Board of Health for the
Peterborough County-City Health Unit
AGENDA
Board of Health Meeting
Wednesday, December 9, 2015 – 5:30 p.m.
Dr. J. K. Edwards Board Room, 3rd Floor
Peterborough County-City Health Unit
Jackson Square, 185 King Street, Peterborough

1. Call to Order

~ Recognition of Traditional Territory ~

1.1. **Welcome to New PCCHU Board Member:**
Councillor Art Vowles, Hiawatha First Nation

1.2. **Commemoration of Dr. J. K. Edwards Board Room**

2. Confirmation of the Agenda

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

5. Confirmation of the Minutes of the Previous Meeting

5.1. **November 11, 2015 (p. 4)**

6. Business Arising From the Minutes

6.1. **Request for Correspondence to City and County Councils regarding the Public Health Funding Review and 2015 PCCHU Cost-Shared Budget**
Larry Stinson, Interim Director, Corporate Services
Reference: Item 8 (M-2015-140) and Item 8.2.c (M-2015-142)

7. Staff Reports

7.1. **Staff Presentation: Proposed Food Label Changes (p. 12)**
Luisa Magalhaes, Registered Dietitian

7.2. **Staff Presentation: Child Health Status Report (p. 20)**
Andrew Kurc, Epidemiologist
Gail Chislett, Health Promoter
Reference Documents:
Summary (p. 35)
Infographic (p. 52)

7.3. **Staff Report: 2016 Cost-Shared Budget Approval (p. 53)**
Bob Dubay, Manager, Accounting

8. Consent Items

All matters listed under Consent Items are considered to be routine, housekeeping, information or non-controversial in nature and to facilitate the Board's consideration can be approved by one motion.

Board Members: *For your convenience, circle the items you wish to consider separately:*
8.1b 8.2a 8.3a

8.1. **Correspondence**

a. Correspondence for Direction

b. Correspondence for Information (p. 57)

8.2. **Staff Reports**

a. Staff Report: Dental Integration (p. 86)
Sarah Tanner, Manager, Oral Health

8.3. **Committee Reports**

a. Committee Report: Governance (p. 90)
Scott McDonald, Chair, Governance Committee

~ BREAK / TOUR OF JACKSON SQUARE ~

9. New Business

10. In Camera to Discuss Confidential Matters

In accordance with the Municipal Act, 2001:
- Section 239(2)(a) the security of the property of the municipality or local board;
- Section 239(2)(d) labour relations or employee negotiations;

11. a2tions for Open Sesǎ2y

12. Date, Time, and Place of the Next Meeting

Date: January 13, 2015
Dr. J. K. Edwards Board Room, 3rd Floor, Peterborough County-City Health Unit, Jackson Square, 185 King Street, Peterborough

13. Adjournment

ACCESSIBILITY INFORMATION: The Peterborough County-City Health Unit is committed to providing information in a format that meets your needs. To request this document in an alternate format, please call us at 705-743-1000.

Board of Health for the
Peterborough County-City Health Unit
DRAFT MINUTES
Board of Health Meeting
Wednesday, November 11, 2015 – 4:45 p.m.
Board Room, Peterborough County-City Health Unit
10 Hospital Drive, Peterborough

In Attendance:

Board Members:	**Councillor Lesley Parnell, Chair**
	Mr. Scott McDonald, Vice Chair
	Deputy Mayor John Fallis
	Mr. Gregory Connolley
	Ms. Kerri Davies
	Councillor Henry Clarke
	Councillor Gary Baldwin
	Mayor Mary Smith
	Councillor Trisha Shearer
Staff:	**Dr. Rosana Salvaterra, Medical Officer of Health**
	Ms. Alida Tanna, Administrative Assistant
	Mr. Larry Stinson, Interim Director, Corporate Services
	Ms. Natalie Garnett, Recorder
	Brittany Cadence, Supervisor, Communication Services
	Donna Churipuy, Manager, Environmental Health Program
	Patti Fitzgerald, Acting Director, Public Health Programs; Chief Nursing Officer; Manager, Sexual Health
Regrets:	**Mayor Rick Woodcock**
	Chief Phyllis Williams
	Mr. Andy Sharpe

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1. Call to Order

1.1. Closing Ceremony – 10 Hospital Drive

Councillor Parnell welcomed everyone and provided a short history of the building on 10 Hospital Drive.

Deputy Chief Keith Knott and Elder Merritt Taylor of Curve Lake First Nation provided a blessing of the building and land.

Dr. Rosana Salvaterra provided an overview of Dr. J. K. Edwards and his involvement with the building at 10 Hospital Drive.

Simon Lee, Public Health Inspector, presented a framed illustration of the commemorative plaque to the children of Dr. Edwards.

A bagpipe salute concluded the closing ceremony at 5:05 p.m.

Following a short break, Councillor Parnell called the meeting to order at 5:14 p.m.

1.2. **Recognition of Departing Board Member – Councillor Trisha Shearer, Hiawatha**

Councillor Shearer was recognized for her contributions to the Peterborough County-City Health Unit.

2. Confirmation of the Agenda

MOTION:
That the Agenda be approved as circulated.
Moved: Councillor Clarke
Seconded: Mr. McDonald
Motion carried. (M-2015-136)

3. Declaration of Pecuniary Interest

There were no declarations of Pecuniary Interest.

4. Delegations and Presentations

5. Confirmation of the Minutes of the Previous Meeting

5.1. **October 14, 2015**

MOTION:
That the minutes of the Board of Health meeting held on October 14, 2015, be approved as circulated.
Moved: Councillor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-137)

6. Business Arising From the Minutes

7. Staff Reports

8. Consent Items

MOTION:
That items 8.2.a, 8.2.b, 8.2.d, and 8.2.e 3 be approved as part of the Consent Agenda.
Moved: Councillor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-138)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the Q3 2015 Program Report for information.
Moved: Councillor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-138)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit receive the Q3 2015 Corporate Services Report for information.
Moved: Councillor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-138)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit approve the amended 2015 budgets funded 100% by the Ministry of Health and Long-Term Care and One-Time Funding as follows:

100% Funded Programs
Healthy Smiles Ontario - $427,300
Chief Nursing Officer - $121,500
Infection Prevention and Control Nurses - $90,100
Infectious Diseases Control - $222,300
Public Health Nurses - $180,500
Enhanced Safe Water - $15,500
Enhanced Food Safety (Haines) - $25,000
Healthy Communities Fund – Partnership Stream - $0
Smoke Free Ontario – $380,800

Electronic Cigarettes Act: Protection and Enforcement – $29,300

<u>One Time Funding Approvals – April 1, 2015 to March 31, 2016:</u>
Mandatory Program: Phone Server – $22,500
Capital: Facilities Renewal – $1,500,000
Mandatory Program: Dental Garage – $195,000
Immunization Clinics - $0
New Purpose-Built Vaccine Refrigerators – $19,000
Public Health Inspector Practicum Program – $10,000
Electronic Cigarettes Act: Protection and Enforcement – $29,300
Smoke-Free Ontario: Expanded Smoking Cessation – $22,500
Moved: Councillor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-138)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit approve the appointment of Dr. James R. Pfaff, former Associate Medical Officer of Health for the Simcoe Muskoka District Health Unit, as Acting Medical Officer of Health for the Peterborough County-City Health Unit, for the period of December 4 – 18, 2015.
Moved: Councillor Clarke
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-138)

<u>Other Items</u>

MOTION:
That the letter dated November 6, 2015 to the Hon. Helena Jaczek from the Board Chair regarding food security and the transformation of social assistance in Ontario also be circulated to the Hon. Amarjeet Sohi, Minister of Housing, the Hon. Jane Philpott, Minster of Health, the Hon. Maryam Monsef, Minister of Democratic Institutions, the Hon. Jean-Yves Duclos, Minster of Families, Children and Social Development, and the Hon. Patty Hajdu, Minister of the Status of Women.
Moved: Ms. Davies
Seconded: Mr. McDonald
Motion carried. (M-2015-139)

MOTION:
That the letter dated November 3, 2015 from the Association of Local Health Agencies to Minister Hoskins regarding the public health funding model be

circulated to the County of Peterborough and the City of Peterborough.
Moved: Deputy Mayor Fallis
Seconded: Ms. Davies
Motion carried. (M-2015-140)

MOTION:
That the following documents be received for information:

1. *Letter dated October 6, 2015 from Premier Wynne, in response to the Board Chair's original letter dated September 30, 2015, regarding the Northern Ontario Evacuations of First Nations Communities.*
2. *Letter dated October 8, 2015 from Dr. Pellizzari to Lorraine Fry, Executive Director Non-Smokers' Rights Association and Donna Kosmack, Manager, South West Tobacco Control Area Network, regarding the Board's endorsement of action for smoke-free multi unit housing.*
4. *Letter dated November 5, 2015 from Lynda Bumstead, Grey Bruce Health Unit, in response to her original letter September 30, regarding the Bruce Grey Food Charter.*
5. *Letter dated November 6, 2015 to the Lorne Coe, President, Association of Local Public Health Agencies from the Board Chair regarding electronic participation at board of health meetings.*
7. *Letter dated November 6, 2015 to the Hon. Tracy MacCharles from the Board Chair regarding results of the 2015 Nutritious Food Basket for the Peterborough County-City Health Unit.*
8. *Letter dated November 6, 2015 to Evelyn Vaccari and Lyndsay Davidson, Ontario Society of Nutrition Professionals in Public Health (OSNPPH), from the Board Chair regarding the Board's endorsement of the OSNPPH position statement on responses to food insecurity.*
9. *Resolutions/Letters from other local public health agencies:*
   a. *<u>Northern Ontario Evacuations of First Nations Communities</u>*
      Perth
   b. *<u>Smoke-Free Multi Unit Housing</u>*
      Northwestern

Moved: Deputy Mayor Fallis
Seconded: Ms. Davies
Motion carried. (M-2015-141)

8.2.c. **<u>Staff Reports and Presentations</u>**

MOTION:
That the Board of Health for the Peterborough City County Health Unit approve the amended 2015 provincial share of cost-shared budget for public health programs and services per the summary below:

Programs Funded Jan. 1 to Dec. 31, 2015
2015 Provincial Share of Budget Request - $6,148,732
2015 Provincial Share of Approved Budget - $6,006,200
Shortfall – ($142,532)

and that the report be forwarded the County and City Councils.

Moved: Deputy Mayor Fallis
Seconded: Mr. McDonald
Motion carried. (M-2015-142)

9. New Business

9.1 Staff Presentation: Day in the Life of the President of the Ontario Public Health Association

Larry Stinson, Interim Director, Corporate Services provided a presentation on the his role as President of the Ontario Public Health Association.

MOTION:
That the staff presentation "Day in the Life of the President of the Ontario Public Health Association" be received for information.
Moved: Councillor Baldwin
Seconded: Mayor Smith
Motion carried. (M-2015-143)

9.2 Staff Presentation: Ontario Association of Communicators in Public Health

Brittany Cadence, Manager, Communication Services provided a presentation on the Ontario Association of Communicators in Public Health.

MOTION:
That the staff presentation "Ontario Association of Communicators in Public Health" be received for information.
Moved: Councillor Baldwin
Seconded: Mayor Smith
Motion carried. (M-2015-144)

The meeting recessed at 6:05 p.m. and reconvened at 6:42 p.m.

9.3 Staff Presentation: Climate Change

Donna Churipuy, Manager, Environmental Health, provided a presentation on Climate Change.

MOTION:
That the staff presentation "Climate Change" be received for information.
Moved: Councillor Baldwin
Seconded: Mayor Smith
Motion carried. (M-2015-145)

10. In Camera to Discuss Confidential Personal and Property Matters

MOTION:
That the Board of Health for the Peterborough County-City Health Unit go In Camera to discuss one item under Section 239(2)(b) Personal matters about an identifiable individual, including municipal or local board employees, at 7:27 p.m.

Moved: Councillor Baldwin
Seconded: Mr. Connolley
Motion carried. (M-2015-146)

MOTION:
That the Board of Health for the Peterborough County-City Health Unit rise from In Camera at 7:46 p.m.
Moved: Councillor Baldwin
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-147)

11. Motions from In Camera for Open Session

12. Date, Time, and Place of the Next Meeting

MOTION:
That meetings of the Board of Health for the Peterborough County-City Health Unit begin at 5:30 p.m., and that these meetings be held at 185 King Street, 3rd Floor, Peterborough.
Moved by: Deputy Mayor Fallis
Seconded by: Mr. Connolley
Motion carried. (M-2015-148)

December 9, 2015 – J. K. Edwards Board Room, Peterborough County-City Health Unit, 185 King Street, 5:30 p.m.

13. Adjournment

MOTION:
That the meeting be adjourned.
Moved by: Deputy Mayor Fallis
Seconded by: Councillor Shearer
Motion carried. (M-2015-149)

The meeting was adjourned at 7:50 p.m.

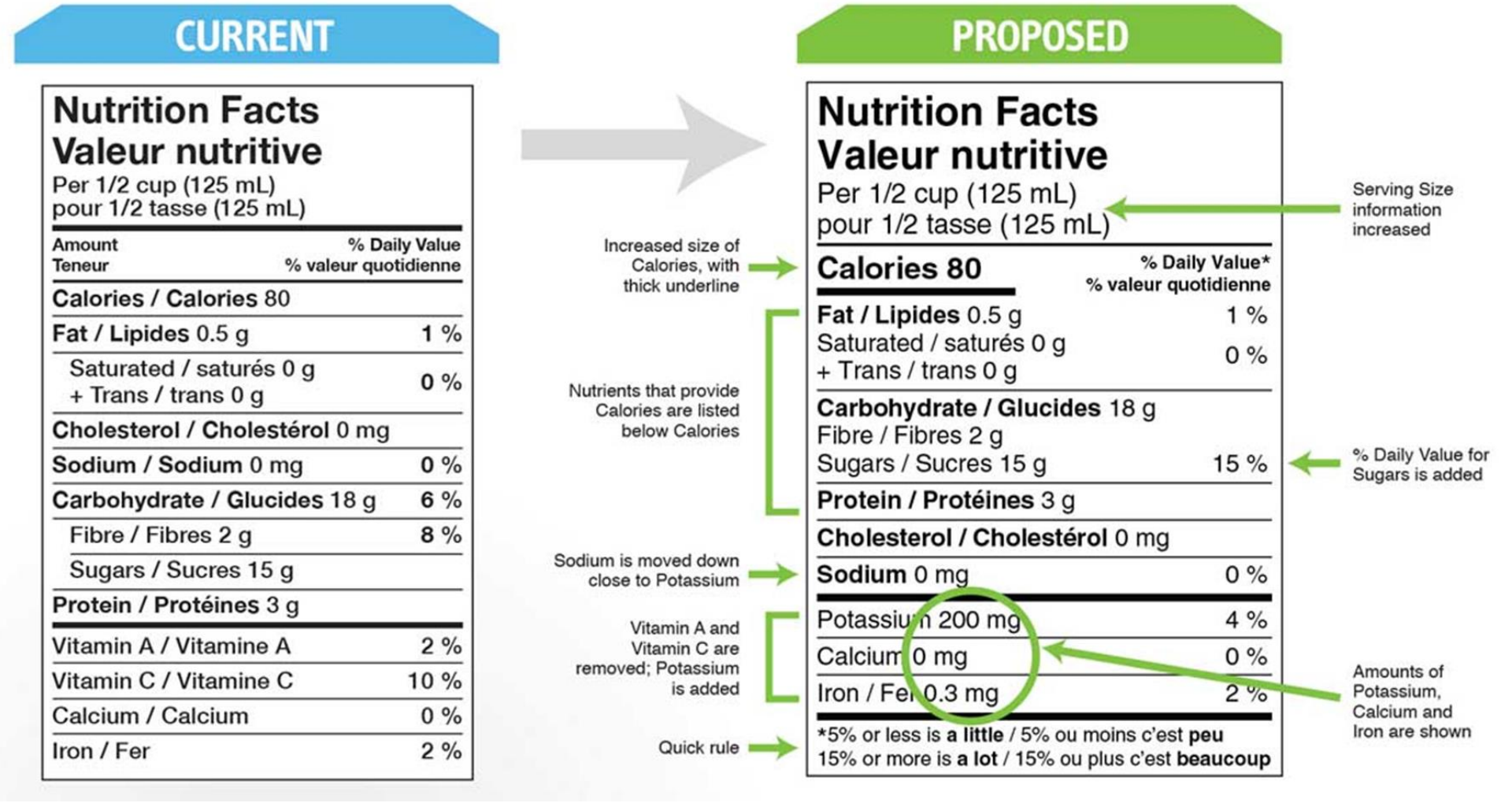
Chairperson

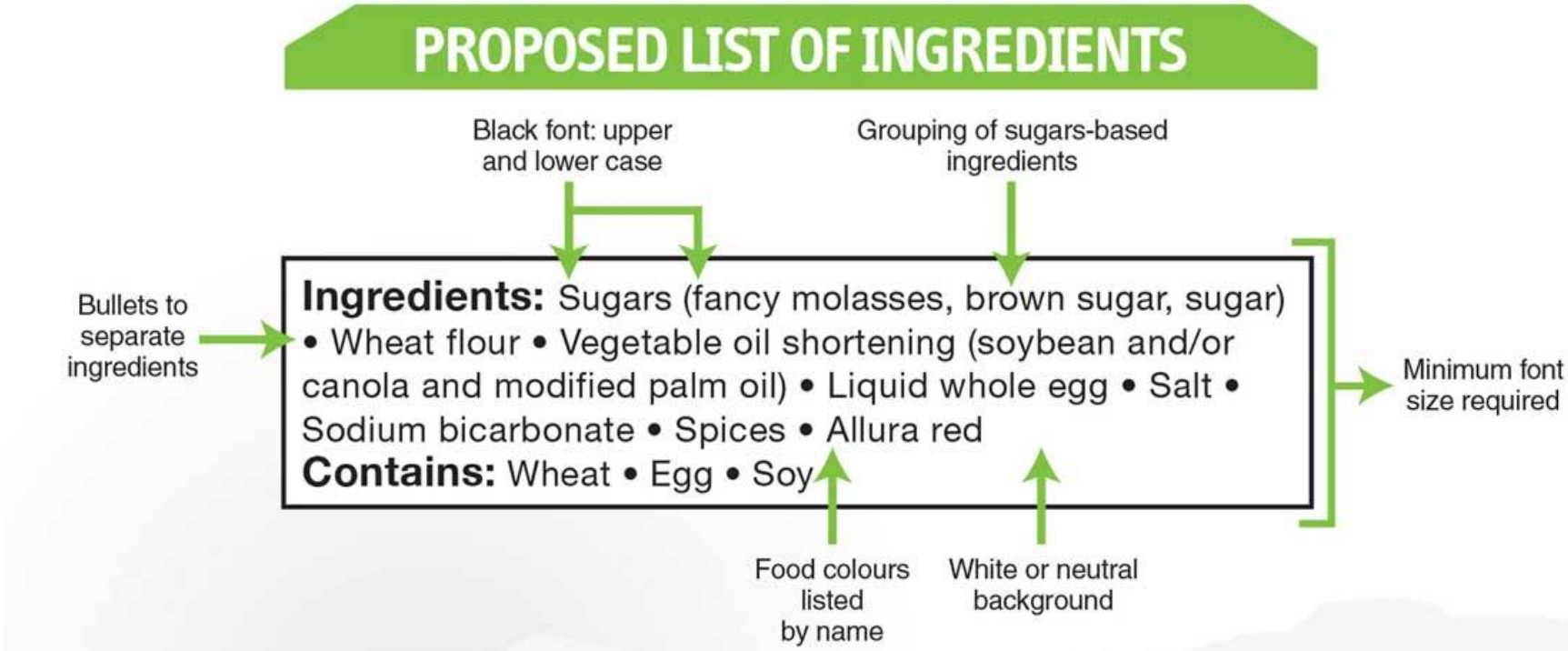
Medical Officer of Health

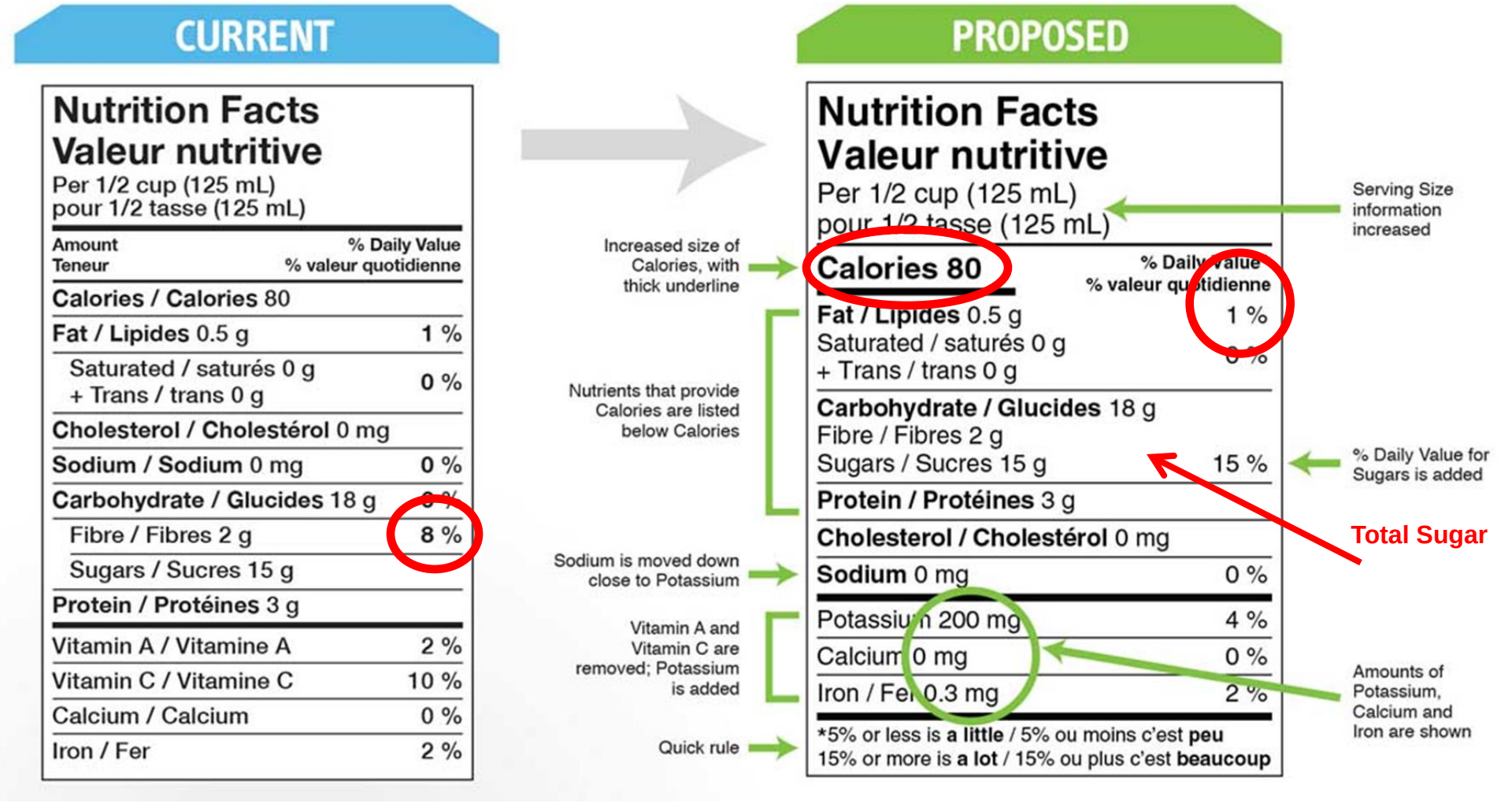
Proposed Food Label Changes

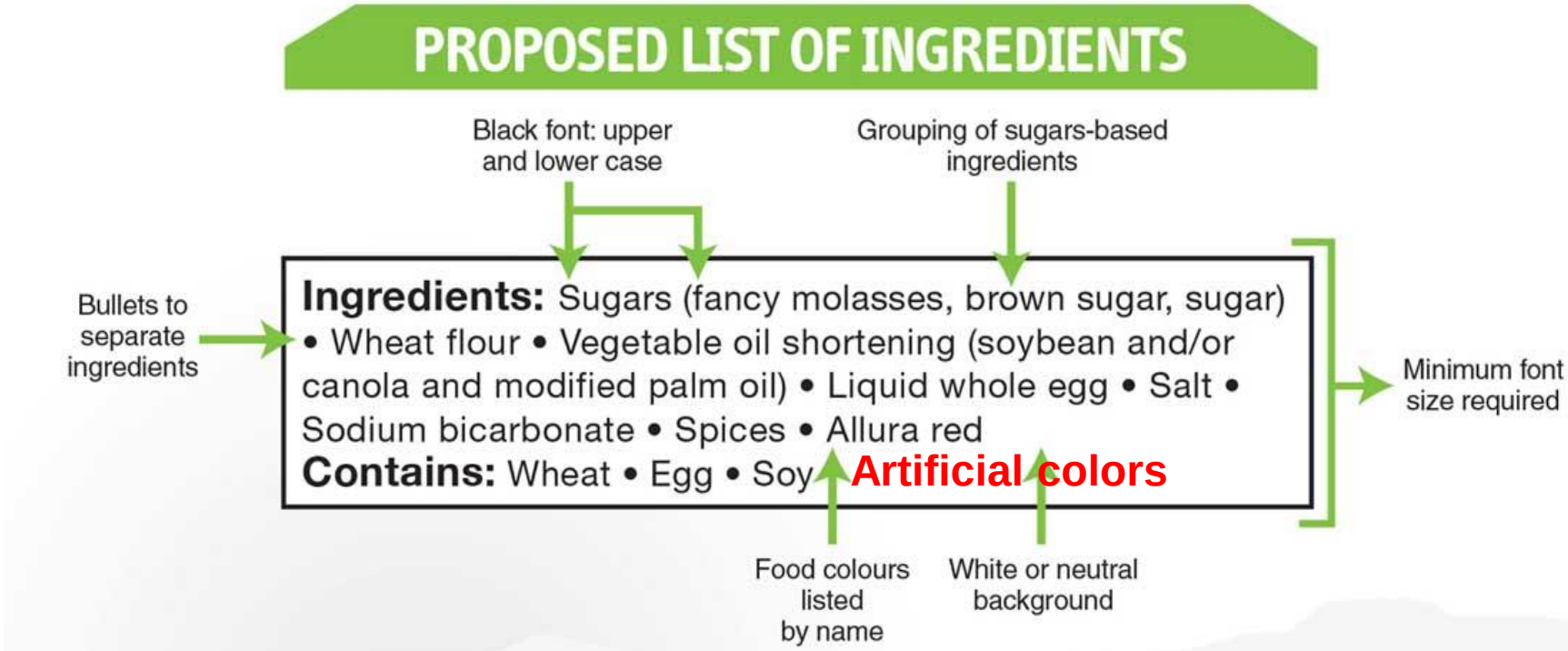
Presentation to: Board of Health
By: Luisa Magalhaes, RD, MHSc
Public Health Nutritionist,
Community Health Program
Date: December 9, 2015

NOTICE: Proposed recommendations as noted within the posted agenda package may not be indicative of the final decision made by the Board of Health at the meeting. Should a member of the public or media outlet wish to confirm or clarify any Board position following the meeting, please contact the PCCHU Communications Supervisor or refer to the meeting summary issued shortly thereafter. Final motions are recorded in posted approved Minutes.






