standards*, public health programs and services have included a stronger focus on the social determinants of health and health equity. It has been more formally recognized that the health of individuals and communities is significantly influenced by complex interactions between social and economic factors, the physical environment, and individual behaviours and conditions.

The *Ontario Public Health Standards* incorporate and address the determinants of health throughout and include a broad range of population-based activities designed to promote the health of the population and reduce health inequities by working with community partners.

Public health programs and services are delivered in communities within local health units, each of which is governed by a board of health. Boards of health are established by the authority of the *Health Protection and Promotion Act* (HPPA), and include regional municipalities, single-tier municipalities and boards prescribed by regulation. Each must respond to the unique demographic, social, economic, and geographic conditions within their health units to ensure that the health needs within their communities are met.

For the last twenty-plus years, Ontario's public health system has been on the front line of high-profile public health emergencies and events. This includes the 2000 outbreak of E. coli O157:H7 in Walkerton and the Severe Acute Respiratory Syndrome (SARS) outbreak three years later. Public health and its capacity and effectiveness were thoroughly examined through the lens of these events, which identified serious systemic deficiencies resulting from years of political neglect and underfunding in the structures that provide the programs and services that protect and promote health, prevent disease, and monitor community health. Many reports from this time provided evidence-based recommendations to improve public health's capacity and efficacy.

Three major initiatives were undertaken by the provincial government to start to strengthen the public health system. They were:

- The May 2006 release of the *Revitalizing Ontario's Public Health Capacity*, the Final Report of the Capacity Review Committee, which included 50 recommendations for the public health work force, accountability, governance and funding, strengthening local service delivery, research and knowledge exchange, strategic partnerships and next steps for the local public health sector. This report remains an excellent reference for understanding public health in Ontario and the importance of reinforcing its capacity. Many of its recommendations have been implemented, however, its recommendations on local public health restructuring were not undertaken.

- The replacement of the outdated prescriptive 1998 *Mandatory Health Programs and Services Guidelines* with the 2008 *Ontario Public Health Standards (OPHS),* a comprehensive set of evidence-based guidelines for the provision of public health services. These were revised in 2018 and updated in June 2021 *Ontario Public Health Standards* and they remain the blueprint for the activities of all boards of health throughout the province. They are also the foundation for the Public Health Accountability Framework that sets out the conditions for the receipt of the provincial government's portion of cost-shared funding. Each of these is further described below.

- The creation of a public health agency for Ontario with the mandate to focus on the provision of scientific and technical support to the provincial government, public health units and front-line health

care workers, similar to the Centers for Disease Control in the United States. In 2007, Public Health Ontario (then known as the Ontario Agency for Health Protection and Promotion, which remains its legal name) was established to "provide the scientific evidence and expert guidance that shapes policies and practices for a healthier Ontario."

These initiatives did start to strengthen the local public health system. There were some high-profile public health events such as the 2009 H1N1 pandemic and the emerging vector-borne diseases in Ontario due to climate change (e.g. West Nile, Lyme Disease).

In 2017, the province released its Expert Panel on Public Health that recommended "ways to strengthen and increase the integration of the public health sector within the rest of the health care system across the province." It was not well received by the public health and municipal sectors as it essentially recommended that the local public health system be "integrated" within the acute health care system under the 14 Local Health Integration Networks. It was not implemented as then the June 2018 provincial election happened with a change in government.

In the 2019 Ontario Provincial Budget, the province set out its plans for Public Health Modernization including the goal of establishing 10 regional public health entities and 10 new regional boards of health with one common governance model by 2020–21. After much expression of concern about this approach, the provincial government announced in the fall of 2019 that there would be a consultation on both Public Health and Emergency Health Services (Paramedics) lead by a Provincial Advisor, Jim Pine, who is the Chief Administrative Officer for Hastings County. Rather than using the terms "modernization" or "transformation" of public health, the provincial government refers to it as "Strengthening Public Health."

In 2020, the COVID-19 pandemic emerged as an ongoing global viral pandemic of coronavirus disease 2019 (COVID-19), a novel infectious disease caused by severe acute respiratory syndrome coronavirus 2. The COVID-19 Pandemic was officially announced by the World Health Organization (WHO) in March 2020 and the Ontario Premier declared a state of emergency for the province on March 17, 2020.

The provincial government amended the public health funding formula for 2020. It was announced that the funding is split 70% provincial and 30% municipal. However, the key difference between this and the former funding split of 75/25, was that the new cost-sharing formula now covers everything. Previously there was 100% provincial funding for some provincially-driven programs such as oral health, with cost-sharing only for the mandatory Ontario Public Health Standards' programs.

As of early 2021, effective COVID-19 vaccines were available to the public, although in limited amounts at the start of the roll-out. Local public health was, and is, at the forefront of working to protect Ontarians, particularly those who were especially vulnerable (i.e., seniors in long-term care homes, immunocompromised), from the serious impacts of this deadly pandemic.

As of November 2022, the COVID-19 pandemic continues with multiple waves with mutated variants of the virus. Local public health is exhausted and has reduced staff given the challenging three years with the necessary focus on the pandemic response.

These extraordinary efforts by local public health have come at the expense of nearly all the routine programs and services mandated by the *Ontario Public Health Standards* as resources were redeployed

almost exclusively to the pandemic response. This has resulted in a backlog of public health work that will have immediate and longer-term impacts on population health. alPHa documented these impacts in the February 2022 paper *Public Health Resilience in Ontario.*

Legislation Governing Boards of Health

The *Health Protection and Promotion Act* and the *Ontario Public Health Standards* that are published under its authority govern nearly all of the activities of boards of health. Summaries of these key documents are presented in this section to familiarize board of health members with these, but you are encouraged to read these in full.

Several other pieces of provincial legislation are also significant to the activities of boards of health, medical officers of health and their designates. A detailed and comprehensive itemization and description is beyond the scope of this manual, but a list of links to and brief outlines of some of the key public health-related provincial statutes are provided in Appendix 2. The provincial government's E-Laws Website provides convenient access to all of Ontario's Acts and their associated Regulations.

As a BOH member, you are encouraged to keep up to date on current legislation, including announced or proposed changes, as well as opportunities to provide input on consultations.

One of alPHa's principal roles is to keep its members informed of such changes and give opportunities to have influence. Please review alPHa's updates and policy materials to remain current.

The Health Protection and Promotion Act

The *Health Protection and Promotion Act* (HPPA) is the most important piece of provincial legislation for boards of health, as it enables their existence, structures, governance and functions, outlines the authority of the medical officers of health and boards of health, prescribes the broad responsibilities for local public health and serves as the parent legislation for the regulations and guidelines that prescribe the more detailed requirements that serve the purpose of the Act, which is to "*provide for the organization and delivery of public health programs and services, prevention of the spread of disease and the promotion and protection of the health of the people of Ontario"* (R.S.O. 1990, c. H. 7, s. 2).

There are currently 19 different Regulations made under the HPPA, including those that govern board of health composition, qualifications of staff, food safety, swimming pool health and safety, school health, and communicable disease control.

The original Act came into force on July 1, 1984, replacing the *Public Health Act*, the *Venereal Disease Prevention Act,* and the *Sanatoria for Consumptives Act*. It has undergone over 40 revisions since that time to keep it aligned with current evidence, best practices, and changes to other pieces of legislation.

The old *Public Health Act* provided a clear mandate to boards of health in community sanitation and communicable disease control but provided little or no direction on additional preventive programs considered part of the modern-day approach to public health. Part II Section 5 of the HPPA expands this mandate to require boards of health to provide or ensure the provision of health programs and services

in the areas of preventive dentistry, family health, nutrition, home care and public health education.

HPPA Part II Section 5 - Mandatory health programs and services

Every board of health shall superintend, provide, or ensure the provision of health programs and services in the following areas:

1. Community sanitation, to ensure the maintenance of sanitary conditions and the prevention or elimination of health hazards.

    1.1 The provision of safe drinking water by small drinking water systems.

2. Control of infectious diseases and reportable diseases, including provision of immunization services to children and adults.
3. Health promotion, health protection and disease and injury prevention, including the prevention and control of cardiovascular disease, cancer, AIDS, and other diseases.
4. Family health, including:
    i. counselling services;
    ii. family planning services;
    iii. health services to infants, pregnant women in high-risk health categories and the elderly;
    iv. preschool and school health services, including dental services;
    v. screening programs to reduce the morbidity and mortality of diseases;
    vi. tobacco use prevention programs; and
    vii. nutrition services.

4.1 Collection and analysis of epidemiological data.

4.2 Such additional health programs and services as are prescribed by the regulations.

Part II Section 7 further serves the current approach by empowering the Minister of Health to publish standards for the provision of these mandatory programs and services. The first *Mandatory Health Programs and Services Guidelines* were published in 1984, with revisions for 1998, providing minimum province-wide standards for programs and services aimed at reducing chronic and infectious diseases and improving family health.

These were revised into the Ontario Public Health Standards (OPHS) that came into effect on January 1, 2009 and were again revised for 2018 and 2021. In both cases, this was accomplished with extensive support and input from Ontario's public health professionals. The OPHS are supported by protocols, guidance documents and toolkits that public health staff use to implement effective health promotion and protection programs locally.

The Nine Parts of the *Health Protection and Promotion Act*

Part I - Interpretation
Definitions essential to interpreting the application of the Act and its regulations.

Part II - Health Programs and Services
Introduces the requirements for the delivery of basic mandatory health programs and services. This is the section that gives the *Ontario Public Health Standards* the status of legal requirements. It also authorizes boards of health to provide additional programs and services that may be specific to local needs under Section 9.

Part III - Community Health Protection
Provisions relating to the monitoring and enforcement activities that are necessary for the prevention, elimination, or reduction of the effects of health hazards in the community. These include the traditional duties of public health inspectors (e.g. restaurant inspections, health hazard complaint response) and the types of corrective actions that may be taken to manage risks to health (e.g. issuing orders, seizure, and destruction, closing premises). Part III of the HPPA also includes several clauses specifically addressing health hazards in food.

Part IV - Communicable Diseases
This part is similar to Part III but is specific to decreasing or eliminating risks to health presented by communicable disease. In addition to setting out the types of actions a medical officer of health or the Minister of Health may take to address these risks, this part sets out the reporting requirements that form the basis for monitoring communicable diseases in the community.

Part V - Rights of Entry and Appeals from Orders
This is the part that authorizes designated people (e.g. public health inspectors) to enter any premises in order to inspect, take samples, and perform tests and other duties under the Act. It is also the section that sets out the process by which a person to whom an order has been issued can appeal it.

Part VI - Health Units and Boards of Health
Part VI specifies the composition, operation, and authority of boards of health, their legal status, and the relationship with provincial and municipal authorities. It contains the specific requirement that municipalities pay for costs incurred by the board for its duties under the Act (s. 72), but also enables the province to make offsetting grants (s.76). It also includes rules for the appointment of the MOH.

P*art VI.1- Provincial Public Health Powers*
This is the latest legislative addition from 2011. It provides that the Chief Medical Officer of Health, when they are of the opinion that a situation exists anywhere in Ontario that constitutes or may constitute a risk to the health of any persons, to act with the powers of a Board of Health or Medical Officer of Health, and where there is an immediate risk to the health of persons provide directives to any health care provider or health care entities respecting precautions and procedures to be followed to protect the health of persons. It also outlines where the CMOH shall consider the precautionary principle, order the provision of information, and where the Minister may make an order for the emergency procurement of medications and supplies.

Part VII - Administration
Noteworthy provisions under this part include empowering the Minister to ensure that boards of health comply with the Act; the establishment of public health labs; the appointment, qualifications, and duties of the Chief Medical Officer of Health; and protecting individuals carrying out duties in good faith under the Act from personal liability.

Part VIII - Regulations
The Lieutenant Governor in Council (also known as the provincial Cabinet) is empowered to make regulations to prescribe more detailed standards and requirements for a variety of areas important to public health. An important example of this is the *Food Premises Regulation*, which sets out detailed standards for the maintenance and sanitation of food premises, as well as for the safe handling, storage, and service of food.

Part IX - Enforcement
This Part contains the enforcement provisions under the Act and provides for a range of penalties for a range of offences.

For your reference:
Health Protection and Promotion Act and HPPA Associated Regulations
Please click on the middle tab for the regulations.

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

The *Ontario Public Health Standards* (OPHS) are province-wide standards that steer the local planning and delivery of public health programs and services by boards of health. They set minimum requirements for fundamental public health programs and services targeting the prevention of disease, health promotion and protection, and community health surveillance. These are published by the Minister of Health under the authority of Section 7 of the HPPA, which also obliges boards of health to comply with them.

Where Section 5 of the HPPA specifies the areas in which programs and services must be provided, the OPHS set out goals and outcomes for both society and boards of health. Requirements for assessment and surveillance, health promotion and policy development, and disease prevention are provided. The OPHS are mandatory and they ensure the maintenance of minimum standards for core public health programs and services for all Ontario.

The OPHS set the policy foundation for public health programs and services through 90 outcome-focused requirements spread across four foundational standards and nine programs standards. Rather than measuring performance through compliance, they are meant to enable and demonstrate public health's contribution to population health outcomes through population health assessment and evidence-informed and risk-based approaches to improving it. They are also the basis for the accountability framework that sets out the conditions under which boards of health receive the provincial share of local public health funding.

Public health's impact on population health is realized through a multitude of activities on a wide range of issues, often in partnership with other organizations. Clinical service delivery (where appropriate for a population-based approach), education, inspection and surveillance, advocacy, policy development and enforcement of legislation are among the required activities undertaken by the sector every day. Each is focused on the upstream prevention of poor health outcomes. Ontario's local public health system reflects the diversity of Ontario's population, and the OPHS therefore recognizes the disparate demographic, geographic, economic, and social conditions under which the 34 boards of health operate and provides the flexibility required for local planning and service delivery.

The following infographic is taken from the 2018 edition of the OPHS. It outlines the core functions of public health (assessment and surveillance, health promotion and policy development, health protection, disease prevention, and emergency management) across four domains (Social Determinants of Health, Healthy Behaviours, Healthy Communities and Population Health Assessment) that are guided by four principles (Need, Impact, Capacity, and Partnership, Collaboration and Engagement). In so doing, it illustrates the contribution of public health to improving population health outcomes.

Figure 2: Policy Framework for Public Health Programs and Services

Goal	To improve and protect the health and well-being of the population of Ontario and reduce health inequities			
Population Health Outcomes	• Improved health and quality of life • Reduced morbidity and premature mortality • Reduced health inequity among population groups			
Domains	**Social Determinants of Health**	**Healthy Behaviours**	**Healthy Communities**	**Population Health Assessment**
Objectives	To reduce the negative impact of social determinants that contribute to health inequities	To increase knowledge and opportunities that lead to healthy behaviours	To increase policies, partnerships and practices that create safe, supportive and healthy environments	To increase the use of population health information to guide the planning and delivery of programs and services in an integrated health system
Programs and Services	**Goals** • To increase the use of public health knowledge and expertise in the planning and delivery of programs and services within an integrated health system • To reduce health inequities with equity focused public health practice • To increase the use of current and emerging evidence to support effective public health practice • To improve behaviours, communities and policies that promote health and well-being • To improve growth and development for infants, children and adolescents • To reduce disease and death related to infectious, communicable and chronic diseases of public health importance • To reduce disease and death related to vaccine preventable diseases • To reduce disease and death related to food, water and other environmental hazards • To reduce the impact of emergencies on health			
Principles	**Need** • Assess the distribution of social determinants of health and health status • Tailor programs and services to address needs of the health unit population	**Impact** • Assess, plan, deliver, and manage programs and services by considering evidence, effectiveness, barriers, and performance measures	**Capacity** • Make the best use of available resources to achieve the capacity required to meet the needs of the health unit population	**Partnership, Collaboration and Engagement** • Engage with multiple sectors, partners, communities, priority populations, and citizens • Build and further develop the relationship with Indigenous communities. These relationships may take many forms and need to be undertaken in a way that is meaningful to the particular community and/or organization

Protecting and Promoting the Health of Ontarians: Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (2018, revised June 2021). ISBN 978-1-4868-0928-8 (PDF) Queen's Printer of Ontario (p.8)

What Public Health Does: OPHS Foundational and Program Standards

Foundational Standards

The four Foundational Standards outline requirements that are common to each of the subsequent Program Standards:

1. *Population Health Assessment*: measurement, monitoring, analysis, and interpretation of population health data to ensure that public health responses to current and evolving conditions are effective, and to improve population health with programs and services that are informed by the population's health status, including social determinants of health and health inequities.

2. *Health Equity*: assessment of the social determinants of health to foster understanding of the impact of various social constructs within their communities, help identify priority populations and tailor programs to meet their needs so that all people can reach their full health potential regardless of race, ethnicity, religion, gender, age, social class, socioeconomic status or other socially determined circumstance. This is also the springboard for the priority of Indigenous engagement and delivering public health programs to Indigenous people.

3. *Effective Public Health Practice*: the application of skills in evidence-informed decision-making, research, knowledge exchange, program planning and evaluation, and communication, to ensure that public health practice is transparent, responsive to current and emerging evidence, and emphasizes continuous quality improvement.

4. *Emergency Management:* effective emergency planning ensures that boards of health are resilient and prepared to respond to and recover from threats to public health or disruptions to public health programs and services.

Program Standards

1. *Chronic Disease Prevention and Well-Being:* Reduction of the burden of chronic diseases (e.g. obesity, heart and respiratory diseases, diabetes, mental illness, and addictions) through a comprehensive health promotion approach that addresses risk and protective factors in areas such as built environment, healthy eating, healthy sexuality, mental health promotion, oral health, physical activity, and sleep.

2. *Food Safety:* reduction of the burden of food-borne illnesses through detection and response to food-borne illness and associated risk factors, promotion, and enforcement of safe food-handling practices, and respond to food-related issues that may arise from floods, fires, and power outages.

3. *Healthy Environments:* reduction of exposure to health hazards and promotion of the development of healthy environments that support health and mitigate existing and emerging risks, including the impacts of a changing climate. This includes addressing local needs related to healthy built and natural environments, exposure to hazardous environmental contaminants and biological agents, exposure to radiation including UV light and radon, extreme weather, indoor and outdoor air pollutants, and other emerging environmental exposures.

4. *Healthy Growth and Development*: achievement of optimal preconception, pregnancy, newborn, child, youth, parental, and family health. Topic areas for this standard include breastfeeding, healthy pregnancies, healthy sexuality, mental health promotion, oral health, preconception health, pregnancy counselling, preparation for positive parenting and visual health. This is also the area that mandates the provision of the Healthy Babies, Healthy Children program.

5. *Immunization*: reduction or elimination of the burden of vaccine-preventable diseases through immunization by ensuring that children have up-to-date immunizations in accordance with recommendations and legislated requirements (e.g. *Immunization of School Pupils Act*), promotion of immunization programs for all ages and the importance thereof, outbreak management of vaccine preventable diseases, and oversight of provincially-funded vaccine inventory management (storage and distribution requirements).

6. *Infectious and Communicable Diseases Prevention and Control*: reduction of the burden of communicable diseases and other infectious diseases of public health importance through detection, investigation and management of risks and exposures and public communications and awareness strategies. Public health has specific responsibilities for surveillance, outbreak and case management, control of specific diseases such as rabies and tuberculosis, promoting and enforcing infection control practices, and working with community partners to prevent diseases transmitted sexually or through injection drug use.

7. *Safe Water*: prevention or reduction of the burden of water-borne illnesses and injuries related to drinking water and recreational water use. This includes surveillance of drinking water systems, public beaches, swimming pools, spas, and splash pads. Training of operators, enforcement of related regulations and public notification of risks to health from adverse drinking or recreational water are key public health activities.

8. *School Health*: achievement of optimal health of school-aged children and youth through partnership and collaboration with school boards and schools though health assessments and the implementation of strategies to address health inequities and other factors that affect healthy growth and development. Public health has defined responsibilities in the areas of oral health, vision screening (new in 2018) and childhood immunizations as well as supporting activities related to concussion and injury prevention, healthy eating and physical activity, mental health promotion, UV exposure and many others.

9. *Substance Use and Injury Prevention*: reduction of the burden of substance use (including tobacco, opioids, e-cigarettes, alcohol, cannabis) through comprehensive tobacco control programs, supporting access to substance use harm reduction programs, mental health promotion and strategies to prevent youth initiation; reduction of the burden of preventable injuries through programs that address such things as concussions, falls prevention, road safety and violence.

Strengthened Accountability: Public Health Accountability Framework and Organizational Requirements

The 2018 OPHS is the first one that embeds a formal accountability framework that supports an effective accountability relationship between boards of health and the Ministry of Health (MOH) through the clear articulation of the latter's expectations and the requirement of the former to report on the work they do, how they do it, and the outcomes.

The stated objectives are to ensure that boards of health have the necessary foundations for the delivery of programs and services, financial management, governance, and public health practice; to support a strong public health sector; and to provide evidence of the value of public health and its contribution to population health outcomes leading to better health for Ontarians.

Detailed expectations, organizational requirements and reporting mechanisms are laid out in section 3 of the OPHS, but the principal obligations for all the Common Domains are as follow:

1. The board of health shall submit an Annual Service Plan and Budget Submission to include all programs and services delivered by boards of health and program costing for Ministry-funded programs.

2. The board of health shall submit action plans as requested to address any compliance or performance issues.

3. The board of health shall submit all reports as requested by the Ministry.

4. The board of health shall have a formal risk management framework in place that identifies, assesses, and addresses risks.

5. The board of health shall produce an annual financial and performance report to the general public.

6. The board of health shall comply with all legal and statutory requirements.

The following infographic illustrates the various expectations and reporting mechanisms that are features of the framework:

Figure 5: Public Health Accountability Framework

The Accountability Framework is composed of four Domains

Domain	Delivery of Programs and Services	Fiduciary Requirements	Good Governance and Management Practices	Public Health Practice
Objectives of Domain	Boards of health will be held accountable for the delivery of public health programs and services and achieving program outcomes in accordance with ministry published standards, protocols, and guidelines.	Boards of health will be held accountable for using ministry funding efficiently for its intended purpose.	Boards of health will be held accountable for executing good governance practices to ensure effective functioning of boards of health and management of public health units.	Boards of health will be held accountable for achieving a high standard and quality of practice in the delivery of public health programs and services.

Organizational Requirements incorporate one or more of the following functions:

The Accountability Framework is supported by:

Accountability Documents	• **Organizational Requirements:** Set out requirements against which boards of health will be held accountable across all four domains. • **Ministry-Board of Health Accountability Agreement:** Establishes key operational and funding requirements for boards of health.
Planning Documents	• **Board of Health Strategic Plan:** Sets out the 3 to 5 year local vision, priorities and strategic directions for the board of health. • **Board of Health Annual Service Plan and Budget Submission:** Outlines how the board of health will operationalize the strategic directions and priorities in its strategic plan in accordance with the Standards.
Reporting Documents	• **Performance Reports:** Boards of health provide to the ministry regular performance reports (programmatic and financial) on program achievements, finances, and local challenges/issues in meeting outcomes. • **Annual Report:** Boards of health provide to the ministry a report after year-end on the affairs and operations, including how they are performing on requirements (programmatic and financial), delivering quality public health programs and services, practicing good governance, and complying with various legislative requirements.

Protecting and Promoting the Health of Ontarians: Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (June 2021). ISBN 978-1-4868-0928-8 (PDF) Queen's Printer of Ontario (p.61)

Transparency and Demonstrating Impact: Public Health Indicator Framework and Transparency Framework

In addition to the accountability planning and reporting tools, the 2018 OPHS has embedded a requirement to monitor progress and measure success of boards of health using public health indicators. These are intended to measure the impacts of mandated public health programs and services.

Some of these are set at the provincial level to measure outcomes in all public health units. Others will be established by local boards of health for the standards that are aimed at responding to local needs, priorities, and contexts (i.e., Chronic Disease Prevention and Well-Being, Healthy Growth and Development, School Health, and Substance Use and Injury Prevention). The broad categories of measurable population health outcomes include improved health and quality of life, reduced morbidity and premature mortality, and reduced health inequities.

The following infographic summarizes the components of this framework:

Figure 6: Public Health Indicator Framework for Program Outcomes and Contributions to Population Health Outcomes

Goal	To provide an evidence-informed basis for monitoring progress and measuring success of boards of health in achieving program outcomes, and understanding the contribution to population health outcomes
Objectives	• Monitoring progress in the delivery of public health programs and services • Measuring board of health success in achieving program outcomes • Assessing public health's contributions to population health outcomes

Program Outcomes	
Focus Area	**Indicators and Information**
Chronic Disease Prevention and Well-Being; Healthy Environments; Healthy Growth and Development; School Health; Substance Use and Injury Prevention	• Locally determined program outcome indicators Indicators will be developed in accordance with locally determined programs of public health interventions
Food Safety	• Proportion of food premises that shift between moderate and high risk based on annual risk categorization assessment • Percentage of Salmonella and E. Coli foodborne outbreaks investigated for which a probable source was identified • Incidence of reportable Salmonella, Campylobacter and E. Coli foodborne illness cases
Immunization	• Percentage of 7 and 17 year olds whose vaccinations are up-to-date for all *Immunization of School Pupils Act* (ISPA) designated diseases • Percentage of grade 7 students whose vaccinations are up-to-date for Hepatitis B, Meningococcal and HPV (12 and 13 year olds) • Percentage of public health units that meet the provincial reporting rate for adverse events following immunization (AEFI) for the three vaccines administered through school-based programs (HPV, Meningococcal, and Hepatitis B)
Infectious and Communicable Diseases Prevention and Control	• Incidence rate of Hepatitis C, Gonorrhea, and Syphilis • Percentage of active respiratory Tuberculosis (TB) cases that complete recommended treatment
Safe Water	• Percentage of re-inspections of spas per year • Percentage of recreational water premises with no critical infractions in the last year (pools, spas, wading pools, splash pads, and receiving basins for water slides)
Contributions to Population Health Outcomes	
Improved Health & Quality of Life	• Adoption of healthy lifestyle behaviours • Perceived health • Health expectancy • Life satisfaction
Reduced Morbidity and Mortality	• Overweight/Obesity • Incidence and prevalence of chronic diseases • Chronic disease and substance use related morbidity and mortality • Life expectancy • Avoidable deaths • Infant mortality • Small for gestational age • Rate per 100,000 of VPD outbreaks by disease • Incidence rates of reportable VPDs • % of the public with confidence in immunization programs

Reducing Health Inequities among Population Groups	• Relative index of inequality associated with:
	  ○ Chronic Diseases
	  ○ Injuries
	  ○ Substance Use
	  ○ Healthy Growth and Development
	• Vulnerability associated with:
	  ○ Early development
	  ○ School readiness
	• Deprivation Index
	• Food Security
	• Disability Rates

Protecting and Promoting the Health of Ontarians: Ontario Public Health Standards: Requirements for Programs, Services, and Accountability (2018, June 2021). ISBN 978-1-4868-0928-8 (PDF) Queen's Printer of Ontario (p.74).

The 2018 OPHS has also embedded a Transparency Framework, which is meant to increase transparency in the public sector and promote public confidence in the public health system.

This is achieved through requirements of boards of health to disclose information to the public that supports making informed decisions to protect their health (e.g. restaurant inspection reports, drinking water advisories, infection control lapses) and reports on the activities of boards of health and associated level of investment (e.g. annual reports, strategic plans). The following infographic summarizes the components of this framework:

Figure 7: Draft Transparency Framework[23]

Goal	Promote awareness, understanding, and public confidence in Ontario's public health system.	
Domains	**Protecting the Public's Health**	**Public Reporting**
Objectives	The public knows of the work of public health to protect and promote individual and community health	The public knows how Boards of Health are responding to local community needs

BOH Responsibilities	Post on the board of health website:
	• Results of routine and complaint based inspections of:
	  ○ Food Premises
	  ○ Public Pools and Spas
	  ○ Recreational Water Facilities
	  ○ Personal Services Settings
	  ○ Tanning Beds
	  ○ Recreational Camps
	  ○ Licensed Child Care Settings
	  ○ Small Drinking Water Systems
	• Convictions of tobacco and e-cigarette retailers
	• Infection prevention and control lapses
	• Drinking water advisories for small drinking water systems
	• Status of beach water quality
		Post on the board of health website:
		• Strategic Plan
		• Annual performance and financial report

[23]The Transparency Framework is draft and subject to change.

72

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Roles and Responsibilities

The Board of Health

As summarized above, The *Health Protection and Promotion Act* provides the authority to local boards of health to control communicable disease and other health hazards in their communities and the *Ontario Public Health Standards* describe in detail how this authority is to be exercised.

In carrying out its mandate, the governing body must provide a policy framework within which its staff can define the health needs of the community and design programs and services to meet these needs. All programs and services are approved by the board of health.

The board should adopt a philosophy and management process that allows it to carry out its mandate in an efficient, effective, and economical manner. This should be complemented with a sound organizational structure that reflects the responsibilities of the component parts. The board of health is the governing body, the policy maker of the health unit. It monitors all operations within the unit and is accountable to the community and to the MOH as described above.

The primary functions of the BOH are to provide good governance and strategic leadership to the organization. It is important to note that while the BOH works closely with the MOH/CEO, it is the MOH/CEO's responsibility to lead the public health unit in achieving board-approved directions. Therefore, the responsibility for the day-to-day management and operations of the health unit lies with the MOH/CEO.

The Board of Health:

- establishes general policies and procedures which govern the operation of the health unit and provide guidance to those empowered with the responsibility to manage health unit operations;
- upholds provincial legislation governing the mandate of the BOH under the *Health Protection and Promotion Act* and others;
- ensures accountability to the community by ensuring that its health needs are addressed by the appropriate programs and ensuring that the health unit is well-managed;
- ensures program quality and effectiveness and financial viability;
- establishes overall objectives and priorities for the organization in its provision of health programs and services, to meet the needs of the community;
- hires the MOH and associate medical officer(s) of health with approval of the Minister;
- assesses the performance of the MOH and associate medical officer(s) of health;
- assesses the Board's own performance and ensures Board effectiveness; and
- follows the requirements of the MOHLTC Public Health Accountability Framework.

The Medical Officer of Health

Every board of health is required by Section 62(1)(a) of the HPPA to appoint a full-time, fully qualified medical officer of health (MOH) without exception. The MOH reports to the BOH and is primarily responsible for public health programs and services to the board of health.

As such, the MOH:

- reports directly to the board of health on issues relating to public health concerns and to public health programs and services under the HPPA or any other Act;
- provides policy advice to the BOH;
- directs employees of and others whose services are engaged by a board of health whose duties relate to the delivery of mandated public health programs and services;
- accountable to the board for day-to-day operations of the health unit;
- supervises and evaluates performance of senior staff and advises or assists department heads in hiring staff;
- encourages and promotes the continuing education of all staff;
- evaluates the effectiveness of programs and services;
- recommends appropriate changes and reports these findings regularly to the board; and
- engages on issues relating to local health system planning, funding, and service delivery with the local Ontario Health Team(s) where the geographic area intersects with the public health unit in whole or in part.

In most boards of health (about two-thirds), the MOH serves the dual function of MOH and Chief Executive Officer (CEO) of the board of health. In the others, the MOH and CEO (or CAO in some cases) are separate positions, where the former takes on more responsibility for the administrative and operational aspects of the agency. The BOH determines the roles and responsibilities of these positions.

To ensure that the intent of section 67 of the HPPA is consistently applied across all boards of health (i.e. that the MOH reports directly to the BOH on matters related to public health in all cases) the Ministry requires the following (extracted from the 2018 MOHLTC *Policy Framework on Medical Officer of Health Appointments, Reporting, and Compensation, p.4*):

- that the MOH have a direct reporting relationship to the board of health (i.e., a solid line for matters of public health significance/importance on the organizational chart regardless of the board of health governance model);
- that the MOH be part of the senior management team;
- that staff responsible for the delivery of public health programs and services under the HPPA or any other Act must report directly to the MOH without any need to report to intermediaries (i.e., a solid line relationship between staff and the MOH).

Governance

Governance can be thought of as the stewardship or oversight of the affairs—particularly the strategic direction—of an organization. The BOH, acting in its governance role, sets the desired goals for the organization and establishes the systems and processes to support achievement of those goals.

Critical elements of an effective public health unit governance policy framework include:

- principles of governance and BOH accountabilities;
- statement of the BOH's obligations to act in the best interest of the public health unit;
- defined roles and responsibilities of the BOH;
- defined roles and responsibilities of individual BOH members, including a code of conduct;
- guidelines for the selection of BOH members;
- a range of specific skills and expertise;
- standing and ad hoc committees that support the BOH;
- clear differentiation between governance and management;
- maintaining focus on strategic leadership and direction; and
- self-evaluation and continuous quality improvement.

As outlined in the Public Health Legislation section above, each of these elements will be defined within the context of the prescriptive provincial policies that are laid out in the HPPA, OPHS and related documents that each BOH is obliged to follow. alPHa's Governance Toolkit expands upon the above by giving guidance, practical tools and templates to help BOHs govern more effectively.

Guidelines for Board of Health Members

A member of a BOH should:

- commit to and understand the purpose, policies, and programs of the health unit;
- attend board meetings, and actively participate on committees and serve as officers;
- actively participate in setting the strategic directions for the organization;
- acquire a clear understanding of the financial position of the health unit and ensure that the finances are adequate and responsibly spent;
- serve in a volunteer capacity without regard for remuneration or profit;
- be able to work and participate within a group, as a team;
- be supportive of the organization and its management;
- know and maintain the lines of communication between the board and staff;
- take responsibility for continuing self-education and growth;
- represent the public health in the community;
- be familiar with local resources;
- be aware of changing community trends and needs;
- attend related community functions;
- have a working knowledge of parliamentary procedure; and
- be aware of the definition of conflict of interest and when to declare it.

Board of Health Members and Structures

BOH Members

There are three categories of BOH members:

1. **Elected Officials or Municipal Appointments**. These may be appointed to an autonomous BOH to represent their municipality. In the case of the seven regional boards of health, Regional Council acts as the BOH and all members are elected officials. In other boards, some municipalities may select to appoint a community representative, rather than a municipal elected member, to the BOH who then works with the municipality who appointed them.

2. **Public Appointees**. The composition of autonomous BOHs is outlined in Section 49 of the HPPA. Section 49(3) provides for the appointment of one or more provincial members by the Lieutenant Governor in Council (Provincial Cabinet). Applications to be a provincial member on a BOH can be made through to the Ontario Public Appointments Secretariat. Board vacancies are posted to this provincial website.

3. **Citizen Representatives**. Some boards of health provide for representation by citizen members, who are often appointed by local council to the board.

BOH Structures

Autonomous

In autonomous BOHs, the administrative structures of the public health unit and the municipality or municipalities are separate. Most autonomous boards of health have multiple obligated municipalities with representation on the BOH. Some may have citizen representatives appointed by municipalities and/or public appointees. When there are a number of municipalities represented on a board, the municipalities themselves may work out a rotating schedule of representation so that all obligated municipalities have an opportunity to be on the board regularly. There is also a category is known as "Autonomous/ Integrated," where only one municipality appoints representatives and operations are integrated with the municipality's administrative structure. There are 24 autonomous BOHs in Ontario:

Algoma
Brant County
Chatham-Kent*
Eastern Ontario
Grey Bruce
Haliburton-Kawartha-Pine Ridge
Hastings-Prince Edward
Huron-Perth
Kingston, Frontenac, Lennox & Addington
Lambton*
Leeds, Grenville, Lanark
Middlesex-London
North Bay Parry Sound
Northwestern
Peterborough
Porcupine
Renfrew
Simcoe Muskoka
Southwestern
Sudbury
Thunder Bay
Timiskaming
Wellington-Dufferin-Guelph
Windsor-Essex

**autonomous/integrated*

Regional

In a Regional BOH, staff operates under the administration of regional government (also known as an upper-tier municipality with lower tier municipalities within the regional boundaries). Regional boards of health have no citizen representatives and no public appointees.
The 6 regional boards of health in Ontario are:

- Durham
- Halton
- Niagara
- Peel
- Waterloo
- York

Single-Tier / Semi-Autonomous

In Single-Tier municipalities (where the municipal has both lower and upper tier responsibilities), municipal councils serve as the board of health and the staff of the health unit operates under the municipal administrative structure. A subset of this category is “Semi-Autonomous,” in which the municipal council appoints members to a separate board of health but retains authority for budget and staffing approvals.

Presently, there are 4 municipal boards of health, two of which are Semi-Autonomous and 2 of which have municipal council acting as the BOH. They have no provincial appointees and the 2 cases where the BOH is independent of municipal council, citizen appointees are possible.

- Haldimand-Norfolk - Council acts as BOH
- Hamilton - Council acts as BOH
- Ottawa - Semi-Autonomous
- Toronto - Semi-Autonomous

Public Health Unit Map

The Ministry of Health

Minister

The Minister of Health is the cabinet member with the portfolio for public health and is the lead minister named in public health-related legislation. Under the HPPA, the Minister of Health is given the authority to publish guidelines for the provision of mandatory health programs and services (the OPHS), to make regulations related to controlling diseases of public health significance, to make appointments of public health staff (e.g. medical officers of health, inspectors) and exercise certain powers in the case of emergencies.

Section 76 of the HPPA gives the Minister the power to make discretionary grants for the purposes of the HPPA on such terms and conditions as the Minister considers appropriate. This is the authority under which provincial grants are used to fund boards of health, which are in turn governed by the conditions of the Accountability Framework described above.

The Minister also has the power to appoint assessors to determine whether a BOH is providing health programs and services specified in the HPPA and is complying in all respects with the HPPA and the regulations. Assessments are also used to ascertain the quality of the management or administration of the affairs of the BOH.

The Minister must approve all MOH and Associate MOH appointments, as well as any dismissal of a MOH or an Associate MOH by the BOH as part of the set-out process for such a dismissal.

Office of the Chief Medical Officer of Health

The Ontario Chief Medical Officer of Health (CMOH) has the critical role in leading the public health system as a whole–focusing on their legislated role in *the Health Protection and Promotion Act*, linking with Public Health Ontario and providing public health advice both within and beyond government. This includes the provision of advice and direction to boards of health, medical officers of health and to the people of Ontario. The CMOH is both appointed by the Ontario Legislature for a five-year term while is also an Assistant Deputy Minister within the Ministry of Health.

Within the Ministry, the Office of Chief Medical Officer of Health is responsible for determining provincial public health needs, developing public health initiatives and strategies, and monitoring public health programs delivered by Ontario's local public health units (described below). Ontario's public health programs focus on disease prevention and control, screening for health conditions, and public education on health matters such as communicable diseases and healthy living.

The CMOH reports directly to the Deputy Minister of Health. The Office of the CMOH works to ensure that appropriate actions are taken to respond to urgent and emergency situations. It engages with local, national, and international partners to develop public health strategies. It advises other parts of government on the potential health impacts of government initiatives, and they provide training and other supports to advance Ontario's public health system. (Sourced from the Ontario Public Health System | Public Health Ontario).

The CMOH powers, when of the opinion that a situation exists anywhere in Ontario that constitutes or may a risk to the health of any persons, under the HPPA includes:

- Investigate and take any action they consider appropriate to prevent, eliminate or decrease the risk
- act anywhere in Ontario with the powers of a BOH or MOH;
- request information from a BOH;
- issue a directive to any health care provider or health care entity respecting precautions and procedures to be followed to protect the health of persons;
- provide written information to the MOH Minister so they can order emergency procurement of medications and supplies;
- that they, and ensure provision of, required public health programs not being provided by a BOH;
- investigate, advise, guide and, if remedial action is not taken, issue a written direction in cases where the Minister of Health is of the opinion that a BOH has failed to comply with the Act, its regulations or provincial program standards. If the BOH fails to comply with the direction, the CMOH may act on behalf of the BOH;
- investigate situations, which, in the opinion of the Minister of Health, constitute or may constitute a risk to the health of persons; and take appropriate action to prevent, eliminate and decrease the risk to health caused by the situation.

The Office of the Chief Medical Officer/Public Health Division is headed by the CMOH. There are 5 branches within the Division that report to the Executive Lead, Public Health. The five branches are:

- *Accountability and Liaison Branch*
- *Health Promotion and Prevention Policy and Programs Branch*
- *Health Protection and Surveillance Policy and Programs Branch*
- *Immunization*
- *Strategy and Planning Branch*

The *Health System Emergency Management Branch,* which formerly was under the Office of the CMOH/Public Health Division, is now under the Pandemic Response and Recovery Division as it serves the entire health system—both the health care and public health systems.

Current Ministry of Health Organizational Chart

Provincial Government's Public Health Web Page

Public Health Funding

The funding of public health and the delivery of public health programs in Ontario is unique in Canada. In other provinces, public health is funded provincially and operates as part of regional health authorities. According to the HPPA:

72. (1) The obligated municipalities in a health unit shall pay,

(a) the expenses incurred by or on behalf of the board of health of the health unit in the

performance of its functions and duties under this or any other Act; and

(b) the expenses incurred by or on behalf of the medical officer of health of the board of health in the performance of his or her functions and duties under this or any other Act. 1997, c. 30, Sched. D, s. 8.

(2) In discharging their obligations under subsection (1), the obligated municipalities in a health unit shall ensure that the amount paid is sufficient to enable the board of health,

(a) to provide or ensure the provision of health programs and services in accordance with sections 5, 6 and 7, the regulations and the guidelines; and

(b) to comply in all other respects with this Act and the regulations. 1997, c. 30, Sched. D, s.8.

This means that the obligated municipalities within a health unit are legally 100% responsible for funding the costs of delivering public health programs and services. That said, Section 76 of the HPPA states the following:

76. The Minister **may** make grants for the purposes of this Act on such conditions as he or she considers appropriate. 1997, c. 15, s. 5 (2).

This enables the Province to provide funding for these programs and services, and it has traditionally done so as a matter of policy, but it is not under the same legal obligation as the municipal governments for funding local public health.

To illustrate, prior to 1997, funding responsibility for public health was shared by the Province (75%) and municipalities (25%). On January 1, 1998, as part of the Local Services Realignment initiative, the Province of Ontario transferred all funding responsibility for public health to municipalities through amending the HPPA, but this lasted little more than a year. Without amending the HPPA, in March 1999, the Province announced that a grant of up to 50% would be provided to help offset the costs on the obligated municipalities. The 50/50 cost-sharing arrangement continued until 2005. In 2004, the Province announced an incremental increase to its funding share, to 55% in 2005, 65% in 2006, and 75% in 2007.

For 2020, the provincial government amended this long-standing public health funding formula. It was announced that the funding is split 70% provincial and 30% municipal. However, the key difference between this and the former funding split of 75/25, was that the new cost-sharing formula now covers everything. Previously there was 100% provincial funding for some provincially-driven programs such as oral health, with cost-sharing only for the mandatory Ontario Public Health Standards' programs.

Given to the needed provincial COVID-19 mitigation funding to keep local public health whole during the ongoing pandemic, the full 2020 funding changes and their impacts have not been fully realized to date, although it is a huge overwhelming concern for all local public health agencies. It is alPHa's position that the 75-25% OPHS funding and the 100% funding for provincial programs should be restored.

It is worth noting that growth limitations imposed by the Province on increases to the Ministry share of the contribution in the intervening years have resulted in an erosion of the total funding envelope and

in many cases boards of health have contributed more than 25% to offset shortfalls.

Association of Local Public Health Agencies www.alphaweb.org

Who We Are

Established in 1986, the Association of Local Public Health Agencies (alPHa) is the non-profit organization that provides leadership to Ontario's public health units and their boards of health.

A Strong Association

alPHa's mission statement is to, through a strong and unified voice, advocate for public health policies, programs, and services on behalf of member health units in Ontario. The strength and unity of this voice is best served when all of Ontario's communities are represented. alPHa is currently enjoying unprecedented recognition and credibility in many public policy discussions, and its voice is strong as the representative of all 34 Ontario health units.

alPHa works closely with the senior leadership of its member health units, including board of health members, medical and associate medical officers of health, and senior public health managers in each of the following public health disciplines:

- nursing
- inspection
- dentistry
- nutrition
- epidemiology
- health promotion
- business administration

alPHa represents the interests of member public health units and lends expertise to members on the governance, administration and management of public health units and their boards of health. The Association also works with governments and other health organizations, advocating for healthy public policy and a strong, effective, and efficient public health system in Ontario.

What We Do

Through policy analysis, discussion, partnership and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention and surveillance services in all of Ontario's communities. alPHa also provides member benefits such as group plans, networking opportunities, and recognition, to name just a few. Here are key activities that we engage in as the voice of Ontario's public health units:

Advocacy – alPHa communicates on behalf of members on public health matters to government and decision-makers. It also develops and disseminates positions and reports on key public health issues and

relevant legislation.

Communications – alPHa keeps members informed on the latest news and events as well as emerging issues.

Education – alPHa holds timely and informative sessions on matters affecting the governance and delivery of public health programs and services.

Representation – alPHa representatives participate on key public health working groups and committees.

Members of alPHa

Membership is open to all Ontario public health units and their boards of health. Representatives from member public health units include:

- board of health members
- medical and associate medical officers of health
- senior public health managers in nursing, inspection, dentistry, nutrition, epidemiology, health promotion and business administration

alPHa's members also comprise of the following Affiliate Organizations:

- Association of Ontario Public Health Business Administrators (AOPHBA)
- Association of Public Health Epidemiologists in Ontario (APHEO)
- Association of Supervisors of Public Health Inspectors of Ontario (ASPHIO)
- Health Promotion Ontario (HPO)
- Ontario Dietitians in Public Health (ODPH)
- Ontario Association of Public Health Dentistry (OAPHD)
- Ontario Association of Public Health Nursing Leaders (OPHNL)

Benefits of Membership with alPHa

alPHa delivers good value to its members through the use of its resources. alPHa does not receive funding from the government of Ontario. We are funded through our members, sponsors, and events. The financial support we receive from our members accounts for 70 percent of our annual budget, so it is top priority to show good value for their membership fees. Our members are the boards of health and local public health units in Ontario and we maintain a strong focus on their collective needs.

Through participation in alPHa, members are better positioned to do their jobs locally and have the opportunity to participate at the provincial level to help shape the future of the local public health system in Ontario. As transformation of local public health continues to be considered by the Province, there has never been a better time to be a member of alPHa.

Recognizing that health unit resources vary across the province, alPHa's membership requirements are

graded to ensure that any board of health in Ontario can enjoy all of the membership benefits equitably and have access to member services such as advocacy, communications, education, and professional development.

WHAT WE DO FOR OUR MEMBERS

Promote

alPHa supports its members to be better understood and valued by municipal and provincial governments. We create communications tools that are designed to inform municipal politicians about local public health and encourage their interest in participating on boards of health. We meet with provincial policy advisors and senior government staff to ensure they understand the role, value, and expertise of local public health.

Represent

alPHa communicates health units' issues, concerns, and solutions on public health matters to government and decision-makers. It facilitates joint meetings between members and provincial decision-makers to share information and expertise to improve Ontario's public health system. alPHa focuses on representing its members in responding to member resolutions and public health sector issues where a collective voice best serves the membership as a whole; e.g., issues that impact the structure and funding of local public health. alPHa is regularly invited to identify members for provincial or partner committees addressing issues of primary importance for local public health.

alPHa maintains strong relationships with key partners, stakeholders and decision makers who impact our members.

Support

alPHa ensures that members are aware of proposed legislation and matters that are of interest to public health units. alPHa facilitates the sharing of member positions, resolutions, and discussion documents to encourage broader support for member issues among alPHa's membership.
alPHa has established the "Current Consultations" page on its web site where information is posted about government consultations. Members are informed and provided links through email and alPHa's "Information Break" e-newsletter. alPHa has also established a web page for posting existing and proposed health promoting local by-laws, categorized by social determinants of health.

Connect

alPHa works with members to coordinate networking opportunities for public health professionals working in local public health. alPHa has established web-based approaches for the sharing of information wherever possible, for example providing work space for working groups to post information. alPHa also helps members in their day-to-day jobs, by keeping members informed on latest news and events as well as emerging issues through current technologies, including our website, e-newsletters, and group mailing lists.

Enrich

alPHa provides professional development to support excellence in public health leadership and public

health unit management and governance professional development is delivered throughout the year through an annual conference, symposiums, and other educational opportunities. alPHa holds timely, relevant, and informative sessions and programs to enrich members' knowledge on issues, developments and challenges affecting the delivery of public health programs and services.

HOW WE DO IT

A 21-member Board of Directors oversee alpha's business, consisting of 7 medical officers of health or associate medical officers of health, 7 board of health trustees and representation from each of the 7 public health disciplines listed above. All regions of the province are represented to ensure that all communities' interests can be served. The Board meets at least 5 times each year to discuss emerging and ongoing issues in public health policy, governance, funding, and programs and services.
alPHa also conducts regular meetings of its **Boards of Health Section** and **Council of Medical Officers of Health** (COMOH) to discuss issues particular to their positions. In addition, ad hoc committees are frequently assembled to discuss action plans for Association Resolutions, as well as emerging issues raised by members, public, government or media. These committees often provide the opportunity for wider participation in alPHa business by interested health unit staff with expertise in the operational and programmatic aspects of these issues. In addition, alPHa's Affiliate members frequently meet and contribute to alPHa's public policy efforts.

alPHa is regularly invited to appoint official representatives to both ad hoc and standing policy analysis and advocacy committees struck by government, other associations, agencies, and coalitions.

Our staff regularly consults with other partners in the health and policy sector, including government ministries, Public Health Ontario, the Association of Municipalities of Ontario, the Ontario Medical Association and Ontario Health.

VALUE-ADDED BENEFITS OF MEMBERSHIP

❖ Member Services

- **Electronic mailing lists**: interactive e-mail lists where members can seek advice from colleagues and send and receive information instantly throughout the province. It also allows alPHa staff to request and receive broad input from each of its members when formulating its positions.
- **alPHaWeb**: our website, www.alphaweb.org, includes extensive resources on public health issues, information about alPHa, links to the web presence of each of its members, and job postings. Secure Members' Areas are also available for the posting of non-public material such as meeting information.
- **Educational opportunities**: seminars, workshops, and general meetings as described above.

❖ Products

- **Directories**: alPHa updates its online *Directory of Public Health Agencies*, which contains contact information for each of Ontario's health units, including sub-offices and direct lines for senior management staff.

- **Group Affinity Programs**
  alPHa periodically negotiates group rates for member health units and their employees including group rates on personal home and auto insurance

AT YOUR SERVICE

The alPHa Staff is a small professional team and is responsive and capable. Through the Executive Director, staff support the governance role of the alPHa Board as well as the policy, representation, communications, member services and professional development work alPHa members rely on.

Key Stakeholders

alPHa works closely with a number of stakeholders as part of its role representing leadership in the public health system.

Ontario Ministry of Health
Ontario Chief Medical Officer
Public Health Ontario
Association of Municipalities of Ontario
Ontario Medical Association
Ontario Public Health Association
Canadian Public Health Association

alPHa also works with faculty and students in post-secondary Public Health programs in Ontario, particularly with the Dalla Lana School of Public Health at the University of Toronto.

Appendix 1 – Links to Key alPHa Resources

Key alPHa Documents

- **alPHa Constitution**
- **Strategic Plan**
- **Annual Report**
- **alPHa resolutions**
- **alPHa correspondence**
- **alPHa Position Papers and Reports**

- **BOH Shared Resources Page**, including: **BOH Orientation Manual** and **BOH Governance Toolkit**

- **A Review of Board of Health Liability 2018**

- **Information Break** - sent by email. alPHa's monthly newsletter is delivered to all members by email and highlights public policy submissions, key events, and activities.
- Public Health Matters Primer – Infographic
- Public Health Matters – Video
- alPHa Brochure

Social Media

- **alPHa's Social Media Accounts:** Twitter **@PHAgencies** and **LinkedIn**

Many members follow alPHa on social media. If you are active on Twitter or LinkedIn, please follow and like alPHa's tweets and retweets that help to profile association activities with members and stakeholders.

Appendix 2: Legislation and Other Governing Documents

Database of all Ontario Acts and Associated Regulations http://www.e-laws.gov.on.ca

Provincial legislation of Public Health Interest:
Just click on the link for information on the legislation and its details.

- *Cannabis Control Act 2017*
- Child Care and Early Years Act
- Healthy Menu Choices Act
- Immunization of School Pupils Act
- Mandatory Blood Testing Act
- Safe Drinking Water Act
- Skin Cancer Prevention Act (Tanning Beds)
- Smoke-Free Ontario Act

Acts Pertaining to Health Units as Public Bodies

- Accessibility for Ontarians with Disabilities Act (AODA)
- French Language Services Act
- Municipal Act
- Municipal Conflict of Interest Act
- Municipal Freedom of Information and Protection of Privacy Act
- Occupational Health and Safety Act
- Personal Health Information Protection Act

Appendix 3: History of Health Units in Ontario

The pattern of local public health services administration for Ontario was established in 1833 when the Legislature of Upper Canada passed an Act allowing local municipalities "*to establish Boards of Health to guard against the introduction of malignant, contagious and infectious disease in this province*." This delegation of public health responsibility to the local level established 150 years ago has persisted to the present day. There are currently 34 boards of health in Ontario.

Important Milestones

1873 The first *Public Health Act* is passed.

1882 The first board of health is established.

1884 A more comprehensive *Public Health Act* is prepared by Dr. Peter B. Bryce. This Act establishes the position of the medical officer of health and the relationship with the board of health. Within two years of passage, 400 boards of health are in operation.

1886 The *Compulsory Vaccination Act* is passed.

1934 The Eastern Ontario Health Unit becomes the first county-wide health unit in Ontario, established with a grant from the Rockefeller Foundation. It included the four eastern counties of Stormont, Dundas, Glengarry, and Prescott. At this time, Ontario had 800 local boards of health and 700 medical officers of health, most of whom were part-time.

1944 The *Public Health Act* is amended with the legislative foundation for the establishment of public health units. 27 health units are established by the end of 1949, with an additional 10 in place by 1965.

1948 The World Health Organization defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

1967 The *Public Health Act* is amended to require organized municipalities to provide full-time public health services. The district health unit concept was introduced based on the collective experience of operating health units in Ontario. Economies of scale concepts were introduced that suggested optimum population sizes (100,000) for health unit catchment areas. The province encourages health units to regroup on a multi-county basis to become more efficient.

1984 The *Health Protection and Promotion Act* (HPPA) is proclaimed, replacing the *Public Health Act* and several other public health-related statutes. It sets out minimum standards for public health programs and services throughout the province. It has been kept current with several amendments but remains substantially the same to the present day.

1997 The HPPA was revised as part of Bill 152, the *Services Improvement Act*. Through this legislation, municipal governments were made 100% responsible for the funding of public health whereas the provincial government can provide grants as a matter of policy, not legislation.

1998 The *Mandatory Health Programs and Services Guidelines* (the precursor to the present-day Ontario Public Health Standards) are in effect.

2004 Following the SARS outbreak, the government of Ontario announced *Operation Health Protection: An Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario.*

2006 The *Smoke-Free Ontario Act* is introduced, which bans smoking in all enclosed public places. This replaced the patchwork municipal by-laws at the time.

2006 The government of Ontario introduces the *Health System Improvements Act,* which includes enabling legislation for the Ontario Agency for Health Protection and Promotion, Ontario's "CDC of the North."

2006 The Final Report of the Capacity Review Committee is released.

2007 The Ontario Agency for Health Protection and Promotion is established in Toronto.

2008 The *Ontario Public Health Standards* are completed in collaboration with boards of health and Ontario public health professionals. These come into effect on January 1, 2009 and replace the 1998 *Mandatory Health Programs and Services Guidelines*.

2010 The Ontario Agency for Health Protection and Promotion changes its operational name to Public Health Ontario.

2011 The first accountability agreements are put in place between boards of health and the Ministry of Health. In addition, the HPPA is amended to give the Chief Medical Officer of Health the power to issue directives to a board of health or local medical officer of health.

2017 The *Patients First Act* includes a clause that formalizes engagement between the local Medical Officer of Health and LHIN CEOs on issues related to local health system planning, funding, and service delivery.

2017 The report from the Minister's Expert Panel on Public Health Report—*Public Health Within an Integrated Health System*—is released.

2018 The Elgin-St.Thomas and Oxford County Public Health Units formally merge on May 1 as the Oxford - Elgin - St. Thomas Public Health Unit, which is branded as Southwestern Public Health.

2018 The modernized *Ontario Public Health Standards: Requirements for Programs, Services, and Accountability* begin to be implemented.