CURRENT
Nutrition Facts
Valeur nutritive
Per 1/2 cup (125 mL)
pour 1/2 tasse (125 mL)
Amount Teneur
% Daily Value % valeur quotidienne
Calories / Calories 80
Fat / Lipides 0.5 g 1 %
Saturated / saturés 0 g + Trans / trans 0 g 0 %
Cholesterol / Cholestérol 0 mg
Sodium / Sodium 0 mg 0 %
Carbohydrate / Glucides 18 g
Fibre / Fibres 2 g 8 %
Sugars / Sucres 15 g
Protein / Protéines 3 g
Vitamin A / Vitamine A 2 %
Vitamin C / Vitamine C 10 %
Calcium / Calcium 0 %
Iron / Fer 2 %
PROPOSED
Nutrition Facts
Valeur nutritive
Per 1/2 cup (125 mL)
pour 1/2 tasse (125 mL)
Calories 80
% Daily Value
% valeur quotidienne
Fat / Lipides 0.5 g 1 %
Saturated / saturés 0 g
+ Trans / trans 0 g
Carbohydrate / Glucides 18 g
Fibre / Fibres 2 g
Sugars / Sucres 15 g 15 %
Protein / Protéines 3 g
Cholesterol / Cholestérol 0 mg
Sodium 0 mg 0 %
Potassium 200 mg 4 %
Calcium 0 mg 0 %
Iron / Fer 0.3 mg 2 %
*5% or less is a little / 5% ou moins c'est peu
15% or more is a lot / 15% ou plus c'est beaucoup
Increased size of Calories, with thick underline
Nutrients that provide Calories are listed below Calories
Sodium is moved down close to Potassium
Vitamin A and Vitamin C are removed; Potassium is added
Quick rule
Serving Size information increased
% Daily Value for Sugars is added
Total Sugar
Amounts of Potassium, Calcium and Iron are shown



Placing mandatory nutrition information (i.e., calories and sugar) on all alcoholic beverages

Implications for PCCHU

- Assess our capacity to facilitate education piece
- Target education initiatives to childcare staff, Student Nutrition Program coordinators, families, individuals

Health Canada Santé Canada

Health Canada
www.hc-sc.gc.ca

EatRight Ontario

Report on Child Health 2015

for more information and references
www.pcchu.ca

WHY WORRY?

"Some parents shoulder a burden of multiple challenges which results in more adverse child outcomes and increases the likelihood of the next generation being similarly affected." Dr. Rosana Salvaterra, Medical Officer of Health

Key Findings: Literature

Significant influences in child health, growth and development:

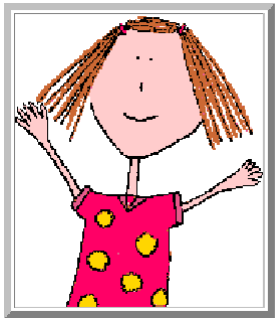
- **the prenatal and early years**
- **the family**
- **the socio-ecological context**
- **the social determinants of health**

Birth to Five: The CRITICAL Years for:

- **brain development**
- **mental health** throughout the lifespan
- **empathy, socialization, attachment, and responsiveness**
- **physical**, **socio-emotional, language, and cognitive outcomes**
- vulnerability to **deprivation, risk, and adversity**
- paving the way for **chronic diseases of adulthood**
- **investment** to counteract negative outcomes and boost adult health

Likely to thrive?

More



- Higher levels of parental education
- Adequate housing
- Sufficient food and finances
- Nuturing, stimulating home environment

Less

- Poverty
- Inadequate housing
- Food insecurity
- Unemployment
- Low education
- Lone parent
- Teen parent

Birth to Five: The CRITICAL Years

The first years of a child's life are critical for health, growth, and development, and lay the foundation for adult health. Children are more likely to thrive when their parents: provide a nurturing and stimulating home environment; have access to sufficient food and finances; have adequate housing; and have higher levels of formal education.

Peterborough County-City HEALTH UNIT ...because health matters!

FAMILY TYPE

Most of the 5,440 Peterborough* families with children 0-5 years of age are couples (80%), however in the City, 25% are lone parents. (2010)

Singles or Couples

with children 0-5

Children in lone parent families are at increased risk for poorer: vocabulary, school achievement, behaviour, and mental health.

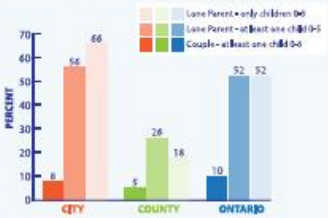
FAMILY INCOME

Nine out of ten couple families have middle to high income status. Low income disproportionately affects lone parents living in the City. (2005)

Low Income Families

with children 0-5

Children living in poverty are at increased risk for poorer: development, school achievement, behaviour, and health.



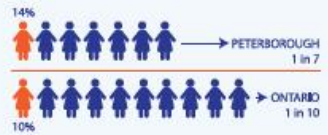
EMPLOYMENT

Unemployment rates for female lone parents with young children are higher than those for their male counterparts. (2005)

Unemployed Female Lone Parents

with children 0-5

Children with unemployed parents are at increased risk for poorer: social competency, behaviour, and mental health.



Report on Child Health 2015

for more information and references
www.pcchu.ca

WHY WORRY?

"Some parents shoulder a burden of multiple challenges which results in more adverse child outcomes and increases the likelihood of the next generation being similarly affected." Dr. Rosana Salvaterra, Medical Officer of Health

FOOD SECURITY

Female lone parent families living in poverty likely suffer the most food insecurity. (2011/2012)

Food Insecure Households

with children 0-17

Children experiencing food insecurity are at increased risk for poorer: development, behaviour, health, and mental health.

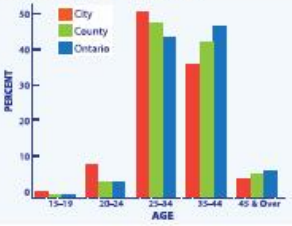
PARENTAL AGE

While only 8% of parents are under the age of 25, twice the proportion of young parents live in the City compared to the County. (2010)

Age Groups

parents with children 0-5

Children with parents 15-19 are at increased risk for poorer: development, language skills, school readiness, and school achievement.



MATERNAL EDUCATION

Most Peterborough mothers of young children have post-secondary education. However, 31% of female lone parents in the City and 15% in the County have not completed high school. (2005)

School Completion

mothers with children 0-5

Children whose mothers have little formal education are at increased risk for poorer: development, behaviour, and school achievement.

HOUSING

Affordable housing costs less than 30% of before-tax income, and is a big challenge for lone parent and low income families with children. (2005)

Unaffordable Housing

Children living in inadequate housing are at increased risk for poorer: growth, development, school achievement, and health.

*"Peterborough" includes the City and the County of Peterborough. The term "parent" includes all primary caregivers within the child's home.

November 2015

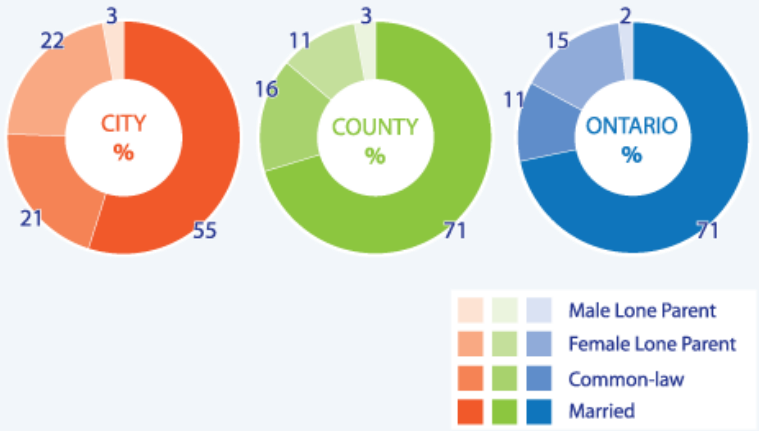
Lone parents

FAMILY TYPE

Most of the 5,440 Peterborough* families with children 0-5 years of age are couples (80%), however in the City, 25% are lone parents. (2010)

Singles or Couples
with children 0-5

Children in lone parent families are at increased risk for poorer: vocabulary, school achievement, behaviour, and mental health.



Key Findings

Lone parents with young children are disproportionately represented in the City.

Many lone-parents struggle with poverty, unemployment, and low education.

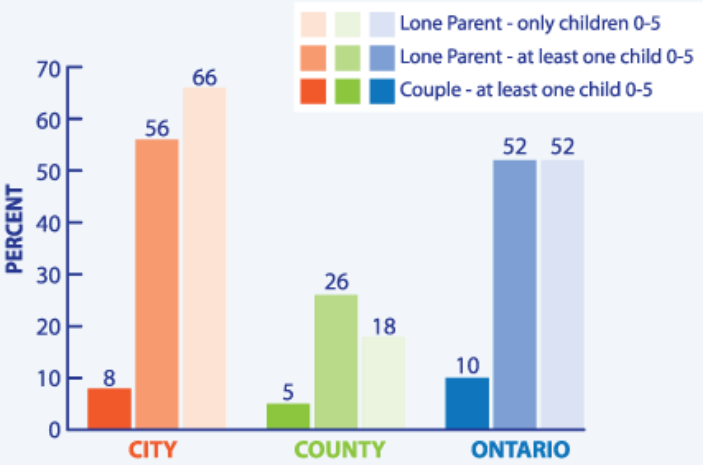
Low income

FAMILY INCOME

Nine out of ten couple families have middle to high income status. Low income disproportionately affects lone parents living in the City. (2005)

Low Income Families
with children 0-5

Children living in poverty are at increased risk for poorer: development, school achievement, behaviour, and health.



Key Findings

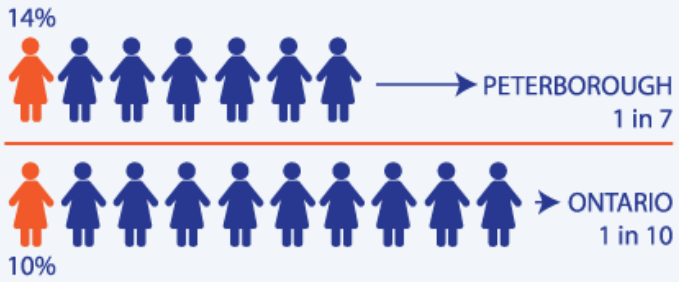
Low income disproportionately affects lone parents with young children living in the City.

Unemployed

EMPLOYMENT

Unemployment rates for female lone parents with young children are higher than those for their male counterparts. (2005)

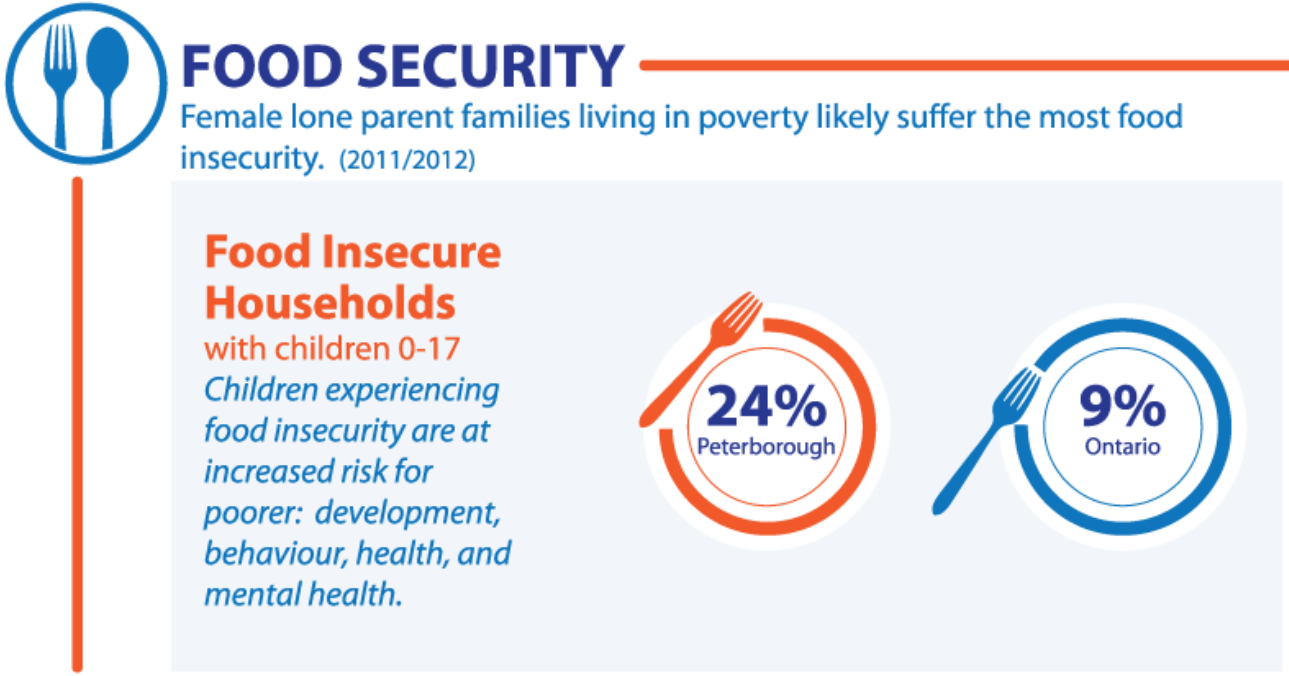
Unemployed Female Lone Parents
with children 0-5
Children with unemployed parents are at increased risk for poorer: social competency, behaviour, and mental health.



Key Findings

Unemployment affects a significant proportion of female lone-parent families.

Food insecure



Key Findings

Food insecurity is an issue for parents.

Young parents

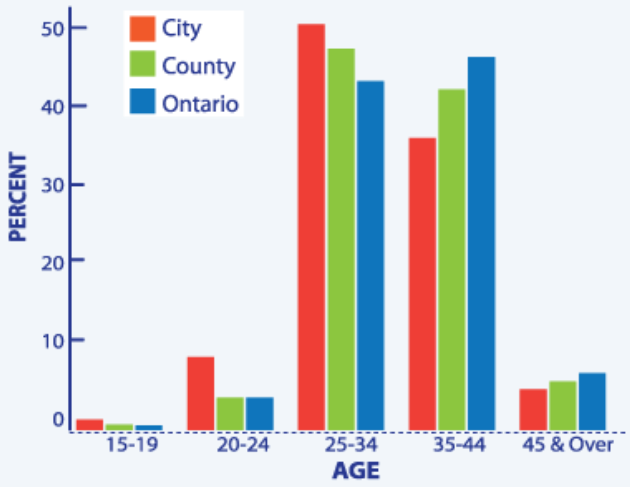
PARENTAL AGE

While only 8% of parents are under the age of 25, twice the proportion of young parents live in the City compared to the County. (2010)

Age Groups

parents with children 0-5

Children with parents 15-19 are at increased risk for poorer: development, language skills, school readiness, and school achievement.



Key Findings

Although teen births are declining, Peterborough has a higher rate of teen pregnancies and births than Ontario.

A higher proportion of young parents lives in the City than in the County.

Teen parents are disproportionately represented in the City.

Low education

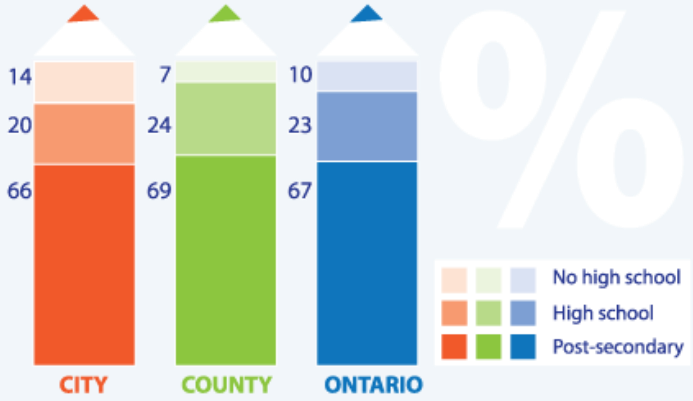
MATERNAL EDUCATION

Most Peterborough mothers of young children have post-secondary education. However, 31% of female lone parents in the City and 15% in the County have not completed high school. (2005)

School Completion

mothers with children 0-5

Children whose mothers have little formal education are at increased risk for poorer: development, behaviour, and school achievement.



Key Findings

Improving parental access to education is a priority for some families.

Inadequately housed

HOUSING

Affordable housing costs less than 30% of before-tax income, and is a big challenge for lone parent and low income families with children. (2005)

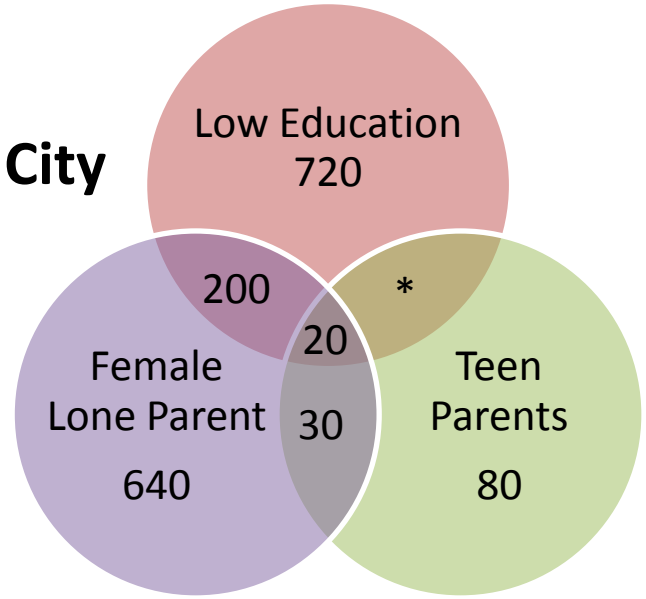
Unaffordable Housing

Children living in inadequate housing are at increased risk for poorer: growth, development, school achievement, and health.

Key Findings

Affordable housing is a significant challenge for lone-parent and low income families.

Number of parents who are female lone parents, and/or who have not completed high school, and/or who are teen parents with at least one child under the age of six in private households in Peterborough City and County, 2005



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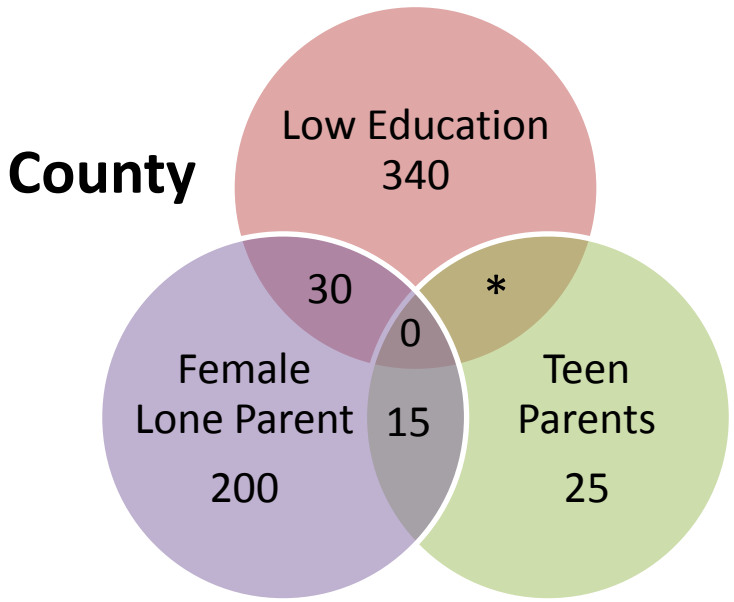

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The lives of young children at increased risk of poor outcomes must be improved …

through improving the circumstances of **young, female lone-parents (with children from birth to five years of age), who have limited formal education, and who are living in poverty in the City**.

Thoughts? … Questions?

CHILD HEALTH SUMMARY SERIES

2015

Companion Documents to
REPORT ON CHILD HEALTH
Peterborough County-City Health Unit
2015

1. In Summary: Family Demographics

Executive Summary

This first summary report, *In Summary: Family Demographics,* is condensed from the Peterborough County-City Health Unit's *REPORT ON CHILD HEALTH (2015)* and addresses family socio-economic status (SES) in the City and County of Peterborough ("Peterborough"). Emphasis is placed on families with children from birth to five years of age, since this period is critical for health and development. Emphasis is also placed on demographic indicators such as income, education, employment, and housing, which are social determinants of health. The profile which emerges speaks to the family burden of risk. Risk factors, or negative conditions in a child's life, increase the likelihood of that child having poorer health, growth, and development outcomes.

While most Peterborough families are doing well, it appears that some face multiple challenges, placing their children at increased risk of poor outcomes. The key findings for Peterborough families with children from birth to five years of age relate to this concern:

1. Although teen births are declining, Peterborough has a higher rate of teen pregnancies and births than Ontario.

2. A higher proportion of young parents live in the City than in the County.

3. Teen parents with children under the age of six are disproportionately represented in the City.

4. Lone parents with children under the age of six are disproportionately represented in the City.

5. Many lone-parent families with children under the age of six struggle with poverty, unemployment, and low education.

6. Affordable housing is a significant challenge for lone-parent and low income families.

7. Improving parental access to education is a priority for some families.

8. Unemployment affects a significant proportion of female lone-parent families.

9. Low income disproportionately affects lone parents living in the City.

10. Food insecurity is an issue for parents.

These findings indicate that a proportion of young Peterborough children face cumulative risk for poor outcomes. As well, the findings highlight differences between parents in the City and in the County. There is a greater number and higher proportion of vulnerable families in the City.