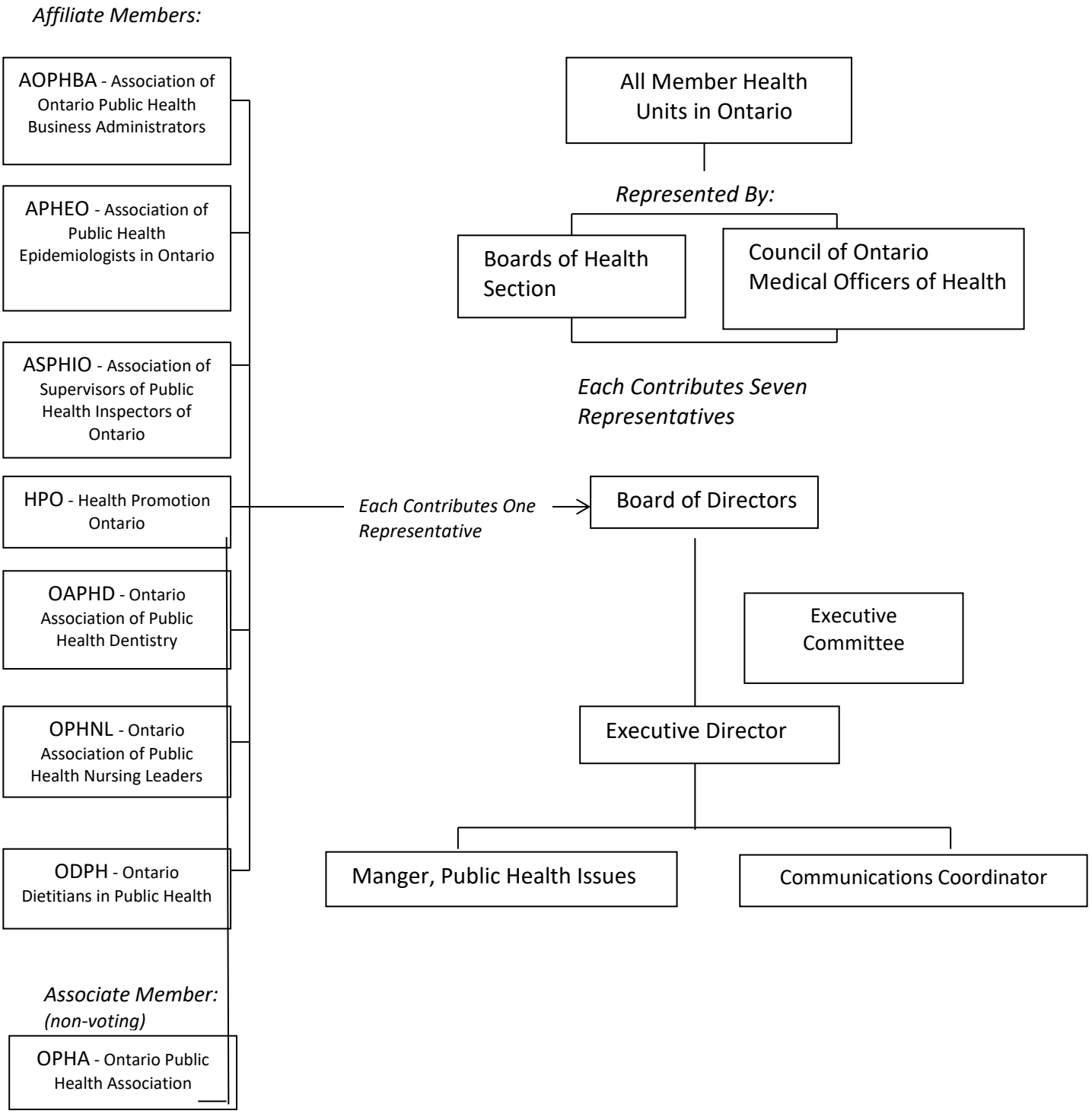
2019 The Spring 2019 Provincial Budget outlines the provincial direction on Public Health Modernization (i.e., restructuring of the local public health system). Later that year, the province announced that Jim Pine, County of Hastings CAO would serve as an advisor for renewed consultations on strengthening and modernizing public health and emergency health services.

2020 The Huron County and Perth District Health Units formally merge on January 1 as the Huron Perth Health Unit, branded as Huron Perth Public Health.

2020 In March 2020, the World Health Organization declared that COVID 19 was a global pandemic. Public health, provincial and local, focused primarily on public health measures with the objective of keeping people safe from this unknown (at the time) infectious disease. All consultations on public health modernization were paused.

2020 The province revised the public health funding to 70% provincial and 30% municipal and this formula now includes all the previously funded provincial programs. Due to the needed provincial mitigation funding to keep local public health whole during the COVID-19 pandemic, these funding changes and their impacts were not felt or fully understood at the time.

APPENDIX 4- Association of Local Public Health (alPHa) Organizational Chart **(as of November 2022)**



From:	allhealthunits on behalf of Rachel Quesnel
To:	"allhealthunits@lists.alphaweb.org"
Cc:	Penny Sutcliffe
Subject:	[allhealthunits] FW: Board of Health Motion Re Physical Literacy for Healthy Active Children | Résolution du Conseil de santé sur la littératie physique pour une jeunesse saine et active
Date:	Friday, December 30, 2022 8:15:27 PM
Attachments:	L_DOEs_Sports_and_Recreation_Early_Years_Centres_Physical_Literacy_for_Healthy_Active_Children_2022-12-30.pdf L_DOEs_Sports_and_Recreation_Early_Years_Centres_Physical_Literacy_for_Healthy_Active_Children_2022-12-30_FR.pdf

ATT: Ontario Boards of Health
Please see attached letter from Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer, Public Health Sudbury & Districts, outlining a Board of Health resolution regarding physical literacy for healthy active children.

Thank you,
Hélène Leroux *on behalf of Rachel Quesnel*

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

From: Rachel Quesnel <quesnelr@phsd.ca>
Sent: December 30, 2022 8:10 PM
To: Bruce Bourget <bourgeb@rainbowschools.ca>; Danny Viotto <danny.viotto@hscdsb.on.ca>; Joanne Bénard <Joanne.Benard@sudburycatholicschools.ca>; Lucia Reece <reecel@adsb.on.ca>; Paul Henry <paul.henry@nouvelon.ca>; Sébastien Fontaine <sebastien.fontaine@cspgno.ca>; Sylvie Petroski <sylvie.petroski@cscdgr.education>; 'info@sudburysports.com' <info@sudburysports.com>; 'danlee@sympatico.ca' <danlee@sympatico.ca>; 'richard@sportforlife.ca' <richard@sportforlife.ca>; 'drew@sportforlife.ca' <drew@sportforlife.ca>; Carole Dodge <caroled@betterbeginningssudbury.ca>; Susan Nicholson <susan.nicholson@ocof.net>; Tyler Campbell <tyler.campbell@greatersudbury.ca>; 'Miranda.Mackie@greatersudbury.ca' <Miranda.Mackie@greatersudbury.ca>; Donna Moroso <donna.moroso@msdsb.net>
Cc: kieran.moore1@ontario.ca; loretta@alphaweb.org; France Gélinas <fgelinas-co@ndp.on.ca>; Jamie West <jwest-co@ndp.on.ca>; Michael Mantha <mmantha-co@ndp.on.ca>; Allan Hewitt <ahewitt@espanola.ca>; Alton Hobbs <ahobbs@assiginack.ca>; Anne Whalen <awhalen@sables-spanish.ca>; Belinda Ketchabaw <belindaketchabaw@nairncentre.ca>; Brent St.Denis <brentstdenis@gmail.com>; Brigitte Sobush <brigitte.sobush@greatersudbury.ca>; Candy Beauvais <cbeauvais@municipalityofkillarney.ca>; CAO Clerk Chapleau <clerk@chapleau.ca>; Carrie Lewis <clerk@gordonbarrieisland.ca>; Emily Dance <clerktreasurer@billingstwp.ca>; Jill Beer (Mayor) and Clerk <town@espanola.ca>; Joan Seidel <karin@baldwin.ca>; Joseph Burke <jburke@espanola.ca>;

Lisa Locken <lisa.locken@greatersudbury.ca>; Marc Gagnon <cao@frenchriver.ca>; Melanie Bouffard <mbouffard@frenchriver.ca>; Melissa Lamontagne <Melissa.Lamontagne@greatersudbury.ca>; Pam Cress <pcress@townofnemi.on.ca>; Patsy Gilchrist <burpeemills@vianet.ca>; Rheal Forgette <rforgette@markstay-warren.ca>; Ruth Frawley <centralm@amtelecom.net>; Silvio Berti <clerk.administrator@tehkummah.ca>; Stasia Carr <scarr@gorebay.ca>; Tammy Godden <tgodden@stcharlesontario.ca>; Penny Sutcliffe <sutcliffep@phsd.ca>
Subject: Board of Health Motion Re Physical Literacy for Healthy Active Children | Résolution du Conseil de santé sur la littératie physique pour une jeunesse saine et active

Le message français suit l'anglais.

Attached is a letter from Dr. Penny Sutcliffe, Medical Officer of Health and Chief Executive Officer, Public Health Sudbury & Districts, outlining a Board of Health resolution regarding physical literacy for healthy active children.

Thank you,
Hélène Leroux *on behalf of Rachel Quesnel*

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

Ci-joint vous trouverez une lettre de la D^re^ Penny Sutcliffe, médecin-hygiéniste et directrice générale, Santé publique Sudbury et districts, qui présente une résolution du Conseil de santé portant sur la littératie physique pour une jeunesse saine et active.

Merci,
Hélène Leroux *au nom de Rachel Quesnel*

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

Public Health
Santé publique
SUDBURY & DISTRICTS

December 30, 2022

VIA ELECTRONIC MAIL

Directors of Education, Local School Boards
Sports and Recreation Organizations
Early Learning Centres

Dear Recipient:

Re: Physical Literacy for Healthy Active Children

At its meeting on October 20, 2022, the Board of Health carried the following resolution #29-22:

> *WHEREAS being physically active every day helps children and youth perform better in school, learn new skills, build strong muscles, improve blood pressure and aerobic fitness, strengthen bones and reduce the risk of depression[i]; and*
>
> *WHEREAS the implementation of stay-at-home orders, closures of schools, and indoor and outdoor spaces to mitigate the spread of COVID-19 is the reduction of physical activity levels in all age groups[ii]; the percentage of youth meeting the Canadian physical activity recommendations for children and youth fell from 50.8% in 2018 to 37.2% in 2020[iii]; and*
>
> *WHEREAS the Government of Canada's national policy document Common Vision for Increasing Physical Activity and Reducing Sedentary Living in Canada: Let's Get Moving identifies physical literacy as the foundation for an active lifestyle[iv]. Studies show that children who have high physical literacy scores are more likely to meet national physical activity or sedentary behaviour guidelines[v]; and*
>
> *WHEREAS physically literate individuals have been shown to have the motivation, confidence, physical competence,*

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

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

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

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

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

Chapleau
34 rue Birch Street
Box / Boîte 485
Chapleau ON P0M 1K0
t: 705.860.9200
f: 705.864.0820

toll-free / sans frais
1.866.522.9200

phsd.ca

knowledge and understanding to value and take responsibility for engaging in physical activities for life[vi] *and these skills help them make healthy, active choices that are both beneficial to and respectful of their whole self, others, and their environment* [vii]*; and*

WHEREAS the school community offers one of the best opportunities to improve the quality of sport and physical activity participation for children and youth; and

WHEREAS the Ontario Public Health Standards require that: "community partners have the knowledge of and increased capacity to act on the factors associated with the prevention of chronic diseases and promotion of wellbeing, including healthy living behaviours, healthy public policy, and creating supportive environments." [viii] *This includes knowledge of the importance and impact of physical literacy on increasing physical activity participation thereby reducing the risk of chronic disease;*

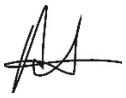
THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts encourage all area school boards, sport and recreation organizations, and early learning centres to work to improve physical activity levels among children and youth across Sudbury and districts, including through collaboration with Sport for Life Society, Active Sudbury and Public Health Sudbury & Districts, agencies that provide comprehensive physical literacy training to teachers, coaches, recreation providers and early childhood educators; and

FURTHER THAT a copy of this motion be shared with the Sport for Life Society, Active Sudbury, local members of Provincial Parliament, all Ontario Boards of Health, and area school boards, early learning centres and sport and recreation organizations.

As we look ahead to increase physical activity and to decrease sedentary behaviours in the population; the need for improving physical literacy is greater than ever before. It is crucial that we embrace physical literacy as a catalyst for children and youth to be active and healthy. We know that *it takes a village to raise a child* and the collaboration of multiple sectors to embed physical literacy development in plans, programs, and policies. Therefore the Board of Health for Sudbury & Districts encourages all area school boards, sport and recreation organizations, and early learning centres across Sudbury and districts to work to

improve physical activity levels among children and youth through collaboration with agencies that provide comprehensive physical literacy programming, including the Sport for Life Society, Active Sudbury and Public Health Sudbury & Districts.

Sincerely,



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

cc: Dr. Kieran Moore, Chief Medical Officer of Health
Loretta Ryan, Association of Local Public Health Agencies
France Gélinas, Member of Provincial Parliament, Nickel Belt
Jamie West, Member of Provincial Parliament, Sudbury
Michael Mantha, Member of Provincial Parliament, Algoma-Manitoulin
All Ontario Boards of Health
Constituent Municipalities

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[i] Centre for Disease Control and Prevention. Healthy Benefits of Physical Activity for Children (2021). Taken from: https://www.cdc.gov/physicalactivity/basics/adults/health-benefits-of-physical-activity-for-children.html

[ii] Science Table. The Impact of Physical Activity on mental Health Outcomes during the COVID-19 Pandemic. (2022) taken from : The Impact of Physical Activity on Mental Health Outcomes during the COVID-19 Pandemic - Ontario COVID-19 Science Advisory Table (covid19-sciencetable.ca)

[iii] Statistics Canada. The unequal impact of the CVID-19 pandemic on the physical activity habits of Canadians. (2022) Taken from: https://www150.statcan.gc.ca/n1/pub/82-003-x/2022005/article/00003-eng.htm

[iv] Government of Canada. A common Vision for increasing physical activity and reducing sedentary living in Canada: Let's Get Moving. (2018) Taken from: https://www.canada.ca/en/public-health/services/publications/healthy-living/lets-get-moving.html

[v] Tremblay MS, Longmuir PE, Barnes JD, Belanger K, Anderson KD, Bruner B, Copeland JL, Delisle Nyström C, Gregg MJ, Hall N, Kolen AM, Lane KN, Law B, MacDonald DJ, Martin LJ, Saunders TJ, Sheehan D, Stone MR, Woodruff SJ. Physical literacy levels of Canadian children aged 8-12 years: Descriptive and normative results from the RBC Learn to Play-CAPL project. BMC Public Health. 2018;18(Suppl 2):1036.

[vi] The International Physical Literacy Association, May 2014. Taken from: https://physicalliteracy.ca/physical-literacy/

[vii] Government of Ontario HEALTH AND PHYSICAL EDUCATION, 2019 | The Ontario Curriculum, Grades 1–8. 2019 taken from: https://preview-assets-us-01.kc-usercontent.com/fbd574c4-da36-0066-a0c5-849ffb2de96e/db4cea83-51a1-458d-838a-4c31be56bc35/2019-health-pysical-education-elem-PUBLIC.pdf

[viii] Government of Ontario. (June, 2021) Ontario Public Health Standards: requirements for Programs, Services and Accountability. Taken from: https://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/

From:	allhealthunits on behalf of Loretta Ryan
To:	"All Health Units"
Cc:	Board
Subject:	[allhealthunits] 2023 Budget Consultations
Date:	Wednesday, January 11, 2023 3:26:21 PM

PLEASE ROUTE TO:

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

2023 Budget Consultations

Dear alPHa Members,

The Government of Ontario is seeking public input on the 2023 Budget via a public online survey, an invitation for written submissions, and a series of public hearings.

Public Survey:

The government's online survey launched today (January 11th). Respondents are invited to choose their top two or three priorities from a list of options under each of nine topic areas. Please note that under the fourth item (*When you think about your community, what services or resources could use more government support?)*, "Public health resources for businesses, schools and other community groups" is one of the options. There are no open-ended questions. Click here to complete the survey.

Written Submissions:

alPHa will be providing a written submission and invites input from its members (to be provided to me at loretta@alphaweb.org by January 20, 2023). We also encourage our members to provide submissions of their own, to ensure that local perspectives are considered.

Public Hearings:

alPHa has requested to appear before the Standing Committee on Economic Affairs at the Toronto session of its pre-budget consultation hearings on February 14th. We have identified speakers and are working on the deputation. Please note these hearings are already underway and we have provided a link to the news release below, which includes a few other opportunities around the province.

Please note the consultation closes on **February 10th**, notwithstanding the public hearings that occur after this date.

Please click here for the 2023 Pre Budget Consultation page.

Please click here for the Standing Committee on Economic Affairs News Release

We hope you find this information helpful.

Take Care,

Loretta

Loretta Ryan, CAE, RPP
Executive Director
Association of Local Public Health Agencies (alPHa)
480 University Avenue, Suite 300
Toronto, ON M5G 1V2
Tel: 416-595-0006 ext. 222
Cell: 647-325-9594
loretta@alphaweb.org
www.alphaweb.org

From: City of Hamilton <hello@hamilton.ca>
Sent: January 12, 2023 12:51 PM
To: clerk@hamilton.ca
Subject: Webform submission from: Request to Speak to a Committee of Council
Submitted on Thu, 01/12/2023 - 12:50
Submitted by: Anonymous
Submitted values are:

Committee Requested

Committee
Board of Health

Will you be delegating in-person or virtually?
In-person

Will you be delegating via a pre-recorded video?
No

Requestor Information

Requestor Information
Kojo Damptey
Hamilton Centre for Civic Inclusion
423 King Street East
Hamilton, Ontario. L8N 1C5
kdamptey@hcci.ca
[redacted]

Preferred Pronoun
he/him

Reason(s) for delegation request
I am delegating on the issue of restructuring the Board of Health as it pertains to 8.1.

Will you be requesting funds from the City?
No

Will you be submitting a formal presentation?
No

From: City of Hamilton <hello@hamilton.ca>
Sent: January 12, 2023 4:10 PM
To: clerk@hamilton.ca
Subject: Webform submission from: Request to Speak to a Committee of Council

Submitted on Thu, 01/12/2023 - 16:09
Submitted by: Anonymous
Submitted values are:

Committee Requested

Committee
Board of Health

Will you be delegating in-person or virtually?
In-person

Will you be delegating via a pre-recorded video?
No

Requestor Information

Requestor Information
Lyndon George
Hamilton Anti-Racism Resource Centre
McMaster Continuing Education Centre -1 James St. North, Room 106
Hamilton , ON. L8R2K3
Lyndon@harrc.ca
905525-9140 ext 20464

Preferred Pronoun
he/him

Reason(s) for delegation request
Reforming Hamilton's Board of health

Will you be requesting funds from the City?
No

Will you be submitting a formal presentation?
No

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	January 16, 2023
SUBJECT/REPORT NO:	Board of Health Orientation Part 2: Population Health Assessment and Public Health Priorities (BOH23002) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Ruth Sanderson (905) 546-2424 Ext. 4859 Nancy Sullivan (905) 546-2424 Ext. 5752
SUBMITTED BY: **SIGNATURE:**	Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services

COUNCIL DIRECTION

Not Applicable.

INFORMATION

As outlined in the first meeting of the Board of Health for this Council term, several presentations are being provided as part of a comprehensive orientation plan for new board members, and a continuing education program for all board members.

The first presentation (Report BOH22018) at the November 28, 2022 Board of Health provided an overview of board of health governance and accountability as per the relevant legislation and Ontario Public Health Standards (Standards), as well as the roles and responsibilities of Board of Health members. In the accompanying presentation to Board of Health Report BOH23002, members are provided with information on population health assessment, health equity and how these concepts are used to identify the population health needs for Hamilton and priorities for Public Health Services. The following provides a brief overview of the information included in the presentation.

The Standards require Boards of Health to improve population health and reduce health inequities.[1] To achieve this, Public Health Services provides a broad range of programs and services in the areas of chronic disease prevention, mental health and well-being, substance use and injury prevention, school health, healthy growth and development, healthy environments, food and water safety, immunization and infectious disease prevention and control. Population health assessment and health equity are considered foundational to the work of public health, which means that they underlie and support all programs and services.

What is Population Health Assessment?

When individuals seek medical care, a physician or clinician will often ask several questions to assess their health. Public Health professionals use a similar approach; however, instead of focusing on individuals, we assess the overall health of a community or segments of it. Measuring population health produces important information about emerging health issues, health inequities and priority populations that informs program planning and decision-making. This includes the identification of public health priorities that require targeted investment of resources in order to have the greatest impact on the health of our population. The process of measuring the health of the population and using the information to inform action is known as population health assessment.

What is Health Equity?

Health is influenced by a broad range of factors. It is estimated that 50% of our health is determined by social and economic determinants. These are factors beyond our biology, behaviours, and lifestyle choices, including: gender, ethnicity, income, education, stable housing, and social networks. Health equity means that all people can attain their full health potential and are not disadvantaged from attaining it due to social position or other socially determined circumstance.[1] Conversely, health inequities are avoidable or modifiable differences in the health status between groups caused by socially determined circumstances. Health inequities are typically systematic – that is, beyond our individual control – and unfair.[2]

Public health has an important role to play in achieving health equity. The Standards require boards of health to identify local health inequities, share this information with partners, and collaborate with others to work on strategies to reduce health inequities in

[1] Ministry of Health (2021). Ontario Public Health Standards: Requirements for Programs, Services and Accountability. http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/

[2] Chief Medical Officer of Health (CMOH) of Ontario. Improving the Odds: Championing Health Equity in Ontario (2018). http://www.health.gov.on.ca/en/common/ministry/publications/reports/cmoh_18/default.aspx

our community.[1] Public health cannot eliminate health inequities alone and must work with other local partners.[2,3]

How do we use this information to identify priorities?
Population health assessment, including a comprehensive understanding of health inequities, allows Public Health Services to identify the population health needs of the Hamilton community. Population health needs are typically longstanding issues that require many years and collective action by multiple partners and at multiple levels to address; public health is one of many contributors. Public Health Services contributes to addressing local population health needs by:

1. Using the information to prioritize and adapt public health programs and services; and,
2. Sharing information with the board of health, community and healthcare partners, and the public to inform and influence local collective action.

Public Health Services has identified four priority population health needs for the Hamilton community:

- Child and youth healthy growth and development;
- Climate change;
- Health equity; and,
- Mental health and substance use.

These are not new to Hamilton. In fact, the health issues and inequities associated with them have worsened through the COVID-19 pandemic. To contribute to collective action, Public Health Services has identified public health specific actions that will be implemented to adapt and improve existing programs and services to address these population health needs. Although focused planning and resourcing is required to move the needle on these priority population health needs, it is important to note that this does not negate the importance of public health's other mandated work. Public Health Services will continue to carry out all if its important programs and services.

Detailed information on Public Health Services' population health assessment process and results, Hamilton's population health needs, and specific public health actions are provided in the accompanying presentation.

[3] Chief Medical Officer of Health of Canada. From risk to resilience: An equity approach to COVID-19 (2020). https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/from-risk-resilience-equity-approach-covid-19.html

APPENDICES AND SCHEDULES ATTACHED

Not Applicable.

Hamilton

Board of Health Orientation Part 2: Population Health Assessment and Public Health Priorities

January 16, 2023

Public Health Mandate

- Boards of Health are required to increase the use of population health information to guide the planning and delivery of programs and services in an integrated health system

- A key step is to understand the health of our local population as well as priority populations – this process is referred to as **population health assessment**

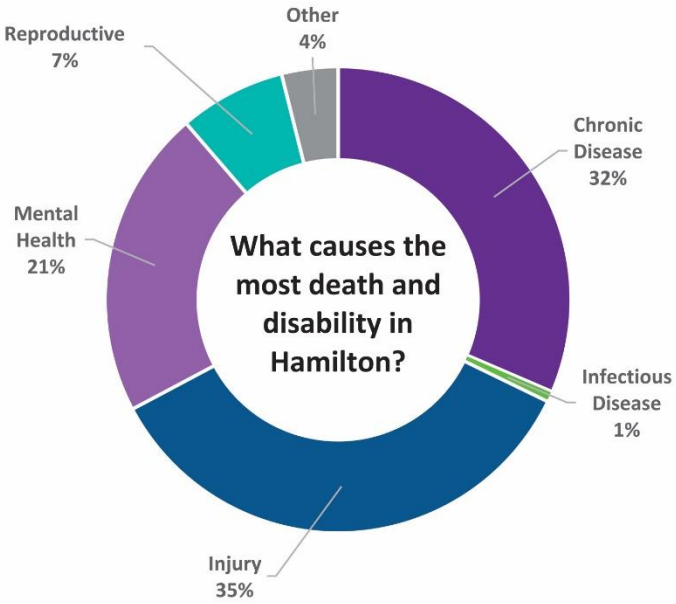
What is Population Health Assessment?

Population Health Assessment is the measuring, monitoring, analysis, and interpretation of the health of the population.

- Planning and Evaluation
- Decision Making
- Accountability
- Strategic Spending
- Policy Development
- Awareness and Advocacy

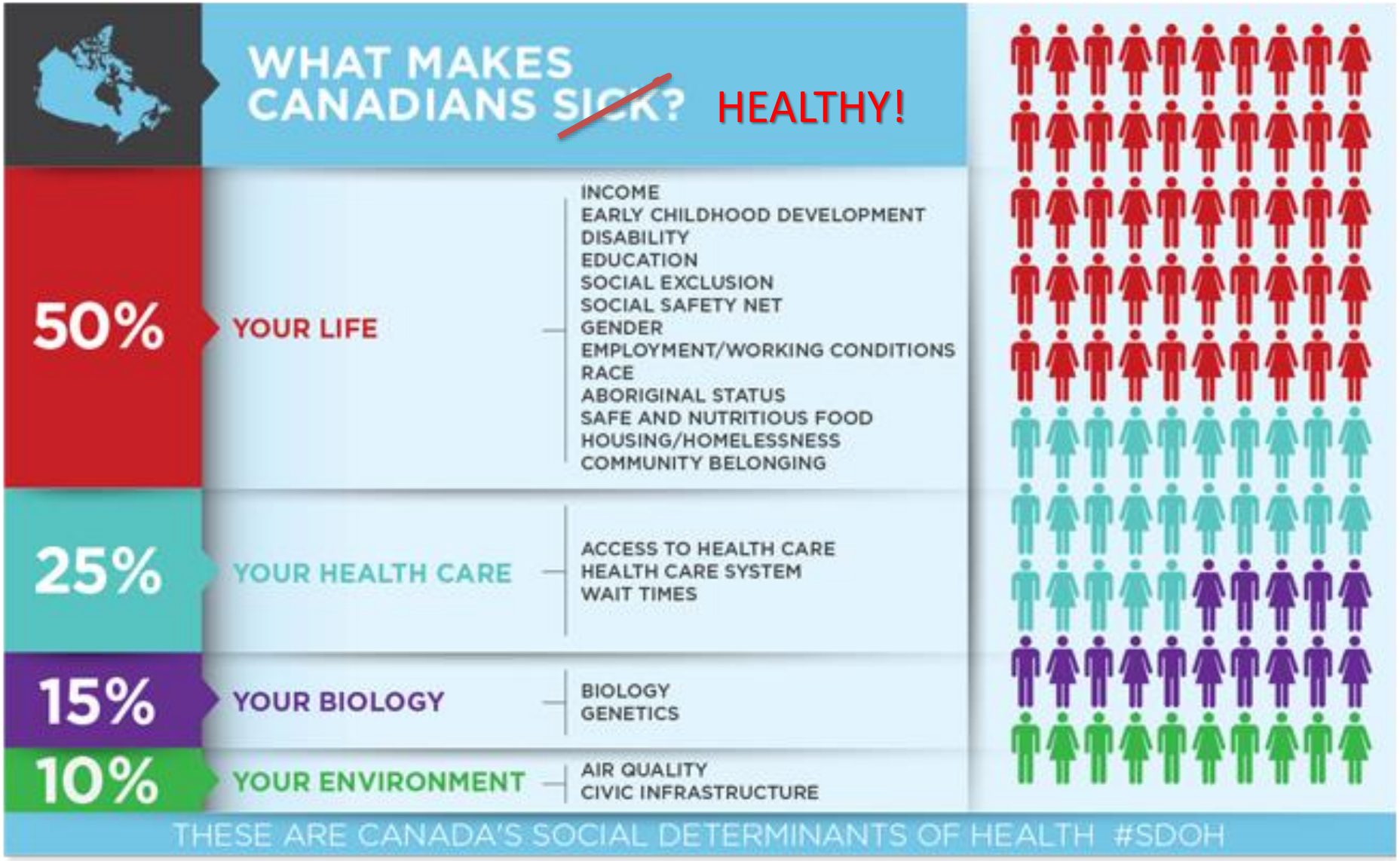
On any given day residents in Hamilton….

Each day there are approximately…



Health Check 2018
Hamilton.ca/HealthCheck

*Estimates are approximate and do not account for seasonality.



Source: Canadian Medical Association (2013)

What is Health Equity?

- Health is influenced by a broad range of determinants, many of them are social determinants which are factors beyond our biology, behaviours, and lifestyle choices.

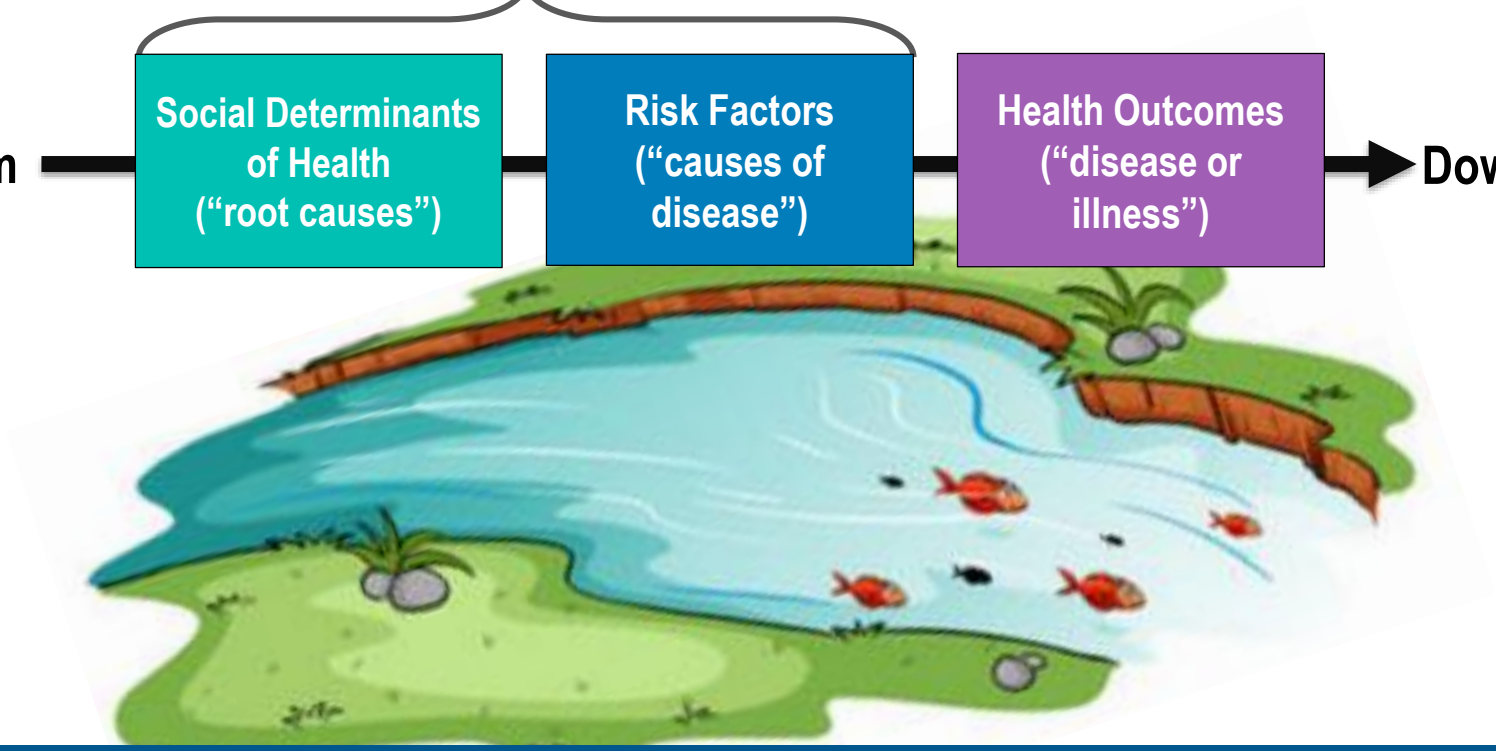
- **Health equity** is when all people can attain their full health potential because they are not disadvantaged by social determinants of health.

Source: Robert Wood Johnson Foundation

Public Health Focus

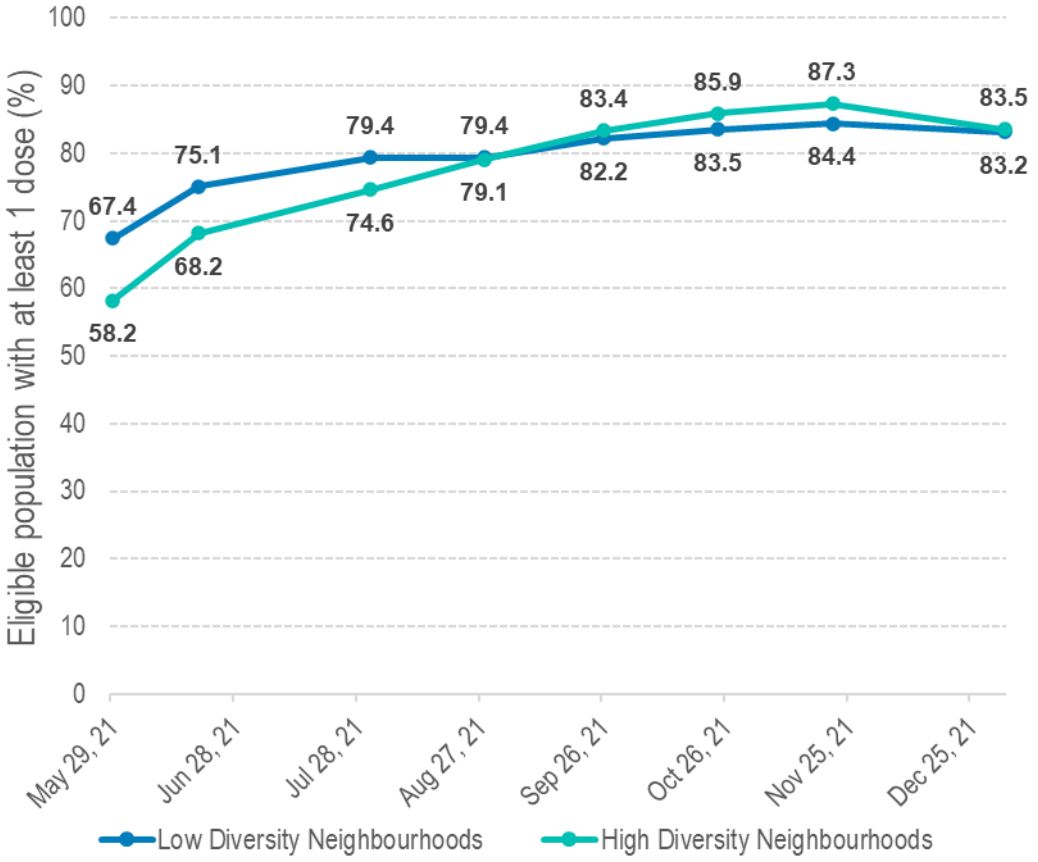
Public health focuses on upstream efforts to promote health and prevent disease

Upstream → **Social Determinants of Health ("root causes")** → **Risk Factors ("causes of disease")** → **Health Outcomes ("disease or illness")** → **Downstream**



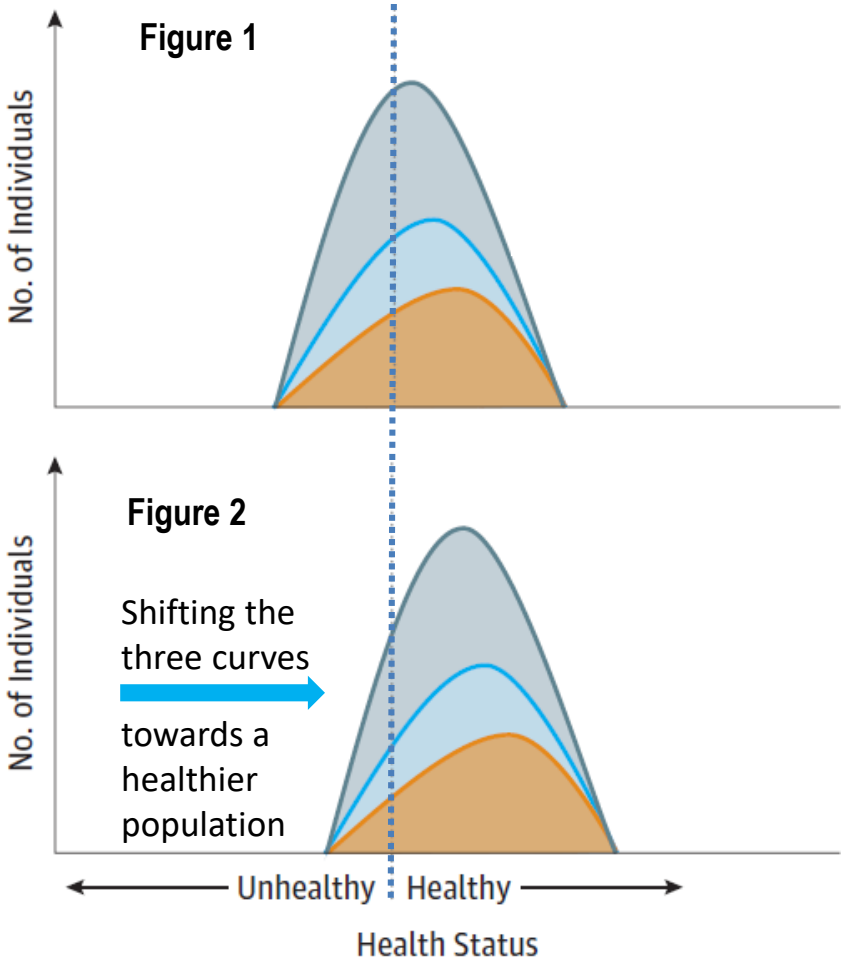
Health Equity Example: COVID-19 Vaccination Rates for Hamiltonians

- At the beginning of the COVID-19 vaccine rollout, neighbourhoods with more diverse, racialized populations had lower vaccine rates
- The community worked together to prioritize Black and racialized people for vaccination by April 2021
- By August 2021, the inequity was reduced so that the most racialized neighbourhoods had a similar rate to the least racialized neighbourhoods



Source: Public Health Ontario. Available at: https://www.hamilton.ca/people-programs/public-health/diseases-conditions/coronavirus-covid/covid-19-data#social-determinants

Public Health's Role in Producing Population Health



Entire community affected through population-based policies & interventions

- Focused on determinants of health, health promotion and prevention over the lifespan

Specific populations affected through clinical outreach

- Proactive management of behavioural risks and chronic conditions

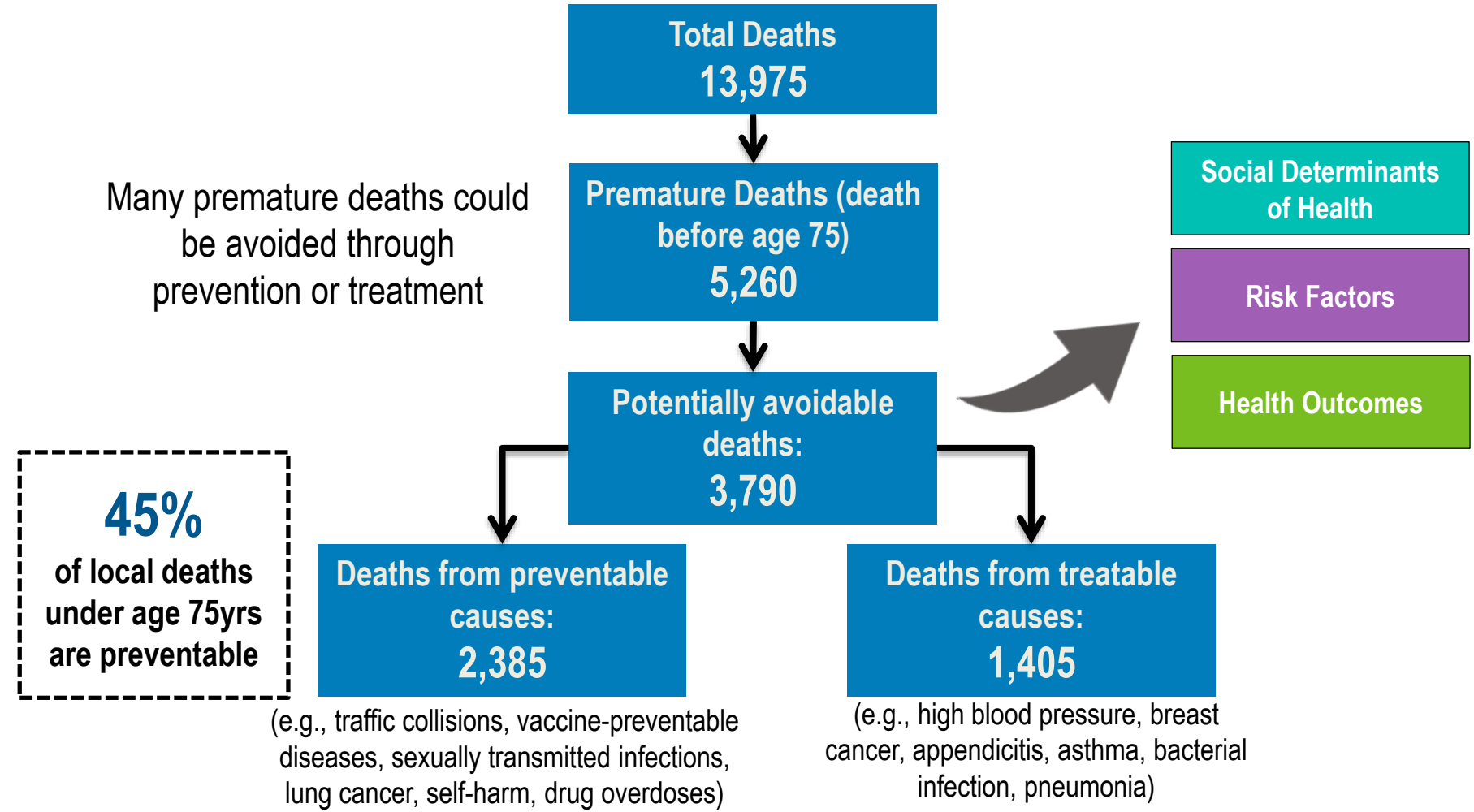
Patients seek care for acute health problems

- Reactive to individual patient needs

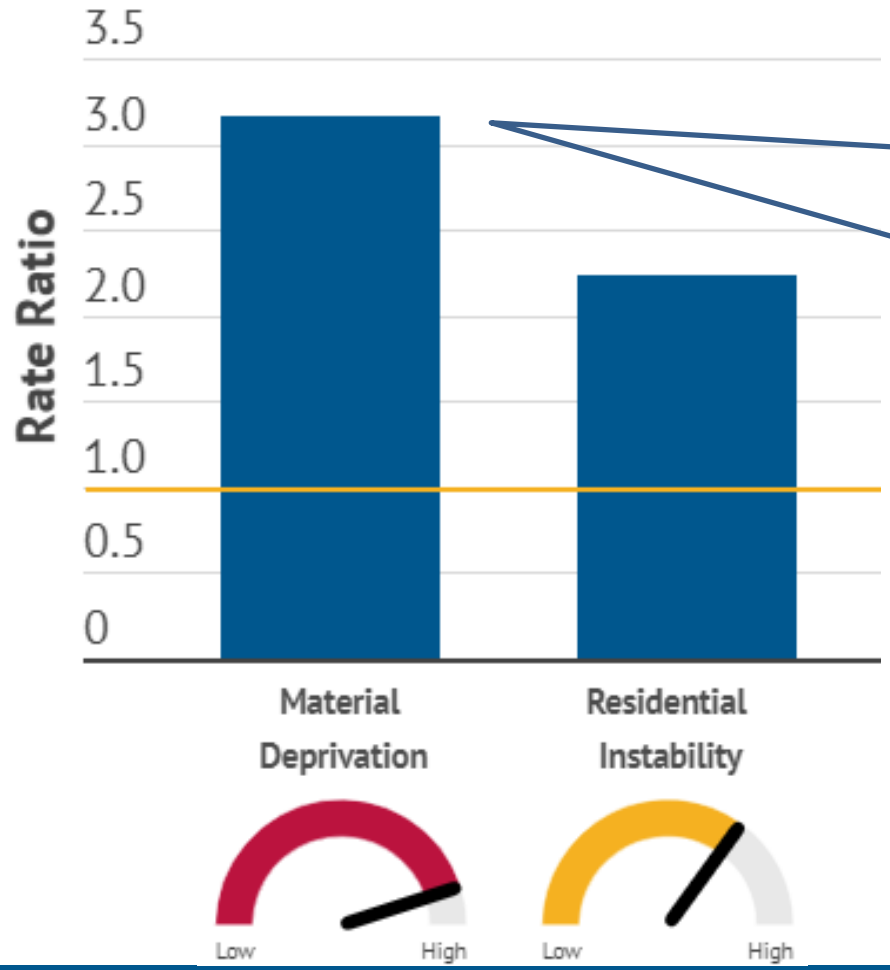
Adapted from Washington AE et al JAMA 2016 315(5); 4590460

Premature Deaths

Hamiltonians (2014-2016)



Do all Hamiltonians have the same likelihood of dying prematurely from an avoidable cause?



Hamiltonians living in the most materially deprived neighbourhoods are **three times** more likely to die from a potentially avoidable cause

Source: Public Health Ontario (2018). Health Equity Snapshots

Evidence to Action

Public Health's role is to:

1) **Identify** population health needs
2) **Contribute** to collective action on addressing the population health needs

Population health assessments, combined with other evidence are used to determine Hamilton's Population Health Needs.

Source: National Collaborating Centre for Methods and Tools

Identifying Priority Population Health Needs

- Used Health Check 2018
  - Population health assessment to be updated by early 2024
- Used other existing information and intelligence:
  - Existing population health assessment (Health Check 2018)
  - Evidence review re: disproportionate impacts of COVID-19
  - Key documents outlining the deficits of care (Ontario Public Health Association and Association of Local Public Health Agencies)
  - Insight from the frontlines and partners

Priority Population Health Needs for Hamilton

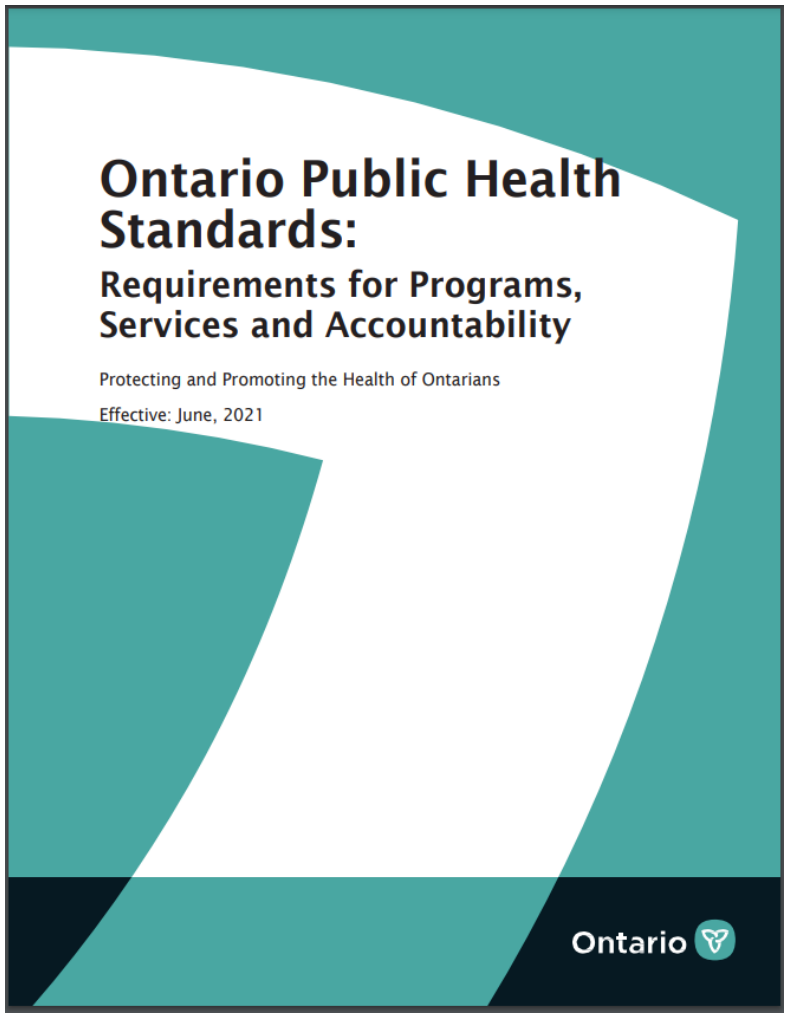
Health Equity

Child and Youth Healthy Growth and Development

Mental Health and Substance Use

Climate Change

Scope of Public Health Programs and Services



Program Standards

1. Chronic Disease Prevention & Well-Being
2. Food Safety
3. Healthy Environments
4. Healthy Growth & Development
5. Immunization
6. Infectious and Communicable Diseases Prevention & Control
7. Safe Water
8. School Health
9. Substance Use & Injury Prevention

Foundational Standards

1. Health Equity
2. Population Health Assessment
3. Effective Public Health Practice
4. Emergency Management

Priority Population Health Needs and Public Health Services Actions

- Priority Population Health Needs are:
  - Long-standing issues that require collective action by multiple partners
  - Not new, have worsened through the COVID-19 pandemic
- Public Health Services identified priority actions to adapt and improve existing programs and services to address population health needs
  - Will be incorporated into the Annual Service Plan and Budget Submission

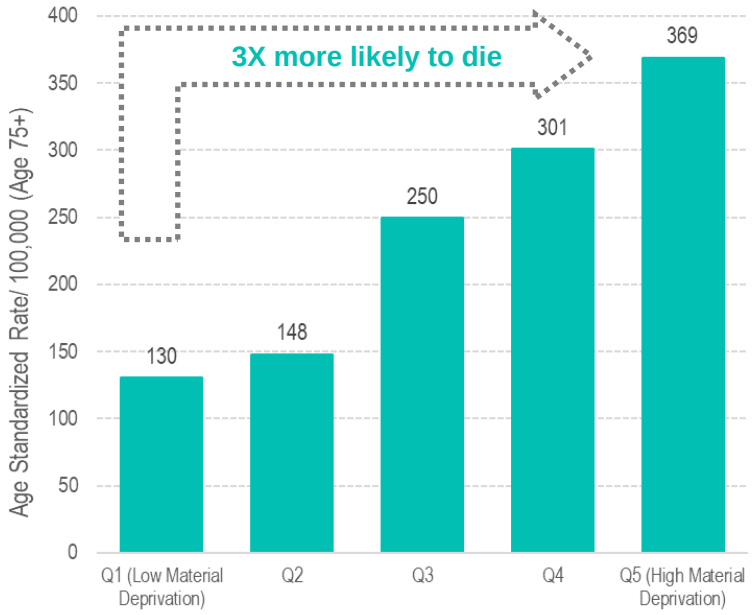
Health Equity

Health Equity

Population Health Assessment - Highlights

- The poorest Hamiltonians live over a decade shorter than the wealthiest Hamiltonians
- Those living in Hamilton's poorest neighbourhoods are 3 times more likely to die prematurely from a preventable or treatable cause compared to those living in the wealthiest neighbourhoods
  - This inequity is widening in Hamilton and is greater than in most Ontario public health units.
- Males are 1.5 times more likely to die prematurely than females from a potentially avoidable cause.
- Racialized people in Hamilton were disproportionately impacted by COVID-19.

Potentially Avoidable Mortality by Deprivation Quintile 2014-15, City of Hamilton



Source: PHO. Snapshots: City of Hamilton: Health Inequities in Potentially Avoidable Mortality 2014-15

Impacts of COVID-19 Pandemic on Health Equity

Women and Black, Indigenous, and People of Colour (BIPOC) communities experienced greater health and socioeconomic impacts

- ***Higher rates of infection, increased income and job loss, greater financial strain***

Seniors, people living in low income, and persons with disabilities face greater service loss and barriers to accessing information

Social and structural conditions that contribute to health inequities were exacerbated

- ***Racism, sexism, discrimination; inadequate housing; poor working conditions and lack of protections; barriers to services and care***

Health Equity

Goal: Public health practice results in decreased health inequities such that everyone has equal opportunities for optimal health and can attain their full health potential without disadvantage due to social position or other socially determined circumstances.

- Ontario Public Health Standards, Health Equity foundational standard

Priority Action Areas for Public Health

- **Competency Development**
- **Data for Equity**
- **Community Collaboration**
- **Awareness and Communication**

Health Equity

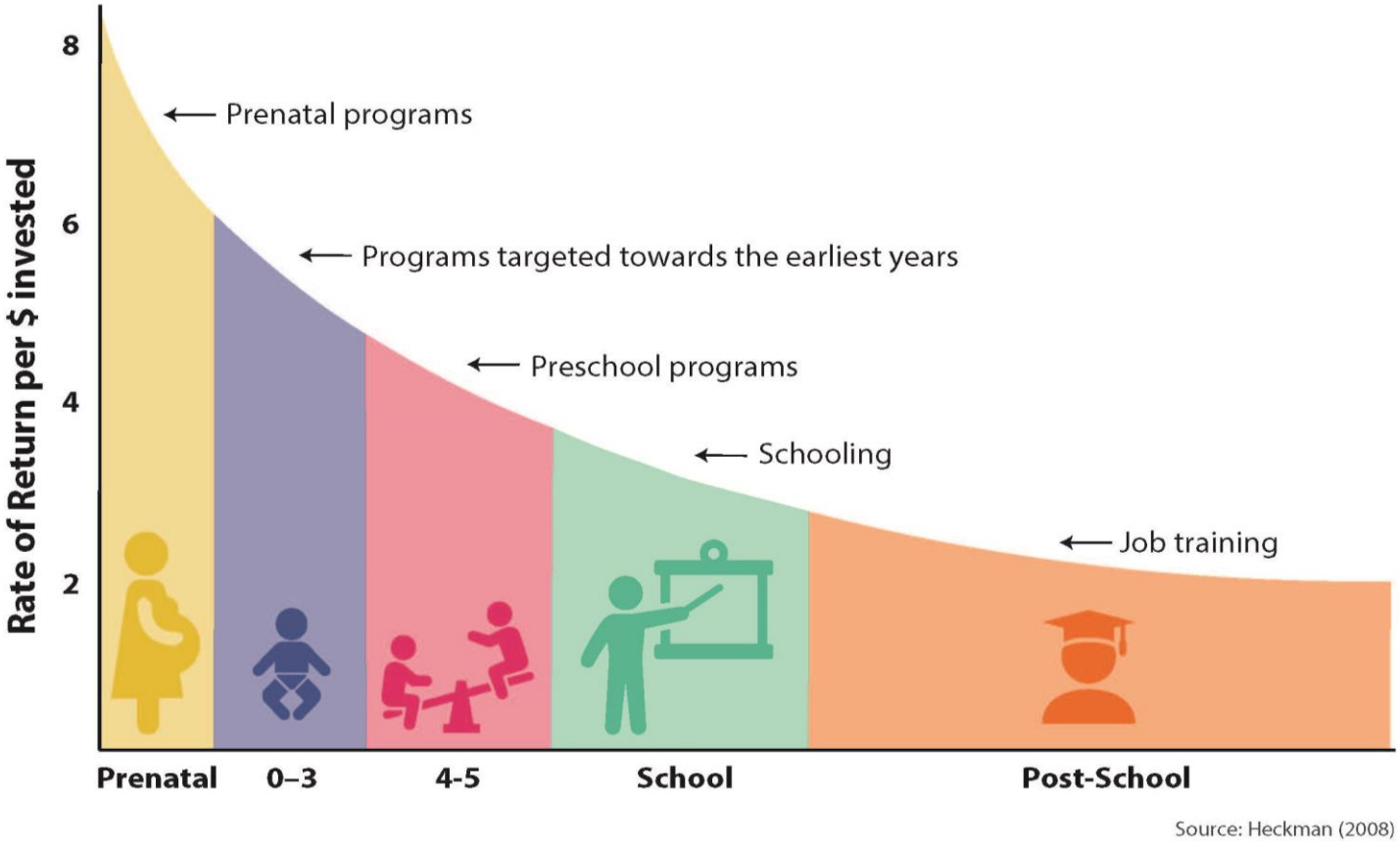
Public Health Services Priority Action Areas

Competency Development	Enhance staff competency to improve equitable health outcomes in Public Health Services programs by ensuring all staff have the required knowledge and skills to apply equity and anti-racism principles to their work.
Data for Equity	Enhance use of data on the social determinants of health to enhance understanding of health inequities in Hamilton and inform Public Health Services program planning.
Community Collaboration	Continue to engage priority populations in identifying and addressing health inequities and collaborate with community partners to reduce health inequities through multi-sectoral action.
Awareness and Communication	Increase public and community partners' awareness of local health inequities and their structural causes to drive collective action.

Child and Youth Healthy Growth & Development

Child and Youth Healthy Growth & Development

It is well documented that intervening in the early years provides the building blocks for educational attainment, economic productivity, and lifelong health.

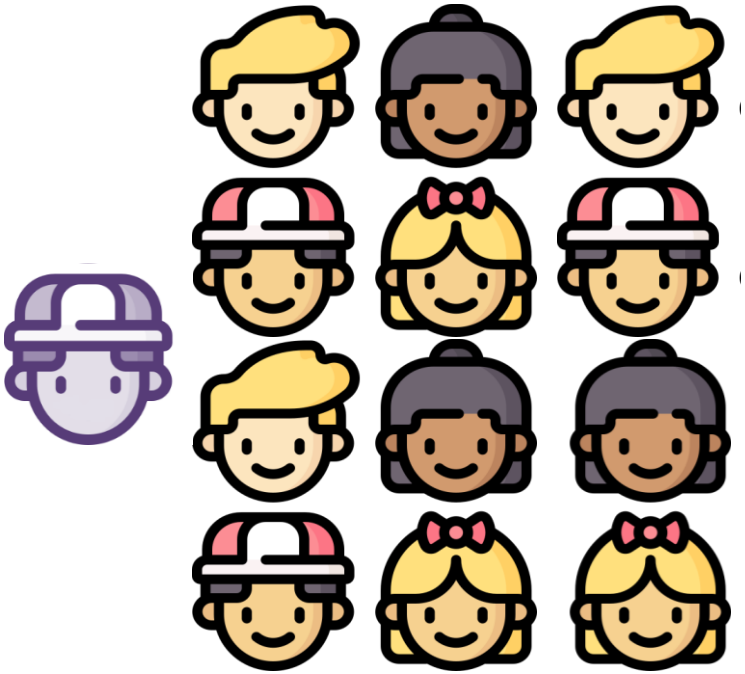


Source: Heckman (2008)

Child and Youth Healthy Growth & Development

Population Health Assessment - Highlights

- Every week, nearly four of Hamilton's youth visit the emergency department for self harm
  - Significant increase in visits from 2009 – 2020
- 30% of Hamilton kindergarten students in 2018 were likely to experience future challenges in their school years and beyond in at least one of the five core areas of early child development.
- 1 in 13 Hamilton students required urgent dental care according to 2019/20 school dental screening in publicly funded schools.
- The estimated percentage of Hamilton students without a vaccine record was higher after the 2021/22 school year compared to pre-pandemic school years.