Findings suggest that in order to improve child health, growth, and development outcomes, and enhance the life trajectories of vulnerable Peterborough children, the life circumstances of families shouldering a burden of risk must be improved. Specifically, the life circumstances of young, female lone-parents (with children from birth to five years of age), who have limited formal education, and who are living in poverty in the City must be improved.

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1. In Summary: Family Demographics

Healthy child development lays the foundation for adult health and sketches the blueprint for the next generation. Poor child health and developmental outcomes represent a burden to society and a cost to health, education, justice, and social systems over the lifespan. Assessing the status of our children's health and investing in appropriate early interventions can modify their trajectory and positively contribute to the overall health of our community.

This series of summary reports condensed from the *REPORT ON CHILD HEALTH (2015)*[1] is intended to describe child health in the City and County of Peterborough ("Peterborough"); provide information and perspective for the community; and influence planning and policy directions.

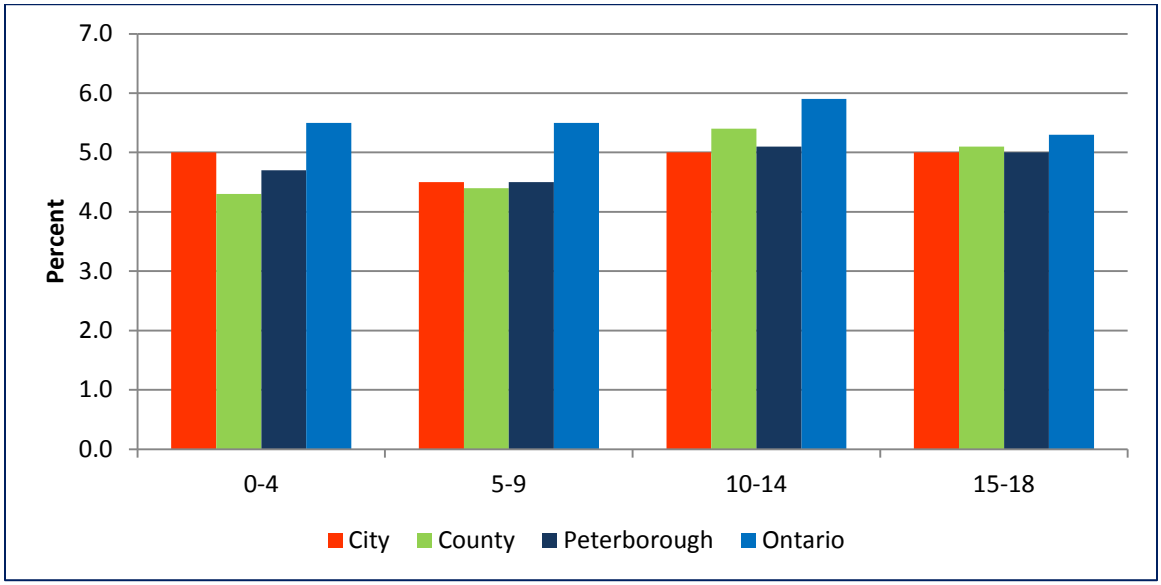
This first summary report *FAMILY DEMOGRAPHICS* addresses family socio-economic status (SES). Emphasis is placed on families with children from birth to five years of age, since research shows that these are the critical years for child health and development. As well, emphasis is placed on indicators related to child health, growth, and development outcomes. The socio-demographic profile of families in an area (including age of parents and children, family structure and diversity, parental education, family income and employment, and housing and food security) speaks to the overall family burden of risk and the likelihood of poor child outcomes, as well as to the kind of supports and programs that families will likely find beneficial.

Child Population

According to the 2011 Census, there were 26,015 children and youth under the age of 19 in Peterborough, accounting for nearly one in five (19.3%) residents (Figure 1). By comparison, children and youth accounted for just over one in five (22.3%) residents in Ontario, indicating that there is a smaller proportion of children and youth in Peterborough compared to the province. In the City of Peterborough ("City"), there were 15,250 children and youth under the age of 19 compared to 10,765 in Peterborough County ("County"). Children under the age of five and those between the ages of five and nine represented 5.0% and 4.5% in the City, a greater proportion than in the County (4.3% and 4.4%, respectively). There was a greater proportion of youth aged 10 and older in the County, indicating that there were more young families in the City.

[1] For more information on references, data sources, and methodology, please contact the Peterborough County-City Health Unit.

Figure 1 - Proportion of children and youth under the age of 19, Peterborough, City, County, and Ontario; 2010

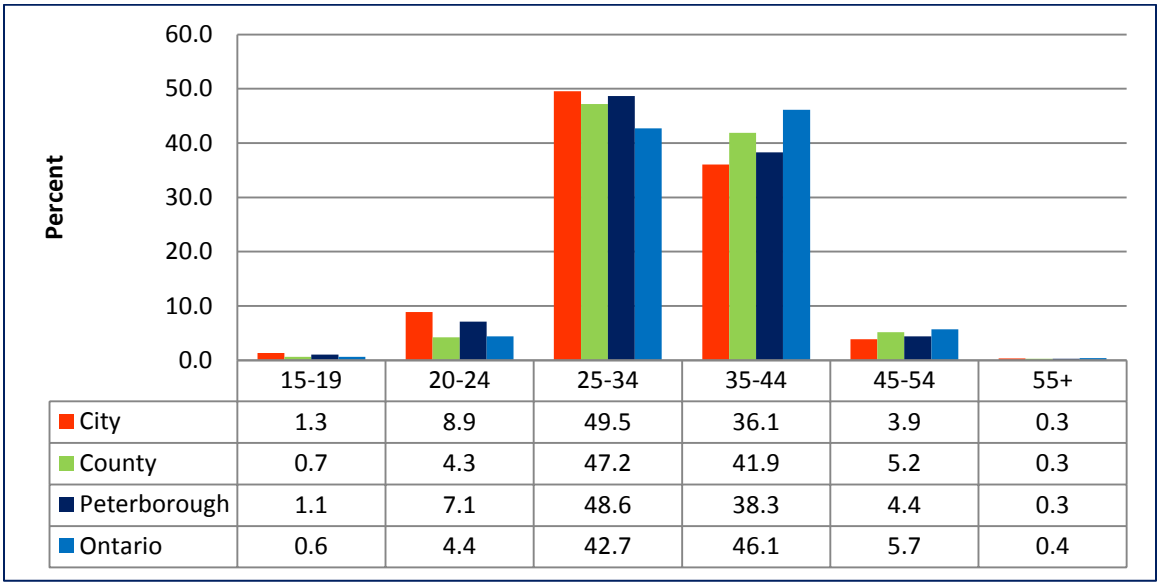


In order to plan future services for children and youth, it is valuable to examine future population projections. By 2020, the population aged zero through 18 is expected to be approximately 26,100. This does not represent an increase in the number of children and youth in the area and will make up a smaller proportion of the total population at 17.4% compared to 19.3% in 2011.

Parent Population by Age Group

A custom analysis of the 2011 Census by Statistics Canada indicates that there were 9,775 parents between the ages of 15 and 69 ***with at least one child under the age of six*** living in private households in Peterborough (Figure 2). Of these, 61.5% lived in the City, while 38.5% lived in the County. When examining specific age groups of parents, just *over* half (56.8%) of Peterborough parents with children under the age of six were under the age of 35. In Ontario, by comparison, just *under* half (47.7%) of parents were under the age of 35, indicating that there is a slightly younger cohort of parents in Peterborough with young children. In addition, 1.3% of the parents with children under six in the City are between the ages of 15 and 19; while this is not a large group, it is twice that of the County (0.7%) and the province (0.6%). This holds true for all parents under 25 years of age: the City has approximately double the proportion of young parents with young children compared to the County or Ontario.

Figure 2 - Proportion of parents aged 15 to 69 with at least one child under the age of six in private households, Peterborough, City, County, and Ontario; 2010



	15-19	20-24	25-34	35-44	45-54	55+
City	1.3	8.9	49.5	36.1	3.9	0.3
County	0.7	4.3	47.2	41.9	5.2	0.3
Peterborough	1.1	7.1	48.6	38.3	4.4	0.3
Ontario	0.6	4.4	42.7	46.1	5.7	0.4

Teen Parent Families

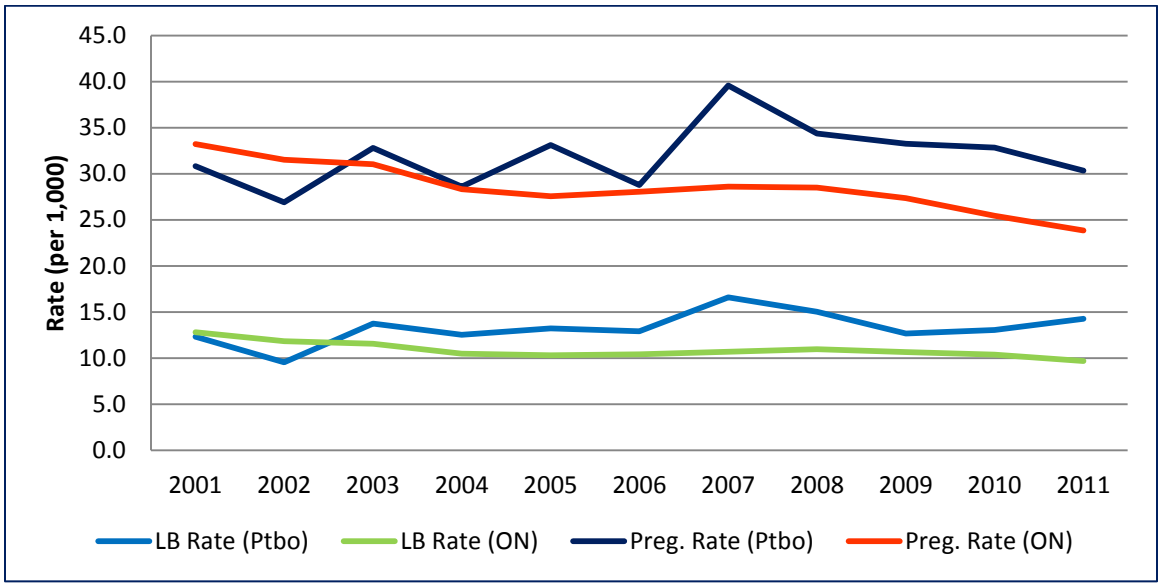
Peterborough young parents with children under the age of six:

- **15 – 19 year olds:** ***1.3%*** of City parents; ***0.7%*** of County parents; ***0.6%*** of Ontario parents
- **20 – 24 year olds:** ***8.9%*** of City parents; ***4.3%*** of County parents; ***4.4%*** of Ontario parents

There is a large body of research connecting child outcomes to parent demographic indicators. When considering parent ages, in comparison to younger mothers, older mothers demonstrate higher levels of sensitivity to their children and more supervisory and monitoring behaviours. In general, they provide more stimulating, engaging home environments. Having a teen parent exposes a child to cumulative risk of poor health and development, since a group of other related risk factors are likely also present: lone parent household; unemployment; poverty; depression; lower levels of literacy and cognitive development; lack of high school degree; low levels of parenting knowledge; one or more residential changes in the past year; and substandard housing.

In Peterborough, live birth (LB) rates and pregnancy rates among teens 15 to 19 years of age are higher than the province (Figure 3). Pregnancy rates in this age group increased between 2001 and 2007 from 30.8 pregnancies per 1,000 to 39.6 per 1,000. However, since 2007, the pregnancy rate decreased to 30.4 per 1,000 (in 2011). By comparison, the pregnancy rate in Ontario has been declining since 2001 and was 23.8 per 1,000 in 2011.

Figure 3 - Rates of LBs and pregnancies among young women aged 15 to 19, Peterborough (Ptbo) and Ontario (ON); 2001-2011



Pregnancies in teens, especially in those involved in risk behaviours and with little prenatal health care, can increase the risk of poor outcomes, including: inadequate maternal weight gain, a low birth weight infant, a preterm infant, and increased infant and maternal mortality rates. Children of teenaged parents are at increased risk for poor outcomes, and are more likely to have developmental delay, poorer socio-emotional adjustment, less school readiness, and poorer language skills and school achievement.

In 2010, there were 105 parents from 15 to 19 years of age with at least one child under the age of six living in Peterborough; 80 (76.2%) of these parents resided in the City. In 2005, of the teenaged female lone parents in the City, two-thirds had not completed high school, compared to almost half in Peterborough.

Family Structure

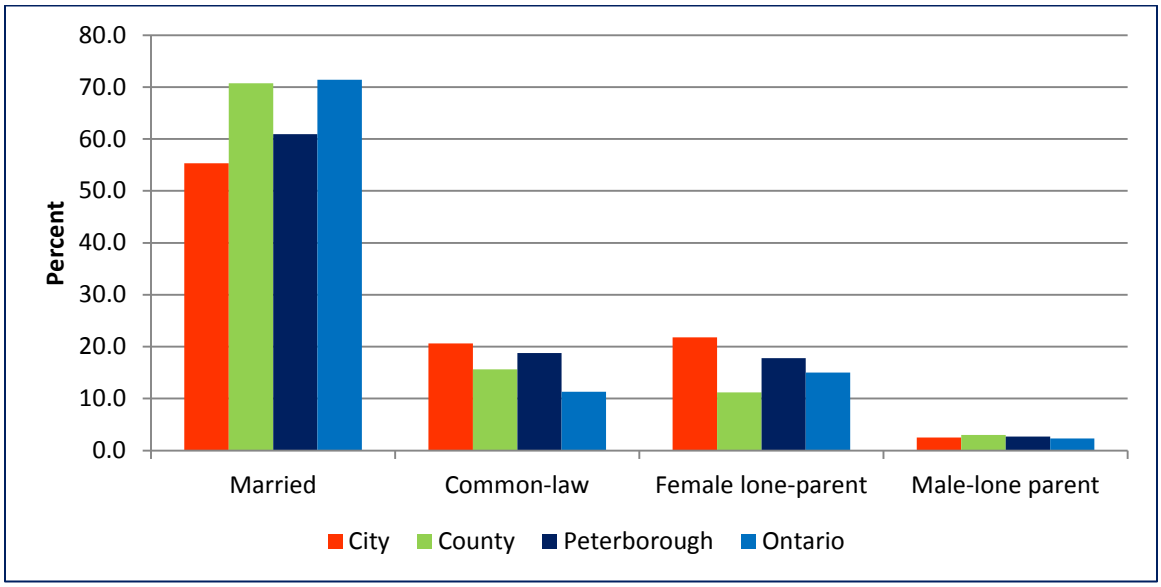
A body of literature shows children born into a traditional marriage and growing up with two married, biological parents are more likely to have better cognitive, academic, and behavioral outcomes than children growing up in other family types, including lone parent families and step-families. In general, marital biological families and couple families have a better family income, education and literacy, and less environmental stressors (e.g., poor housing and neighbourhoods) than do lone parent families. The benefits experienced by children growing up in a well-established two-parent family may be more related to the on-going home stability and richer family capital than to the family structure.

There were 5,440 families with parents between the ages of 15 and 69 ***with at least one child under the age of six*** living in Peterborough in 2010. Two thirds of the families with young children (63.0%) lived in the City while 37.0% of families lived in the County. Family structures varied by area (Figure 4):

- **Married, with children at home:** 55.3% of City families, 70.7% of County families, 71.4% of Ontario families;

- **Common-law, with children at home:** 20.6% of City families, 15.6% of County families, 11.3% of Ontario families;
- **Female lone-parent**: 21.8% of City families, 11.2% of County families, 15.0% of Ontario families; and
- **Male lone-parent:** 2.5% of City families, 3.0% of County families, 2.3% of Ontario families.

Figure 4 - Proportion of census family structures for parents aged 15 to 69 with at least one child under the age of six in private households, Peterborough, City, County, and Ontario; 2010



Lone-Parent Families

Living in a lone parent household is a risk factor for poor child outcomes such as lower receptive vocabulary ability, poorer educational attainment, higher levels of physical aggression (especially in boys), more likelihood of committing a property offence, and poorer mental health. Lone parenting often co-occurs with other demographic-related risk factors. When, for example, a lone-parent family also lives in poverty, and in poor housing, and the parent has a low level of education, the child is more likely to experience poor health, growth, and development. Children in higher income lone parent families show less emotional/behavioural disorders on average. However, children of low-income single parents can do well in a stable, supportive home environment where a positive parenting approach is used (positive parenting protects the child from the increased risk of poor child outcomes).

In Peterborough in 2010, there were 1,115 lone parents with children under the age of six. Two thirds (66.8%) of these were female lone parents living in the City.

In 2005, for Peterborough lone-parent families with children under the age of six:

- ***50.8%*** lived in low income,
  - ***22.2%*** of teenaged female lone-parents lived in low income (***33.3%*** in the City);
- ***13.8%*** were unemployed; and
- ***28.4%*** had not completed high school;
  - ***44.4%*** of teenaged female lone-parents had not completed high-school (***66.6%*** in the City).

Family Housing Profile

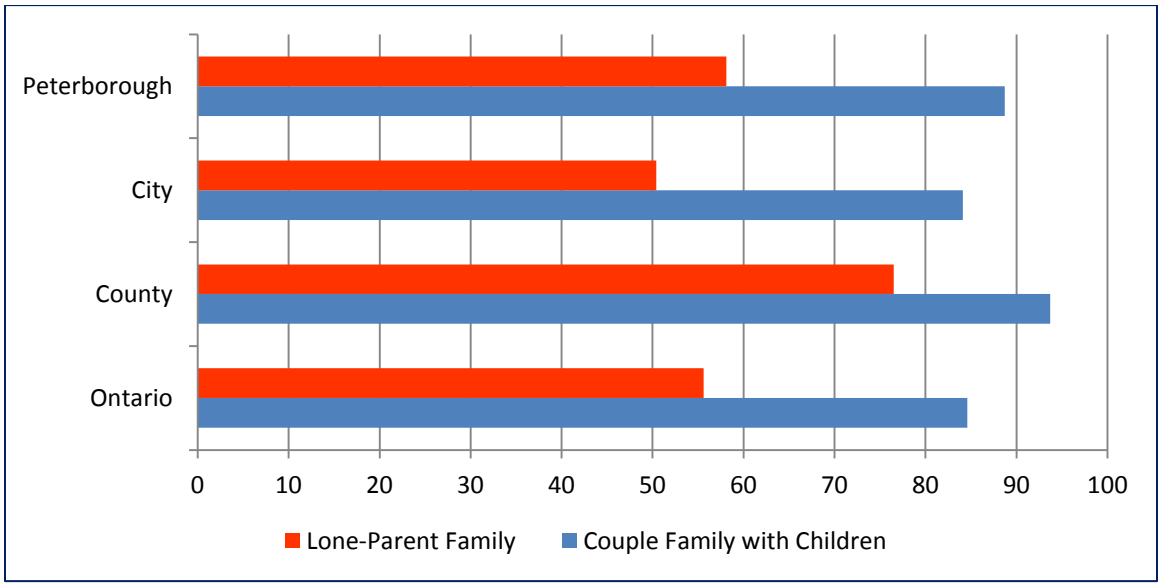
Physical environments are included among the determinants of health, and housing specifically is a social determinant of children's health. Housing quality and security is closely related to income.

For a parent, housing quality and security means knowing that the home is:

- affordable (<30% of before-tax income);
- large enough for everyone;
- constructed to standards;
- free of mould, lead, and toxins;
- in good repair;
- adequately lit and heated;
- supplied with potable water;
- connected to a safe sewage disposal system;
- handy to community resources; and
- situated in a safe, healthy, and reasonably quiet neighbourhood.

In Peterborough in 2005, 88.7% of couple families with children (all ages) owned the home in which they reside compared to 11.3% who rent (Figure 5). This is similar to Ontario and the City; however, in the County, an even greater proportion of families with children owned their home at 93.7%. Slightly more than half (58.1%) of lone-parent families owned their home in Peterborough, similar to Ontario. In the County, 76.5% of lone-parent families owned their home compared to 50.4% in the City.

Figure 5 - Tenure (owned) by household type, Peterborough, City, County, and Ontario; 2005



Substandard housing may have a host of problems (e.g., not meeting fire regulations, leaking roof, leaking plumbing, mould, inadequate insulation, asbestos, inadequate heating and cooling systems, unsafe stairs, rusty or lead water pipes, unsafe wiring, lead paint, excessive noise levels, and vermin). Children living in poorly maintained and substandard housing have a greater risk of asthma and respiratory problems; stomach, liver, or digestive problems; elevated blood pressure; visits to the emergency department; and tobacco, alcohol, and illicit substance use. For a child, household crowding is associated with an increased incidence of infectious diseases and injuries, household food insecurity, slow physical growth, less physical activity, less sleep, higher blood pressure, poor coping, poor cognitive and emotional functioning, and poor homework completion and school performance.

> *Canada Mortgage and Housing Corporation:* "A household is in ***core housing need*** if its housing does not meet one or more of the adequacy, suitability or affordability standards and it would have to spend 30% or more of its before-tax income to access local housing that meets all three standards."

According to custom analyses by Statistics Canada for the Needs Assessment of the City of Peterborough's Housing and Homelessness Ten Year Plan, 1,030 lone-parent families and 940 couple families (married and common-law) with children were paying 30% or more of their income on housing costs in 2005. This accounted for 18.2% of lone-parent families in Peterborough compared to just 6.7% of couple families. A slightly higher proportion of lone-parent families living in the City were paying 30% or more on housing costs at 21.3% of all households compared to 12.7% in the County. Similarly, among couple families with children, a higher proportion of households in the City were paying 30% or more of income on housing costs compared to the County (8.1% and 5.6%, respectively).

A census metropolitan area (CMA) is an area consisting of one or more neighbouring municipalities situated around a major urban core. In 2011, the CMA of Peterborough was the third worst rated in Canada in core housing needs for all residents. In addition, the CMA of Peterborough is in the **forefront for core housing need for lone-parent families** among all Canadian CMAs at 33.1% of lone parents.

Parent Education

Education and literacy are included among the determinants of health. A parent's level of formal education is connected to child outcomes. For example, low maternal education is linked to an increased risk of developing post-partum depression, which is associated with numerous poor child outcomes. Low maternal education has been linked to poorer developmental outcomes in very low birth weight infants. As well, mothers with low levels of education use fewer and simpler words during parent-child interactions. In families where mothers have low levels of education: children show low receptive language ability; cognitive delays in toddlers are more likely to persist into the preschool years; children show more problem behaviours and less social competence; and children do less well in school. As well, in general, better educated parents: have higher incomes (more resources to invest in their children); read more to their children and model recreational reading; have a wider range of vocabulary; value education more; and have high yet developmentally appropriate expectations around child educational effort and achievement.

In 2005, just over one in ten (11.3%) mothers aged 15 through 69 with children under the age of six at home in Peterborough had no certificate, diploma or degree – that is to say, they had less than a high-school education.

This was similar to the province (10.0%); however, in the City of Peterborough, 13.9% of mothers with young children did not have a high-school education compared to 7.4% in the County.

Looking at the highest parental *household* education attainment by census family structure provides a more revealing picture for Peterborough than simply looking at maternal education (Table 1). Among common-law and lone-parents of young children in the City of Peterborough, at least one in three had not completed high school or equivalent and as such can be said to have low educational attainment. A much smaller proportion of common-law and female lone-parents of young children in the County had low educational attainment. By comparison, a higher proportion of Ontario parents who are not married and have young children have completed high school or equivalent. Given the negative impact of low levels of parental education on child outcomes, the prevalence of low education parents of young children in the City of Peterborough is of concern.

Table 1 - Proportion of household types (parents aged 15 to 69) with at least one child under six with no certificate, diploma, or degree, Peterborough, City, County, and Ontario; 2005

	City	County	Peterborough	Ontario
Married with children	4.5	5.6	5.0	7.1
Common-law with children	33.5	18.2	27.5	22.2
Female lone-parent, children	31.3	15.0	27.4	22.9
Male lone- parent, children	50.0	50.0	50.0	24.7
Any lone-parent, children	32.1	16.7	28.4	23.1

Parent Employment

Employment is included among the determinants of health. Employment status is related to an individual's SES and the availability of personal resources and choices. Being employed and having a living wage promotes family self-sufficiency, development, health, and well-being. Unemployment, many employment transitions, and unstable employment are associated with parental anger and depression, less maternal sensitivity, low self-esteem, and feelings of loss of control. Child outcomes associated with parental unemployment included increased risk of child behaviour problems, lower levels of social competency, poor child development, and more mental health problems.

In 2005, in Peterborough, **13.8% lone-parents with children under the age of six living in the home were unemployed, higher than 9.8% in the province**. A higher proportion of female lone-parents were unemployed compared to male lone-parents in Ontario (10.2% and 6.5%, respectively). This trend is likely the case in Peterborough as well, however, due to data rounding, unemployed rates among male lone-parents with children under six is indicated as zero. Nonetheless, roughly one in seven female lone-parents (14.4%) with children under six living in the home were unemployed, which was higher than the provincial rate.

Family Income

Income is a social determinant of children's health. Inadequate levels of income reduce parents' ability to provide: material necessities (e.g., adequate food and nutrition, clothing, medicine, and shelter); access to safe neighbourhoods; and good quality services (e.g., child care, education, recreation, and health). Low income reduces the amount and quality of resources parents can invest in their children, and can increase parental stress which worsens parent-child interactions. Children living in poverty are more likely to experience crowded housing, inadequate nutrition, less family stability, less parental nurturing, limited stimulation, and greater exposure to violence.

Poverty in childhood is linked to poor outcomes, including: developmental delays; behavioural, emotional, and social difficulties; childhood adversity; increased levels of stress hormones; poor health in childhood and adulthood; increased likelihood of teen pregnancy and high school dropout; and the inability to participate in the usual activities of society.

In the Peterborough CMA in 2005, 12.5% of all children under the age of six in private households were in low income after tax. In addition, 21.8% of all female lone-parents, and 49.3% of children under the age of six of female lone-parents were in low income after tax.

Median income refers to the "middle point" income for a defined group of households. In 2005, the median after-tax income for all private households in Peterborough was $45,335 compared to $42,349 in the City (Table 2). Both of these figures are approximately $10,000 less than Ontario. For couple households with children, the median income was just over $71,000 in both Peterborough and the City, slightly less than Ontario. However, female lone-parent families had the lowest median income at roughly $32,000 in both Peterborough and the City; again, this was slightly less compared to the rest of the province. On the other hand, male lone-parent families in the region had a median income on-par with the province and made approximately $11,700 more than female lone-parent families.

Table 2 - Median after-tax income in 2005 in Canadian dollars, Peterborough, City, and Ontario; 2005

	City	Peterborough	Ontario
All private households	42,349	45,335	52,117
Couple households with children	71,670	71,258	74,095
Female lone-parent families	31,636	32,142	34,206
Male lone-parent families	44,353	42,920	43,972

There was a smaller proportion of Peterborough families with at least one child under the age of six living in low-income compared to Ontario at 12.9% and 15.5%, respectively (Table 3). A higher proportion of lone-parent

families were in low-income compared to couple families (50.8% and 6.9%). In addition, there was a higher proportion of low-income families living in the City compared to the County, with the greatest disparity between lone-parent families (56.3% and 26.1%, respectively).

Table 3 - Proportion of families with at least one child under six in low-income status after-tax by family structure, Peterborough, City, County, and Ontario; 2005

	City	County	Peterborough	Ontario
Families with *any* children under six	17.6	5.8	12.9	15.5
Couple families	8.3	5.1	6.9	10.1
Lone-parent	56.3	26.1	50.8	51.9

Income Assistance

Peterborough City lone-parent families with low-income status, 2005:

- ***66.0%*** of lone-parents with only children under six
- ***56.3%*** of lone-parents with at least one child under six, and possibly children 6-18 as well
- ***23.3 %*** of lone-parents with only children 6-18

Parents with no significant income sources (e.g., 'other' income), who are unable to work or find employment, receive government assistance. The Province of Ontario provides social assistance through two income funding streams: Ontario Works (OW) and Ontario Disability Support Program (ODSP), offered in Peterborough through the Social Services Department of the City of Peterborough. OW helps people who are in financial need, providing basic income support and health benefits, as well as assistance in gaining employment. ODSP provides income support and health benefits, as well as employment supports for people with a disability, as determined by an independent review board. In December of 2013, there were 3,424 OW cases in the City of Peterborough and of those 34.0% were families with children under the age of 18. There were also 4,557 ODSP cases in the City, 13.7% of which had children.

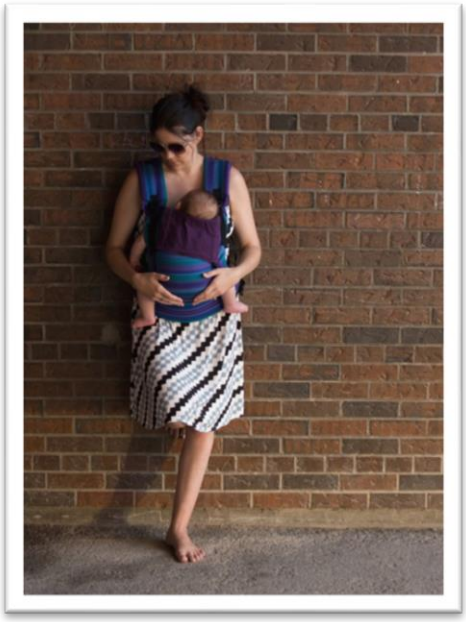
Food Security

Food security is recognized as an important social determinant of health (1). Food security exists in a household when all people, at all times, have physical and economic access to sufficient, safe, and nutritious food to meet their dietary needs and food preferences for an active and healthy life (2).

Household food insecurity is defined as inadequate or insecure access to food because of financial constraints. Households experiencing severe food insecurity reported reduced food intake and disrupted eating patterns among adults and/or children.

More Peterborough families experience food insecurity than Ontario families. Among all Peterborough households that are food insecure, female lone parent families living in poverty likely suffer the most food insecurity.

A higher prevalence of food insecurity has been identified in households with: low income; social assistance, worker's compensation, or employment insurance as the principle source of income; lone mothers with children; children; recent immigrants; and off-reserve aboriginals.



In 2011/2012 approximately one in nine households (11.5%) in Peterborough experienced food insecurity, significantly more than the 7.2% of Ontario households. **When considering households of parents with children under 18, 23.6% of households experience some food insecurity compared to 8.7% in Ontario.** While this data does not necessarily reflect the experience of all members in the household, it is a concern given that the proportion of households experiencing food insecurity in Peterborough is significantly greater than the province.

Among children, food insecurity has been linked to poorer health status and the development of a variety of chronic health conditions including asthma. Family food insecurity increases the risk for mental health problems in children, and puts teenagers and young adults at risk of depression, social anxiety, and suicide. Children living in food insecure households are also more likely to: be diagnosed with iron deficiency anemia (which increases the risk of irreparable cognitive delays); have higher rates of hospitalization; have significant negative developmental problems; and have behavourial problems. The experience of severe food insecurity in childhood has lasting impacts on health – children who have experienced hunger are more likely to have poorer physical and mental health in adolescence and early adulthood, and are at greater risk for developing chronic conditions and displaying risk-related behaviours.

Family Burden of Risk

Low SES families facing one challenge, such as low income, usually face several other challenges which understandably go hand-in-hand. For example, low income often goes along with: lack of employment or inadequate employment; low education; poor housing or housing insecurity; food insecurity; and living in a poor neighbourhood. Some families face additional challenges, such as being lone parent families, teen parents, members of ethnic or cultural minorities, and/or new immigrants. As challenges increase, cumulative disadvantage, family stress, and the "family burden of risk" all increase.

As the family burden of risk increases, the risk for poor child outcomes increases. Children and youth from low-SES backgrounds: suffer more illness and poor health; experience more growth and developmental problems; show lower academic achievement; and have higher rates of depression, anxiety, attention deficits, impulsivity, aggressive behaviour, and conduct disorders than do those from high-SES backgrounds. In early childhood, SES influences the level of cognitive stimulation in the home (e.g., availability of books and rich communication), which predicts language-related skills regardless of the quality of parental care and maternal intelligence. Lifelong health impacts on children living with low SES may result from cumulative effects, developmentally embedded effects, and a clustering of effects due to: low birth weight; poor diet; lack of protective and health-promoting resources; increased exposure to stressors; fewer educational and social opportunities; and increased exposure to risk factors (e.g., environmental tobacco smoke or infectious agents) and violence. Early stress is thought to play a big part in poor health outcomes in children living with low SES.

Peterborough Families - How are They Doing?

Socio-demographic findings show that most Peterborough families with children up to five years of age are doing well within the selected aspects of their lives. However, it appears that a proportion of these families face challenges, and more often than not, they face multiple disadvantages, placing their children at increased risk of poor health, growth, and development outcomes. A number of **key findings** pertaining to families with children from birth to five reflect this concern:

1. **Although teen births are declining, Peterborough has a higher rate of teen pregnancies and births than Ontario.**
   - There were 62 teen births in Peterborough in 2011 (14.3 live births per 1,000, compared to 9.7 per 1,000 in Ontario).
   - In 2011, the teenage pregnancy rate (which includes live births and therapeutic abortions) was 30.4 per 1,000 in Peterborough compared to 23.8 per 1,000 in Ontario.

2. **A higher proportion of young parents live in the City than in the County.**
   - In the City of Peterborough, 10.2% of the parent population with children under six years of age were aged 15 to 24, compared to 5.0% in both the County and Ontario.

3. **Teen parents with children under the age of six are disproportionately represented in the City.**
   - The City had approximately double the proportion of teen parents (1.3%) compared to the County (0.7%) or Ontario (0.6%).
   - In 2010, over three times the number of teen parents lived in the City compared to the County (80 and 25, respectively).

4. **Lone parents with children under the age of six are disproportionately represented in the City.**
   - In the City, 24.3% families with young children were led by lone parents compared to approximately 14.2% in the County and 17.3% in the province.
   - In the City, more than 21.8% of families with young children were led by female lone-parents compared to 11.2% in the County and almost 15.0% in Ontario.
   - Two thirds (66.8%) of lone parent families with young children in Peterborough were female lone parents living in the City.

5. **Many lone-parent families with children under the age of six struggle with poverty, unemployment, and low education.**
   - More than half (56.3%) lived in poverty, 13.8% were unemployed, and 28.4% had not completed high school.
   - Two-thirds (66.6%) of teenaged female lone parents living in the City had not completed high school.

6. **Affordable housing is a significant challenge for lone-parent and low income families.**
   - In Peterborough in 2005, 18.2% of all lone-parent families with children of all ages paid 30% or more of their income on housing compared to approximately 6.7% of couple families.
   - Among the lowest income households, only 37.1% lone-parent families with children of all ages owned their home compared to 76.5% of two-parent families.

- In 2011, the Peterborough Census Metropolitan Area (CMA) ranked third worst for core housing need for lone parent families (with children of all ages) among all Canadian CMAs.

7. **Improving parental access to education is a priority for some families.**
   - Of all mothers in Peterborough with children under the age of six, 11.3% had no formal education certificate, diploma, or degree (i.e., high school or equivalent).
   - Among common-law and female lone-parent households with children under six, 27.5% and 27.4% respectively did not have a parent in the home who had completed high school, compared to 22.2% and 22.9% in Ontario. In the City, this rate increased to nearly 31.3% of female lone-parent and 33.5% of common-law parent households.
   - Half (50.0%) of male lone parents with young children had not completed high school or equivalent; this was consistent across all of Peterborough and in contrast to 24.7% in Ontario.

8. **Unemployment affects a significant proportion of female lone-parent families.**
   - Approximately one in seven (14.4%) female lone-parents with children under six were unemployed, compared to 9.8% in Ontario.
   - One in ten (9.6%) female lone-parents with children only between the ages of six and 18 were unemployed compared to 6.1% in Ontario.

9. **Low income disproportionately affects lone parents living in the City.**
   - In the City, 66.6% of lone parents with children exclusively five years of age or less had low income status, compared to 18.2% in the County and 51.9% in Ontario.
   - In the City, 56.3% of lone parents with any children five years of age or less had low income status, compared to 26.1% in the County.
   - Lone-parent household median income (in 2005) was $30,000-$40,000 less than that for a couple household with children of any age.

10. **Food insecurity is an issue for parents.**
    - In Peterborough, 23.6% of households with parents of children under the age of 18 had food security issues compared to 8.7% in Ontario.

These key findings describe a group of parents experiencing a burden of risk in their lives. They indicate that a proportion of Peterborough children experience multiple risk factors for poor outcomes. As well, they highlight differences between parents in the City and in the County. There is a greater number and higher proportion of vulnerable families in the City.

Findings suggest that in order to achieve the greatest increase in child health, growth, and development outcomes, the life circumstances of **young, female lone-parents (with children from birth to five years of age), who have limited formal education, and who are living in poverty in the City** must be improved. Advocacy efforts, policy change, and collaborative interventions aimed at providing these vulnerable families with a nurturing and stimulating home environment, access to sufficient food and finances, adequate housing, and higher levels of formal parental education are needed. Successes can spill over to improve the lives of all families who face one or more challenges. Evaluation of these initiatives will speak to their success, and ongoing population surveillance of all families of young children will track change, monitor trends, and inform future directions and strategies.

The life trajectories of young Peterborough children can and must be improved.

Birth to Five: The CRITICAL Years

The first years of a child's life are critical for health, growth, and development, and lay the foundation for adult health. Children are more likely to thrive when their parents: provide a nurturing and stimulating home environment; have access to sufficient food and finances; have adequate housing; and have higher levels of formal education.

Peterborough County-City HEALTH UNIT ...because health matters!

Report on Child Health 2015

for more information and references **www.pcchu.ca**

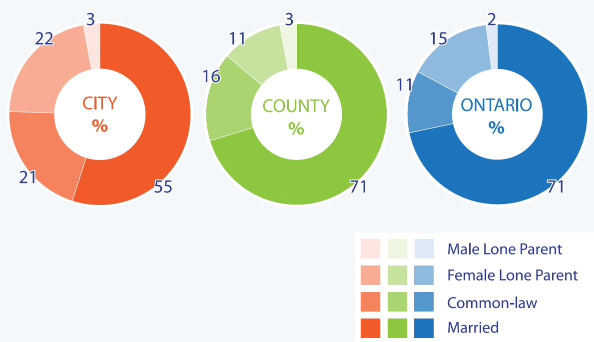
FAMILY TYPE

Most of the 5,440 Peterborough* families with children 0-5 years of age are couples (80%), however in the City, 25% are lone parents. (2010)

Singles or Couples

with children 0-5

Children in lone parent families are at increased risk for poorer: vocabulary, school achievement, behaviour, and mental health.



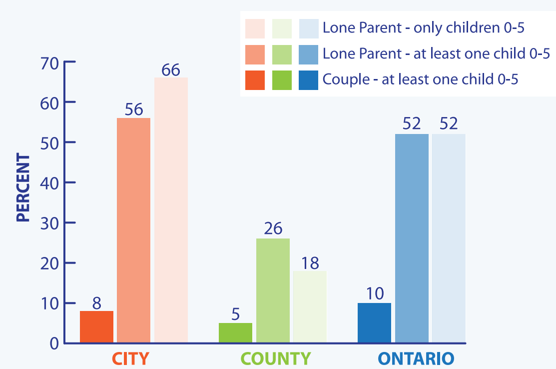
FAMILY INCOME

Nine out of ten couple families have middle to high income status. Low income disproportionately affects lone parents living in the City. (2005)

Low Income Families

with children 0-5

Children living in poverty are at increased risk for poorer: development, school achievement, behaviour, and health.



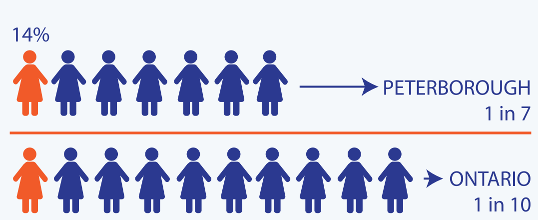
EMPLOYMENT

Unemployment rates for female lone parents with young children are higher than those for their male counterparts. (2005)

Unemployed Female Lone Parents

with children 0-5

Children with unemployed parents are at increased risk for poorer: social competency, behaviour, and mental health.



WHY WORRY?

"Some parents shoulder a burden of multiple challenges which results in more adverse child outcomes and increases the likelihood of the next generation being similarly affected." Dr. Rosana Salvaterra, Medical Officer of Health

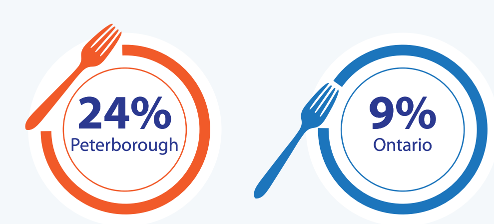
FOOD SECURITY

Female lone parent families living in poverty likely suffer the most food insecurity. (2011/2012)

Food Insecure Households

with children 0-17

Children experiencing food insecurity are at increased risk for poorer: development, behaviour, health, and mental health.



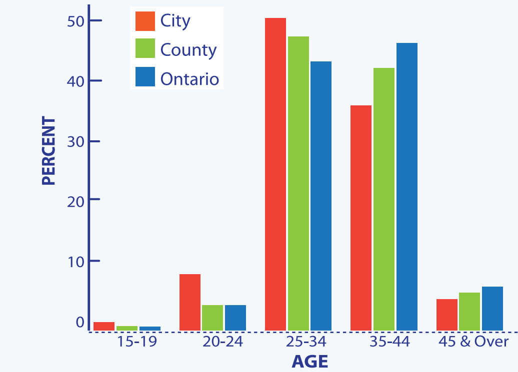
PARENTAL AGE

While only 8% of parents are under the age of 25, twice the proportion of young parents live in the City compared to the County. (2010)

Age Groups

parents with children 0-5

Children with parents 15-19 are at increased risk for poorer: development, language skills, school readiness, and school achievement.



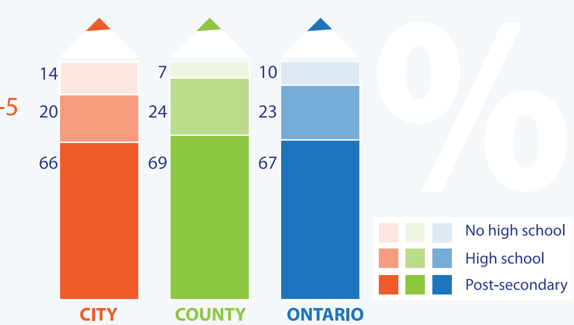
MATERNAL EDUCATION

Most Peterborough mothers of young children have post-secondary education. However, 31% of female lone parents in the City and 15% in the County have not completed high school. (2005)

School Completion

mothers with children 0-5

Children whose mothers have little formal education are at increased risk for poorer: development, behaviour, and school achievement.

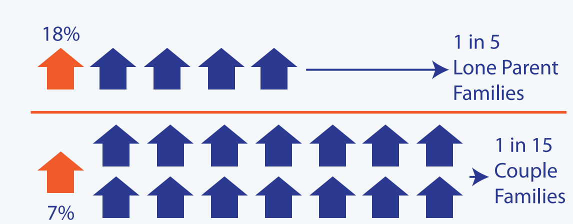


HOUSING

Affordable housing costs less than 30% of before-tax income, and is a big challenge for lone parent and low income families with children. (2005)

Unaffordable Housing

Children living in inadequate housing are at increased risk for poorer: growth, development, school achievement, and health.



*"Peterborough" includes the City and the County of Peterborough. The term "parent" includes all primary caregivers within the child's home.

November 2015

Staff Report

2016 Cost-Shared Budget Approval

Date:	December 9, 2015
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original signed by	***Original signed by***
Rosana Salvaterra, M.D.	Bob Dubay, Manager, Accounting

Recommendations

That the Board of Health for the Peterborough County-City Health Unit approve the 2016 cost-shared budget for public health programs and services in the amount of $8,174,982.

Financial Implications and Impact

This budget includes all cost-shared budgets funded by the Ministry of Health and Long-Term Care (MOHLTC) as well as City, County and First Nations, but does not include other programs and services of the Health Unit funded 100% MOHLTC or by other Ministries of the Province.

Budgeting is simply putting dollar figures to plans. Many assumptions go into the formulation of the budget for the purposes of determining costs.

The most significant factor in the calculation of the Cost Shared budgets is the cost of wages and benefits. The 2016 budget staffing levels have been maintained in total consistent with the previous year at 78.15 Full Time Equivalent staff. Budgeted wages reflect the current collective agreements and a projection of settlement for the smallest bargaining unit OPSEU. OPSEU's agreement expires March 31, 2016.

The second most significant assumption is the increase in funding required from our funding partners. We have informed the City and County staff that they can expect a 1% increase in 2016. The budget has been calculated asking all local funding partners for a 1% increase.

Decision History

The Health Protection and Promotion Act section 72(1) states that the budget for public health programs and services is the responsibility of the obligated municipalities. In 2004, the provincial government announced, "the Ministry will review Board of Health-approved budgets in relation to guidelines and approve its share according to the following" funding ratio "75% province, 25% municipalities".

On February 11, 2015 the Board approved the 2015 cost shared budget in the amount of $8,146,546, an overall 3.16% budget cost increase which included occupancy costs for the new building..

In 2015 the board approved and asked the province for its share of the budget or $6,148,732. In September of 2015, the board was notified that the province approved $6,006,200, a shortfall of $142,532. The province also informed staff that the Board can expect no increase to base funding in 2016. At the same time, the province has also indicated that funding will be available to support a larger role for Public Health in the Provincial initiative to integrate dental services. Integrated dental services are effective January 1, 2016. It is also anticipated by management that some of the Health Units slated for provincial equity funding in 2015 and 2016 will not be in a position to take advantage of provincial funding. As a result it is expected that the province will make one-time operational funding available to Peterborough. The 2016 budget has been formulated to take advantage of available provincial funding while minimizing the cost to local funders.

The County of Peterborough, City of Peterborough fund the Health Unit based on census population data. The Curve Lake First Nation and Hiawatha First Nation contribute based on funding agreements with the Board of Health.

Background

Historical Ministry approvals have been:

	Increase
Increase in 2015 over 2014	7.34% (includes increase to occupancy costs)
Increase in 2014 over 2013	2.00%
Increase in 2013 over 2012	2.00%
Increase in 2012 over 2011	1.62%
Increase in 2011 over 2010	2.85%
Increase in 2010 over 2009	3.0%

For the 2016 budget the following assumptions have been made:

1) No reduction in net total Full Time Equivalent staffing;
2) Salaries are based on existing union settlements and projection of settlement for OPSEU;

3) There will be no new Pay Equity adjustments;
4) Non-union compensation projected as per April 1, 2015 approved rates;
5) General inflation will be 1%;
6) There will be no significant change in Influenza, HPV or Meningitis C immunization rates;
7) CINOT budgets have been removed;
8) Dental Integration will require a larger role for Public Health;
9) OMERS pension rates are known all other benefit costs are estimates;
10) Allocation of local contributions between the City and County are based on published 2011 population census data and First Nation contributions are an estimate of per capita cost based on population data provided by the First Nations; and

Rationale

Under the *Ontario Public Health Standards*, the Board is required to approve an annual budget that does not forecast an unfunded deficit. The planned 2016 budgeted is balanced and does not result in a deficit.

Strategic Direction

The proposed budget allows the Board to address all its strategic priorities.