1 in 13 students require urgent dental care

Impacts of COVID-19 Pandemic on Healthy Growth & Development

Negative impacts on mental health for infants, children, youth, and parents

Decrease in perinatal mental health and lack of parenting supports

Increase in Adverse Childhood Experiences (ACEs)

Children's literacy and math delays, especially for the most vulnerable

Fewer children getting routine immunization and increase in children's dental care needs

Child and Youth Healthy Growth & Development

Goal: To achieve optimal preconception, pregnancy, newborn, child, youth, parental, and family health.

- Ontario Public Health Standards,
Healthy Growth and Development program standard

Priority Action Areas for Public Health

- **Optimal Perinatal Health**
- **Infant and Early Years Mental Health**
- **School Health**

Child and Youth Healthy Growth & Development

Priority Action Areas

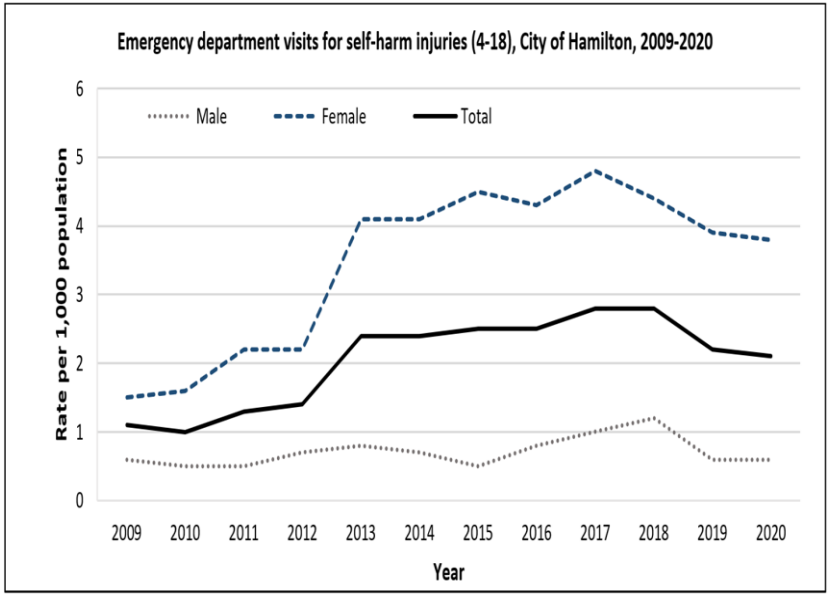
Optimal Perinatal Health	Support the healthiest start in life through prenatal education, early identification of individuals at risk for poor mental health during pregnancy and postpartum, support for breastfeeding and facilitating access to a range of community supports.
Infant and Early Years Mental Health	Reduce the number of children aged 0-6 years at risk for poor social and emotional development through education, early identification and coordinating access to community supports.
Comprehensive School Health	Enhanced school dental screenings and immunization clinics to address deficits of care resulting from pandemic. Maintain and continually improve partnership and collaboration with local schools and school boards through universal school supports and intensive services to priority schools.

Mental Health & Substance Use

Address Mental Health & Substance Use

Population Health Assessment - Highlights

- Mental illness accounts for 21% of healthy years of life lost due to disability or illness for Hamiltonians (2012).
- Suicide is a leading cause of death for Hamiltonians under 45 years of age (2008-2012)
- Intentional self harm Emergency Room visits continue to increase among Hamiltonians and were 181/100,000 in 2018
  - The highest rates were among those <20 years old, particularly females
- Opioid-related deaths have increased exponentially from 26 deaths in 2005 to 166 deaths estimated in 2021
  - Over 65% of opioid deaths are among males 25 to 65 years.
  - Rates of opioid-related death rate were 45% greater for Hamiltonians as compared to Ontarians.



Source: Ambulatory All Visit Main Table (2009-2020), Population Estimates (2009-2020), and Population Projections (2016), Ontario Ministry of Health, IntelliHEALTH ONTARIO, Date Extracted: November 2021.

Mental Health & Substance Use

Goal: To promote community mental health and wellbeing and reduce the burden of substance use.

- Ontario Public Health Standards,
Substance Use and Injury Prevention program standard

Priority Action Areas for Public Health

- Trauma and Violence Informed Care
- Community Mental Health Promotion in Middle Years
- Municipal Policies on Substance Use
- Harm Reduction

Mental Health & Substance Use

Priority Action Areas

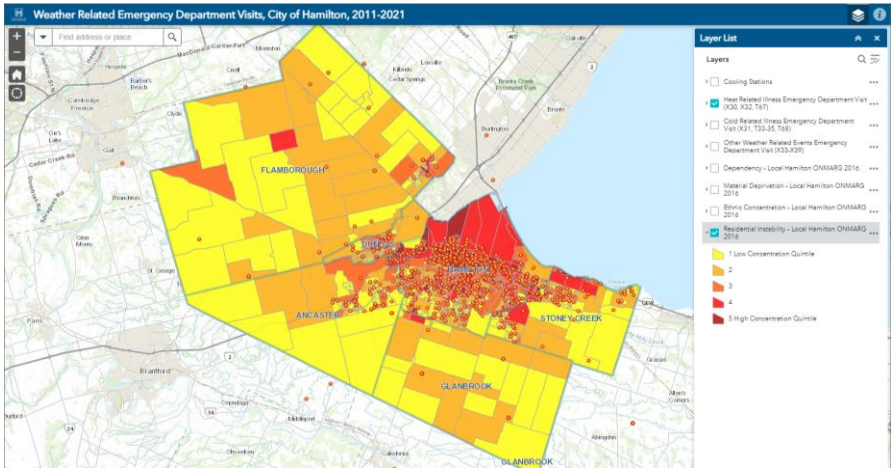
Trauma and Violence Informed Care	Implement an organizational approach to Trauma and Violence Informed Care through staff training, and implementing policies throughout Public Health Services programs.
Community Mental Health Promotion in Middle Years	Collaborate across City divisions and community partners to promote mental well-being, resilience and prevent substance use in youth.
Municipal Policies on Substance Use	Lead the review and update the 2011 Municipal Alcohol Policy in collaboration with City departments. Collaborate with community stakeholders and other public health units to apply to Health Canada to decriminalize the personal possession of illegal substances.
Harm Reduction	Coordinate interventions to support safer substance use and decrease adverse events from individuals using alone.

Climate Change

Climate Change

Population Health Assessment - Highlights

- Hamilton's heatwaves will increase; the total annual number of days at or above 30°C is projected to increase from about 16 days on average to 37 days by 2050.
- There were about 750 emergency department visits (ED) for heat-related illness for Hamiltonians from 2011-21
  - Neighbourhoods with the most housing instability were most disproportionately affected by heat-related illness. Poorer or more racially diverse neighbourhoods were also disproportionately affected.



- Climate change can affect ecosystems and increase spread of infectious diseases, such as vector-borne diseases, into new geographic regions.
  - Lyme disease for Hamiltonians increased from 2 reported cases in 2011 to 13 cases in 2020.

Climate Change

Goal: To promote healthy built and natural environments that support health and mitigate existing and emerging risks, including the impacts of a changing climate.

- Adapted from Ontario Public Health Standards, Healthy Environments program standard

Priority Action Areas for Public Health

- Extreme Heat and Health
- Vector-Borne Diseases
- Data for Climate Change Health Impacts
- Climate and Health Education and Awareness

Climate Change

Priority Action Areas

Extreme Heat and Health	Participate in local efforts to address excessive indoor temperatures in rental housing and identify ways to expand cooling programming and interventions across Hamilton.
Vector-Borne Diseases	Coordinate and work with partners to ensure vulnerable groups understand and have the means to be adequately protected from Vector Borne Disease (e.g. Lyme, West Nile etc.).
Data for Climate Change Health Impacts	Develop a plan to establish an ongoing weather-related health event monitoring system for the City of Hamilton that works towards more real-time communication.
Climate and Health Education and Awareness	Support Corporate Office for Climate Initiatives and others across the City in the development of climate/health promotional material, education/ awareness through research and identification of existing communication channels to priority and at risk populations.

Summary

- Population health assessment provides information to identify current and evolving population health issues, health inequities and priority populations
- Through population health assessment combined with other evidence, four priority population health needs were identified:

Health Equity

Mental Health and Substance Use

Child and Youth
Healthy Growth and Development

Climate Change

- Population health assessment results, population health needs and Public Health Services priorities inform the Annual Service Plan and Budget
  2023 Annual Service Plan & Budget to be reviewed at the February 16, 2023, Board of Health meeting
- Public Health Services will comprehensively review population health data by early 2024 to inform planning for 2024 and beyond

Hamilton

Respiratory Diseases Update

Jordan Walker,

Director, Communicable Disease Control Division

Board of Health

January 16, 2023

Overview

1. Respiratory Season - Situation Report
2. Disease Control Update
3. Vaccine Program Update

Respiratory Season - Situation Report

Local Respiratory Virus Transmission Status

Local COVID-19 Activity: High & Stable

Local Influenza Activity: Moderate & Decreasing

Key Messages:

- COVID-19 reported cases, hospitalizations, test positivity, wastewater signal, and the number of active outbreaks are currently stable, while intensive care unit (ICU) admissions have increased.
- Influenza percent positivity has decreased, while cases have remained stable.

Access to Respiratory Virus Monitoring Information

New Resources

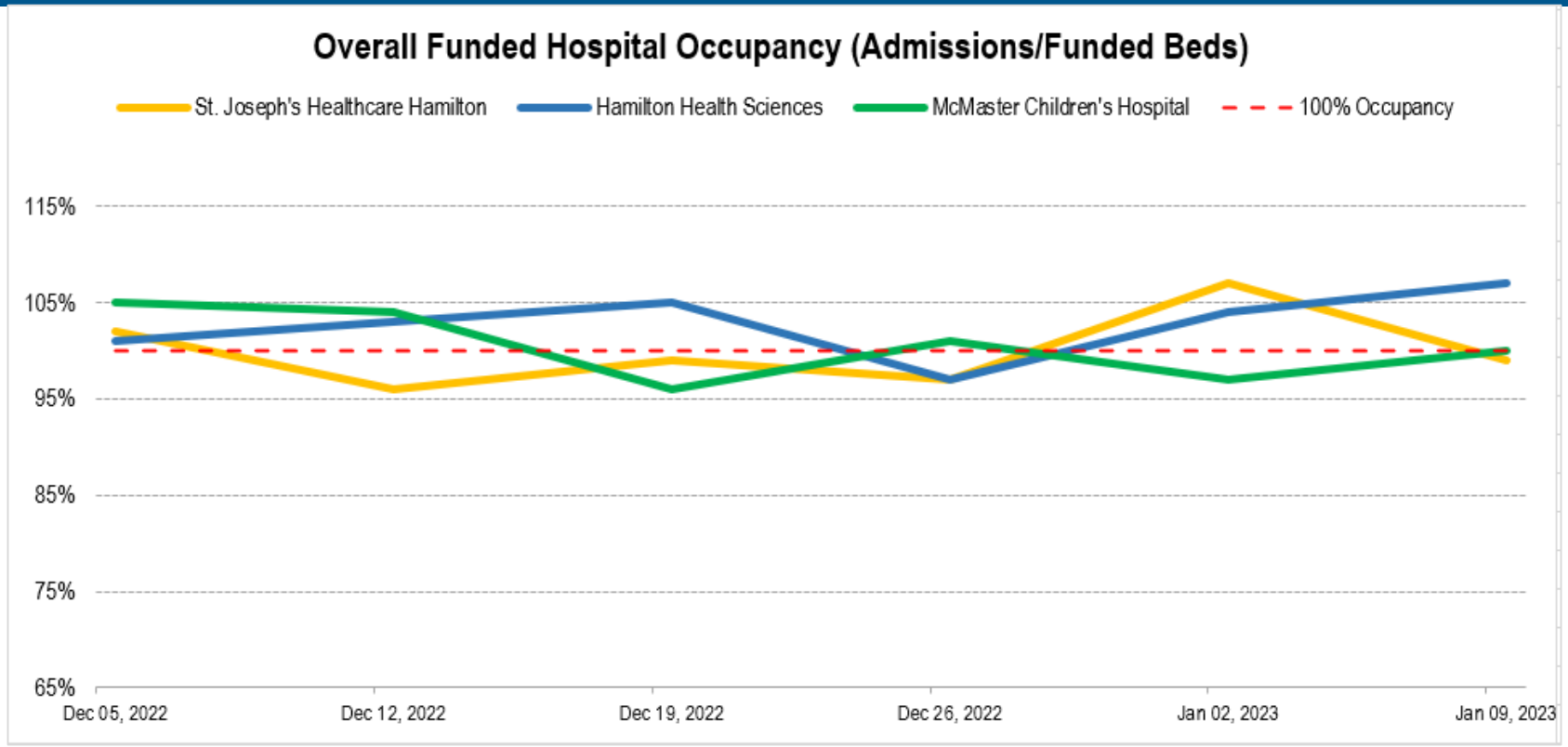
Added December 2022

- Active Outbreaks posted on Open Data Portal (Includes respiratory and enteric outbreaks, updated daily Monday – Friday)
  - https://data-spatialsolutions.opendata.arcgis.com/datasets/93c3500fbcb241358a13cf21409dfad6_4/about
- Influenza Dashboard
  - https://www.hamilton.ca/people-programs/public-health/diseases-conditions/influenza-flu

Ongoing Resources

- Respiratory Virus Transmission Status (updated Wednesdays):
  - https://www.hamilton.ca/people-programs/public-health/diseases-conditions/coronavirus-covid/covid-19-data#transmission-status
- COVID-19 Status of Cases Dashboard (updated Tuesdays and Fridays):
  - https://www.hamilton.ca/people-programs/public-health/diseases-conditions/coronavirus-covid/covid-19-data#status-of-cases
- COVID-19 Vaccine Dashboard (updated on Tuesdays and Fridays)
  - https://www.hamilton.ca/people-programs/public-health/diseases-conditions/coronavirus-covid/covid-19-data#vaccine-distribution

Health System Capacity: Acute Care Occupancy

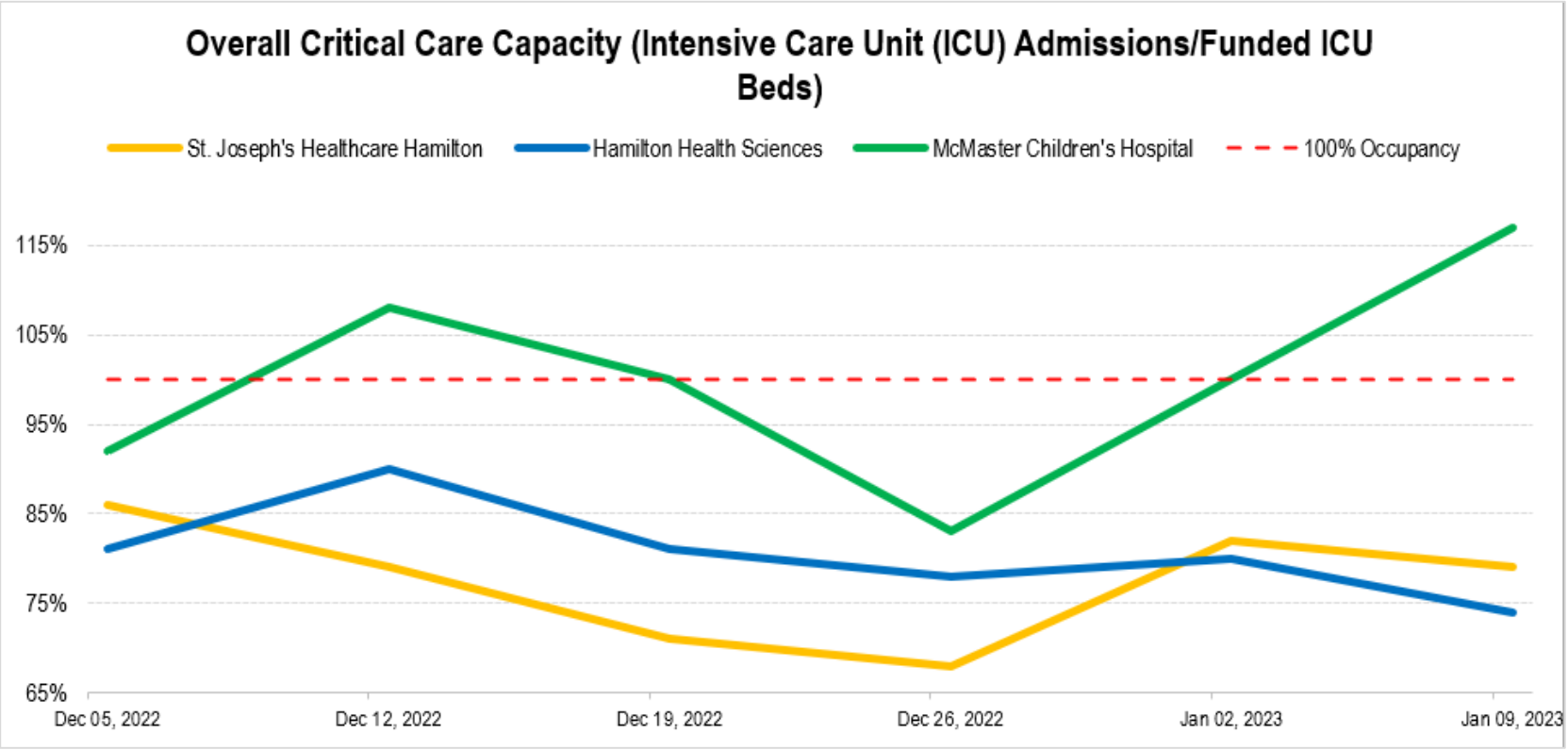


Key Messages:

- Patient volumes/acuity and staffing challenges continue to create capacity pressures in Hamilton's hospitals.
- Hamilton hospitals have been hovering around 100% capacity in acute care beds through-out December 2022 and into January 2023.

Note: Hamilton Health Sciences site excludes McMaster's Children's Hospital. Data current as of January 9, 2023.

Health System Capacity: Intensive Care Unit Occupancy



Key Messages:

- Hamilton's intensive care unit capacity improved in December 2022, while McMaster Children's Hospital sees sustained intensive care unit pressures.

Notes: Hamilton Health Sciences site excludes McMaster's Children's Hospital. Data current as of January 9, 2023.

Health System Capacity: Admissions/Funded Beds

	Hospital	Dec 5, 2022	Dec 12, 2022	Dec 19, 2022	Dec 26, 2022	Jan 2, 2023	Jan 9, 2023
Acute Care Occupancy	SJHH	**102%** 349/342	**96%** 328/342	**99%** 343/346	**97%** 312/322	**107%** 370/346	**99%** 350/354
	HHS	**101%** 669/662	**103%** 682/662	**105%** 695/662	**97%** 642/662	**104%** 688/662	**107%** 708/662
	MCH	**105%** 78/74	**104%** 77/74	**96%** 71/74	**101%** 75/74	**97%** 72/74	**100%** 74/74
Intensive Care Unit Occupancy	SJHH	**86%** 24/28	**79%** 22/28	**71%** 20/28	**68%** 19/28	**82%** 23/28	**79%** 22/28
	HHS	**81%** 70/86	**90%** 77/86	**81%** 70/86	**78%** 67/86	**80%** 69/86	**74%** 64/86
	MCH	**92%** 11/12	**108%** 13/12	**100%** 12/12	**83%** 10/12	**100%** 12/12	**117%** 14/12

Note: SJHH: St. Joseph's Healthcare Hamilton, HHS: Hamilton Health Sciences, MCH: McMaster Children's Hospital

DISEASE CONTROL UPDATE

Current Public Health Measures

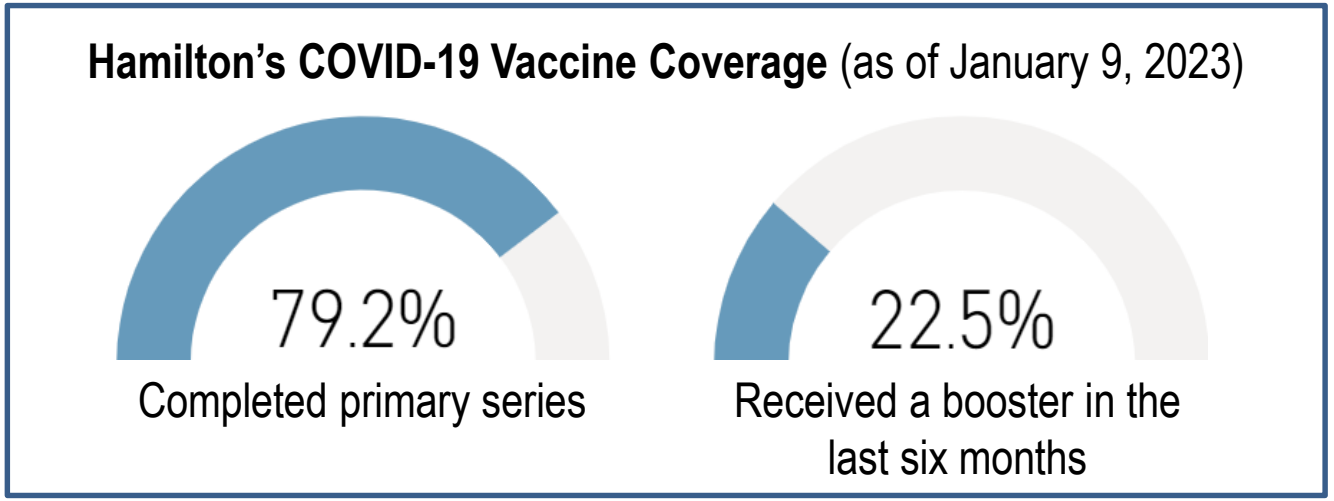
- As the risk to Ontarians from respiratory viruses remains high, emphasizing a multilayer approach:
  - Stay up to date with your vaccinations including COVID-19 and influenza
  - Stay home if you feel unwell
  - Screen for respiratory symptoms daily
  - Masking in crowded indoor public settings
  - Always practice good hand hygiene and regularly clean surfaces – which is especially important for Respiratory Syncytial Virus (RSV) and flu viruses
- If you are at high risk and become ill, there are treatments available, including Paxlovid for COVID-19, Tamiflu for flu and Respiratory Syncytial Virus (RSV) prophylaxis for high-risk infants

VACCINE PROGRAM UPDATE

Vaccine Program Update – Data

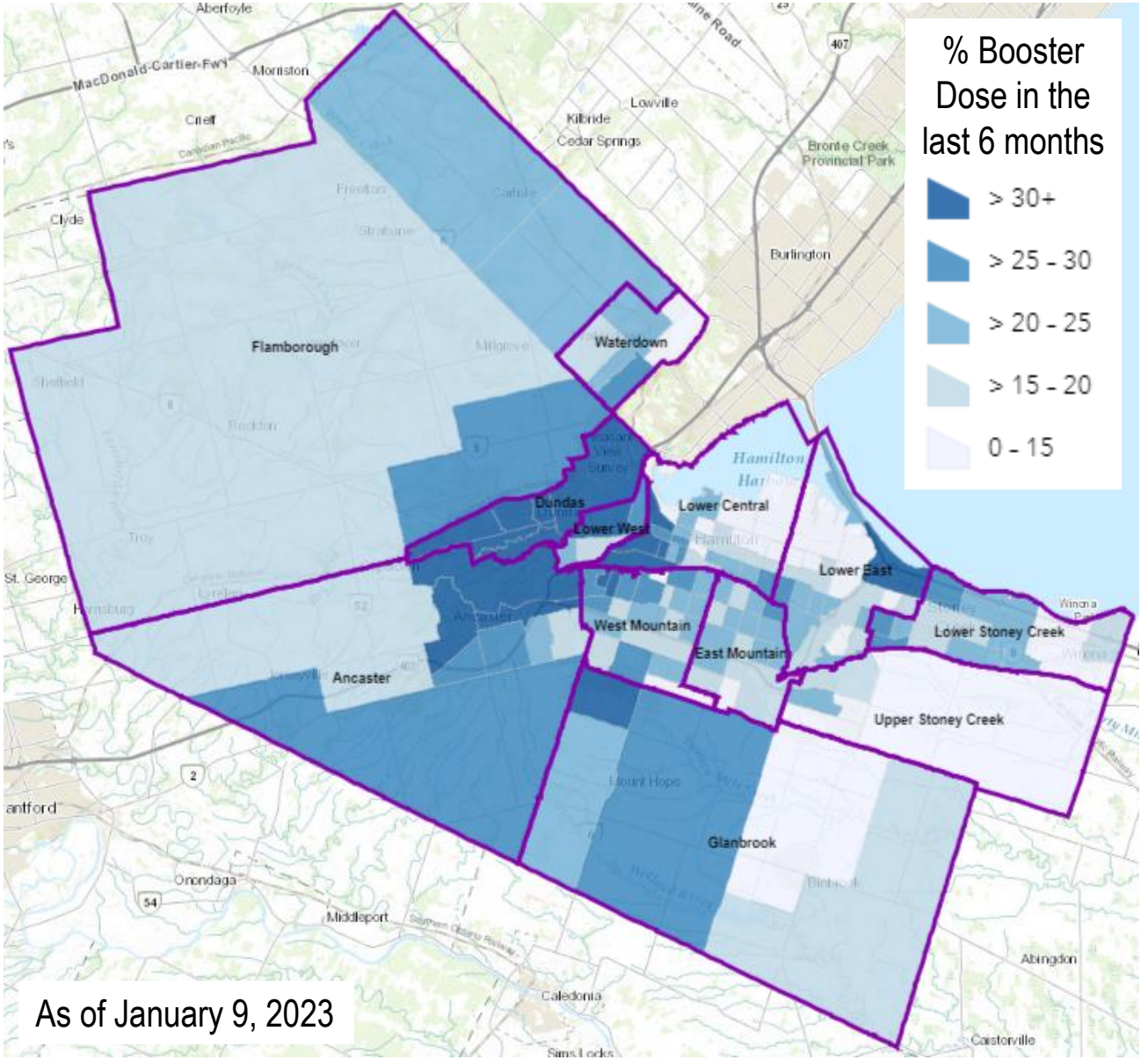
COVID-19 Vaccine Administered in Hamilton

- Administration has slowed in recent months, with approximately **3,000** doses administered in a recent week (January 3 to 9, 2023):
  - Most doses continue to be bivalent booster doses (**93%**)
  - Majority administered in pharmacy (**64%**)



Note: Population aged 6+ months eligible for primary series, 5+ years for a booster

COVID-19 Vaccine Coverage by Geography



Vaccine Program Update – Mobile Clinics

- Two mobile clinics running five days/week
- Focused on Forward Sortation Area (FSA) at highest risk – lower vaccine coverage, higher concentration of racialized population and high material deprivation
- Mobile clinics for Jan 2023 include clinics in areas of highest risk – L8N, L8L, L8H, L8E and L8M, adjacent Forward Sortation Areas and other areas with low vaccination coverage
- Assessment of high risk areas and vaccination coverage is ongoing and mobile clinic sites will continue to be updated based on on-going assessment

Vaccine Program Update - Operations

- Flu vaccine is being offered at mobile clinics on a walk-in basis for anyone ages 6+ months for the month of January 2023
- NEW COVID-19 bivalent booster now available for ages 5-11years
- Continue:
  - Promotion of COVID-19 and Flu vaccine access via pharmacy and primary care sources
  - Vaccine Ambassador work to promote COVID-19 vaccine and begin work with promotion of COVID-19 catch-up of routine vaccinations

Key Messages

- Hamiltonians are recommended to take protective measures to reduce serious health consequences this respiratory virus season:
  - Get the flu shot and stay up-to-date with your vaccines including completion of primary COVID-19 vaccine series and/or seasonal COVID-19 booster (booster in last 6 months)
  - Stay home when you are ill
  - Strongly recommend wearing a mask when in crowded indoor settings and/or when unable to distance
  - Speak to your healthcare provider, know in advance if you're eligible for treatment and where to access

Hamilton

QUESTIONS?

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	January 16, 2023
SUBJECT/REPORT NO:	Pharmacies and Spatial Mapping: COVID-19 and Influenza Vaccinations (BOH23004) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Catherine Holtz (905) 546-2424 Ext. 6708
SUBMITTED BY: **SIGNATURE:**	Dr. Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services

COUNCIL DIRECTION

At its November 28, 2022 Board of Health meeting, direction was provided to Hamilton Public Health Services staff to report back to the Board of Health at its January 16, 2022 meeting, on pharmacies that are, or are not, administering influenza and COVID-19 vaccinations, including geo-data.

INFORMATION

Of 229 Hamilton pharmacies in total:

- 132 pharmacies (58%) offer both COVID-19 and influenza vaccinations;
- 30 pharmacies (13%) offer influenza vaccinations only;
- 3 pharmacies (1%) offer COVID-19 vaccinations only; and,
- 64 pharmacies (28%) offer neither vaccination

The number (and percentage) of pharmacies offering these vaccinations varies by Ward (please see Appendix “A” to Report BOH23004). Please note:

- Data represents a point in time and may not reflect current or future pharmacy vaccine availability. Residents are strongly encouraged to check with local pharmacies to confirm availability; and,
- Data were sourced from the Ministry of Health: Active retail pharmacies (file received December 15, 2022); Pharmacies administering COVID-19 vaccine (as

of December 5, 2022); and, Pharmacies administering influenza vaccine (as of December 7, 2022).

APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report BOH23004	Pharmacies Offering COVID-19 and Influenza Vaccinations by Ward

Pharmacies Offering COVID-19 and Influenza Vaccinations by Ward

Figure 1: Location of Hamilton pharmacies offering influenza and COVID-19 vaccinations

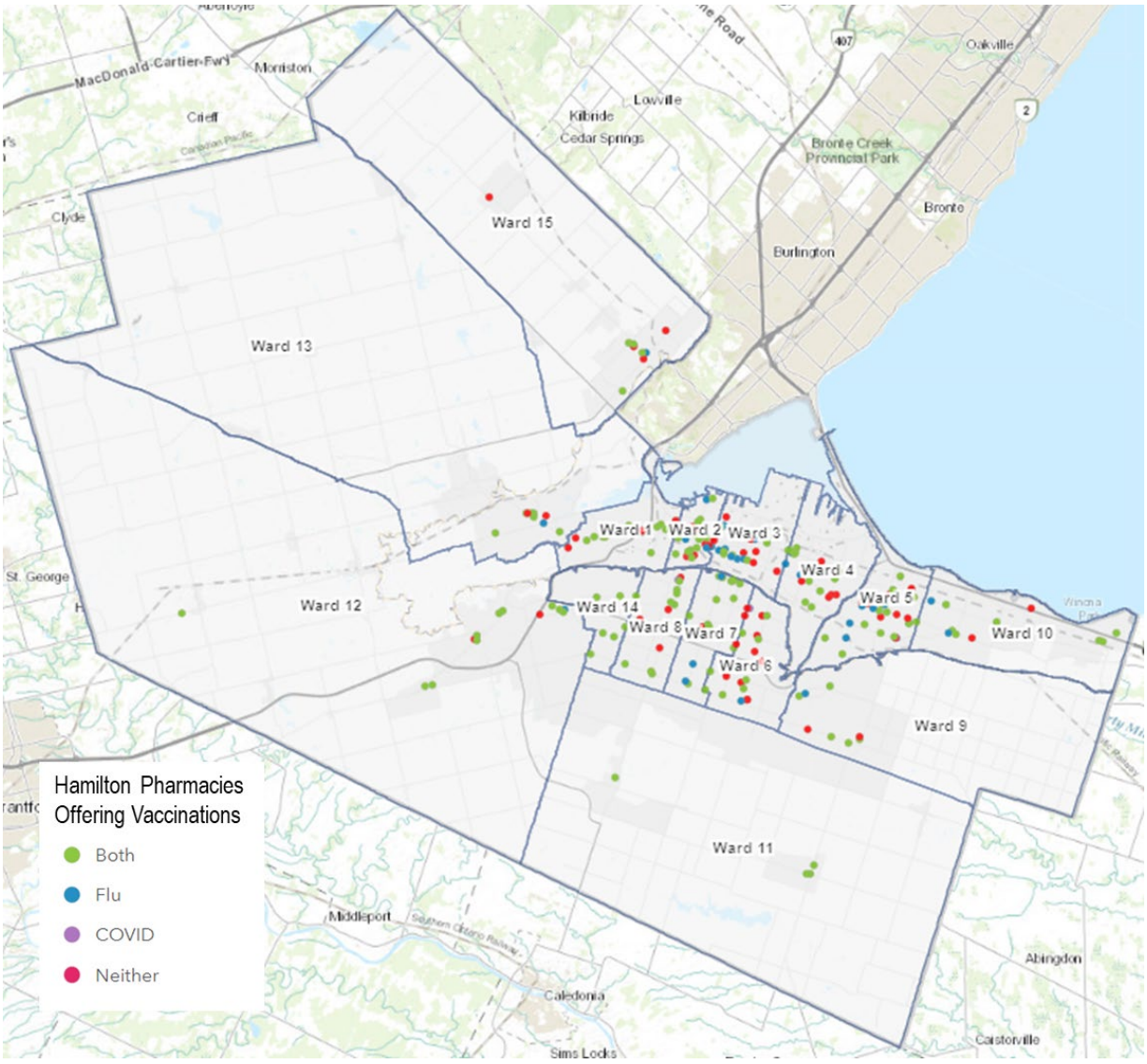


Figure 2: Pharmacy locations in Hamilton Ward 1

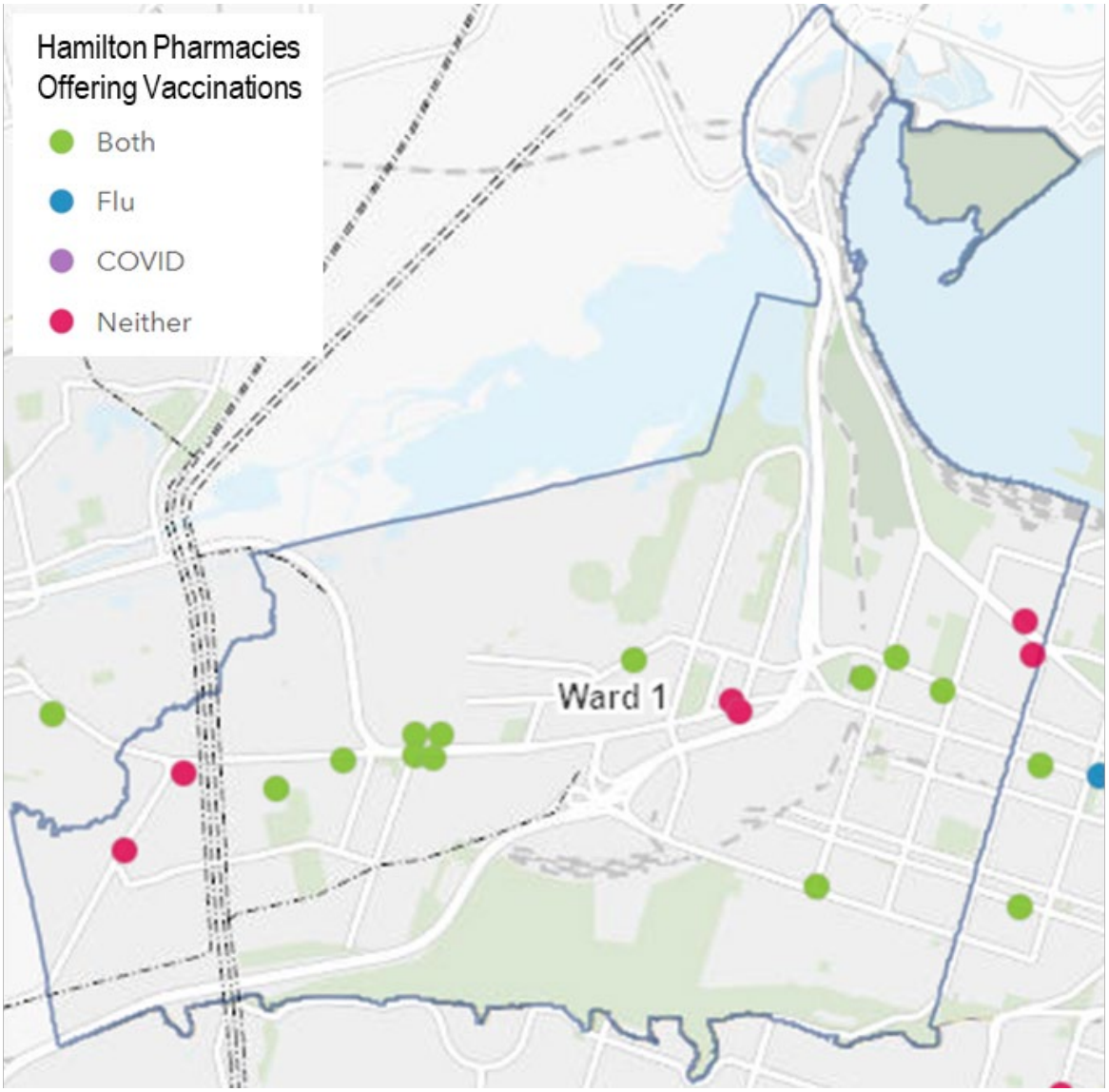


Table 1: Pharmacy Locations in Hamilton Ward 1 (Total 17 Pharmacies)

Both Vaccines	11
COVID-19 Vaccine Only	0
Influenza Vaccine Only	0
Neither Vaccine	6

Figure 3: Pharmacy locations in Hamilton Ward 2

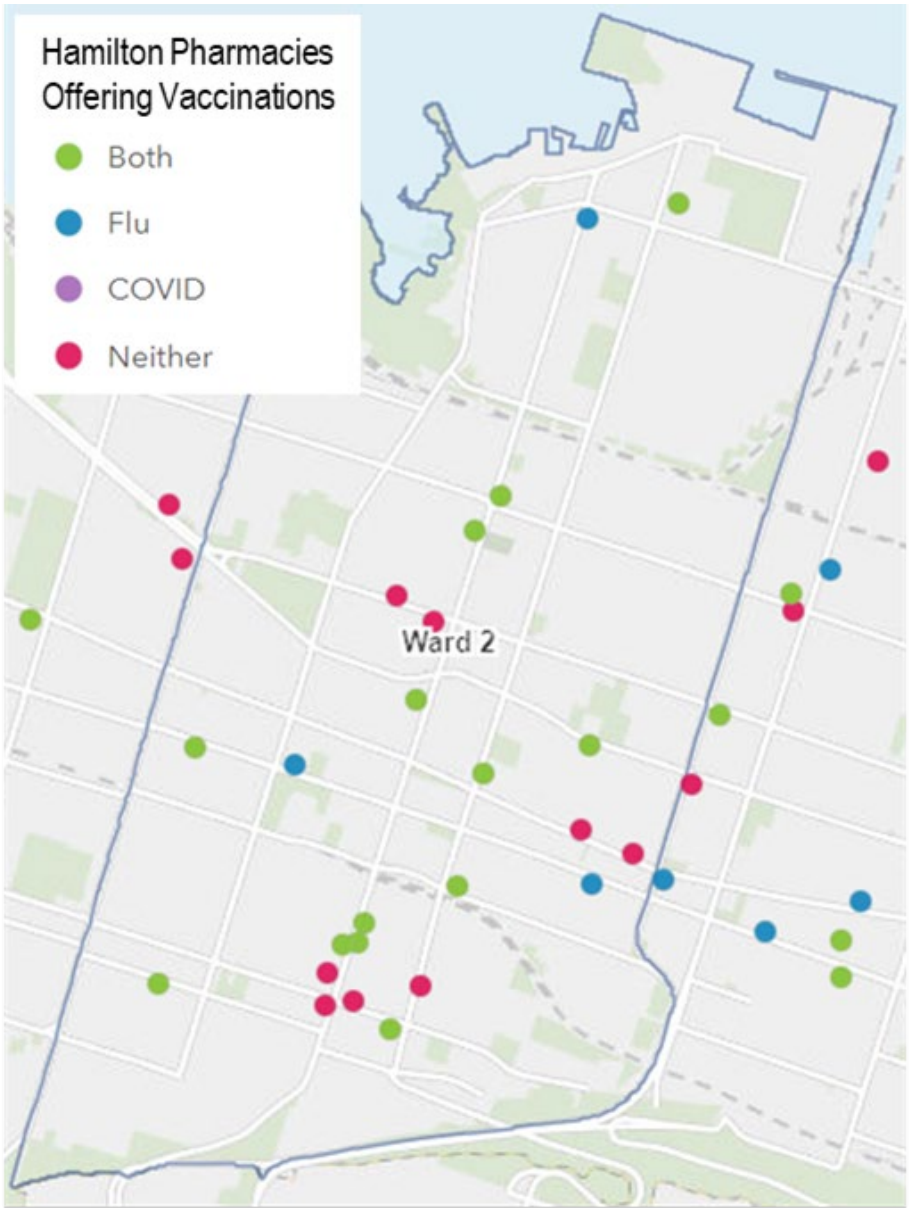


Table 2: Pharmacy Locations in Hamilton Ward 2 (Total 24 Pharmacies)

Both Vaccines	13
COVID-19 Vaccine Only	0
Influenza Vaccine Only	3
Neither Vaccine	8

Figure 4: Pharmacy locations in Hamilton Ward 3

Table 3: Pharmacy Locations in Hamilton Ward 3 (Total 25 Pharmacies)

Both Vaccines	8
COVID-19 Vaccine Only	0
Influenza Vaccine Only	9
Neither Vaccine	8

Figure 5: Pharmacy locations in Hamilton Ward 4

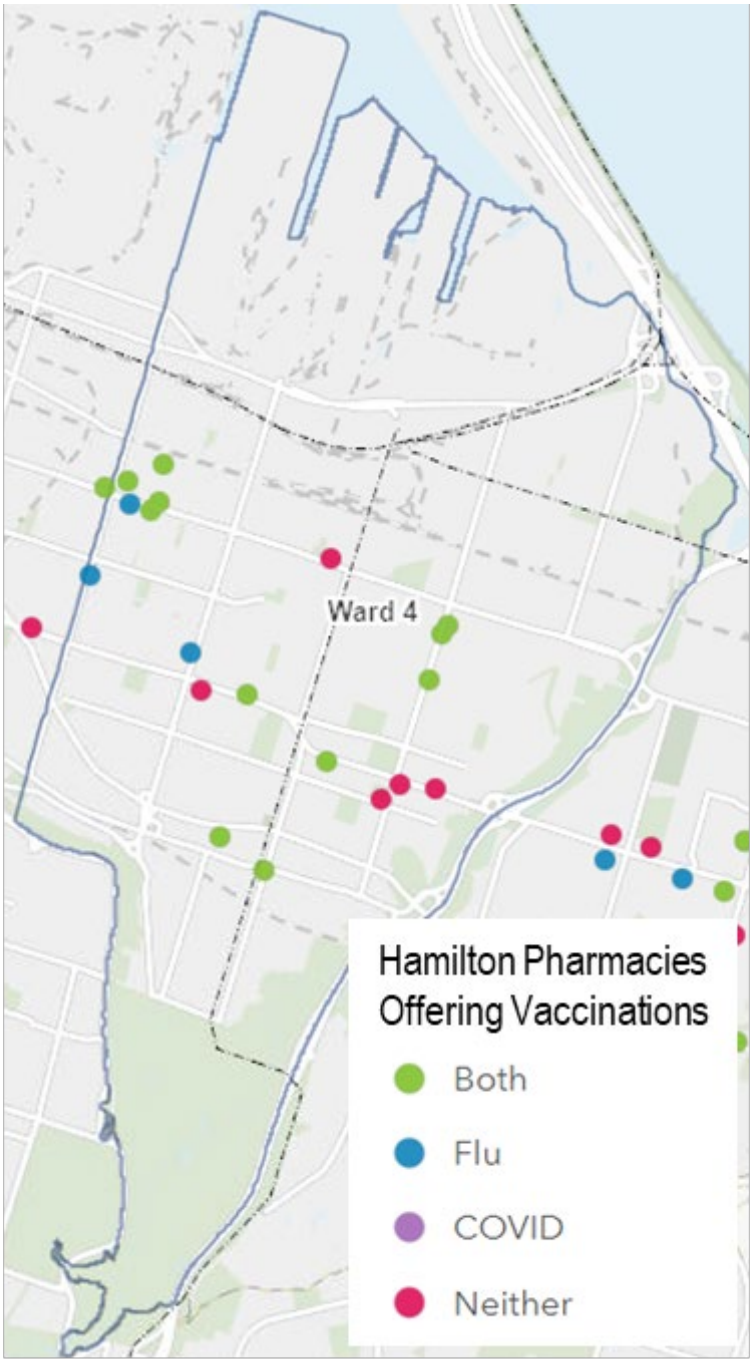


Table 4: Pharmacy Locations in Hamilton Ward 4 (Total 19 Pharmacies)

Both Vaccines	11
COVID-19 Vaccine Only	0
Influenza Vaccine Only	3
Neither Vaccine	5

Figure 6: Pharmacy locations in Hamilton Ward 5

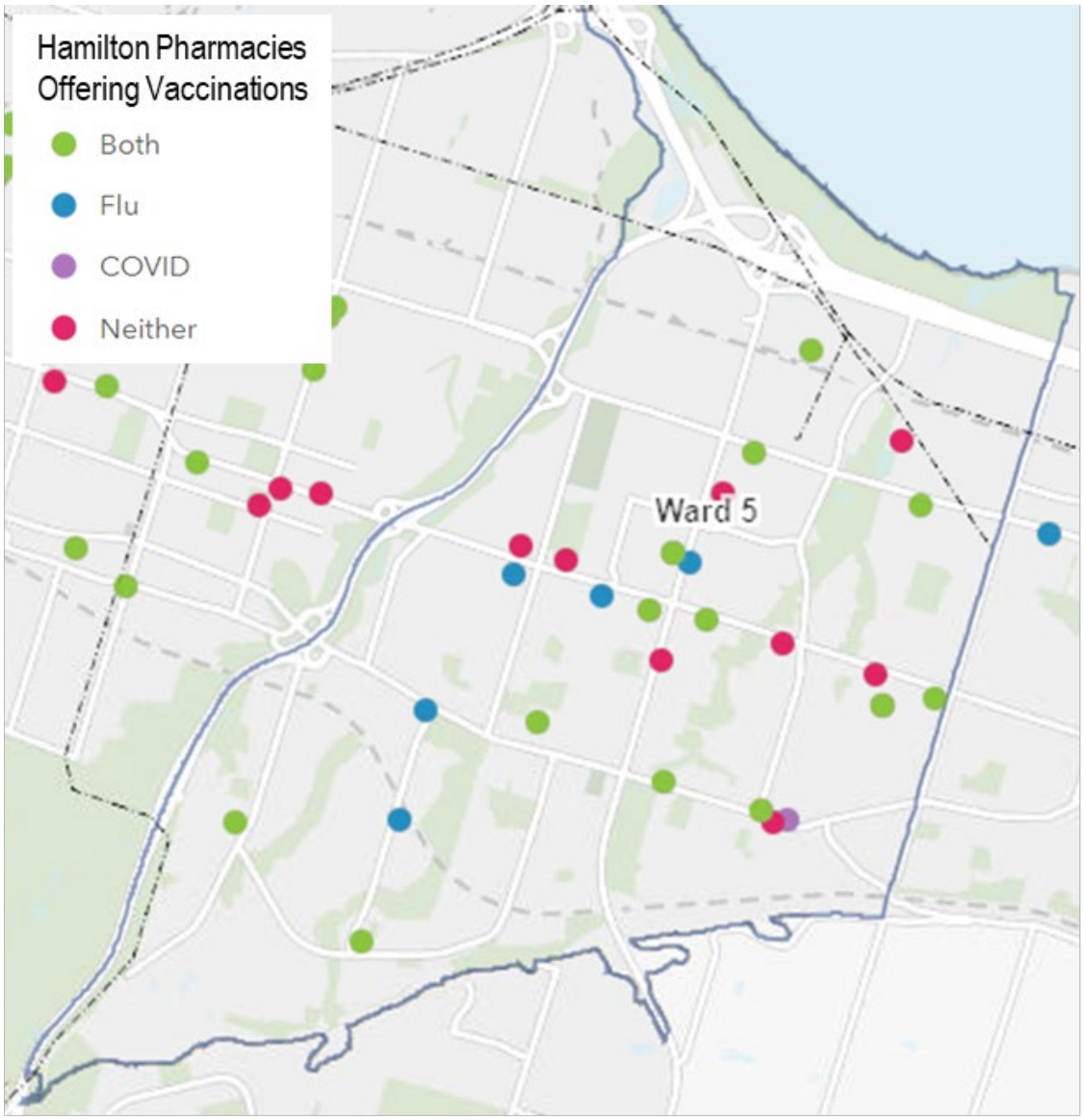


Table 5: Pharmacy Locations in Hamilton Ward 5 (Total 29 Pharmacies)

Both Vaccines	15
COVID-19 Vaccine Only	1
Influenza Vaccine Only	5
Neither Vaccine	8

Figure 7: Pharmacy locations in Hamilton Ward 6

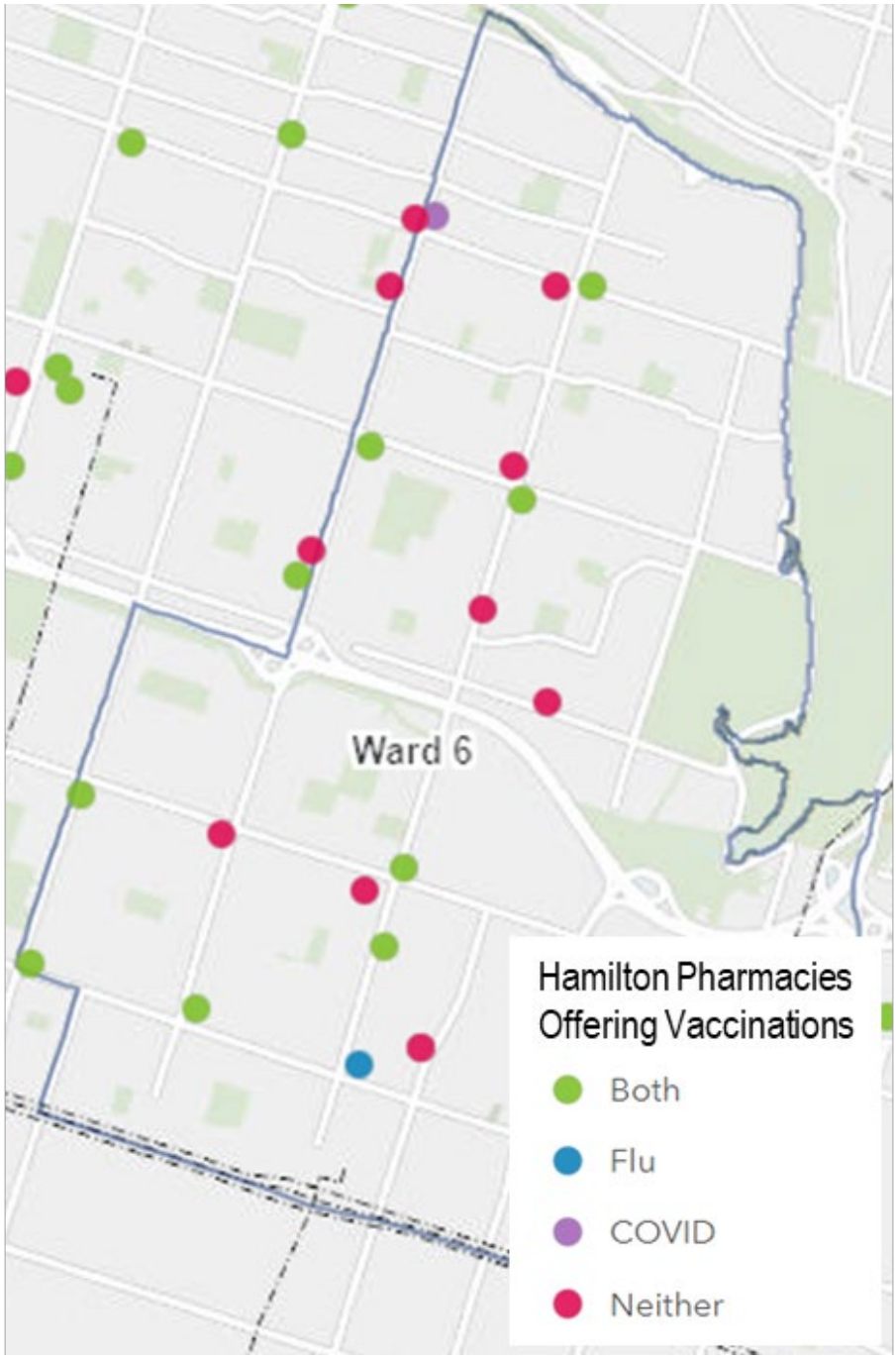


Table 6: Pharmacy Locations in Hamilton Ward 6 (Total 18 Pharmacies)

Both Vaccines	8
COVID-19 Vaccine Only	1
Influenza Vaccine Only	1
Neither Vaccine	8

Figure 8: Pharmacy locations in Hamilton Ward 7

Table 7: Pharmacy Locations in Hamilton Ward 7 (Total 23 Pharmacies)

Both Vaccines	15
COVID-19 Vaccine Only	0
Influenza Vaccine Only	3
Neither Vaccine	5

Figure 9: Pharmacy locations in Hamilton Ward 8

Table 8: Pharmacy Locations in Hamilton Ward 8 (Total 13 Pharmacies)

Both Vaccines	8
COVID-19 Vaccine Only	1
Influenza Vaccine Only	0
Neither Vaccine	4

Figure10: Pharmacy locations in Hamilton Ward 9

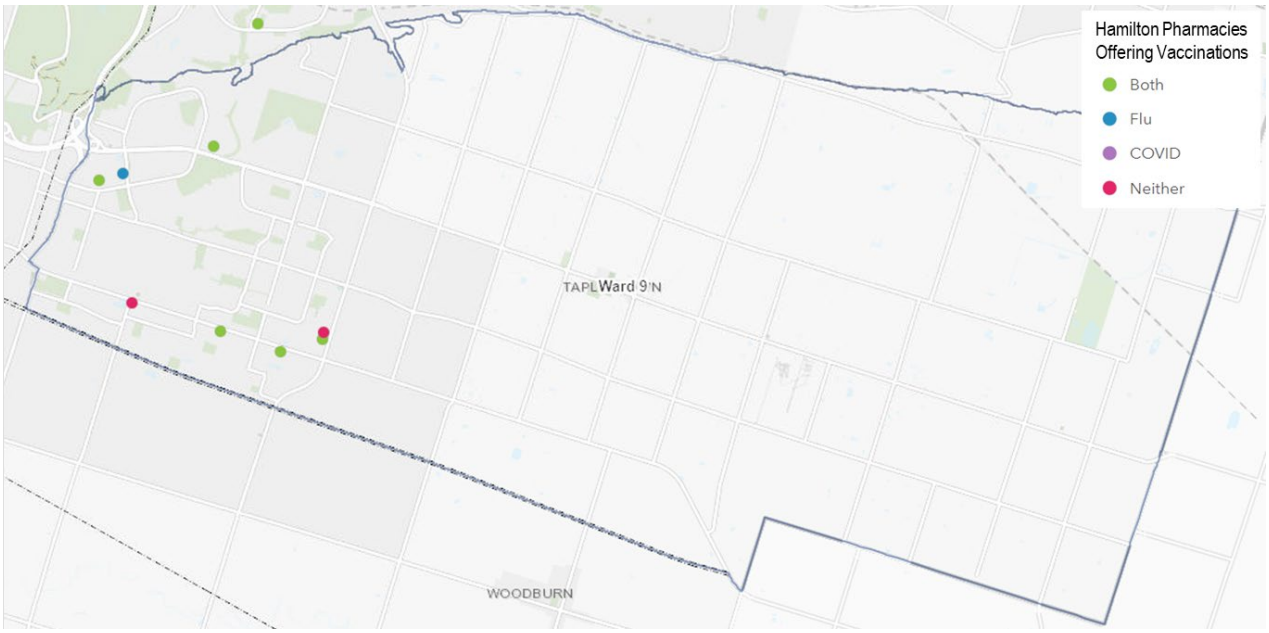


Table 9: Pharmacy Locations in Hamilton Ward 9 (Total 8 Pharmacies)

Both Vaccines	5
COVID-19 Vaccine Only	0
Influenza Vaccine Only	1
Neither Vaccine	2