Contact:

Bob Dubay
Manager, Accounting
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bdubay@pcchu.ca

PETERBOROUGH COUNTY CITY HEALTH UNIT **Draft November 30, 2015**

DRAFT 2016 PUBLIC HEALTH (Including SDW & Vector Borne Disease) BUDGETS – Operations Only

		2016 Budget	2015 Budget	Change	% Increase
	EXPENDITURES				
1	Salaries and wages	5,329,665	5,276,715	52,950	1.00%
2	Employee benefits	1,486,124	1,438,639	47,485	3.30%
3	% benefits of salary and wages	27.884%	27.264%		
4	Staff Training	41,612	36,249	5,363	14.79%
5	Board Training and Employee Recognition	47,879	44,801	3,078	6.87%
6	Travel	68,265	77,636	-9,371	-12.07%
7	Building Occupancy	812,690	812,690		
8	Office Expenses, Printing, Postage	34,824	34,480	345	1.00%
9	Materials, Supplies	398,704	391,786	6,918	1.77%
10	Office Equipment	12,587	12,462	125	1.00%
11	Professional and Purchased Services	352,634	349,143	3,491	1.00%
12	Communication costs	123,798	122,572	1,226	1.00%
13	Information and Information Technology Equipment	58,005	57,431	574	1.00%
	EXPENDITURES	**8,766,788**	**8,654,604**	**112,184**	**1.30%**
	FEES & OTHER REVENUES				
14	Expenditure Recoveries Flu, HPV, MenC	24,500	21,335	3,165	14.83%
15	Expenditure Recoveries & Offset Revenues	567,306	567,193	113	0.02%
	FEES & OTHER REVENUES	**591,806**	**588,528**	**3,278**	**0.56%**
	NET EXPENDITURES - Cost Shared Budget	**8,174,982**	**8,066,076**	**108,906**	**1.35%**
	PARTNER CONTRIBUTIONS – 2016				
16	Ministry of Health & Long-Term Care	6,115,443	5,949,100	166,343	2.80%
17	County of Peterborough	841,241	832,912	8,329	1.00%
18	City of Peterborough	1,205,956	1,194,016	11,940	1.00%
19	Curve Lake First Nation	9,328	9,236	92	1.00%
20	Hiawatha First Nation	3,014	2,984	30	1.00%
21	Local Reserves needed to match Province				
	FUNDING PARTNER CONTRIBUTIONS	**8,174,982**	**7,988,248**	**186,734**	**2.34%**
	Balanced Budget	**0**			

Salary & Benefit Assumptions

1 No reduction in total FTE staffing

2 ONA & CUPE agreement increases October 1, 2016 as per contracts

3 OPSEU increase April 1, 2016 assumption discussed with Larry

4 OMERS rates are known, YMPE is estimate

5 All other benefits are based on estimated rate increases over 2015 rates

Other Assumptions

Budget includes Cost-shared: Mandatory programs, cost shared SDW and VBD.

The full occupancy for 185 King Street is built into budget.

Allows for 1% inflation in 2016.

Fuel costs, green policies and one building will contribute to less Travel costs.

Assumes province will continue funding 100% of enhanced MOH salary – agreement ends March 2016.

Assumes no significant change to Flu, HPV or Men. C immunization levels.

Budget does remove CINOT operations and funding from budget.

Allocation of local contributions between City and County based on published 2011 population census data.

First Nation allocations are estimate of per-capita cost based on band provided population number.

To: All Members
Board of Health

From: Dr. Rosana Salvaterra, Medical Officer of Health

Subject: **Correspondence for Information**

Date: December 9, 2015

Recommendation:

That the following documents be received for information.

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1. Email dated November 19, 2015 from the Association of Local Public Health Agencies to all Ontario Boards of Health regarding the Board Risk Management Workshop. (p. 58)

2. Letter dated November 20, 2015 from the Hon. Deb Matthews to the Board Chair, in response to her initial letter dated September 30, 2015, regarding the basic income guarantee. (p. 65)

3. Letter dated December 2, 2015 from the Board Chair to Ministers Sohi, Philpott, Duclos, Monsef, Hajdu, Matthew, Hoskins, Leal and Premier Wynne regarding food security and the transformation of social assistance in Ontario. (p. 67)

4. Resolutions/Letters from other local public health agencies:

   a. Healthy Babies, Healthy Children Funding
   Thunder Bay (p. 70)
   Wellington-Dufferin-Guelph (p. 73)

   b. Northern Ontario Evacuations of First Nations Communities
   Algoma (p. 77)

   c. Nutritious Food Basket
   Wellington-Dufferin-Guelph (p. 80)

   d. Public Health Funding Review
   Elgin St. Thomas (p. 82)
   Haliburton, Kawartha Pine Ridge (p. 84)

alPHa
Association of Local
PUBLIC HEALTH
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E-mail: info@alphaweb.org

Providing leadership in public health management

WORKSHOP PROCEEDINGS

Managing Uncertainty: Risk Management for Boards of Health
Thursday, November 5, 2015 – 9:00 AM to 4:30 PM
Toronto Ballroom, DoubleTree by Hilton Hotel, 108 Chestnut Street, Toronto, Ontario

NOTE: Links to the PowerPoint presentations at the end of each speaker's summary will take you to the alPHa website. Site member log-in will be required to open the presentations.

Welcome and Introduction

alPHa executive director Linda Stewart welcomed attendees, noting that 24 boards of health were represented today. This skill-building workshop will help participants – board of health members and senior health unit staff – explore risk management from the governance perspective and learn from the case studies of Algoma and KFL&A Public Health, both of which have been assessed by the Ministry for different reasons. Attendees will also an opportunity to self-assess their own health unit's level of risk management.

Corporate Governance and Risk – *Graham Scott, Chair, Institute for Research in Public Policy, Canada Health Infoway / Algoma Public Health Assessor*

Mr. Scott began his presentation with the qualifier that good governance is not easy; it is hard work. Nonetheless, all public health units should strive for good governance. This includes, among other things, actively engaging in risk management. Risk management is the systematic approach to setting an organization's best course of action under uncertainty by identifying, assessing, understanding, acting on, and communicating risk issues. A risk is the chance of something happening that will have an impact on the achievement of organizational objectives. Unlike the *Health Protection and Promotion Act*, the Ontario Public Health Standards (OPHS) and Organizational Standards explicitly state the governance requirements for health units and their boards. The OPHS references the following fiduciary duties of the board of health: care, good faith and loyalty. (Not coincidentally, these duties form the foundation of the *Corporations Act.*) That said, it's helpful to know what bad governance looks like. An example of this is

illustrated by the former Muskoka Parry Sound board of health whose members took it upon themselves to examine the human resource records of the health unit when they had no business doing so.

Fundamentally, when it comes to corporate governance:

- *The Board of Health* ('the board') *is responsible for providing policy and oversight* – Once policies are set, the board monitors to see if these are carried out effectively. To ensure quality performance, the board must ask questions.

- *The Medical Officer of Health (MOH) and management are responsible for operations* – Senior management gives the board information and support which is then used as the basis for determining the policy agenda. **There is no role in Operations for the board of health.**

- *The CEO is the only employee of the board* – The MOH / CEO is responsible for the success or failure of the operations of the organization unless the failure is due to specific board policy direction. This is fundamental to clear accountability. In Algoma's case, the MOH informed the board she had hired a CFO (who turned out to have a criminal background). Though the board had no role in hiring staff, it was the board's responsibility to ensure that the proper hiring process (e.g. reference check) was followed by asking relevant questions.

- *Board of health members must act in the best interests of the organization* – The best interests of the health unit are served only when board of health members put the health unit's interest first. **This is a duty**. Even when facing other pressures, municipally elected officials on boards of health must support decisions that serve the health unit's best interest (e.g. more funding for the health unit) even if those decisions might be unpopular with competing interests or groups.

To start on the path toward good governance, board of health members need a common, shared understanding of their roles, responsibilities and accountabilities. They need strong support mechanisms (committees on finance and audit, governance, etc.) to help manage the work of effective oversight. They will need tools such as functional agendas, work plans, reporting templates, and a board of health policy manual. They also need to monitor the board of health's performance through guidelines for the selection of members and annual performance questionnaires.

However, there remain challenges to achieving good governance. And the greatest risk to an organization is the failure to have or to follow good governance practices. Risk is an integral part of governance best practices. It is everyone's responsibility because the range of risks faced by organizations is large, and can be strategic, reputational, and operational in nature. The next speaker, Corinne Berinstein, will cover this topic in greater detail.

A lively Q&A with Mr. Scott was held. Following are some highlights:

- While it was recognized that the OPHS adequately addresses risk, Mr. Scott noted that the challenge lies in *how* a board of health delivers the Standards.
- Roselle Martino from the Public Health Division, MOHLTC, confirmed that the OPHS and

Organizational Standards will be reviewed (in parallel processes) with the intent to 'modernize' them by the end of 2016. Minister Hoskins will be issuing a communique to the field as early as next week with details on the review process. Broad sector engagement in the process will include alPHa.

- Ms. Martino also confirmed that boards of health should *not* assume that the 2016 funding for health units will be subject to the funding formula that was imposed for 2015 budgets. Mr. Scott acknowledged that given the funding constraints on all sectors, it will be all the more pertinent for organizations, including health units, to show that they have done due diligence and that their house is in excellent order.
- In answer to a question on how Algoma's large sum of missing funds could have gone undetected by the hired auditing firm, Mr. Scott indicated that it helps to develop a checklist to ensure you are a getting a good, quality auditor because one cannot assume all auditors will be high quality.

Participants took time to complete a self-assessment tool (click here for the tool), sections of which they were asked to complete after each speaker. They answered the questions as individuals on the board of health for their own personal reflection.

Click here to view the presentation by Graham Scott.

Managing Uncertainty – *Corinne Berinstein, Senior Audit Manager, Ontario Internal Audit Division, Treasury Board Secretatiat*

Risk intelligence is the organizational ability to think holistically about risk and uncertainty. It uses forward looking concepts and strategies. It is essential to the survival and success of organizations. It can be an opportunity and a threat. Reasons for doing risk management are: it helps your organization meet objectives and improves outcomes, allows you to consider and forecast risk and prioritize efforts more effectively, and enables you to mitigate threats and take advantage of opportunities, helps you prepare for risks, and shows you are practicing good management. Risk management is done at all levels of the organization, from front line staff all the way up to the board of health. Therefore, fostering a healthy risk culture in the health unit where risk is talked about at every level is essential.

In terms of the overall roles and responsibilities, the health unit implements all the steps in risk management while the board of health maintains oversight of risk management. The Ministry of Health and Long Term Care sets the standards of expectations through its OPHS, Organizational Standards, and Accountability Agreements.

The five steps of the risk management process are:

- State objectives;
- Identify risks (there are 14 categories, e.g. legal compliance, equity, financial, HR, political, privacy, etc.);
- Assess risks (use Risk Prioritization Matrix, which measures likelihood, impact, timing)
- Plan and take action (employ mitigation strategies of detection, prevention and

recovery/correction); and
- Monitor and report risks.

The Integrated Risk Management Quick Reference Guide is a handy two page tool for developing a risk management approach for the organization.

Board of health responsibilities regarding risk management are as follows:
- Approving the risk management policy and framework;
- Ensuring staff has the capacity to manage risks;
- Ensuring that all significant risks are identified and mitigation strategies are proposed;
- Ensuring that the board of health has input into risk discussions; and
- Ensuring the board of health has adequate information to monitor the progress of the implementation and effectiveness of mitigation strategies.

Afterward, a Q&A session with Ms. Berinstein was held. Some key statements included:

- While an organization would benefit in having an explicit statement on risk management, it's more important to implement the risk management process (i.e. just do it).
- Boards of health can move in the right direction by forming a Risk Management Committee or renaming their financial/audit to "Financial, Audit and Risk Management Committee".
- To help build a risk management culture in the health unit, Ms. Berinstein urged boards to get senior management's buy-in of and commitment to risk management, identify risk management champions, train them and assign them responsibilities, ensure all staff complete Risk Management 101 training, ensure risk management is an employee performance plan requirement, communicate and report on risk management (e.g. team meetings), and get staff feedback on the risk management culture (what works, what doesn't).
- When asked to recommend a governance model to adopt with risk management in mind, Graham Scott mentioned the Pointer-Orlikoff Healthcare Governance Model. He believes that the Carver model, in comparison, is outdated in a number of respects and therefore less ideal.
- Northwestern Health Unit is willing to share the Ministry's risk monitoring tool with other boards.

Click here to view the presentation by Corinne Berinstein.

Case Studies

"The Perfect Storm": Lessons Learned *– Tony Hanlon, CEO, and Justin Pino, CFO, Algoma Public Health*

Tony Hanlon and Justin Pino from Algoma Public Health described in detail the perfect storm of events and factors that led to the crisis that unfolded at their health unit in early 2015. The crisis revolved around the hiring of an interim Chief Financial Officer with a criminal background. The severe fallout of the scandal prompted the province to appoint Graham Scott to conduct a governance assessment of Algoma. Findings from the assessment were released in June of this year (click here for the report). Dr. Hanlon and Mr. Pino explained how poor governance, inexperience, and a near-complete lack of due diligence on the part of

the Algoma board of health laid the foundation for the crisis. It was also these factors that gave rise to the former business administrator committing fraud over time from 2006 to 2013.

As a result of the crisis, three reviews of the health unit and board were conducted, including the assessment by Mr. Scott. By his recommendation, a new board of health was formed and an interim leadership (MOH, CEO) was installed with staff from Sudbury & District Health Unit. (Since then, Dr. Hanlon has taken on the Interim CEO role on a contract basis and Mr. Pino the CFO role on a permanent basis.) The new leadership has made good governance a priority and implemented a number of best practices (see below).

The lessons learned in Algoma have been many. Boards of health should have the following:

- a membership that is skills-based (members have specific professional expertise in areas such as financial, legal)
- an orientation process for new board members
- professional development program just for board members
- a focus on risk management
- a robust board performance evaluation
- board sub-committees (e.g. Financial, Audit & Risk; Governance, etc.)
- board policies and procedures
- flexibility in the type of board (e.g. regular rotation of board chair)
- operational policies (e.g. Financial, HR)
- employee engagement processes
- plans to hire an executive coach/mentor for new executive hires (MOH, CEO, etc.) and a professional development plan for these positions
- a communications plan for internal and external audiences
- commendable front-line staff

In the Q&A that followed, questions mainly concerned the lack of safeguards and accountability regarding health unit finances as well as the role of the health unit's auditors during the embezzlement of funds. It was suggested that from a system perspective, health units need to think about ways in which they can support each other, particularly weaker health units, to ensure that we have a strong public health system overall in place. In the name of improvement, it was further recommended that every senior public health manager and board of health member read Graham Scott's Algoma Assessment Report.

Click here to view the presentation by Tony Hanlon and Justin Pino.

Risk Management: A Process Perspective *– Hazel Gilchrist, Director, Corporate Services, KFL&A Public Health*

Hazel Gilchrist walked attendees through her health unit's journey to date in risk management. The journey began as a result of one of the recommendations by the provincial Treasury Board in their 2014 audit of KFL&A Public Health. A risk management working group was established to engage the agency in a risk management process that is expected to be completed by 2016. Currently, KFL&A is in the stage of assessing risks.

A risk framework was developed that identified risks, organizational priorities, and organizational strategies. The board of health was involved early on in the risk identification and assessment processes, and posed a number of initial questions. A current risk heat map was generated, which was well received by the board. The heat map revealed a Top 10 list of agency-level risks (strategic planning, performance management, client service standards, security of IT/IM systems and assets, funding, etc.). Although many of these areas are already addressed, there is still room for improvements, the impact of which would be substantial.

After assessing existing controls, future controls and consequences for each of the Top 10 risks, a future risk heat map was created. KFL&A Public Health's next steps include developing and implementing a risk management policy and risk mitigation strategies as well as engaging in risk monitoring, reporting and evaluation. KFL&A will also address program-level and project-level risk management, and cultivate a healthy risk culture across the agency.

Attendees were encouraged to pick up a handout of KFL&A's Organizational Risk Framework (outlines their 35 risks), Current Risk Heat Map, and Future Risk Heat Map.

In the Q&A that followed, Ms. Gilchrist acknowledged Corinne Berinstein's invaluable assistance on the risk management journey. She further underscored that although it has been time consuming and challenging, the journey has also been a great learning opportunity and a chance for KFL&A to maximize its impact in the community.

Click here to view the presentation by Hazel Gilchrist.

Group Discussion – Insights, Comments and Next Steps

Attendees participated in a panel discussion with Ms. Berinstein, Ms. Gilchrist, Dr. Hanlon and Mr. Pino. The following are highlights:

- Health units were advised to move forward with risk management and not wait for the province to complete its review of the OPHS.
- To develop a public health system approach to risk management (and avoid reinventing the wheel), it'd be helpful to develop a common framework with input from those health units that have already established frameworks. A common risk management framework would not only contain generic components applicable to all health units, but it could also be customized by individual health units for their own use. Linda Stewart of alPHa suggested that she could approach the Ministry for resources to aid this process. Ms. Berinstein also offered her assistance with this project.
- There was a suggestion that alPHa hold a follow-up meeting next year on risk management. It could include a celebration of successes.
- Reviews of the health unit's risk management process should be done annually if risks don't change much year to year. They can be done more frequently, if the need arises.
- KFL&A did not invite media to its board education session on risk management as the health unit continues to lay the groundwork.

- KFL&A Public Health is willing to share its audit report by the Ministry. Ms. Berinstein advised that health units inform the Ministry if they plan to share their audit reports with other agencies.
- It's beneficial to get employee buy-in to risk management, and don't make it too onerous for staff to implement.
- Boards should consider if a first-time MOH would benefit from an executive coach.

Wrap Up

Speakers were thanked for participating in today's program. It was announced that the alPHa Board of Directors will be holding follow-up discussions. Special thanks were given to Ms. Berinstein for helping alPHa design the event program.

Treasury Board Secretariat

Minister Responsible for the Poverty Reduction Strategy

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TBS3745MC-2015-635

Ms. Lesley Parnell
Chair
Board of Health
Peterborough County-City Health Unit
10 Hospital Drive
Peterborough, ON K9J 8M1

Dear Ms. ~~Parnell~~ Lesley:

Thank you for your letter of September 30, 2015, regarding a basic income guarantee. I appreciate the time you have taken to share the Board of Heath's recommendations.

As you know, Ontario's income security system is a shared federal and provincial responsibility, and both jurisdictions have programs that replace earnings or provide financial support for individuals. The system includes a number of programs designed to address a wide range of client needs. These programs supplement the earnings of low-income workers and provide a basic level of support for people with no other sources of income.

Although we are not committing to a basic income guarantee at this time, we have taken a number of steps to improve income security and labour protections for some of our most vulnerable workers, and we will continue to assess ways to improve the system.

For example, the Ontario Child Benefit supports children in low- to moderate-income families. As of July 2015, the Ontario Child Benefit was indexed to annual increases in the Ontario Consumer Price Index. The maximum benefit rose to $1,336 per child, and it has more than doubled since it was introduced in 2008.

In November 2014, the *Stronger Workplaces for a Stronger Economy Act, 2014* received Royal Assent. The new act increases protections for vulnerable workers and ties future minimum wage increases to the Consumer Price Index for Ontario. Accordingly, Ontario's general minimum wage rose to $11.25 on October 1 of this year.

We have replaced the Northern Allowance with the Remote Communities Allowance. This new allowance provides $50 more per month for individuals and families than the previous allowance, plus an additional $25 for each family member. Together with social assistance increases, that is an increase of 13 per cent since 2013 for a single person without children receiving Ontario Works and living in a remote community.

We are also calling on the federal government to enhance its support of low-income workers through the Working Income Tax Benefit (WITB). An enhanced WITB would more effectively encourage low-income Canadians to enter the workforce and make it easier for low-wage working families to remain in the labour market.

In addition to these programs, there are various refundable tax credits that provide benefits for low- and moderate-income individuals and families, as well as non-refundable tax credits that reduce personal income tax.

Thank you again for writing. I will keep the Board of Heath's recommendations in mind as we continue to help Ontario's most vulnerable people to lead prosperous and fulfilling lives.

Sincerely,

Deb Matthews

Deb Matthews
Deputy Premier
President of the Treasury Board
Minister Responsible for the Poverty Reduction Strategy

c: The Honourable Dr. Eric Hoskins, Minister of Health and Long-Term Care
The Honourable Tracy MacCharles, Minister of Children and Youth Services

December 2, 2015

The Honourable Amarjeet Sohi, Minister of Housing
The Honourable Jane Philpott, Minister of Health
The Honourable Jean-Yves Duclos, Minister of Families, Children and Social Development
The Honourable Maryam Monsef, Minister of Democratic Institutions
The Honourable Patty Hajdu, Minister of the Status of Women

The Honourable Kathleen Wynne, Premier of Ontario
The Honourable Deborah Matthews, Minister Responsible for the Poverty Reduction Strategy / Deputy Premier / President of the Treasury Board
The Honourable Eric Hoskins, Minister of Health and Long-Term Care
The Honourable Jeff Leal, Minister of Agriculture, Food and Rural Affairs

Dear Ministers and Premier Wynne:

Re: Food Security and the Transformation of Social Assistance in Ontario

At its meeting on November 11, 2015, the Board of Health for the Peterborough County-City Health Unit requested that the enclosed letter to the Honourable Helena Jaczek be sent to you for your consideration.

Sincerely,

Original signed by

Councillor Lesley Parnell
Chair, Board of Health

/at
Encl.

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Peterborough County-City HEALTH UNIT
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November 6, 2015

The Honorable Helena Jaczek
Ministry of Community and Social Services
6th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 1E9

Dear Minister Jaczek:

Re: Food Security and the Transformation of Social Assistance in Ontario

As the Minister of Community and Social Services, we are writing to you to request an update on the transformation of social assistance in Ontario. The results of the 2015 Nutritious Food Basket Costing for the Peterborough County-City Health Unit was accepted at the October 14, 2015 Board of Health Meeting, and released to the public, raising the concern that local poverty and food insecurity rates continue to rise. The report demonstrates an urgent need to address the economic barriers that people living with low incomes experience in accessing nutritious food.

The cost of the Nutritious Food Basket in Peterborough City and County in May 2015 for a reference family of four (male between 31-50 years of age, female between 31-50 years of age, 14 year old boy, 8 year old girl) is $865 per month. This represents a 16.6% increase in food costs since 2010, which outpaces the Bank of Canada inflation rate of 9% for the same time period. Despite the increasing costs of food, the real issue is that incomes are too low and many individuals and families just do not have enough money to pay for their basic needs such as shelter and healthy food. This issue poses serious health risks for our community.

Of particular concern in our community are those who live on fixed incomes, specifically clients of both Ontario Works and the Ontario Disability Support Program. A single man whose source of income is Ontario Works can expect 91% of their income to be required just to cover their rent, making it impossible to afford other basic expenses such as nutritious food. Based on the Nutritious Food Basket calculation, this person would need to spend 39% of their total income to eat healthy. If they tried to cover the cost of both shelter and a nutritious diet, they would be in a deficit of $221 each month. It is clear that social assistance rates in Ontario do not reflect the actual costs of shelter and nutritious food.

The Commission for the Review of Social Assistance Reform, led by Commissioners Frances Lankin and Munir Sheikh released "Brighter Prospects: Transforming Social Assistance in Ontario" in 2012, calling for transformation of social assistance in Ontario. In September 2014, the Premier's Mandate letter to you, as the Minister of Community and Social Services, listed as a specific priority the need to focus efforts on long-term transformation of the social assistance system.

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We note that small changes and increases have been implemented to date, but clearly, as Nutritious Food Basket and related income scenarios show, people in Peterborough living on income from Ontario Works or the Ontario Disability Support Program are still unable to make ends meet. Steps must be taken to increase income to reduce both poverty and food insecurity. Food insecurity rates in Peterborough households have risen to 11.5%; and 23.7% of children under 18 years of age live in a food insecure household.

We look forward to receiving a response detailing next steps towards Social Assistance Reform as supported by Ontario's Poverty Reduction Strategy. As part of this process, we urge you to also consider long term strategies such as the implementation of a Basic Income Guarantee for all low income residents of Ontario.

Your urgent attention is required to ensure people living with low incomes have access to healthy food.

Sincerely,

Original signed by

Councillor Lesley Parnell
Chair, Board of Health

/at

cc: M.P.P. Jeff Leal, Peterborough
M.P.P. Laurie Scott, Haliburton-Kawartha Lakes-Brock
Association of Local Public Health Agencies
Ontario Boards of Health

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November 20, 2015

The Honourable Tracy MacCharles
Minister of Children and Youth Services
Ministry of Children and Youth Services
14th Floor, 56 Wellesley Street West
Toronto, ON M5S 2S3

Dear Minister MacCharles:

Re: Healthy Babies Healthy Children Program Funding

On October 21, 2015, at a regular meeting of the Board of Health for the Thunder Bay District, the Board considered the attached resolution from Sudbury and District Health Unit regarding the Healthy Babies Healthy Children Program. The following resolution was passed.

Resolution No. 129-2015

> **"THAT with respect to Report No. 52 – 2015 (Healthy Babies Healthy Children), we recommend that a letter be sent to the Minister of Children and Youth Services to support the resolution from the Sudbury and District Health Unit advocating to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs."**

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

Sincerely,

Norm Gale, Chair
Thunder Bay District Board of Health

Cc: Ontario Boards of Health

Encl.

Sudbury & District Health Unit
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June 30, 2015

VIA ELECTRONIC MAIL

The Honourable Tracy MacCharles
Minister of Children and Youth Services
Ministry of Children and Youth Services
14th floor, 56 Wellesley StreetWest
Toronto, ON M5S 2S3

Dear Minister MacCharles:

Re: Healthy Babies Healthy Children Program

The Healthy Babies Healthy Children (HBHC) program is a 100% funded Ministry of Child and Youth Services (MCYS) program provided by all 36 Ontario Boards of Health. Established in 1998, HBHC supports healthy child development by identifying vulnerable families and providing or connecting them with appropriate supports.

As with many boards of health across the province, the Sudbury & District Board of Health has been increasingly challenged to meet Ministry expectations for HBHC service provision within the l00% funding envelope. At its meeting on June 18, 2015, the Board of Health carried the following resolution #28-15:

WHEREAS the Healthy Babies Healthy Children (HBHC) program is a prevention/early intervention initiative designed to ensure that all Ontario families with children (prenatal to age six) who are at risk of physical, cognitive, communicative, and/or psychosocial problems have access to effective, consistent, early intervention services; and

WHEREAS the Healthy Babies Healthy Children program is a mandatory program for Boards of Health; and

WHEREAS in 1997 the province committed to funding the Healthy Babies Healthy Children program at 100% and the HBHC budget has been flat-lined since 2008; and

WHEREAS collective agreement settlements, travel costs, pay increments and accommodation costs have increased the costs of implementing the HBHC program, the management and administration costs of which are already offset by the cost-shared budget for provincially mandated programs; and

WHEREAS the HBHC program has made every effort to mitigate the outcome of the funding shortfall, this has becoming increasingly more challenging and will result in reduced services for high-risk families if increased funding is not provided.

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health direct staff to prepare a budget and program analysis of the HBHC program, outlining pressures and options for mitigation, detailing program and service implications of these options as compared against MCYS expectations; and

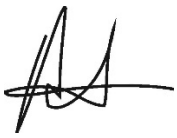
FURTHER THAT the Sudbury & District Board of Health advocate strongly to the Minister of Children and Youth Services to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs.

FURTHER THAT this motion be forwarded to the Association of Local Public Health Agencies, the Chief Medical Officer of Health and all Ontario Boards of Health.

It remains our priority to ensure that the HBHC program can effectively identify and support children and families most in need throughout the Sudbury/Manitoulin District. We look forward to further dialogue with MCYS on how we can best achieve this goal together.

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

Sincerely,



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

cc: Chief Medical Officer of Health (Acting)
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

November 4, 2015

VIA REGULAR MAIL AND EMAIL

The Honourable Tracy MacCharles
Minister of Children and Youth Services
Ministry of Children and Youth Services
14th Floor, 56 Wellesley Street West
Toronto, ON M5S 2S3

Dear Minister MacCharles:

Re. Healthy Babies Healthy Children Program Funding

On November 4th, 2015 at a regular meeting of the Board of Health for Wellington-Dufferin-Guelph Public Health, the Board considered the attached resolutions from Sudbury District Health Unit and Grey Bruce Health Unit regarding the Healthy Babies Healthy Children Program. As with many boards of health across the province, the Board of Health for Wellington-Dufferin-Guelph Public Health has been increasingly challenged to meet Ministry expectations for HBHC service provision within the 100% funding envelope. The following motion was passed:

> "That the Board of Health for Wellington-Dufferin-Guelph Public Health supports the resolutions from Sudbury and District Health Unit and Grey Bruce Health Unit advocating to the Minister of Children and Youth Services to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs."

We are committed to providing high quality service and support to vulnerable families in our community.

Sincerely,

Doug Auld
Chair, WDGPH Board of Health

cc Ontario Public Health Units – via email
Ted Arnott, MPP – via email
Honourable Liz Sandals, MPP, Minister of Education – via email
Sylvia Jones, MPP – via email
Randy Pettapiece, MPP – via email

August 6, 2015

The Honourable Tracy MacCharles
Minister of Children and Youth Services
14th Floor, 56 Wellesley Street West
Toronto ON M5S 2S3

Dear Minister MacCharles:

Re. Healthy Babies Healthy Children Program

On July 24, 2015 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached resolution from Sudbury District Health Unit regarding the Healthy Babies Healthy Children Program. The following motion was passed:

Motion No: 2015-62

Moved by: David Shearman **Seconded by: Gary Levine**

"That the Board of Health for the Grey Bruce Health Unit supports the resolution from Sudbury and District Health Unit advocating to the Minister of Children and Youth Services to fully find all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs."

Carried

Sincerely,

Hazel Lynn MD, FCFP, MHSc
Medical Officer of Health

Cc: All Ontario Boards of Health

Encl.

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June 30, 2015

VIA ELECTRONIC MAIL

The Honourable Tracy MacCharles
Minister of Children and Youth Services
Ministry of Children and Youth Services
14th floor, 56 Wellesley StreetWest
Toronto, ON M5S 2S3

Dear Minister MacCharles:

Re: Healthy Babies Healthy Children Program

The Healthy Babies Healthy Children (HBHC) program is a 100% funded Ministry of Child and Youth Services (MCYS) program provided by all 36 Ontario Boards of Health. Established in 1998, HBHC supports healthy child development by identifying vulnerable families and providing or connecting them with appropriate supports.

As with many boards of health across the province, the Sudbury & District Board of Health has been increasingly challenged to meet Ministry expectations for HBHC service provision within the 100% funding envelope. At its meeting on June 18, 2015, the Board of Health carried the following resolution #28-15:

WHEREAS the Healthy Babies Healthy Children (HBHC) program is a prevention/early intervention initiative designed to ensure that all Ontario families with children (prenatal to age six) who are at risk of physical, cognitive, communicative, and/or psychosocial problems have access to effective, consistent, early intervention services; and

WHEREAS the Healthy Babies Healthy Children program is a mandatory program for Boards of Health; and

WHEREAS in 1997 the province committed to funding the Healthy Babies Healthy Children program at 100% and the HBHC budget has been flat-lined since 2008; and

WHEREAS collective agreement settlements, travel costs, pay increments and accommodation costs have increased the costs of implementing the HBHC program, the management and administration costs of which are already offset by the cost-shared budget for provincially mandated programs; and

WHEREAS the HBHC program has made every effort to mitigate the outcome of the funding shortfall, this has becoming increasingly more challenging and will result in reduced services for high-risk families if increased funding is not provided.

THEREFORE BE IT RESOLVED THAT the Sudbury & District Board of Health direct staff to prepare a budget and program analysis of the HBHC program, outlining pressures and options for mitigation, detailing program and service implications of these options as compared against MCYS expectations; and

FURTHER THAT the Sudbury & District Board of Health advocate strongly to the Minister of Children and Youth Services to fully fund all program costs related to the Healthy Babies Healthy Children program, including all staffing, operating and administrative costs.

FURTHER THAT this motion be forwarded to the Association of Local Public Health Agencies, the Chief Medical Officer of Health and all Ontario Boards of Health.

It remains our priority to ensure that the HBHC program can effectively identify and support children and families most in need throughout the Sudbury/Manitoulin District. We look forward to further dialogue with MCYS on how we can best achieve this goal together.

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

Sincerely,

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

cc: Chief Medical Officer of Health (Acting)
Linda Stewart, Executive Director, Association of Local Public Health Agencies
Ontario Boards of Health

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October 28, 2015

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1

Dear Premier Wynne,

Re: Northern Ontario Evacuations of First Nations Communities

At its meeting on September 22, 2015 the Board of Health for the District of Algoma Health Unit considered the correspondence forwarded by the Sudbury and District Health Unit in regards to the evacuations of First Nations communities in Northern Ontario.

This Board supports their recommendations as outlined in their attached letter and hopes that you will consider the need for a proactive, planned and adequately resourced evacuation system to ensure the safety of all First Nations Communities affected.

Thank you for your consideration.

Sincerely,

Lee Mason
Chair, Board of Health

Attachment

Cc: Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
Hon. David Orazietti, MPP for Sault Ste. Marie
Michael Mantha, MPP for Algoma-Manitoulin
Association of Local Public Health Agencies
Ontario Boards of Health

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June 30, 2015

VIA ELECTRONIC MAIL

The Honourable Kathleen Wynne
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
Email: premier@ontario.ca

Dear Premier Wynne:

Re: Northern Ontario Evacuations of First Nations Communities

At its meeting on June 18, 2015, the Sudbury & District Board of Health carried the following resolution #32-15:

WHEREAS the evacuation and relocation of residents of a number of First Nations communities in Northwestern Ontario and along the James Bay Coast, is required on a close to annual basis due to seasonal flooding and risk of forest fires; and

WHEREAS a safe, effective, and efficient temporary community relocation is challenging within the current reactive model; and

WHEREAS a proactive, planned and adequately resourced evacuation system would ensure the maintenance of quality evacuation centers in pre-selected host municipalities, as well as appropriate infrastructure to ensure the health and safety of evacuees in a culturally acceptable manner; and

WHEREAS the Thunder Bay District Board of Health passed a motion on March 18, 2015, and has submitted a letter dated April 10, 2015 to the Honourable Kathleen Wynne requesting that the provincial government address the ongoing lack of resources and infrastructure to ensure the safe, efficient and effective temporary relocation of First Nations communities in Northwestern Ontario and the James Bay coast when they face environmental and weather related threats in the form of seasonal flooding and forest fires;

THEREFORE BE IT RESOLVED THAT the Sudbury and District Board of Health support the Thunder Bay District Board of Health's resolution 50-2015 dated March 18, 2015; and

FURTHER THAT a copy of this motion be forwarded to the Premier of Ontario, Ministers responsible for Health and Long-Term Care, Community Safety and Correctional Services, Aboriginal Affairs, Northern Development and Mines, Natural Resources and Forestry, local area Members of Provincial Parliament and all Ontario Boards of Health.

It is the Board's hope that you will seriously consider the need for a proactive, planned and adequately resourced evacuation system which would ensure the safe, efficient and effective temporary relocation of First Nation communities in Northwestern Ontario and the James Bay coast when these communities are threatened by seasonal flooding and risk of forest fires.

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

Sincerely,

Penny Sutcliffe, MD, MHSc, FRCPC
Medical Officer of Health

cc: Hon. Dr. Eric Hoskins, Minister of Health and Long-Term Care
Hon. Yasir Naqvi, Minister Community Safety and Correctional Services
Hon. David Zimmer, Minister of Aboriginal Affairs
Hon. Michael Gravelle, Minister of Northern Development and Mines
Hon. Bill Mauro, Minister of Natural Resources and Forestry
Hon. Glenn Thibeault, MPP Sudbury
Hon. France Gélinas, MPP Nickel Belt
Linda Stewart, Executive Director, Association of Local Public Health Agencies

PublicHealth
WELLINGTON-DUFFERIN-GUELPH
Stay Well.

November 4, 2015

DELIVERED VIA E-MAIL
dmatthews.mpp@liberal.ola.org

Minister Responsible for the Poverty Reduction Strategy/Deputy Premier
99 Wellesley Street West
4th Floor, Whitney Block
Toronto, ON M7A 1W3

Attention: The Honourable Deborah Matthews, MPP

Dear Minister Matthews:

Re: Results of 2015 Nutritious Food Basket for Wellington-Dufferin-Guelph Public Health

The results of the 2015 Nutritious Food Basket (NFB) for Wellington-Dufferin-Guelph Public Health (WDGPH) have been released. In 2015, the cost of the NFB in WDG for a reference family of four is **$209.42 per week**. The list of foods used in the survey represents nutrition recommendations and food purchasing patterns of Canadians and includes foods from the four food groups of Canada's Food Guide.

The results of this report have raised significant concern among the members of WDGPH Board of Health about poverty and food insecurity. When housing costs and other basic living expenses are considered, many individuals and families with a limited income do not have adequate funds to purchase nutritious food on a consistent basis. Local data shows that since 2009 when the new nutritious food basket protocol was implemented, there has been a 25% increase in the cost of food over a 7 year period. These issues pose serious health risks for the public health of our community.

This report clearly shows that low-income individuals and families do not have enough money to pay for their basic needs including shelter and healthy food. For example, a case scenario of a single person on Ontario Works fares the worst in this respect as 92% of their income may go to rent leaving insufficient money (8% of income) left over to purchase any food or cover basic expenses. According to the nutritious food basket data, a basic cost to eat healthy for a single person on Ontario works is estimated to be 41% of their income.

.../2

160 Chancellors Way, Guelph, ON N1G 0E1
Telephone: 519-822-2715 | Fax: 519-836-7215 | www.wdgpublichealth.ca

The report suggests that poverty reduction must remain a high priority for the government. We are aware that the government is taking steps to improve poverty. We are conscious of the 2010 review of Ontario's social assistance system that was completed to ensure that social assistance programs make certain that Ontarians can afford to make healthy choices. We also are aware that the government released a Poverty Reduction Strategy 2014 annual report that highlighted some progress. Although we applaud this progress, there is much more that could be done to ensure that everyone in Ontario can afford to eat healthy. WDGPH Board of Health is requesting the provincial government to increase social assistance basic allowance rates to an amount that is adequate to cover basic living expenses, including the cost of healthy eating as determined by the food costing survey. This will allow low income individuals and families to afford to eat healthier and ultimately reduce lifestyle related chronic disease which can contribute to lower healthcare costs.

We look forward to your urgent attention to address the economic barriers that people living with low-incomes experience in accessing healthy food.

Sincerely,

Doug Auld
Chair, WDGPH Board of Health

c.c. The Honourable Liz Sandals, MPP and Minister of Education – via e-mail
Ted Arnott, MPP – via e-mail
Sylvia Jones, MPP – via e-mail
Randy Pettapiece, MPP – via e-mail
Eric Hoskins, Minister, Ministry of Health & Long-Term Care – via e-mail
Dr. Nicola Mercer, MOH & CEO, WDGPH – via e-mail
Ontario Public Health Units

ELGIN ST. THOMAS
PUBLIC HEALTH

November 2, 2015

The Honourable Eric Hoskins
Minister of Health
Ministry of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto, ON M7A 2C4

Dear Mr. Hoskins,

RE: Public Health Funding

On October 14, 2015, the Board of Health for Elgin St. Thomas Public Health considered the attached resolutions from Porcupine and Grey Bruce Health Units and passed the following resolution:

Moved by: David Marr Seconded by: Dave Mennill

WHEREAS the Ministry of Health and Long-Term Care has, on September 4, 2015, released the 2013 report of the Funding Review Working Group with respect to a public health funding model for Mandatory programs, which it has accepted for the 2015 budget year and beyond; and

WHEREAS, based upon current information, the model indicates that approximately 80% of Public Health Units in the Province of Ontario are overfunded, which in and of itself calls into question, the validity of said model; and

WHEREAS, in some large centres there is a possibility that these extra public health funds could effectively be consumed by larger municipal budgets and not utilized for additional public health services; and

WHEREAS, under this model, health units who have been identified as being overfunded, may have many years of shrinking public health services, in the face of higher costs, due to having to deal with a flat lined budget allocation; and

WHEREAS, public health program and service delivery is designed to create healthy Ontarians and communities and thereby reducing the burden of illness and disease; and

WHEREAS, the percentage of public health funding in the overall provincial health budget is approximately 2%; and

Elgin St. Thomas Public Health
1230 Talbot Street, St. Thomas, ON N5P 1G8
Phone: 519-631-9900 Toll Free: 1-800-922-9900 Fax: 519-633-0468
www.elginhealth.on.ca

NOW THEREFORE BE IT RESOLVED THAT, the Board of Health for Elgin St. Thomas Public Health support the resolutions from the Grey Bruce and Porcupine Health Units and opposes this new funding model and the radical long-term shifting of public health resources to wealthier urban centres of the Province; and

FURTHER THAT, the Board of Health for Elgin St. Thomas Public Health calls for the Ministry of Health and Long-Term Care to reverse their decision to support this report, and revise the funding formula which appears biased against smaller, Northern and Rural Health Units and develop a funding formula that addresses the needs of smaller, northern and rural health units; and

FURTHER THAT, the Board of Health of Elgin St. Thomas Public Health calls for the Ministry of Health and Long-Term Care to increase the total funding envelope for public health to reduce the need for other acute health care services for Ontarians and communities; and

FURTHER THAT, this resolution be forwarded to the Premier of Ontario, the Minister of Health and Long-Term Care, AMO, ROMA, alPHa, Local MPs and MPPs, All Municipalities in Elgin St. Thomas and All Ontario Boards of Health.

Carried.

Sincerely,

Heather Jackson

Heather Jackson, Chair
Elgin St. Thomas Board of Health

HJ:ke

HALIBURTON, KAWARTHA,
PINE RIDGE DISTRICT
HEALTH UNIT

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

November 19, 2015

The Honourable Eric Hoskins
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON M7A 2C4

Dear Minister Hoskins

RE: Association of Local Public Health Agencies' (alPHa) Resolution: Public Health Funding Formula

On behalf of the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit, I am writing to endorse alPHa's correspondence and related Resolution: Public Health Funding Formula (enclosed).

We share your primary interest in supporting people to be as healthy as possible, as outlined in Ontario's heatlh care system's strategic plan, Patients First: Action Plan for Health Care. The new Public Health Funding Model will make it challenging for Boards of Health to continue to build and maintain capacity to work within our communities to protect and promote health and prevent disease.

We appreciate your consideration of the resolution and your commitment to work with alPHa and Ontario's boards of health, so we can fulfill our mandates and serve our communities.

Yours truly

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

Mark Lovshin, Chair
Board of Health, HKPR District Health Unit

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200 Rose Glen Road
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LINDSAY OFFICE
108 Angeline Street South
Lindsay, Ontario K9V 3L5
Phone (705) 324-3569
Fax (705) 324-8455

Encl./ 1

Copy to: Hon. Kathleen Wynne, Premier of Ontario
Hon. Charles Sousa, Minister of Finance
Dr. Bob Bell, Deputy Minister, Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health (A)
Roselle Martino, Executive Director, Public Health Division
Jackie Wood, Assistant Deputy Minister (A), Health Promotion Division
Laura Pisko, Assistant Deputy Minister (A), Health Promotion Division
Sharon Lee Smith, Associate Deputy Minister, Policy and Transformation
Paulina Salamo, Director (A) Public Health Standards, Practice & Accountability
Brent Feeney, Manager, Funding and Accountability Unit (MOHLTC)
Brian Pollard, Director, Health Sector Models Branch (MOHLTC)
Victor Fedeli, Critic, Finance (PC)
Catherine Fife, Critic, Finance (NDP)
Jeff Yurek, Critic, Health (PC)
France Gélinas, Critic, Health and Long-Term Care (NDP)
Gary McNamara, President, Association of Municipalities of Ontario (AMO)
Chairs, Boards of Health

Staff Report

Dental Integration

Date:	December 9, 2015
To:	Board of Health
From:	Dr. Rosana Salvaterra, Medical Officer of Health

Original approved by	***Original approved by***
Rosana Salvaterra, M.D.	Sarah Tanner, Program Manager

Recommendations

That the Board of Health for the Peterborough County-City Health Unit receive the staff report, *Dental Integration,* for information.

Financial Implications and Impact

Beginning January 1st, 2016 the Ministry of Health and Long-Term Care (MOHLTC) will fund the provision of Healthy Smiles Ontario (HSO) dental services. Administration will be centralized and handled through a new third party administrator and through PCCHU. The key change in the new program is that PCCHU will no longer pay the claims for fee-for-service private oral health providers. Therefore, in preparing 2016 budgets, PCCHU should not plan for funding related to the administration of direct claims costs, but should continue to plan for maintaining service capacity levels similar to 2015 to support ongoing oral health programming.

The new HSO Program will continue to be 100% provincially funded and PCCHU will continue to operate our Community/Mobile Dental Health Centres.

The MOHLTC is anticipating one-time, extra funding requests in 2015 to cover transition related costs to the new program. PCCHU has submitted an application for this as part of the Third Quarter Reporting process.

Background

To make it easier for eligible children and youth to receive timely dental care, changes are being made to the HSO Program. The need to further improve dental services for children and youth in Ontario was initiated by the Poverty Reduction Strategy which identified dental care as a key priority. In December 2013, the provincial government announced its intent to integrate oral health programs and/or benefits for children and youth from low-income families into one new Integrated Program.

The MOHLTC has committed to ensuring that all children who are eligible for current dental services will continue to be eligible in the new integrated program. Active HSO and Children in Need of Treatment (CINOT) clients will be 'grandparented' into the new program, until July 31, 2016; the end of the benefit year. PCCHU has signed a data sharing agreement to share information from the Oral Health Information and Support System (OHISS) to the MOHLTC, for the purposes of client 'grandparenting', so that clients continue to access services and have time to apply to the new program.

The new integrated HSO program will be launched on January 1, 2016, and aims to:

- Improve access to oral health services for eligible children and youth;
- Reduce inequalities;
- Streamline administration;
- Improve oral health status and oral health outcomes for eligible individuals;
- Enable better measurement and monitoring of program successes; and
- Reduce opportunities for program misuse.

This is a major change for the Province to integrate these programs and implement a major shift in how clients will register for assistance and how oral health providers will submit claims for reimbursement under the new program. We will support clients and our community during this transition and the shift of responsibility of claims processing and client enrollment from PCCHU to the new third party administrator.

Rationale

Currently, there is a patch work of oral health programs and/or benefits with varying eligibility criteria, enrollment processes, delivery partners, service schedules and funding arrangements which can be confusing for some clients and oral health care providers.

The intention of one integrated new HSO program is to streamline administration, and reduce confusion for oral health care providers and clients. Eligibility is being simplified, streamlined and expanded as a result of a change to the income eligibility threshold; children and youth receiving Ontario Works (OW), the Ontario Disability Support Plan (ODSP) and families receiving

Assistance for Children with Severe Disabilities (ACSD) will automatically be eligible and enrolled in the program; and families with limited dental insurance will no longer be excluded.

The provincial government is responsible for establishing the new HSO Program by integrating existing dental programs/benefits, developing and implementing eligibility criteria, and setting and developing the fee/service schedule.

The new HSO program will be part of a continuum of oral health services within PCCHU and will link to and complement activities as required under the Ontario Public Health Standards (OPHS). A new HSO Program Protocol will replace some existing Protocols and will be incorporated under the Child Health Program Standard of the OPHS.

The MOHLTC priority is for local public health agencies to take on an enhanced role with respect to client navigation, preventive services, and program and case management. Our Oral Health program staff will need to determine how they can offer the required case management and need a clear understanding of the case management of:

- Individuals requiring referral to the Children's Aid Society;
- Assisting with eligibility/applications for the core HSO stream; and
- Assisting with eligibility/applications for the Emergency Essential Services stream (replaces CINOT).

Current clients need assistance transitioning from CINOT and current HSO clients to the new HSO Program. Oral health care providers need assistance in understanding the process and whether their clients have been transitioned prior to the sun-setting of programs like CINOT on December 31, 2015. We are waiting for the provincial communications piece, and have met with our Communications Manager to ensure we can use social media and local communications networks to distribute information on the new HSO once it is released. To support the dental community, ongoing communication activities are planned with dental providers to support the implementation of the new program. In terms of community outreach and case management, we will use our current resources such as our Dental Health Centres to support these priorities.

With an implementation date of January 2016, we have been preparing for the last several months by:

- Attending bi-weekly/weekly teleconferences;
- Re-training staff;
- Validating that client data is up-to-date and complete for the Ministry;
- Determining the functionality of OHISS is sufficient for reporting requirements;
- Familiarizing ourselves with new *Healthy Smiles* reports while still working with the old;
- Fielding questions from the dental community, clients, and community organizations to ensure that clients continue to receive uninterrupted and seamless access to services;
- Preparing information for the local Peterborough & District Dental Society;

- Planning to ensure internal programs are updated about new HSO;
- Contacting clients to determine where they are up to with their treatment, and to encourage them to complete by year-end; and
- Providing community dentists with lists of children who have transitioned to the new HSO.

As we develop our Oral Health operational plans for 2016, we will be integrating the implementation of new program and protocols.

Consideration will be given to the allocation of resources required to be able to effectively implement and lead the new components of case management. As the new program is implemented and the new protocols developed, we will need to monitor our ability to meet these demands within current program resources and structure. The new emphasis on case management may require a refocus for some staff, and may necessitate new resources being required.