Figure 11: Pharmacy locations in Hamilton Ward 10

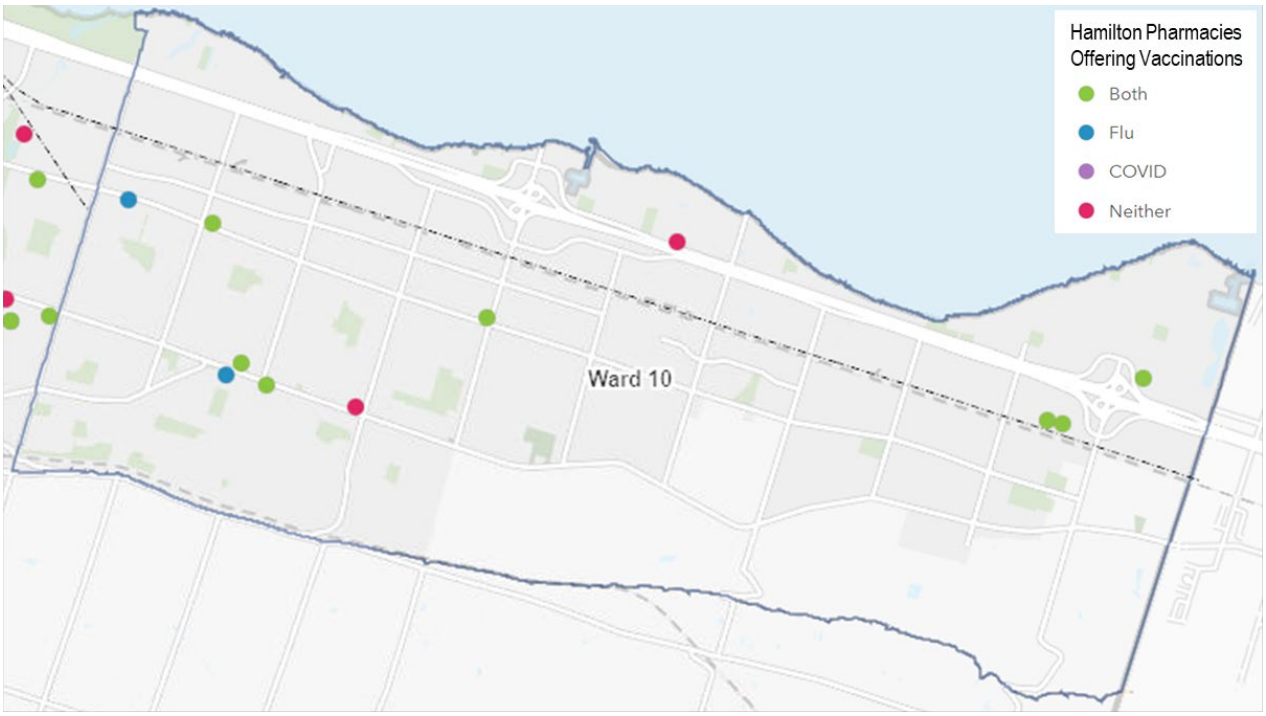


Table 10: Pharmacy Locations in Hamilton Ward 10 (Total 11 Pharmacies)

Both Vaccines	7
COVID-19 Vaccine Only	0
Influenza Vaccine Only	2
Neither Vaccine	2

Figure 12: Pharmacy locations in Hamilton Ward 11

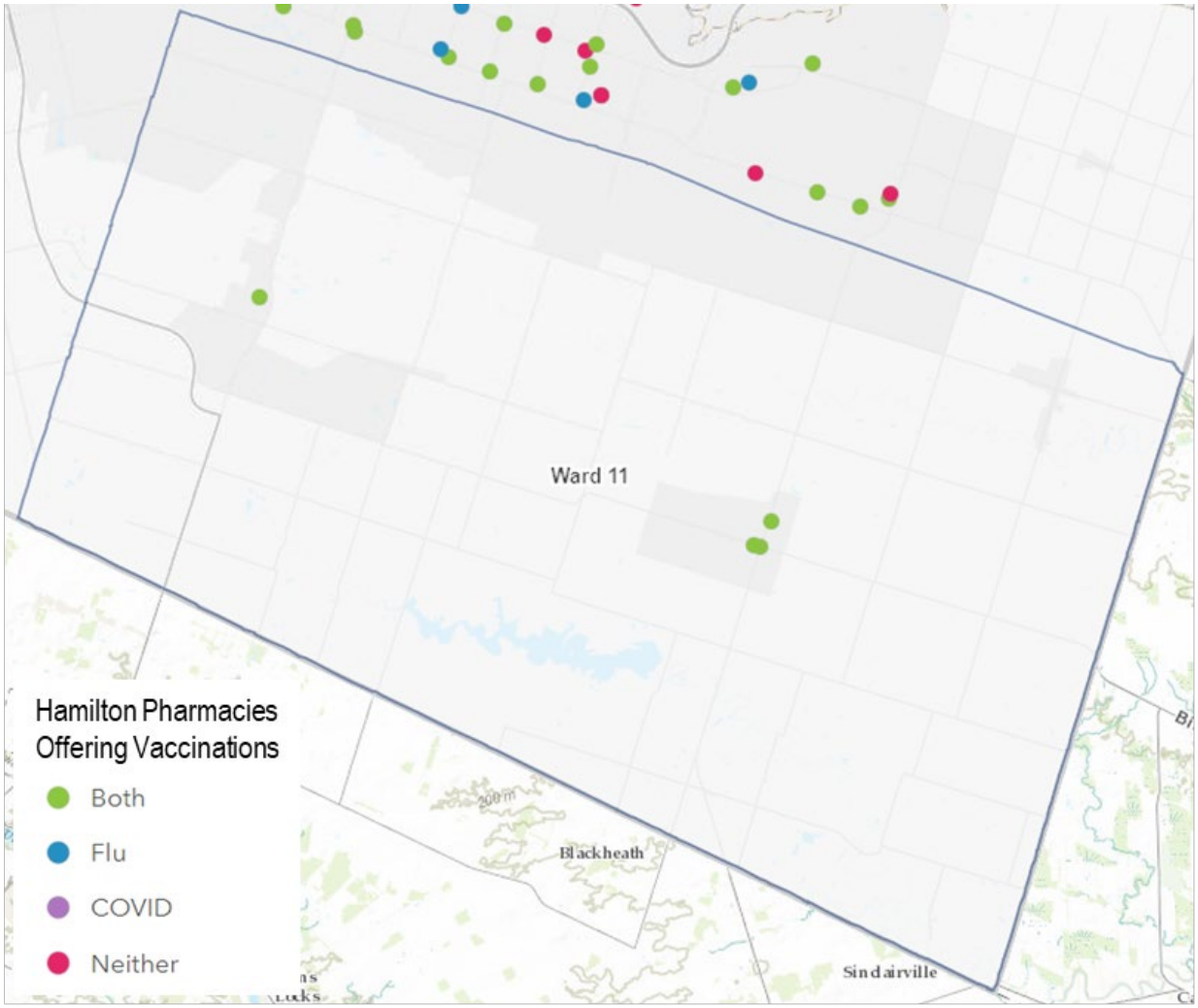


Table 11: Pharmacy Locations in Hamilton Ward 11 (Total 4 Pharmacies)

Both Vaccines	4
COVID-19 Vaccine Only	0
Influenza Vaccine Only	0
Neither Vaccine	0

Figure 13: Pharmacy locations in Hamilton Ward 12

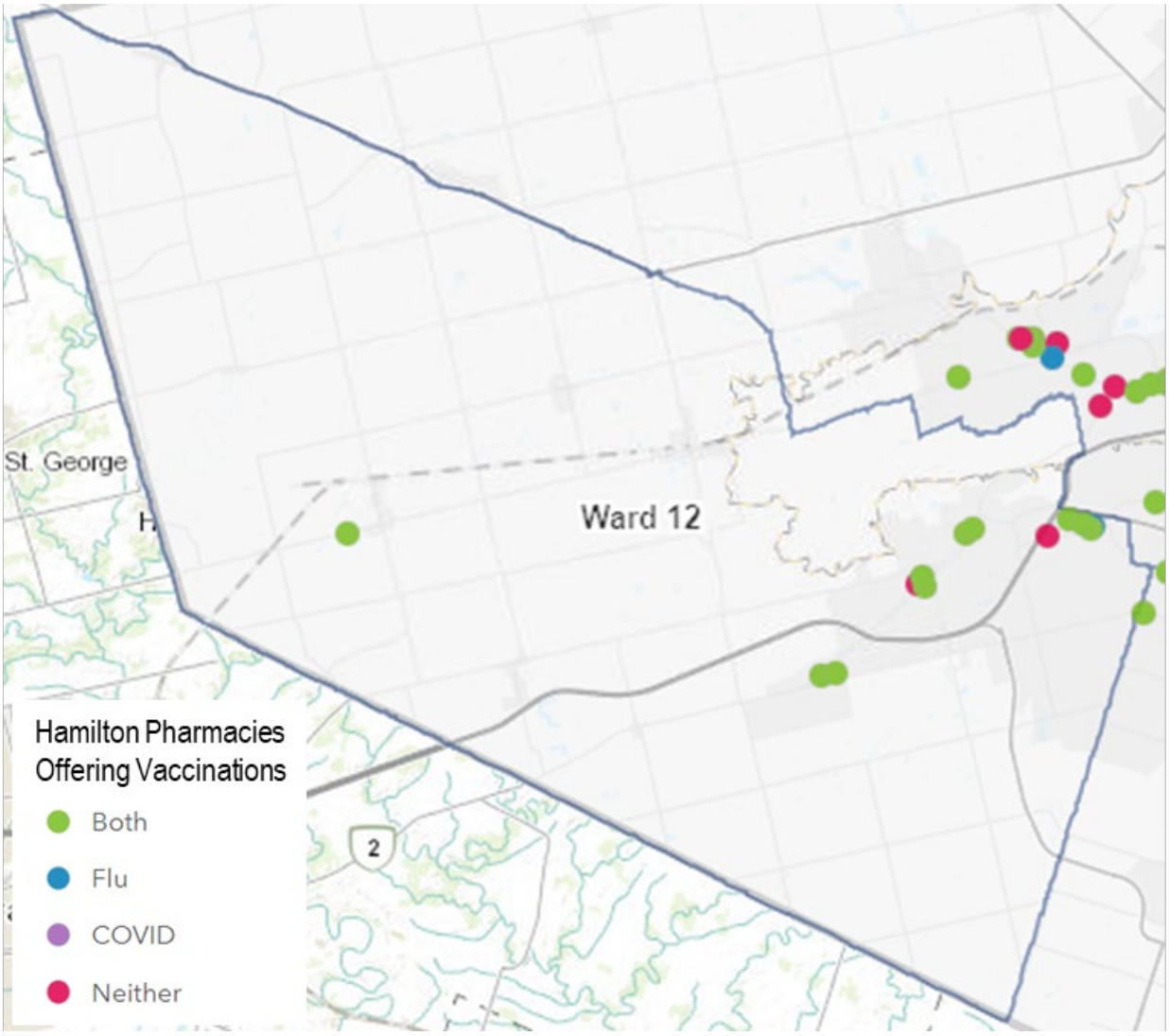


Table 12: Pharmacy Locations in Hamilton Ward 12 (Total 13 Pharmacies)

Both Vaccines	10
COVID-19 Vaccine Only	0
Influenza Vaccine Only	1
Neither Vaccine	2

Figure 14: Pharmacy locations in Hamilton Ward 13

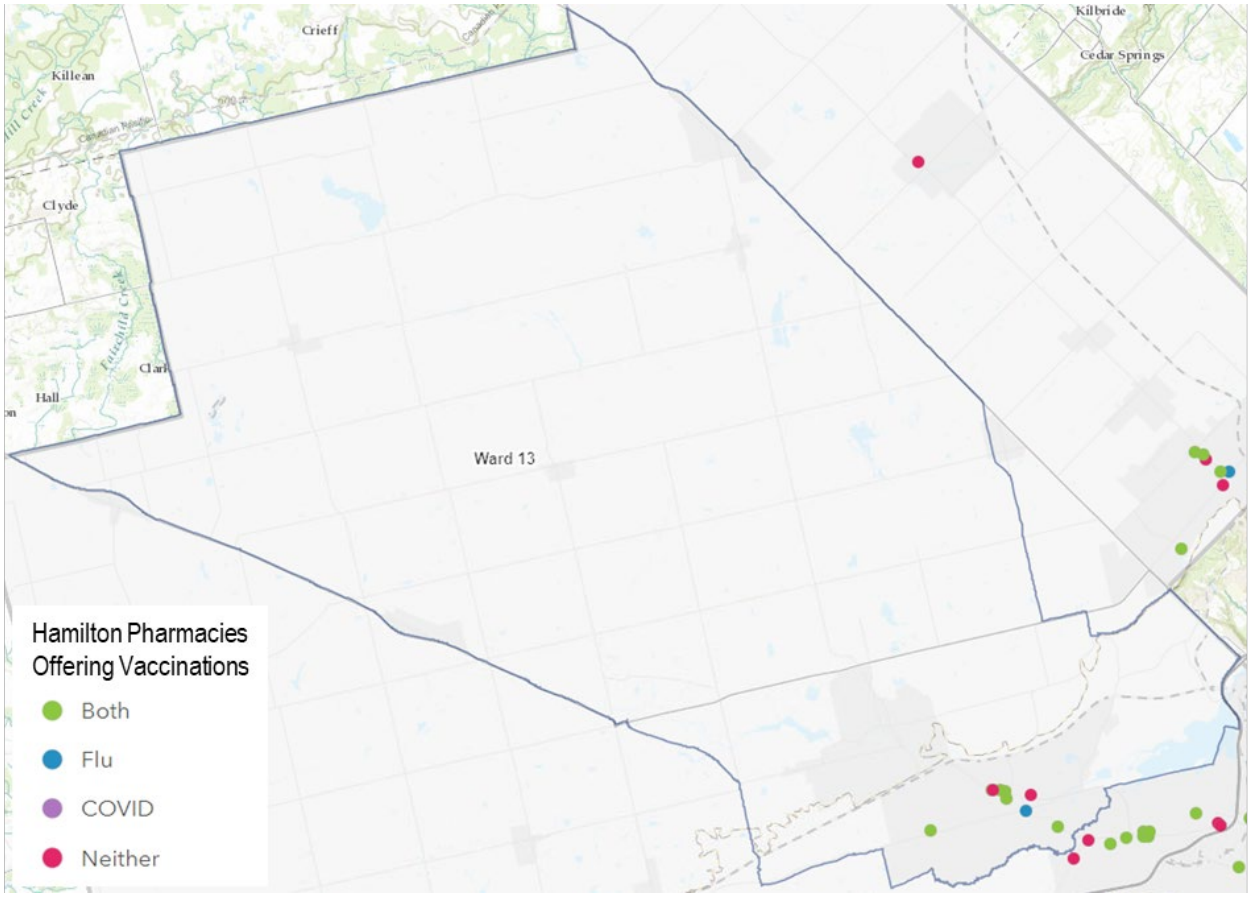


Table 13: Pharmacy Locations in Hamilton Ward 13 (Total 9 Pharmacies)

Both Vaccines	6
COVID-19 Vaccine Only	0
Influenza Vaccine Only	1
Neither Vaccine	2

Figure 15: Pharmacy locations in Hamilton Ward 14

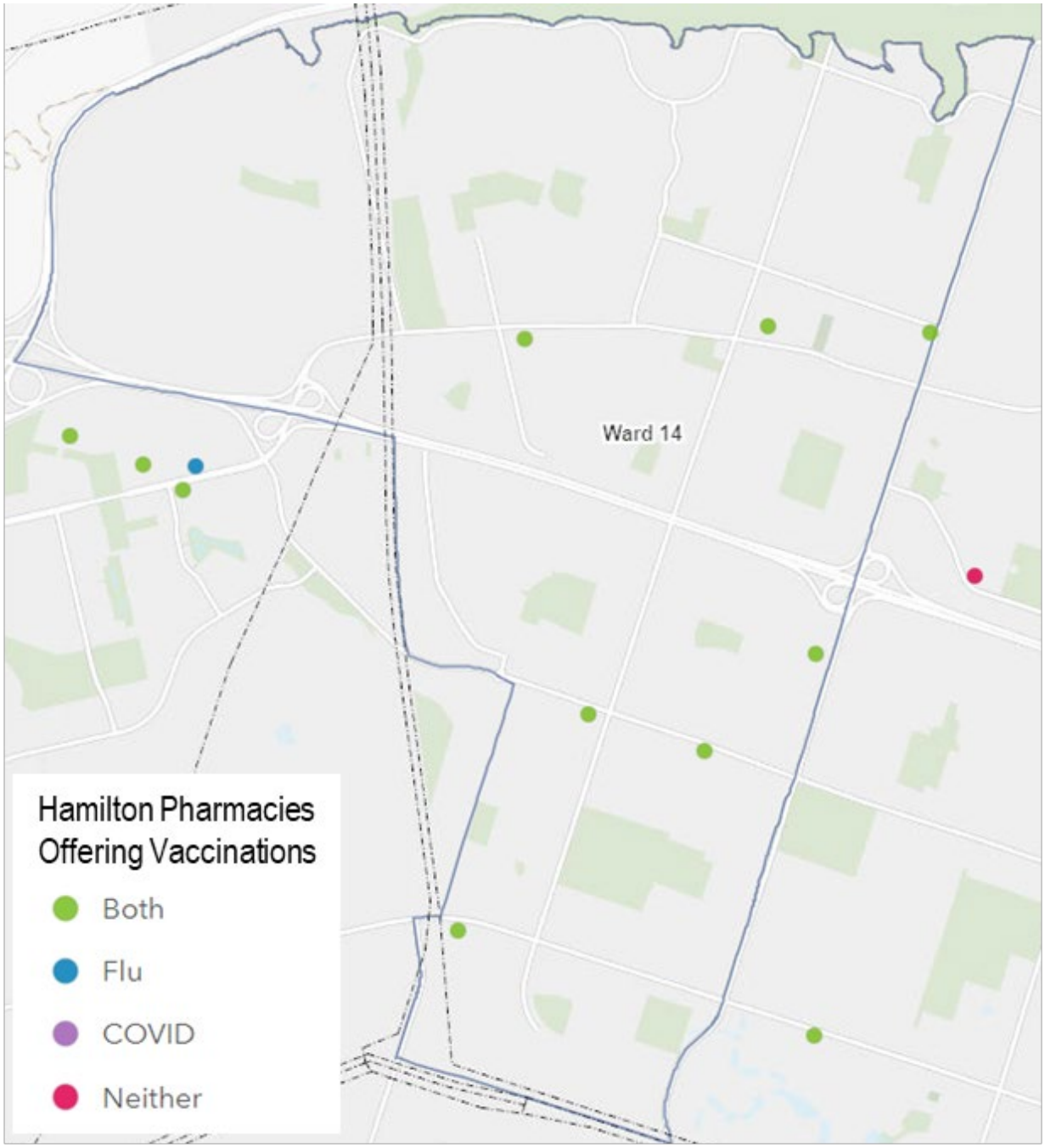


Table 14: Pharmacy Locations in Hamilton Ward 14 (Total 7 Pharmacies)

Both Vaccines	7
COVID-19 Vaccine Only	0
Influenza Vaccine Only	0
Neither Vaccine	0

Figure 16: Pharmacy locations in Hamilton Ward 15

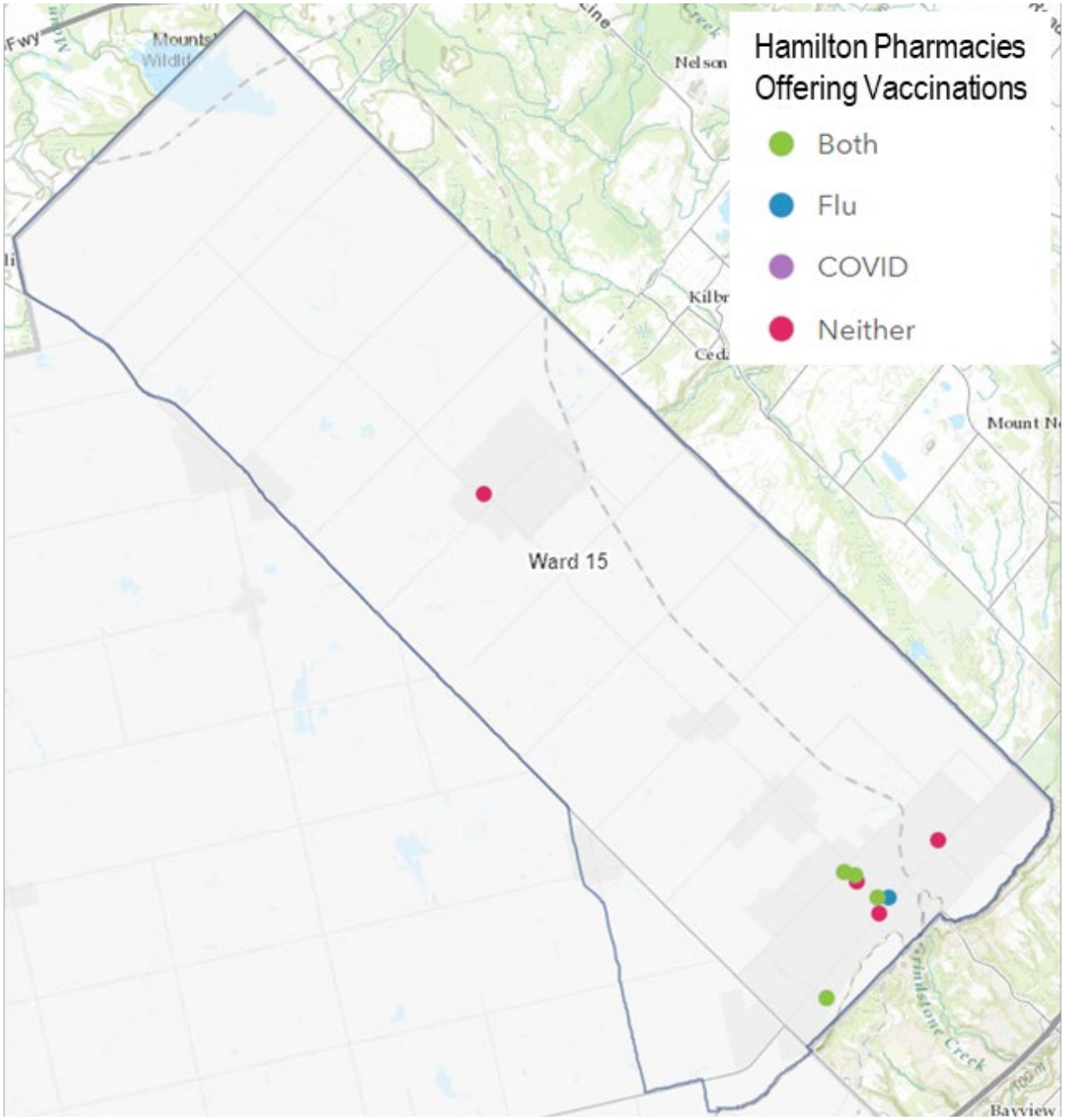


Table 15: Pharmacy Locations in Hamilton Ward 15 (Total 9 Pharmacies)

Both Vaccines	4
COVID-19 Vaccine Only	0
Influenza Vaccine Only	1
Neither Vaccine	4

INFORMATION REPORT

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	January 16, 2023
SUBJECT/REPORT NO:	Cold Alert Trigger and Response Process Review (BOH23005) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Matthew Lawson (905) 546-2424 Ext. 5823
SUBMITTED BY: **SIGNATURE:**	Kevin McDonald Director, Health Environments Division Public Health Services

This report provides information about Cold Alerts issued by Hamilton Public Health Services and the related response process followed by City and community services providers. In addition, information related to a review of the Cold Alert triggers and response process is provided below.

INFORMATION

Background

Since the 2000/2001 winter season, the Office of the Medical Officer of Health has issued 'Cold Alerts' for the purpose of notifying community members of the risk to health from exposure to extreme cold temperatures and how to access support for vulnerable persons in need of shelter. The original Cold Alert threshold value (i.e., trigger) of -15ºC was designed to warn of times when the risk of acute frostbite and hypothermia from exposure were further heightened, especially for those most vulnerable to its effects, such as homeless individuals, the elderly and small children.

The alerts trigger increased outreach to homeless individuals by community agencies to encourage people to access available shelter services and expanded services offered in anticipation of the potential that more individuals would be utilizing identified services during those times. The Cold Alert triggers and response plan have historically been predicated on the understanding that access to warm, dry, safe shelter or housing is essential.

In the fall of 2006, Hamilton Public Health Services received new information from Environment Canada (now Environment and Climate Change Canada), and following consultation and subsequent evaluation with community partners, revised the threshold to include wind chill (i.e., -15ºC, OR -20ºC windchill). The current thresholds are largely consistent with the public health units in Ontario that employ Cold Alert protocols.

Moving Forward

Public Health Services staff will conduct a scientific review of the available evidence related to the impact of cold weather events on health. In addition, the review will include an environmental scan of current Cold Alert thresholds and response protocols for the cities of Toronto, Ottawa, and other Ontario public health unit jurisdictions.

In addition to the planned review referenced above, Public Health Services staff together with Housing Division staff will engage and consult with community service providers and stakeholders with respect to their concerns specific to Cold Alert thresholds and response plans to inform any potential changes in policy. Please refer to Appendix “A” to Report BOH23005 for the current 2022 City of Hamilton Extreme Cold Weather Protocol.

Public Health Services staff plan to bring forward a Recommendation Report detailing specific options and recommendations related to Cold Alert thresholds to the April 3, 2023 Board of Health meeting.

In addition to the Housing Division funding ‘The Hub’ as a warming centre as a mitigation measure through until March 31, 2023, the Housing Division is planning to bring forward a Recommendation Report to the Emergency & Community Services Committee on January 19, 2023 that provides recommendations related to enhanced access to drop-in warming centres for the duration of the 2023 winter season.

More information about the City’s Community Cold Response and to access a complete list of ongoing community resources serving people experiencing homelessness including emergency shelters, and drop-in locations can be found by visiting www.hamilton.ca/cold.

APPENDICES AND SCHEDULES ATTACHED

“Appendix A” to Report BOH23005	City of Hamilton Extreme Cold Weather Protocol (2022)

City of Hamilton Extreme Cold Weather Protocol

COLD Coalition (December 2022)

Public Health - Health Protection Division assesses weather conditions daily.

↓

COLD Alert is called when temperatures reach: Less than -15° Celsius actual or less than -20° Celsius with wind chill.

↓

When a Cold Alert is determined by Public Health, the MOH/designate will send a Cold Alert notification to the community via fax, email and phone. As well, the City of Hamilton website/social media is updated with the most current Cold Alert response information.

*** During extended Cold Alerts, PHS will send reminders every three days.**

↓

Media Contacts:

- Directed to the City of Hamilton's Communications Division Communications@hamilton.ca for city-level response, system-level questions, data, etc.
- Salvation Army acts as contact to speak to agency-level response and actions (Salvation Army Communications Team at on.communications@salvationarmy.ca)

↓

During a Cold Alert, responses include:

COMMUNITY WARM PLACES & RESPONSE:

- More information on available resources can be found at www.hamilton.ca/cold
- Shelters relax service restrictions, where possible, and activate overflow spaces.
- Some drop-ins and other services have extended hours/services or relax criteria, where possible.
- Specific City of Hamilton Recreation Centres and Hamilton Public Library branches are available as warm places during business hours.
- Neighbours and agencies check in on vulnerable individuals (in housing).

OUTREACH TEAMS should:

- Visit their typical places where homeless might be.
- Respond to calls re: new referrals through usual admission process.
- Contact COAST or police if assistance is needed when individuals are refusing to come out of the cold and are not properly equipped for the weather.

COAST will:

- Advise Outreach Teams if Police need to be involved because COAST staff are out on calls.

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

TO:	Mayor and Members Board of Health
COMMITTEE DATE:	January 16, 2023
SUBJECT/REPORT NO:	Ministry of Health Funding and Accountability Report: 2021 Annual Report and Attestation (BOH23001) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Nancy Sullivan (905) 546-2424 Ext. 5756
SUBMITTED BY: **SIGNATURE:**	Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services

RECOMMENDATION

That the Board of Health authorize and direct the Medical Officer of Health to submit the 2021 Annual Report and Attestation to the Ministry of Health in keeping with the information outlined in Board of Health Report BOH23001.

EXECUTIVE SUMMARY

The purpose of Board of Health Report BOH23001 is to provide an overview of Public Health Services program and financial performance in 2021.

Public Health Services has defined program objectives, performance measures, and targets for the full scope of programs and services within a Performance Management and Monitoring System. In 2019, prior to the COVID-19 pandemic, Public Health Services was making significant progress in achieving the targets that had been set as outlined in Board of Health Report BOH20009. Throughout 2020 and 2021, the focus of Public Health Services resources shifted to the COVID-19 pandemic emergency response, including the prevention and control of COVID-19 in our community and implementation of the COVID-19 vaccine program. While significant resources were directed to COVID-19 throughout this time period, Public Health Services also continued to provide essential public health services, particularly those that support our most vulnerable populations. In 2022, Public Health Services began re-opening the programs and services that were on-hold or partially operational during the pandemic in a prioritized way. This includes the re-establishment of performance management and monitoring processes across all programs and services.

In 2021, the Ministry of Health granted the City of Hamilton Board of Health $62,713,900 to support the delivery of programs and services under the Ontario Public Health Standards ("the Standards"), as well as one-time funding to support the COVID-19 general and vaccine programs and various projects/initiatives. As of December 31, 2021, a total of $53,738,491 was spent, with a positive variance of $6,759,609. The City of Hamilton contributed $11,363,720 in support of these same initiatives.

Boards of Health are required to report on program and financial performance to the Ministry of Health for Ministry funded programs under the Standards. Program performance reporting requirements were deferred in 2020 and 2021 due to the COVID-19 pandemic. The Ministry of Health is now resuming these requirements and has recently requested that boards of health submit a 2021 Annual Report and Attestation (the 'Annual Report'). The program and financial performance information summarized in Report BOH23001 will be reported to the Ministry of Health through the 2021 Annual Report.

Alternatives for Consideration – Not Applicable

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: No new financial implications.

Staffing: No new staffing implications.

Legal: No new legal implications.