Strategic Direction

Being able to offer ongoing, improved oral health services fits with the Board of Health Strategic Plan to increase our focus on individuals in our community who are vulnerable and at risk of poor (oral) health outcomes, addressing the underlying causes of inequity and improving access to (oral health) programs, services and resources. The program also builds on the strengths of our local communities, and working strategically with external partners to ensure that local health needs are identified and addressed, with a vision of being community-centered. The Healthy Smiles Ontario oral health services provided, directly impacts the health of individuals and families.

Contact:

Sarah Tanner,
Manager, Oral Health Programs
(705) 743-1000, ext. 207
stanner@pcchu.ca

To: All Members
Board of Health

From: Mr. Scott McDonald, Chair, Governance Committee

Subject: **Committee Report: Governance**

Date: December 9, 2015

The Governance Committee met last on December 1, 2015. At that meeting, the Committee requested that the following items come forward to the Board of Health for consideration. Supporting documentation has been included (and linked) where available.

1. Governance Committee Meeting Minutes:

Recommendation:

That the Board of Health for the Peterborough County-City Health Unit receive for information, meeting minutes of the Governance Committee for August 18, 2015

Please refer to the following documents:

a. Governance Committee Minutes - August 18, 2015 (p. 92)

2. By-Laws, Policies and Procedures

Recommendation:

That the Board of Health for the Peterborough County-City Health Unit approve changes to:

- *2-120 By-Law 3, Calling of and Proceedings at Meetings;*
- *2-340 Medical Officer of Health Performance Review; and,*

be advised that the Governance Committee has reviewed the following documents and recommends no further changes to:

- *2-140 By-Law Number 5, Powers, Duties and Term of Office of the Chairperson and Vice-Chairperson of the Board of Health*
- *2-251 Orientation for Board of Health Members*

Please refer to the following documents:

a. 2-120 By-Law Number 3, Calling of and Proceedings at Meetings (p. 96)
b. 2-340 Medical Officer of Health Performance Review (p. 107)

c. 2-140 By-Law Number 5, Powers, Duties and Term of Office of the Chairperson and Vice-Chairperson of the Board of Health ***(hyperlink)***

d. 2-251 Orientation for Board of Health Members ***(hyperlink)***

Please note that the accompanying procedure for item b (2-341) was previously a separate document has been incorporated. Also, applicable forms will be finalized by the Chair of the Governance Committee in consultation with the Medical Officer of Health.

3. Ontario Public Health Organizational Standards (Management Operations)

Recommendation:

That the Board of Health for the Peterborough County-City Health Unit receive the status update on the Ontario Public Health Organizational Standards (Management Operations) for the Peterborough County-City Health Unit for information.

a. PCCHU Status Update – Management Operations (p. 111)

Board of Health for the
Peterborough County-City Health Unit
MINUTES
Governance Committee Meeting
Tuesday, August 18, 2015 – 5:00 p.m.
City and County Rooms, 150 O'Carroll Avenue, Peterborough

Present:	**Mayor Mary Smith (5:45 p.m.)**
	Mr. Scott McDonald, Chair
	Deputy Mayor Fallis (by teleconference)
	Mr. Greg Connolley
	Councillor Parnell (by teleconference)
Staff:	**Dr. Rosana Pellizzari, Medical Officer of Health**
	Mr. Larry Stinson, Acting Director, Corporate Services
	Ms. Natalie Garnett, Recorder

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1. Call to Order

Mr. McDonald called the Governance Committee meeting to order at 5:06 p.m.

2. Confirmation of the Agenda

MOTION:
That the Agenda be accepted as circulated.
Moved: Mr. Connolley
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-26-GV)

3. Declaration of Pecuniary Interest

4. Delegations and Presentations

5. Confirmation of the Minutes of the Previous Meeting

MOTION:
That the minutes of the Governance Meeting held May 19, 2015 be approved as amended and provided to the Board of Health at its next meeting for information.
Moved: Deputy Mayor Fallis
Seconded: Mr. Connolley
Motion carried. (M-2015-27-GV)

6. Business Arising from the Minutes

6.1. Consent Agenda – Revision to By-Law 3

MOTION:
That the Governance Committee recommend to the Board of Health of the Peterborough County-City Health Unit that it approve the proposed revisions to By-law 3: Calling of and Proceedings at Meetings, Consent Agenda, as amended.
Moved: Mr. Connolley
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-28-GV)

7. Correspondence

8. New Business

8.1 Policies and Procedures for Review

a) 2-185 By-law Number 10 Open and In-Camera Meetings
b) 2-280 Complaints, Public
c) 2-345 Medical Officer of Health Absence

MOTION:
That the Governance Committee recommend to the Board of Health of the Peterborough County-City Health Unit that it approve revisions to the following:

- *2-185 By-Law Number 10 Open and In-Camera Meetings; and*
- *2-280 Complaints, Public*
- *2-345 Medical Officer of Health Absence (no change)*

Moved: Mr. Connolley
Seconded: Deputy Mayor Fallis
Motion Carried. (M-2015-29-GV)

8.2 **Medical Officer of Health Performance Review**

MOTION:

That the Medical Officer of Health Performance Review be deferred to the November 17, 2015 Committee meeting.

Moved: Mr. Connolley
Seconded: Deputy Mayor Fallis
Motion Carried. (M-2015-30-GV)

8.3 **Board/Management Planning Session Feedback**

Dr. Pellizzari advised that she will forward the information to Committee members by email with a link to the notes from the May 30th, 2015 session.

8.4 **Assessor's Report on Algoma Public Health**

a) Ministry Actions and Executive Summary
b) Full Assessment Report

MOTION:

That a staff report providing an update on how the Peterborough County-City Health Unit is meeting organizational standards be brought forward to the Governance Committee, and then circulated to the full Board.

Moved: Mr. Connolley
Seconded: Deputy Mayor Fallis
Motion Carried. (M-2015-31-GV)

9. In Camera to Discuss Confidential Personal Matters

MOTION:

That the Governance Committee go in Camera at 5:57 p.m. to review confidential personal matters.

Moved: Mr. Connolley
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-32-GV)

MOTION:

That the Governance Committee rise from in Camera at 6:44 p.m.

Moved: Mayor Smith
Seconded: Deputy Mayor Fallis
Motion carried. (M-2015-33-GV)

10. Motions from In Camera for Open Session

11. Date, Time and Place of Next Meeting

The next meeting of the Governance Committee will be held on Tuesday, November 17, 2015 at the new office at 185 King Street.

12. Adjournment

MOTION:
That the Governance Committee meeting be adjourned.
Moved by: Mr. Connolley
Seconded by: Mayor Smith
Motion carried. (M-2015-34-GV)

The meeting was adjourned at 6:48 p.m.

Chairperson

Medical Officer of Health

Board of Health

POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-120	**Title:** By-Law Number 3, Calling of and Proceedings at Meetings
Approved by: Board of Health		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 1989-10-11**
Signature:		**Author:**
Date (YYYY-MM-DD)**:** 2015-09-09		
Reference:		

NOTE: This is a **CONTROLLED** document for internal use only, any document appearing in a paper form should **ALWAYS** be checked against the online version prior to use.

By-Law Number 3
Calling of and Proceedings at Meetings

Section 1 - Interpretation

In this By-law:

1.1. "Act" means the *Health Protection and Promotion Act*;

1.2. "Board" means the Board of Health for the Peterborough County-City Health Unit;

1.3. "Director, Corporate Services" means the business administrator of the Board as defined in the Regulations under the Act;

1.4. "Chairperson" means the presiding officer at a meeting;

1.5. "Chairperson of the Board" means the Chairperson elected under the Act;

1.6. "Committee" means an assembly of two or more members that must meet together to transact business;

1.7. "Councils" means the municipal Councils of the Corporations of the County of Peterborough and the City of Peterborough, and the Councils of Curve Lake and Hiawatha First Nations;

1.8. "Medical Officer of Health" means the Medical Officer of Health of the Board as defined under the *Act* and *Regulations*;

1.9. "Meeting" means an official gathering of members of the Board or a committee to transact business;

1.10. "Member" means a person who is appointed to the Board by a Council or the Lieutenant Governor-in-Council or a person who is appointed to a committee by the Board;

1.11. "Motion" means a formal proposal by a member in a meeting that the Board or a committee take certain action;

1.12. "Resolution" means a motion that is carried at a meeting by a majority vote in the affirmative of the members present; and

1.13. "Vice-Chairperson of the Board" means the Vice-Chairperson elected under the Act.

Section 2 – General

2.1. The rules in this By-law shall be observed in the calling of and the proceedings at all meetings of the Board and committees.

2.2. Except as herein provided, the most recent edition of Robert's Rules of Order shall be followed for governing the calling of and proceedings of meetings of the Board and committees.

2.3. No persons shall consume alcohol or tobacco products at a meeting.

2.4. ~~Electronic participation may be approved by the Board of Health Chair in special circumstances~~.

2.5. Subject to any conditions or limitations in the Health Protection and Promotion Act, a member who participates in a meeting through electronic means is deemed to be present at the meeting including, without limitation, for purposes of establishing quorum, full participation rights and full voting rights.

~~2.6. The electronic means must enable the member to hear and to be heard by the other meeting participants. Normal board of health meeting rules and procedures will apply with necessary modifications arising from electronic participation.~~

Section 3 - Convening of Meetings

3.1 The Medical Officer of Health shall call the first meeting of each calendar year.

3.2 The first meeting shall be held after the municipal members, appointed to the Board by their respective councils, are confirmed, and shall be held no later than the 1st day of February.

3.3 At the first meeting of each calendar year, the Board shall:

3.3.1 elect the Chairperson and the Vice-Chairperson of the Board for the year;

3.3.2 appoint members to its committees;

3.3.3 fix, by resolution, the date and time of regular meetings; and,

3.3.4 establish the honourarium paid to each member eligible for compensation in accordance with the Health Protection and Promotion Act.

3.4 A meeting may be rescheduled or cancelled due to the following circumstances:

3.4.1 in the event that an emergency has been declared by the Medical Officer of Health;

3.4.2 if there is indication from members in advance of the meeting that quorum will not be achievable; or

3.4.3 if upon consultation with the Medical Officer of Health, the Chairperson determines there is insufficient business to be considered.

In all instances, the Chairperson will poll members to obtain consensus to proceed with a cancellation. If approval is obtained through a majority vote, members will be notified and a public notice will be issued.

3.5 The Chairperson of the Board can call a special meeting and shall call a special meeting at the written request of a majority of the members.

3.6 The Medical Officer of Health shall:

3.6.1 give notice of the first and each regular and special meeting;

3.6.2 ensure that the notice accompany the agenda and any other matter, so far as known, to be brought before such meeting;

3.6.3 cause the notice to be delivered to the residence or place of business of each member or by e-mail or telephone so as to be received not later than two clear days in advance of the meeting.

3.7 The lack of receipt of the notice shall not affect the validity of the holding of the meeting or any action taken thereat.

3.8 No business other than that stated in the notice of a special meeting shall be considered at such meeting except with the unanimous consent of the members present.

3.9 ~~Special meetings can be held by teleconference.~~

Section 4 - Agenda and Order of Business

4.1 The Medical Officer of Health shall have prepared for the use of each member at the first and regular meetings an agenda of the following items.

4.1.1 Call To Order

4.1.2 Confirmation of the Agenda

4.1.3 Declaration of Pecuniary Interest

4.1.4 Delegations and Presentations

4.1.5 Confirmation of the Minutes of the Previous Meeting

4.1.6 Business Arising from the Minutes

4.1.7 Staff Reports

4.1.8 Consent Items

4.1.9 New Business

4.1.10 In Camera to Discuss Confidential Matters

4.1.11 Motions from In Camera for Open Session

4.1.12 Date, Time and Place of the Next Meeting

4.1.13 Adjournment

4.2 Any items not included on the prepared agenda may be added by resolution.

4.3 Agenda packages will be posted on the Health Unit's website on the same day that agendas are distributed to Board of Health members.

4.4 On the day following Board of Health meetings, Board members will be contacted and advised of the date, time, and location of the next meeting, and asked about their availability for the next meeting.

4.5 The business of each regular meeting shall be taken up in the order described in section 4.1 of this By-law unless otherwise decided by the members.

4.6 Consent Items are items to be considered for the Consent portion (4.1.8) of the agenda and shall be determined by the Medical Officer of Health. Matters selected for Consent Items are to be routine, housekeeping, information or non-controversial in nature.

4.6.1 If the Board wishes to comment or seek clarification on a specific matter noted in the list of Consent Items, the member is asked to identify the item and clarification or comment will be provided or made. An item(s) requiring more than clarification or comment will be extracted and moved to the New Business section of the agenda. The Consent Items, exclusive of extracted items where applicable, can be approved in one resolution.

4.6.2 Matters listed under Consent Items shall include an explanatory note as follows: "All matters listed under Consent Items are considered to be routine, housekeeping, information or non-controversial in nature and to facilitate the Board of Health's consideration can be approved by one motion".

4.6.3 Consent Items will include:

- Staff Reports and Presentations – Information, Housekeeping and Non-Controversial.
- Correspondence – Direction and Information. A Correspondence Report will be prepared and included in the Consent Items section of the agenda. The report will be divided into two sections as follows, Correspondence for Direction and Correspondence for Information. Where possible each item of correspondence for direction will have a staff recommendation included.
- Committee Reports.

4.7 New Business items are those that have not been discussed by meeting attendees previously and that do not belong in staff or Committee reports.

4.8 The Chairperson of the Board shall direct the preparation of an agenda for a special meeting.

4.9 The business of each special meeting shall be taken up in the order as listed on the agenda of such meeting unless otherwise decided by the members.

Section 5 - Commencement of Meetings

5.1 As soon as there is a quorum after the time fixed for the meeting, the Chairperson or Vice-Chairperson of the Board or the person appointed to act in their place and stead, shall take the chair and call the members to order.

5.2 A quorum for any meeting of the Board or a committee shall be a majority of the appointed members.

5.3 If the Chairperson or Vice-Chairperson of the Board or the Chairperson of a committee does not attend a meeting by the time a quorum is present, the Medical Officer of Health shall call the members to order and a presiding officer shall be appointed to preside during the meeting or until the arrival of the person who ought to preside.

5.4 Upon any members directing the attention of the Chairperson to the fact that a quorum is not present, the Medical Officer of Health, at the request of the Chairperson, shall record the names of those members present and advise the chairperson if a quorum is or is not present. If there is no quorum within thirty minutes after the time fixed for the meeting, the Chairperson shall then adjourn until the day and time fixed for the next meeting.

Section 6 - Delegations and Debate

6.1 The Chairperson shall preside over the conduct of the meeting, including preserving good order and decorum, ruling on points of order and deciding all questions relating to the orderly proceedings of the meeting.

6.2 Any individual or group who wishes to make a presentation to the Board shall make a written request to the Chairperson of the Board up to a minimum of twenty-four hours before the start of the meeting.

6.3 The Chairperson of the Board (in consultation with the Medical Officer of Health) shall decide whether the delegation may make a presentation at a meeting and accordingly, shall inform the individual or group whether their request has been approved or denied.

6.4 The Chairperson shall give due consideration to the length of the agenda and the number of delegation requests received, and may limit the number of delegations to a maximum of five (5) per meeting.

6.5 All delegations appearing before the Board shall be permitted to speak only once on an item, unless new information is being brought forward, and/or unless permission is given by the Chairperson of the Board, in consultation with the Medical Officer of Health.

6.6 Delegations and presentations of general interest shall not exceed ten minutes except when answering questions posed by the Chairperson for clarification.

6.7 Unless otherwise directed by resolution, no action respecting a delegation will be taken until the Board has had an opportunity to discuss the delegation and to receive advice from the Medical Officer of Health.

6.8 The Board will be informed of all requests from delegations and the disposition of such requests and, upon review, the Board may reverse the decision of the Chairperson of the Board by resolution.

6.9 Every member shall address the Chairperson respectfully previous to speaking to any motion.

6.10 When two or more members ask to speak, the Chairperson shall name the member who, in their opinion, first asked to speak.

6.11 If the Chairperson desires to leave the Chair to participate in a debate or otherwise, they shall call on the Vice-Chairperson to fill their place until they resume the Chair.

6.12 A member may speak more than once to a motion, but after speaking, shall be placed at the foot of the list of members wishing to speak.

6.13 No member shall speak to the same motion at any one time for longer than ten minutes except that extensions for speaking for up to five minutes for each time extended may be granted by resolution.

6.14 6.14.1 A member may ask a question of the previous speaker and then only to clarify any part of their remarks.

6.14.2 When it is a member's turn to speak, before speaking, they may ask questions of the Medical Officer of Health or staff present, to obtain

information relating to the matter in question and with the consent of the speaker, or other members may ask a question of the same persons.

6.14.3 All questions shall be stated concisely and shall not be used as a means of making statements or assertions.

6.14.4 Any question shall not be ironical, offensive, rhetorical, trivial, vague or meaningless or shall not contain epithet, innuendo, ridicule, or satire.

6.15 Any member who has the floor may require the motion under discussion to be read.

Section 7 - Decorum and Discipline

7.1 A member shall not:

7.1.1 speak disrespectfully of Her Majesty the Queen or any member of the Royal Family, the Governor-General, a Lieutenant Governor, the Board or any member thereof;

7.1.2 use offensive words or unparliamentary language;

7.1.3 disobey the rules of the Board or a decision of the Chairperson or the Board on questions of order, practice or an interpretation of the rules;

7.1.4 speak other than to the matter in debate;

7.1.5 leave their seat or make any disturbance when the Chairperson is putting a question and while a vote is being taken and until the result is declared; and

7.1.6 interrupt a member while speaking except to raise a point of order.

7.2 If a member commits an offense, the Chairperson shall interrupt and correct the member.

7.3 If an offense is serious or repeated, the Board may decide, by resolution, not to permit the member to resume speaking.

7.4 If a member ignores or disregards a decision of the Chairperson or the Board, the Chairperson shall not recognize the member except to receive an apology by the member and until it has been accepted by the Board.

7.5 If a member persists in committing an offense, the Board may order, by resolution, the member to leave the meeting and not resume their seat until they have tendered an apology and it has been accepted by the Board.

Section 8 - Questions of Privilege and Points of Order

8.1 The Chairperson shall permit any member to raise a question relating to the rights and benefits of the Board or one or more of the members thereof and questions of privilege shall take precedence over all other motions except to adjourn and to recess.

8.2 When a member desires to assert that a rule has been violated, they shall ask leave of the Chairperson to raise a point of order with a concise explanation and then shall not speak until the Chairperson has decided on the point of order.

8.3 The decision of the Chairperson shall be final unless a member appeals immediately to the Board.

8.4 If the decision is appealed, the Board shall decide the question "Shall the decision of the chair be sustained?" by majority vote without debate and its decision shall be final.

8.5 When the Chairperson calls a member to order, the member shall cease speaking immediately until the point of order is dealt with and they shall not speak again without the permission of the Chairperson unless to appeal the ruling of the Chairperson.

Section 9 - By-laws

9.1 No motion to pass a By-law shall be considered unless written notice has been received by the members in the manner set out in section 3.6 of this By-law.

9.2 A motion to pass a By-law shall be carried by a two-thirds vote in the affirmative of the members present at that meeting.

9.3 A By-law shall come in to force on the date of passing thereof unless otherwise specified by the Board.

9.4 No motion for the amendment or repeal of the By-laws, or any part thereof, shall be considered unless written notice has been received by the members in the manner set out in section 3.6 of this By-law.

9.5 A motion to amend or repeal the By-laws, or any part thereof, shall be carried by a two-thirds vote in the affirmative of the members present at the meeting at which the amendment or repeal is to be considered.

Section 10 - Motions

10.1 Every motion shall be verbal unless the Chairperson requests that the motion be submitted in writing.

10.2 Debate on a debatable motion shall not proceed unless it has been seconded.

10.3 Every motion shall be deemed to be in possession of the Board for debate after it has been presented by the Chairperson, but may, with permission of the members who moved and seconded a motion, be withdrawn at any time before amendment or decision.

10.4 A main motion before the Board shall receive disposition before another main motion can be received except a motion:

10.4.1 to adjourn;

10.4.2 to recess;

10.4.3 to raise a question of privilege;

10.4.4 to lay on the table;

10.4.5 to order the previous question (close debate);

10.4.6 to limit or extend limits of debate;

10.4.7 to postpone definitely (defer);

10.4.8 to commit or refer;

10.4.9 to postpone indefinitely (withdraw); or

10.4.10 to amend;

which have been listed in order of precedence.

10.5 When a motion that the vote be taken is presented, it shall be put to a vote without debate, and if carried by resolution, the motion and any amendments under debate shall be put forthwith without further debate.

10.6 A motion relating to a matter not within the jurisdiction of the Board shall not be in order.

10.7 A motion to adjourn a meeting or debate shall be in order, except:

10.7.1 when a member has the floor;

10.7.2 when it has been decided that the vote be now taken; or

10.7.3 during the taking of a vote;

and when rejected, shall not be moved again on the same item.

Section 11 - Voting

11.1 Only one primary amendment at a time can be presented to a main motion and only one secondary amendment can be presented to a primary amendment, but when the secondary amendment has been disposed of, another may be introduced, and when a primary amendment has been decided, another may be introduced.

11.2 A secondary amendment, if any, shall be voted on first, and, if no other secondary amendment is presented, the primary amendment shall be voted on next, and if no other primary amendment

is presented, or if any amendment has been carried, the main motion as amended shall be put to a vote.

11.3 A main motion may be divided by resolution and each division thereof shall be voted on separately.

11.4 After the Chairperson commences to take a vote, no member shall speak or present another motion until the vote has been taken on such motion.

11.5 Every member present at a meeting shall vote when a vote is taken unless prohibited by statute and if any member present refuses or fails to vote, he shall be deemed as voting in the negative.

11.6 Any member may require that a vote be recorded.

11.7 If a member disagrees with the declaration by the Chairperson of the result of any vote, the member may object immediately and require that the vote be retaken and recorded.

11.8 After any matter has been decided, any member may move for reconsideration of the matter at a subsequent meeting in the same year but no discussion of the question that has been decided shall be allowed until the motion for reconsideration has carried by two-thirds of the members, and no matter shall be reconsidered more than once in the same calendar year.

Section 12 - Committees

12.1 The Board may strike committees and appoint members to such committees to consider such matters as directed by the Board.

12.2 The Medical Officer of Health shall preside over the first meeting of each calendar year until a Chairperson and Vice-Chairperson of the committee are elected by its members.

12.3 The Chairperson of a committee shall:

12.3.1 preside over all meetings of the committee;

12.3.2 report on the deliberations and recommendations of the committee to the Board; and

12.3.3 perform such other duties as may be determined from time to time by the Board or the committee.

12.4 The Chairperson of a committee may appoint non-Board members to the committee.

12.5 The number of non-Board members of a committee shall not exceed the number of Board members of the same committee at any time.

12.6 The number of Board members on a committee shall not be a majority of the members of the Board of Health.

12.7 It shall be the duty of a committee:

12.7.1 to report to the Board on all matters referred to it and to recommend such action as it deems necessary;

12.7.2 to forward to an incoming committee for the following year any matters not disposed of; and

12.7.3 to provide to the Board any information relating to the committee that is requested by the Board.

12.8 All committees shall be dissolved no later than immediately preceding the first meeting as set out in section 3 of this By-law.

12.9 The Board may dissolve, by resolution, any committee at any time.

Section 13 - Minutes

The Medical Officer of Health shall ensure that full and accurate minutes are kept of the proceedings of all meetings including a text of the By-laws and the resolutions passed by the Board.

Review/Revisions

On (YYYY-MM-DD)**: 2014-06-11**
On (YYYY-MM-DD)**: 2013-12-11**
On (YYYY-MM-DD)**: 2013-04-10**
On (YYYY-MM-DD)**: 2010-10-13**
On (YYYY-MM-DD)**: 2007-10-11**
On (YYYY-MM-DD)**: 2005-01-12**
On (YYYY-MM-DD)**: 2003-07-03**
On (YYYY-MM-DD)**: 1998-10-28**
On (YYYY-MM-DD)**: 1992-10-14**

Peterborough County-City HEALTH UNIT ...because health matters!