HISTORICAL BACKGROUND

In 2019, prior to the COVID-19 pandemic, Public Health Services staff worked to maximize the efficiency, transparency and usefulness of the Public Health Services` Performance Management and Monitoring System. This was done by streamlining and integrating the System with the annual planning and budget cycles, and by better defining program objectives, performance measures and strengthening targets for the full scope of Public Health Services programs & services. The information generated by the System is used by staff and management to inform program planning and drive continuous quality improvement. Semi-annual performance reports were provided to the Board of Health. Overall, Public Health Services was making significant progress in achieving set targets (see the 2019 Year-End Public Health Services Performance Report (BOH20009) from the June 2020 Board of Health meeting). Due to the COVID-19 pandemic, implementation of the performance management system was put on-hold

throughout 2020 and 2021; focus shifted to monitoring and reporting on performance related to COVID-19 only. In June 2022, Public Health Services restarted a regular performance management and monitoring cycle for all programs and continues to expand the system as program and services return to full capacity.

Boards of health are also required to report to the Ministry of Health on program and financial performance for Ministry funded programs under the Standards. Due to COVID-19, the Ministry of Health deferred program performance reporting requirements in 2020 and 2021. Financial reporting continued throughout the COVID-19 pandemic. The Ministry of Health is now resuming and catching up on their program performance reporting requirements. Recently, boards of health were asked to complete a 2021 Annual Report and to include program outcome data for 2019 and 2020. The due date to submit the 2021 Annual Report to the Ministry of Health is January 13, 2023. Public Health Services has requested an extension until January 28, 2023 to allow for Board of Health review of performance information prior to submission. A template for the 2021 Annual Report was provided by the Ministry of Health. The template is comprised of the following sections:

1. Narrative descriptions and key achievements for specific programs as well as one-time projects/initiatives;
2. Financial year-end actuals for mandatory programs as well as one-time projects/initiatives;
3. Program outcome indicator results for 2019, 2020 and 2021; and,
4. Attestation on each of the organizational requirements.

This Board of Health Report BOH23001 summarizes available information on financial actuals and key program activities and achievements for 2021, as well as program outcome indicator results for 2019, 2020 and 2021, for Ministry funded programs and services under the Standards. This information will be reported to the Ministry through the 2021 Annual Report.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

The Standards include a Public Health Accountability Framework and Organizational Requirements to ensure that boards of health have the necessary foundations within the four domains of program and service delivery, financial management, governance and public health practice to successfully implement the Standards. These include monitoring and reporting requirements for boards of health to demonstrate accountability to the Ministry of Health. The Annual Report is one of several funding and accountability reporting tools that boards of health are required to submit to the Ministry.

RELEVANT CONSULTATION

Not Applicable.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

Program Performance

Throughout 2020 and 2021, Public Health Services was focused on the COVID-19 pandemic emergency response. This included actions to prevent and control COVID-19 transmission in our community, such as: monitoring the status of COVID-19; communicating information to the public, board of health and partners; and, managing cases and outbreaks. Public Health Services also provided leadership in our community for the planning and distribution of the COVID-19 vaccine, one of the most complex vaccination campaigns in Ontario's history. Performance related to COVID-19 was reported throughout the pandemic in monthly COVID-19 updates to the Board of Health. Supporting this level of response required the redeployment of a significant proportion of the Public Health Services workforce. As a result, several Public Health Services programs and services were on-hold or partially operational for over 2 years.

While much of Public Health Services' resources were focused on the COVID-19 emergency response, Public Health Services continued to provide essential public health programs and services, with a focus on supporting our most vulnerable populations. Some key program achievements included:

- Continuing to provide emergency dental treatments to children and low-income adults and seniors;
- Receiving a new dental care bus and preparing it to provide dental services to low-income seniors as part of the Ontario Seniors Dental Care Program;
- Continuing to inspect high and moderate risk food premises, as well as providing timely response to food recall notifications, suspect or confirmed reported foodborne outbreaks and food-related complaints;
- Responding to complaints/inquiries about health hazards in the environment and assessing/inspecting facilities where there is an elevated risk of illness associated with exposures to health hazards;
- Implementing actions to reduce the risk of heat-related illness and mitigate health impacts due to cold weather;
- Continuing to provide breastfeeding, childhood nutrition, parenting, healthy pregnancies, early childhood development, and mental well-being services by shifting to virtual provision of services and prioritizing face-to-face services for those at greatest risk;
- Providing service delivery to high needs schools in the City to support the creation of healthy school communities with a focus on COVID-19 recovery and promoting positive mental health; and,

- Continuing the local opioid response and providing weekly data reporting and information sharing, mental health services, Mobile Van service and expanded naloxone and harm reduction supply distribution.

Appendix "A" to Board of Health Report BOH23001 provides program outcome indicator results for 2019, 2020, and 2021 for Ministry funded programs under the Standards.

2021 Financial Actuals for Ministry Funded Programs under the Standards

In 2021, the Ministry of Health continued to provide funding based on a 70%/30% Provincial/Municipal funding formula to support the delivery of public health programs and services under the Standards (Mandatory Programs), except the Ontario Seniors Dental Care Program which remained 100% provincially funded. Overall, the City of Hamilton Board of Health received $28,973,500 for Mandatory Programs and the Ontario Seniors Dental Care Program, spent $28,434,731, and $538,769 will be recovered by the ministry. The Ministry of Health also provided one-time mitigation funding to offset the increased costs for municipalities as a result of the cost-sharing change from a mixed 75%/25% and 100% funding model prior to 2020. A total of $2,215,800 was granted, which was fully claimed. The City of Hamilton contributed $11,363,720 to support the delivery of Mandatory Programs.

The Ministry of Health also reimbursed extraordinary costs above the Mandatory Program subsidized expenditures associated with COVID-19 at 100%. In addition, the Ministry of Health provided one-time 100% funding to support the implementation of specific projects/initiatives. Overall, the City of Hamilton Board of Health received $31,524,600 in one-time funding and spent $25,303,760 as of December 31, 2021. For the period of January 1, 2022 to March 31, 2022, an additional $690,800 was spent; the remaining $6,068,809 will be recovered by the Ministry of Health.

Appendix 'B' to Board of Health Report BOH23001 provides a detailed overview of the provincial portion of the 2021 financial actuals for Ministry funded programs and services under the Standards.

2021 Attestation of Compliance

As part of the Ministry of Health Annual Report, boards of health are required to complete a certificate of attestation to demonstrate compliance with the Organizational Requirements as outlined in the Standards. In 2021, Public Health Services achieved full compliance with 55 out of the 64 organizational requirements. Of the nine requirements that were not fully met, most (eight out of nine) were related to the inability to deliver the full scope of public health programs & services as required by the Standards due to capacity constraints related to the COVID-19 emergency response, as described above. As Public Health Services programs and services re-open, return to full capacity and resume full-service levels, compliance with these requirements will be restored. The remaining requirement that was not fully met is: "board of health has a self-evaluation process of its governance practices and outcomes that is completed at

least every other year". The last Board of Health self-evaluation was completed in November 2020. Due to the municipal election in October 2022, the next board of health self-evaluation was delayed until Q4 2023 to allow for orientation of the new Board of Health.

Next Steps
In 2022, a primary focus for Public Health Services was to transition from the COVID-19 emergency response to sustained monitoring, prevention and response. This involved integrating COVID-19 work into existing Public Health Services programs (Infectious Disease and Vaccine). As part of this transition, staff who were deployed to support the COVID-19 emergency response returned to their home programs at the end of April 2022. Since that time, Public Health Services has re-opened programs and services in a prioritized way and enhanced some service levels to address the deficits of care and backlog of services due to COVID-19.

In parallel, the Public Health Services Performance Monitoring and Measurement System continues to be improved to provide the breadth and depth of information needed to ensure performance on the full scope of Public Health Services priorities and program objectives. In Q2 2023 staff will bring forward to the Board of Health a 2022 year-end Public Health Services performance report, including an annual financial and performance report for the general public.

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 BOH23001	Program Outcome Indicator Results for 2019 – 2021

Appendix “B” to Report BOH23001

2021 Financial Actuals for Ministry of Health Funded Programs under the Ontario Public Health Standards

Public Health Services Program Outcome Indicator Results for 2019, 2020 and 2021

(II) Denotes program was on-hold due to redeployment of staff to COVID-19 emergency response.

Program Outcome Indicator	2019 Target	2019 Result	2020 Result	2021 Result	Comments
Chronic Disease Prevention and Well-Being Program Standard					
% of elementary and secondary schools with a School Travel Plan[i]	75%	80% (119/149)[ii]	(II)	(II)	Target met in 2019. No progress made in 2020 and 2021 due to COVID.
% of elementary schools and secondary schools with a school travel plan that have active transportation policies[i]	50%	25% (30/119)[ii]	(II)	(II)	Target unmet in 2019; impacted by labour disputes in schools in 2019/2020 school year. No progress made in 2020 and 2021 due to COVID.
% of Ontario Seniors Dental Care Program (OSDCP) clients who cancelled/did not show up to clinic appointment[i]	N/A	N/A	4.1% (41/1010)	3.9% (88/2275)	From March 2020, due to dental college restrictions related to COVID-19, only emergency/urgent clients were seen in the clinic and very few cancelled.
% of eligible clients enrolled in OSDCP who accessed the clinic service[i]	N/A	N/A	94.4% (865/916)	96.2% (2185/2272)	From March 2020, due to dental college requirements related to COVID-19, only emergency/urgent clients were seen in the clinic. Implemented required infection prevention and control measures in Q3/Q4 2020, which increased the number of clients that could be seen.
% of OSDCP clients who received preventive Services[i]	N/A	N/A	2.6% (26/1010)	(II)	No preventive services provided after March 2020 due staff redeployment to the COVID-19 and dental college restrictions related to COVID-19.

Program Outcome Indicator	2019 Target	2019 Result	2020 Result	2021 Result	Comments
Food Safety Program Standard					
% of food premises that change from moderate-risk to high-risk based on annual risk categorization assessment[iii]	N/A	4.3% (70/1615)	0.3% (4/1370)	0% (0/1504)	Risk assessments are done once per year and continued throughout the pandemic.
% of food premises that change from high-risk to moderate-risk based on annual risk categorization assessment[iii]	N/A	14.9% (94/631)	0.5% (3/562)	0% (0/605)	Risk assessments are done once per year and continued throughout the pandemic.
% of Salmonella and E. Coli food-borne outbreaks investigated for which a probable source was identified[iii]	N/A	0%	0%	0%	There were no Salmonella or E. Coli food-borne outbreaks investigated in 2019, 2020 or 2021.
Incidence of reportable foodborne illness cases for Salmonella[iii]	N/A	67	38	40	Case incidence is trending downwards since 2019. Health seeking behaviors is generally low for mild to moderate gastrointestinal symptoms, leading to an underestimation of true disease burden. The COVID-19 pandemic may have decreased health seeking further due to restrictions or attributing symptoms to a COVID infection. Salmonellosis is commonly linked to frozen raw breaded chicken products; on April 1, 2019 the CFIA introduced new control measures for manufacturers to address the risks associated with these products.

Program Outcome Indicator	2019 Target	2019 Result	2020 Result	2021 Result	Comments
Incidence of reportable foodborne illness cases for Campylobacter[iii]	N/A	64	47	80	Case incidence is trending upwards since 2019. Lower incidence in 2020 may be due to COVID-19 pandemic impacts on testing and reporting. Public Health Inspectors have noticed an increase in severity of disease for those diagnosed with campylobacter.
Incidence of reportable foodborne illness cases for E. Coli[iii]	N/A	3	0	10	Case incidence is trending upwards since 2019.
Healthy Environments Program Standard					
% of assigned milestones completed from the Air Quality Task Force Action Plan 2019[i]	20%	28.6% (4/14)	⏸	⏸	Target met in 2019. No progress made in 2020 and 2021 due to COVID-19.
% of assigned milestones completed from the Bay Area Climate Change Partnership project[i]	100%	83.3% (5/6)	100% (6/6)	-	Target met by end of 2020.
% of radon kits distributed to the public[i]	100%	44.4% (444/1,000)	⏸	⏸	Target unmet in 2019. Distribution was part of the Radon Prevalence Study. To increase participation/uptake, another campaign was planned from Q2 2020. No progress made in 2020 and 2021 due to COVID-19.

Program Outcome Indicator	2019 Target	2019 Result	2020 Result	2021 Result	Comments
Healthy Growth and Development Program Standard					
% of available breastfeeding support appointments that are accessed	N/A	83.6% (838/1002)	89% (154/174)	81% (146/181)	In 2019, breastfeeding support was provided solely through face-to-face appointments. In 2020 shifted to rate of completion instead of rate of available visits due to staff redeployment to the COVID-19 emergency response, which limited # available visits. Home visits suspended during COVID, shifted to virtual scheduled visits.
# of Breastfeeding Support "Significant Interactions" (By interaction type)[i]	N/A	468 phone calls, 122 emails	1169 phone calls, 609 emails, 138 consults/other communications	922 phone calls, 454 emails, 68 consults/other communications	Main intervention in 2019 was face to face home visiting. Due to staff redeployment to COVID-19 emergency response in 2020 and 2021, 1:1 breastfeeding support shifted to telephone and email only.
% of pregnant women in Hamilton who registered for PHS prenatal class out of the total number of women who gave birth[i]	N/A	7.3% (417/5740)	25.7% (1433/ 5585)	26.6% (1571/ 5910)	Face to face prenatal classes were suspended in 2020 due to COVID-19. Delivery of prenatal education was solely through online prenatal education program throughout 2020 and 2021.
% of client participants with any increased knowledge, skills and/or confidence on all session objectives following group sessions[i]	90%	93.6% (1,031/1,101)	⏸	⏸	Target met in 2019. No progress made in 2020 and 2021 due to COVID-19.
% of pregnant women screened out of the total # of residents who gave birth in Hamilton[i]	15%	11% (557/5091)	12% (605/4884)	17.5% (894/5116)	Target unmet in 2019 and 2020, met in 2021.

Program Outcome Indicator	2019 Target	2019 Result	2020 Result	2021 Result	Comments
% of clients confirmed as high risk who were referred to blended home visiting[i]	90%	100% (573/573)	100% (468/468)	100% (434/434)	Target met in 2019, 2020 and 2021.
% of clients who complete the full 2+ year program (Nurse Family Partnership)[i]	40%	45% (20/44 clients enrolled in 2017)	45% (23/51 clients enrolled in 2018)	43% (18/42 clients enrolled in 2019)	Target met in 2019, 2020 and 2021.
# of CPNP/Prenatal Nutrition program new client registrations[i]	N/A	298	203	281	CPNP suspended in person groups in March 2020, moved to individual phone contacts only and mailouts of educational materials and program incentives including grocery gift cards.
# of Health Connections Phone Line calls completed[i]	N/A	_	2777 calls (1069 for breastfeeding support)	2086 calls (863 for breastfeeding support)	
Immunization Program Standard					
% of 7-year olds whose vaccinations are up-to-date for all Immunization of School Pupils Act (ISPA) designated diseases[iii]	N/A	86.4%[ii]	N/A	N/A	Data not released by Public Health Ontario (PHO) for 2019/2020 and 2020/2021 school years.
% of 17-year olds whose vaccinations are up-to-date for all Immunization of School Pupils Act (ISPA) designated diseases[iii]	N/A	66.4%[ii]	N/A	N/A	Data not released by Public Health Ontario (PHO) for 2019/2020 and 2020/2021 school years.
% of grade 7 students whose vaccinations are up-to-date for hepatitis B (12 and 13-year olds)[iii]	N/A	70.3%[ii]	14.3%[ii]	21.9%[ii]	Vaccination coverage is trending downwards. As a result of the COVID-19 pandemic, there has been limited public health capacity

Program Outcome Indicator	2019 Target	2019 Result	2020 Result	2021 Result	Comments
% of grade 7 students whose vaccinations are up-to-date for meningococcal (12 and 13-year olds)[iii]	N/A	86.5%[ii]	79.8%[ii]	19.1%[ii]	to deliver school-based immunization programs, as well as to enter and assess immunization records. Immunization coverage estimates for the 2019-20 and 2020-21 school years are substantially lower than in previous school years.
% of grade 7 students whose vaccinations are up-to-date for HPV (12 and 13-year olds)[iii]	N/A	61.2%[ii]	1.2%[ii]	0.5%[ii]	
Infectious and Communicable Disease Prevention and Control Program Standard					
Incidence rate of Hepatitis C[iii]	N/A	35.9	21.4	23.9	The hepatitis C incidence rate is trending downwards. Hepatitis C disproportionately affects persons who inject drugs. Although services for provision of harm reduction supplies continued throughout the pandemic, access to testing for this at-risk population decreased during the pandemic. Decrease in testing could have contributed to a lower incidence rate of hepatitis C.
Incidence rate of Gonorrhea[iii]	N/A	86.0	80.6	88.9	Incidence rate of Gonorrhea infections is stable with a slight increase in 2021 compared to 2019. Due to staff redeployment to the COVID 19 emergency response, HPHS closed several of their sexual health clinics. However, many local organizations continued to offer in person and barrier free care.

Program Outcome Indicator	2019 Target	2019 Result	2020 Result	2021 Result	Comments
Incidence rate of Syphilis[iii]	N/A	17.4	26.7	40.2	The syphilis incidence rate is trending upwards. Rates of infectious syphilis have increased in both males and females and is highest among individuals aged 30 to 39 years old. The general increase in syphilis rates could be attributed to many factors such as: a decrease in sexual health promotion campaigns during the COVID-19 response, a lack of awareness of this emerging disease by the general population, and widespread uptake of HIV PrEP.
# and % of active respiratory Tuberculosis (TB) cases that complete recommended treatment[iii]	N/A	Case Count = 6 % = 100%	Case Count = 4 % = 100%	Case Count = 3 % = 100%	Percentage of TB cases completing treatment within the report year is high and stable. Due to low case counts, interpret with caution. Active TB cases are followed by case managers for the duration of treatment. In 2020 Hamilton Public Health implemented Video Directly Observed Therapy (DOT) for active TB cases. Implementation has been overall successful and well received by clients.
Safe Water Program Standard					
% of Class A pools with no critical infractions[iii]	N/A	39.13% (18/46)	63.04% (29/46)	47.83% (22/46)	Most critical infractions are due to seasonal pre-opening inspections and infractions must be corrected prior to opening for the season.

Program Outcome Indicator	2019 Target	2019 Result	2020 Result	2021 Result	Comments
% of Class B pools with no critical infractions[iii]	N/A	56.25% (36/ 64)	25.37% (17/ 67)	26.87% (18/67)	Most critical infractions are due to seasonal pre-opening inspections and infractions must be corrected prior to opening for the season.
% of spas with no critical infractions[iii]	N/A	23.53% (4/17)	50.00% (9/18)	77.78% (14/18)	Education and resources provided by inspectors to operators may have improved inspection outcomes.
% of wading pools with no critical infractions[iii]	N/A	100% (6/6)	40% (2/5)	100% (5/5)	Critical infractions in 2020 were due to construction upgrades and infractions were corrected prior opening.
% of splash pads with no critical infractions[iii]	N/A	100% (62/62)	100% (66/66)	100% (64/64)	
School Health Program Standard					
% of high-risk schools where portable preventive dental services were delivered in school[i]	43%	66.7% (4/6)[ii]	⏸	⏸	Target met for 2019. No progress made in 2020 and 2021 due to COVID-19.
% of JK, SK and grade 2 students who received an oral health assessment in all publicly funded schools[i]	89%	61.4% (9385/ 15292)[ii]	⏸	⏸	Target unmet for 2019; measure based on school year 2019/2020 and program paused in March 2020 due to COVID-19. No progress made in 2020 and 2021 due to COVID-19.

Program Outcome Indicator	2019 Target	2019 Result	2020 Result	2021 Result	Comments
% of Healthy Smiles Ontario (HSO) clients who cancelled/did not show up to clinic appointment[i]	<20%	19.5% (391/2,002)	17.4% (81/466)	8.5% (28/30)	Target met for 2019, 2020 and 2021. Preventive clinics closed April 2020, due COVID-19 (staff redeployment and dental college restrictions). Only emergency and urgent treatment services provided at HPHS downtown dental clinic. Enrollment continued so HSO clients could see a dentist in the community.
% of SK students who received a vision health assessment (screening) in all publicly funded schools[i]	N/A	99.3% (3044/ 3064)[ii]	⏸	⏸	No progress made in 2020 and 2021 due to COVID-19.
% of students who did not pass the screening tests and require a full Comprehensive Eye Examination after vision screening[i]	N/A	61.5% (3044/ 4951)[ii]	⏸	⏸	No progress made in 2020 and 2021 due to COVID-19.
Substance Use and Injury Prevention Program Standard					
% of partner organizations who are satisfied with the Hamilton Drug Strategy[i]	90%	89.0% (65/73)	⏸	⏸	Target unmet in 2019. The Hamilton Drug Strategy partner satisfaction survey was scheduled to be completed annually. No progress made in 2020 and 2021 due to COVID-19.

Program Outcome Indicator	2019 Target	2019 Result	2020 Result	2021 Result	Comments
% of eligible external stakeholders providing naloxone through the Ontario Naloxone Program (ONP)[i]	40%	41.9% (13/31)	54.8% (17/31)	61.2% (19/31)	Target met in 2019, 2020 and 2021. PHS is the administrator of the ONP in Hamilton. PHS works with the Ministry to onboard eligible organizations. Eligibility is based on ministry-defined criteria.
% of Needle Exchange Van service requests that were responded to[i]	100%	84.6% (3,839/4,538)	86.4% (4053/4690)	90.1% (3120/3464)	Target unmet. Call volume demand for van services during the evening shift continues to exceed capacity and in addition the Van experienced service interruptions in 2020 and 2021 as a result of COVID-19.
% of needles distributed that are returned to the harm reduction program[i]	58%	47.0% (538,049/ 1,145,080)	62.5% (650,718/ 1,040,258)	89.46% (796,077/ 889,836)	Target unmet in 2019. Target met in 2020 and 2021. PHS continues to promote needle exchange within the community, including the addition of community disposal bins and health promotion.
# of needles given out in Harm Reduction Program[i]	N/A	1,386,411	1,040,258	889,836	Decrease in 2020 and 2021 due to impact of COVID-19 pandemic with decrease in service provider hours and public availability, in addition to local shift in preference to inhalation as method of administration over injection.

Program Outcome Indicator	2019 Target	2019 Result	2020 Result	2021 Result	Comments
% of tobacco retailers in compliance with display, handling and promotion sections of the Smoke-Free Ontario Act (SFOA, 2017) at time of last inspection[i]	N/A	96.5% (110/114)	⏸	⏸	No progress made in 2020 and 2021 due to COVID-19.
% of vapour product retailers in compliance display, handling and promotion sections of the Smoke-Free Ontario Act (SFOA, 2017) at time of last inspection[i]	97%	95.0% (286/301)	⏸	⏸	Target unmet in 2019. Vapour product retailers may have be non-compliant due to learning curve of new legislation (SFOA, 2017). PHS re-inspects those retailers that are non-compliant. No progress made in 2020 and 2021 due to COVID-19.
% of tobacco vendors in compliance with youth access legislation at the time of last inspection[i]	90%	90.3% (650/720)	⏸	⏸	Target met in 2019. No progress made in 2020 and 2021 due to COVID-19.
% of vapour product vendors in compliance with youth access legislation at the time of last inspection[i]	90%	89.2% (290/325)	⏸	⏸	Target unmet in 2019. Vapour product retailers may be non-compliant due to learning curve of new legislation (SFOA, 2017). PHS re-inspects those retailers that are non-compliant. No progress made in 2020 and 2021 due to COVID-19.
% of targeted schools that received a presentation on injury prevention[i]	100%	35.1% (13/37)	⏸	⏸	Target Unmet in 2019. This may have been impacted by the work to rule situation schools experienced in Q3/Q4 of 2019. No progress made in 2020 and 2021 due to COVID-19.

Program Outcome Indicator	**2019 Target**	**2019 Result**	**2020 Result**	**2021 Result**	**Comments**
Percent of injury prevention Age Friendly Plan recommendations completed with partners in the Age Friendly Collaborative Governance Committee and its working groups[i]	100%	100% (3/3)	⏸	⏸	Target met in 2019. No progress made in 2020 and 2021 due to COVID-19.

[i] Locally defined indicator.
[ii] Represents school year of September to June, rather than calendar year.
[iii] Ministry defined indicator.

2021 Financial Actuals for Ministry of Health Funded Programs under the Ontario Public Health Standards (Provincial Portion)

As part of the Ministry of Health 2021 Annual Report and Attestation, boards of health are required to provide financial year-end actuals for each Ministry funded program delivered for the period of January 1, 2021 to December 31, 2021.

Base Funding:

1. **Mandatory Programs – Cost-Shared (70% provincially funded / 30% levy funded)**: The Ministry granted **$26,725,400** as the 70% provincial contribution in 2021 to support the delivery of programs and services under the Standards (Mandatory Programs). Overall, mandatory programs were underspent due to staff being redeployed to COVID and/or staff hiring issues. As per Ministry direction, expenditures from the COVID-19 General Program were claimed under Mandatory Programs to fully spend funding. Of the $26,725,400 in funding, **$13,722,780** was spent on mandatory programs, and **$13,002,620** was spent on the COVID-19 General Program. The City of Hamilton contributed $11,363,720 to support the delivery of Mandatory Programs.

2. **Ontario Seniors Dental Care Program (100% provincially funded)**: This program was underspent due to staff being redeployed to COVID and/or staff hiring issues, the Ministry approved a total of **$2,248,100**. Actual expenditures were **$1,709,331**, with **$538,769** to be recovered by the Ministry.

One-Time Funding:

Several one-time 100% funding opportunities were approved. The timelines for these were either January 1, 2021 to December 31, 2021 or April 1, 2021 to March 31, 2022. Boards of Health are required to report actuals for both timelines up to December 31, 2021.

1. **Cost-Sharing Mitigation:**
   For the period of January 1 to December 31, 2021, the Ministry granted **$2,215,800** in one-time mitigation funding to offset the increased costs of municipalities as a result of the 70% (provincial) / 30% (municipal) cost-sharing change for mandatory programs from a mixed 75/25% and 100% funding model prior to 2020, which was fully claimed.

2. **COVID-19: General Program (Non-Vaccine):**
   For the period of January 1 to December 31, 2021, HPHS requested **$12,066,390** to reimburse extraordinary costs above the ASPB subsidized expenditures associated with COVID-19 case and contact management, outbreak management, infection prevention and control, and surveillance. The Ministry granted **$4,990,000**. Of the **$22,358,287** of actual expenditures, **$20,700,948** was claimed under the Mandatory program as stipulated by the Ministry of Health. This left expenditures of **$1,657,339** to be claimed under COVID-19 General Program, with **$3,332,661** to be recovered by the Ministry.

3. **COVID-19: Vaccine Program:**
   For the period of January 1 to December 31, 2021, HPHS requested **$34,461,200** to reimburse extraordinary costs above the ASPB subsidized expenditures associated with the planning and implementation of the COVID-19 vaccine program. The Ministry granted $**23,921,700**. Actual expenditures were **$21,807,839**, with **$2,113,861** to be recovered by the Ministry.

4. **Raccoon Rabies Outbreak Response:**
   For the period of April 1, 2021 to March 31, 2022, HPHS requested **$216,830** to reimburse costs for response to raccoon rabies outbreak in the community. Eligible costs include salary and benefits for Public Health Inspector position(s). The Ministry granted **$54,300.** For the Annual Report reporting period of April 1,2021 to December 31, 2021, the actual expenditures were **$52,783**. At December 31st, 2021, there was an outstanding recoverable by the Ministry of **$1,517**. This Funding was is fully spent by March 2022.

5. **New Purpose-Built Vaccine Refrigerators:**
   For the period of April 1, 2021 to March 31, 2022, HPHS requested **$225,350** to purchase two (2) 25 cu. ft. and seven (7) 55 cu. ft. new purpose-built vaccine refrigerators used to store publicly funded vaccines. The Ministry granted **$188,600**. For the Annual Report reporting period of April 1, 2021 to December 31, 2021 actual expenditures were **$0.** The balance of actual expenditures in January-March 2022 was **$123,145**, with **$65,455** to be recovered by the Ministry after the 2022 Settlement is submitted to the Ministry sometime in June 2023.

6. **Public Health Inspector Practicum Program:**
   For the period of April 1, 2021 to March 31, 2022, HPHS requested **$10,000** to hire Public Health Inspector Trainees for program support and to provide future Public Health Inspectors with training and hands-on field experience. This funding has been in place for many years and must be requested annually. The Ministry granted **$30,000**, which is fully spent.

7. **Ontario Seniors Dental Care Program Capital: Mobile Dental Clinic Bus**:
   To expand the mobile clinical service capacity with a 9-foot ADI wheelchair accessible Mobile Dental Clinic (bus). The bus was received in March 2021. For the period of April 1, 2021 to March 31, 2022, the Ministry granted **$40,000** to complete the project. For the Annual Report reporting period of April 1, 2021 to December 31, 2021, actual expenditures were **$21,937**, with **$18,063** to be recovered by the Ministry.

8. **School-Focused Nurse Initiative:**
   For the funding period of April 1, 2021 to March 31, 2022, the Ministry granted **$2,300,000** to support additional nursing FTE capacity to provide rapid-response support to school boards and schools in facilitating Public Health and preventative

measures related to the COVID-19 pandemic. For the Annual Report reporting period of April 1, 2021 to December 31, 2021, actual expenditures were **$1,733,862.** The balance of actual expenditures in January to March 2022 was **$566,138**, so funding is fully spent.