Board of Health

POLICY AND PROCEDURE

Section: Board of Health	**Number:** 2-340	**Title:** Medical Officer of Health Performance Appraisal
Approved by: Medical Officer of Health **Signature:** _____ **Date** (YYYY-MM-DD)**:**		**Original Approved by Board of Health On** (YYYY-MM-DD)**: 2009-02-11** **Author:** Medical Officer of Health
Reference:		

NOTE: This is a **CONTROLLED** document for internal use only, any document appearing in a paper form should **ALWAYS** be checked against the online version prior to use.

POLICY

The Board of Health facilitates performance by creating an environment where the MOH and all employees of the PCCHU achieve their best. A written appraisal system will be used to provide an objective and uniform way to evaluate employees on the job. It is a constructive process to build on strengths, correct weaknesses, and maximize performance.

1. The Medical Officer of Health's (MOH) performance is to be appraised before the end of the probationary period, in order to recommend to the Board of Health appointment to regular appointment status, extension of probationary period, or termination of employment.

2. At the beginning and end of each year, the Board Chair will meet with the MOH to set and review an annual work plan which includes professional development goals.

3. The Medical Officer of Health's appraisal will be conducted by a committee of the Board of Health chaired by the Chair of the Board of Health every two (2) years.

4. ~~Annual reviews of performance will include the setting and review of objectives; and professional development plan with a 360º component at least every two years.~~

4. ~~On alternate years, t~~This review is to be conducted by the current Chair, Vice Chair, and a past Chair of the Board, when possible.

5. ~~The MOH is responsible for completing a self appraisal.~~

5. The Board will incorporate ~~a~~ feedback ~~form~~ from internal ~~and external~~ stakeholders such as board of health members and staff as part of the 360° component every two (2) years. If relevant, the MOH may incorporate any such processes from their professional college into th~~e~~is appraisal process. ~~If the 360° component corresponds with a municipal election, the component should be postponed to the beginning of the next calendar year.~~

6. External stakeholders will be approached for feedback by the Board at least every five (5) years and where appropriate.

~~7.~~ As part of the performance appraisal, the MOH is responsible for completing a self-appraisal~~. The MOH is to receive a full copy of the completed appraisal document. The Director, Corporate Services will retain the original including the self-assessment in the MOH's personnel file.~~

8. Formal performance appraisals do not take the place of ongoing evaluation and feedback. If the MOH's work is not adequate, the matter is to be dealt with while details and facts are fresh and will not wait for the formal review. The MOH's performance must return to the required standard within a specified time period or further action may be taken by the Board.

Historical Record

Revisions:
Board of Health, November 10, 2010

Review:
By-Laws, Policies and Procedures Committee, October 27, 2010

PROCEDURE

The Chair of the Board of Health will:

~~1. Schedule the performance appraisal before the end of the probationary period and then at least every year, preferably around the Medical Officer of Health's (MOH) anniversary date.~~

~~2. Provide the MOH with copies of the following documents in advance of the interview:~~
- ~~A copy of the previous MOH Performance Appraisal Form (Performance Planner)~~
- ~~A blank copy of the MOH Performance Appraisal Form~~
- ~~A blank copy of the Self Appraisal Form~~
- ~~A blank copy of the Confidentiality Agreement~~

1. Meet with the Medical Officer of Health (MOH) at the beginning and end of the Chair's term to

review the annual workplan, which includes the setting of professional development goals.

2. Schedule the performance appraisal before the end of the probationary period and then at least every two (2) years, preferably around the Medical Officer of Health's (MOH) anniversary date.

3. Convene a meeting with the immediate past Chair and the Vice Chair to review the required materials, confirm the process, and develop the timeline. This sub-committee can consult with any other persons they feel could provide relevant input to the performance appraisal, review the job description, operational plans, significant events and any other pertinent items from the period under review.

~~4. When a 360° component is planned as part of the review:~~
~~• request from the Medical Officer of Health in advance of the interview, a list of staff and potential external stakeholders for potential feedback; and~~
~~• request feedback prior to the performance review using the Feedback Agreement and Appraisal Form. (A meeting to discuss the completed form may be requested by the Board or appraiser. They may elect to remain anonymous.).~~

4. Work with the Secretary of the Board to organize the 360° component of the appraisal. This would begin with a request to the MOH for a list of staff and external stakeholders, when warranted, who could be approached for potential feedback.

~~5. Consult with any other persons they feel could provide relevant input to the performance appraisal. Review the job description, operational plans, significant events and any other pertinent items from the period under review. (This will include external stakeholders).~~

~~6. Complete the Performance Appraisal Form. Grade each factor using the definitions included in the performance appraisal form and support the decision with comments and examples wherever possible. The appraisal should also include an assessment of performance relative to the Learning and Development Objectives and overall program objectives set in the previous performance appraisal. In the Board's comments, clearly indicate whether the overall performance is satisfactory or not. For probationary MOHs indicate if probation has been completed satisfactorily.~~

~~7.~~ Conduct the interview. This part may require more than one meeting. Begin the process with the MOH's self-appraisal. Use the information collected from the various sources to grade each factor on the appraisal form, using the definitions included in the performance appraisal form and support the decision with comments and examples wherever possible. When weighing all of the feedback, ~~G~~genuinely consider the MOH's input and make changes/additions to the factor comments, examples and even grading where warranted. ~~Determine with the MOH the Learning and Development Objectives as well as overall program objectives for the coming year structured according to the headings in the PCCHU Strategic Plan.~~

8. Complete the Performance Appraisal Form. The appraisal should also include an assessment of

performance relative to any learning or performance objectives set in the previous performance appraisal. In the Board's comments, clearly indicate whether the overall performance is satisfactory or not. For probationary MOHs indicate if probation has been completed satisfactorily.

9. Sign and date the Performance Appraisal Form and have the MOH do the same. The MOH's signature means that they have read and understood the review. Ensure that a signed version of the Confidentiality Agreement is received.

10. Provide the MOH a full copy of the completed Performance Appraisal Form. The Director of Operations ~~Corporate Services~~ is to retain the original including the self-appraisal ~~assessment~~ in the MOH's personnel file.

Review/Revisions

On (YYYY-MM-DD)**:** 2012-12-12 (Board)
On (YYYY-MM-DD)**:** 2012-11-26 (Governance)
On (YYYY-MM-DD)**:** 2010-11-10 (Board)
On (YYYY-MM-DD)**:** 2010-10-27 (By-Laws, Policies and Procedures Committee)

Requirements	Details	Lead	Comments
6.1 Operational plan	The board of health shall ensure that the administration establishes an operational plan for the organization which:	Rosana Salvaterra (RS) and Patti Fitzgerald (PF)	
	a. Describes the composition, responsibilities and function of the public health unit;		An organizational chart is maintained by the MOH Executive Assistant.
	b. Documents the internal processes for managing day-to-day operations of programs and services to achieve the required board of health outcomes as per OPHS;		• Organizational and program policies and procedures • Committee minutes • Reports to the Ministry and Board of Health
	c. Demonstrates that the operational activities of the public health unit are aligned with the OPHS, the board of health's goals, objectives and priorities, as described in the strategic plan;		The MOH performance planner and those of the management team incorporate elements of the strategic plan. Reports to the Board of Health acknowledge relevant strategic directions. Operational Plans and Logic Models are reviewed and Operational Plans are developed on an annual basis. These are informed by BOH strategic directions and based on the outcomes and requirements set out in the Ontario Public Health Standards. Logic model components include: Population Health Assessment and Surveillance; Education and Awareness; Skill Building; Environmental Support; and Healthy Public Policy as the Program Areas of Focus. Operational Plans include activities that are linked to OPHS Requirements and detail the activities, staff responsibilities, resource requirements and timing. Quarterly reports on implementation of the planned activities are provided to the Medical Officer of Health and Board of Health. The Strategic Plan includes actions related to indicator development and enhanced accountability.
	d. Includes objectives, activities, timeframes, responsibilities, intended results, monitoring processes, an organizational chart and internal reporting requirements;		
	e. Contains planned activities based on an assessment of its communities' needs;		The PCCHU planning process includes a Situational Assessment that determines local need, potential impact, capacity and opportunities for partnership. A comprehensive Program Review is conducted with each health unit program and committee every three years.
	f. Demonstrates efforts to minimize barriers to access; and		A Health Equity Mapping tool is used to assess programs and activities and identify opportunities for addressing disparities and improving access by priority populations. Each program reviews priority populations on an annual basis and planning discussions are framed to ensure coordination, and where appropriate integration of strategies.

Requirements	Details	Lead	Comments
			A policy and procedure to ensure that all programs and services are accessible to vulnerable and priority populations has been developed and will be evaluated.
	g. Describes the monitoring of key performance indicators to support continuous quality improvement and evidence-informed public health practice.		In addition to Quarterly Compliance Reports, Accountability Agreement Indicators are reported to the Ministry of Health and Long-Term Care as required. New strategies and activities that have been modified are evaluated to ensure short-term outcomes are achieved. Executive Committee will be launching a CQI strategy in 2016 as part of the new strategic plan. The Research Committee is developing a new policy for audits.
	The development of the operational plan shall involve staff at all levels of the organization and include input from community partners and shall be reviewed and updated at least annually, or more often as required by local circumstances, with the date of the most recent revisions noted.		All staff are engaged in operational plan development and through Program Meetings bring ideas and solutions to program challenges forward on an ongoing basis. Community partners and other stakeholders provide input into operational planning through coalitions, partnerships and community needs assessments at the program or issue-based level. Staff are developing a community engagement framework.
	Achievement of the operational plan shall be monitored and reported in status reports on a quarterly basis to board members and staff.		Operational plans are reviewed annually. BOH receives quarterly reports based on the OPHS requirements, which are actualized through the operational plans.
6.2 Risk management	The board of health shall ensure that the administration monitors and responds to emerging issues and potential threats to the organization, from both internal and external sources, in a timely and effective manner. Risk management is expected to include but is not limited to: financial risks, HR succession and surge capacity planning, operational risks, and legal issues.	Larry Stinson (LS)	The Board is provided briefing notes and updates on emerging and potential threats from all levels at each of its meeting. Staff presentations are made regarding contingency planning, liabilities and other areas of Board development. The Board is provided quarterly financial summaries, including an analysis of any areas of financial concern. The Board has developed policies, procedures and by-laws and these are reviewed by Governance then affirmed by the Board every two years on an ongoing basis. A succession plan was developed and updated annually. A Business Continuity Plan has been developed and has been reviewed and updated annually.
6.3 Medical Officer of Health provides direction to staff	The employees of and the persons whose services are engaged by a board of health are subject to the direction of and are responsible to the medical officer of health of the board if their duties relate to the delivery of public health programs or services under this or any other Act. (HPPA, s.67(2))	RS	Compliant.
6.4 Eligibility for appointment as a Medical Officer Of Health	No person is eligible for appointment as a medical officer of health or an associate medical officer of health unless (a) he or she is a physician; (b) he or she possesses the qualifications and requirements prescribed by the	RS	Compliant.

Requirements	Details	Lead	Comments
	regulations for the position; and (c) the Minister approves the proposed appointment. (HPPA, s.64)		
6.5 Educational requirements for public health professionals	The educational and experiential qualifications of boards of health staff are specified for the positions of business administrator, public health dentist, dental hygienist, public health inspector, public health nurse, and public health nutritionist. (HPPA, Reg.566)8	LS, RS, PF	Job Descriptions for all classifications identify minimum requirements including education and/or equivalent experience. Successful applicants are required to provide proof of degrees attained and where appropriate current college registration.
6.6 Financial records	The board of health shall keep or cause to be kept (a) books, records and accounts of its financial affairs; (b) the invoices, receipts and other documents in its possession that relate to the financial affairs of the board.	LS	An annual audit is conducted by an external, unaffiliated, independent auditor. Policies, procedures and by-laws have been developed and are reviewed every two years by Governance Committee and the Board every two years.
	The board of health shall cause to be prepared statements of its financial affairs in each year including but not limited to (a) an annual statement of income and expenses; (b) an annual statement of assets and liabilities; and (c) an annual estimate of expenses for the next year. (HPPA, s.59(1) and (2))	LS	Budgets showing revenues and expenses are prepared for Board approval on an annual basis and the Board conducts quarterly reviews of financial performance. Audited Financial Statements are prepared and approved by the Board of Health annually.
6.7 Financial policies and procedures	The board of health shall ensure that the administration implements appropriate financial management and oversight which ensures that the following are in place:	LS	
	a. A plan for the management of physical and financial resources;		The Board has approved Purchasing and Management of Property By-Laws. The new strategic plan includes the development of an asset management policy. An inventory of exiting furniture and equipment has been completed.
	b. A process for internal financial controls, which is based on generally accepted accounting principles;		There are organizational Policies and Procedures on purchasing and internal controls. Accounting follows GAAP and external audit reports on statements.
	c. A process to ensure that areas of variance are addressed and corrected;		Accounting produces monthly financial reports by manager. Managers are expected to identify and address variances. Quarterly presentations made to Board outlining variances.
	d. A procedure to ensure that the procurement policy is followed across all programs/services areas;		There are organizational Policies and Procedures on purchasing and internal controls.
	e. A process to ensure the regular evaluation of the quality of service provided by contracted services, in accordance with contract standards;		A process to review existing service contracts has been developed. Plans are in place to review RFP/Tender process to ensure appropriate criteria and scrutiny.
	f. A process to inform the board of health regarding resource allocation plans and decisions, both financial and workforce related, that are required to address shifts in need and capacity; and		The Board approves an annual budget. There are quarterly reports to Board including performance to budget and performance to operating plan. Areas of concern are brought to the Board's attention and staff present recommendations to address areas of significant variance for

Requirements	Details	Lead	Comments
			Board approval.
	g. A budget forecast for the current fiscal year that does not project a deficit.		A balanced annual budget is presented to the Board for approval.
6.8 Procurement	The board of health shall comply with Section 270(2) of the *Municipal Act, 2001,* which requires that the board of health ensures that the administration adopts policies with respect to its procurement of goods and services. Such policies shall include:	LS	
	a. The types of procurement processes that shall be used;		The Board has approved a Purchasing By-Law and there are policies and procedures on purchasing.
	b. The goals to be achieved by using each type of procurement process;		There are organizational Policies and Procedures on purchasing and procedures on types of requests that are available to address needs.
	c. The circumstances under which each type of procurement process shall be used;		Policies and Procedures specify type of procurement process to be followed by procurement type and by dollar amount
	d. The circumstances under which a tendering process is not required;		The policy and procedure outlines when tendering is not required.
	e. The circumstances under which in-house bids will be encouraged as part of the tendering process;		Addressing in-house bids is not applicable.
	f. How the integrity of each procurement process will be maintained;		Tenders are prepared and reviewed by internal stakeholders. Stakeholders participate in proposal evaluations. This process will be reviewed and updated in 2016.
	g. How the interests of the board, the public and persons participating in the procurement process will be protected; and,		Major tenders widely circulated through online procurement portals (e.g., MERX or Bidingo). Tenders are evaluated considering quality, vendor reputation and price.
	h. How and when the procurement processes will be reviewed to evaluate their effectiveness.		Procurement processes will be reviewed at each new procurement cycle (i.e., each time procurement is re-tendered).
	i. The board of health is expected to implement procurement policies and practices that align with those of the relevant municipality as appropriate.		Policies and procedures align with municipal, BPS and Ministry requirements.
6.9 Capital funding plan	A board of health may acquire and hold real property for the purpose of carrying out the functions of the board and may sell, exchange, lease, mortgage or otherwise charge or dispose of real property owned by it. HPPA, s.52(3) does not apply unless the board of health has first obtained the consent of the councils of the majority of the municipalities within the public health unit served by the board of health. (HPPA, s.52(3) and (4))	LS	Approval to acquire and hold property was given when the Board formed. A capital replacement list being developed.
	The board of health that owns its own building(s) shall maintain a capital funding plan, which includes policies and procedures to ensure that funding for capital		Ministry policy <u>does not</u> allow Boards to maintain surpluses – all capital funding must be applied for. Advocacy is under way through the provincial association and PCCHU to have capital budget

Requirements	Details	Lead	Comments
	projects is appropriately managed and reported.		designated for public health. Advocacy also under way to allow health units to retain surpluses or some other method of developing capital funding. Through condominium purchase, the contribution to a reserve fund will be expensed annually assuring adequate resources for common space building upkeep.
6.10 Service level agreements	Where a board of health functions as part of a municipal or regional government and is required to contribute financially to the corporate provision of services (e.g., IT, HR, financial management services), the board of health shall ensure that the administration negotiates a service level agreement with its local government which includes a description of the scope, volume and timeliness of services to be provided for a specific cost.	n/a	n/a
6.11 Communications strategies	The board of health shall ensure that the administration develops an overall communication strategy that is complementary to the program specific communication strategies required in the OPHS and its Protocols, and addresses both external and internal audiences. The communication strategy shall include:	RS	Policies and procedures have been approved for media relations, graphic design, social media management, online communities, and healthcare provider communications. Communications guidelines have been developed for other external audiences including schools, and post-secondary institutions. Internal audiences and guidelines for research project dissemination have been developed and an overall communications strategy for the Health Unit has been drafted.
	a. Guidelines for sharing information with community partners and staff;		Specific guidelines have been created to address communications to healthcare providers and schools.
	b. A plan to ensure consistency in messaging at all levels, to all audiences;		A graphic design policy and procedure have been created to ensure consistency in messaging. Webpage templates are in place and some program staff have been trained on updating and managing content. Almost all publicly issued material is vetted by the Communications Supervisor. We have graphic design and Logo standards and the remaining identity standards will be developed as part of the branding project.
	c. Dissemination plans to disseminate relevant research findings for each approved research project proposal;		Included as part of the policy and procedure for Evidence-Generating Activities.
	d. Guidelines for use of relationships with media channels (e.g., print, radio, television, web) to share health information with general public and targeted populations or audiences;		Guidelines for use of relationships with media channels (e.g., print, radio, television, web) to share health information with general public and targeted populations or audiences is covered in our media relations policy and procedure; a social media policy and procedure has been developed.
	e. Plan for use of multiple modalities to ensure accessibility;		Print materials for public use include an accessibility line offering to provide the information in an alternative format. A social media policy and procedure has been developed.

Requirements	Details	Lead	Comments
	f. Strategies for educating community partners and the public about key public health issues; and		• The public and media are notified about every Board of Health meetings, and meeting summaries are shared with the media immediately following each meeting. • MOH regularly presents on various PH topics in the community. • Monthly Examiner column. • Presentations have been offered to municipal councils and service clubs to educate partners and the public on what we do and relevant issues to public health (Annual Reports, Strategic Plan) • Public health issues are routinely monitored (e.g. fluoride, wifi, TCE, etc.) and fact sheets, web pages, and online resources are created as necessary. Public meetings are held to present information if required. • Health Unit staff are encouraged to participate in professional networks to enhance sharing and coordination regionally and provincially. • The Health Unit maintains its own social media accounts on Facebook and Twitter
	g. An internal communication strategy, including the posting of minutes of senior management team meetings, which informs staff of significant management decisions.		Executive and Management meetings are posted. Post BOH briefings are provided to all three union presidents. Internal communications plans are developed for specific projects, e.g. The Move to King Street, organizational culture, influenza immunization etc. Standards are established for frequency of team meetings. In-services are provided to all staff where appropriate and All Staff Days are held annually. A new intranet has been developed and will be launched early in 2016.
6.12 Information management	The board of health shall ensure that the Medical Officer of Health, as the designated health information custodian under the Personal Health Information Protection Act, maintains information systems that support the organization's mission and workforce by providing infrastructure for data collection/analysis, program management, administration and communications.	Executive Committee	IT maintains the security of all databases and ensures back-up to prevent data loss. Corporate Services provides infrastructure and seeks funding opportunities to improve and maintain infrastructure. The Policy and Procedure on P&Ps now states 1/3 of all P&P will be reviewed annually – part of review is having MOH sign off.
	The board of health shall ensure that the Medical Officer of Health establishes, maintains and implements policies and procedures related to data collection and records management, which ensure:		
	a. Compliance with all applicable legislation, regulations and policies, including the HPPA,		The health unit is in compliance with MFIPPA and PHIPA legislation. All privacy breaches and MFIPPA/PHIPA access requests are tracked.

Requirements	Details	Lead	Comments
	Municipal Freedom of Information and Protection of Privacy Act (MFIPPA), and Personal Health Information Protection Act (PHIPA) to the management of all personal information and personal health information in board of health records;		Several new and revised PHIPA policies & procedures have been introduced. A Privacy Committee meets quarterly to review.
	b. Data quality in the creation and collection of data;		Documentation policy and procedure exist. CQI initiative will address data quality. Audits are conducted regularly.
	c. Confidentiality in how records are used and accessed;		Confidentiality is described in the records policy and all staff sign annual Confidentiality Agreements at the time of their performance review. All records are either password protected and/or locked. New procedure on handling personal health information off premise. Privacy Impact Assessments are completed for remote clinic connectivity as required.
	d. Use of current and appropriate security features, including strong encryption of personal health information during transfers and when stored on mobile devices;		Encryption is in place.
	e. A records maintenance process that includes remediation of errors;		Documentation procedure outlines process for staff if a correction to a record is needed. PHIPA procedure outlines process if a client requests a correction to his /her record.
	f. Appropriate records retention process that varies by type of record;		Records policy and retention/disposal schedule has been updated.
	g. Secure disposal of records; and		See above. Secure shredding is available at both sites.
	h. That the purposes and appropriate uses of data being created are communicated to and respected by staff and management who collect, enter, store, analyze, use and/or destroy the data.		Staff receive PHIPA training. Also covered in the new/revised PHIPA policies and procedures.
	This requirement applies to all information that the board of health has in its control, including personal information and personal health information.		Policies and procedures apply to all records and information
6.13 Research ethics	The board of health shall ensure that the administration establishes, maintains and implements policies and procedures related to research ethics that reflect accepted standards of practice.	RS	The Research Committee reviews all research proposals. New policies and procedures have been developed. Research ethics review is to be done by academic health science centres or PHO.

Requirements	Details	Lead	Comments
6.14 Human resources strategy	The board of health shall ensure that the administration establishes a human resources strategy, based on a workforce assessment which considers the competencies, composition and size of the workforce, as well as community composition, and includes initiatives for the recruitment, retention, professional development and leadership development of the public health unit workforce. The board of health shall ensure that the administration establishes and implements written human resource policies and procedures which are made available to staff, students, and volunteers. All policies and procedures shall be regularly reviewed and revised, and include the date of the last review/revision. Written policies and procedures shall be maintained concerning:	LS	A Succession Plan policy and procedure has been implemented. Key positions are identified on an annual basis. Job descriptions are currently being reviewed for currency and accuracy. New policies to support professional development, training and education have been developed. An HR Strategy is included as one of the new 2013-17 Strategic objectives. A Labour-Management Committee has been established with each of the three bargaining units. The recruitment and hiring procedure has been reviewed and updated. The attendance management policy and procedure is currently under review.
	a. Orientation of public health unit staff;		There is a policy and procedure on orientation as well as an orientation checklist and modules.
	b. The availability of job standards and position descriptions for staff;		Job descriptions are posted to the Health Unit intranet site which is accessible by all staff.
	c. A process to ensure that staff meet qualifications for their positions, job classifications and licensure (as required);23 Ontario Public Health Organizational Standards		The CNO has developed and implemented a policy and procedure on verification of qualifications for professional (regulated) staff.
	d. Contents of a personnel file and provisions for access; complete personnel files shall be maintained for each staff member, with appropriate policies and practices regarding the confidentiality of personnel information;		All staff members have personnel files and there are Policy & Procedures on access to files. HR, Labour, employment, disciplinary and other Policies and Procedures being reviewed, developed and approved.
	e. Occupational health and safety policies;		Policies, procedures, checklists, forms and other documents available on the Intranet for all staff access. An OH&S committee meets quarterly or as required. OH&S committee has terms of reference. OH&S Policies and Procedures are reviewed by PP&F committee and OH&S committee
	f. Recruitment and retention strategies, including workplace health practices;		All positions have job descriptions to assist in recruiting. Program managers with the guidance of HR have reviewed job interview questions for positions where recruitment needs arise. BOH has adopted the national standard for employee mental health and the survey will be undertaken in 2016. Joint Occupational Health and Safety Committee surveys, provide recommendations as well as oversight

Requirements	Details	Lead	Comments
	g. A code of conduct;		The management team has developed a Management Framework to guide management conduct. A new Respect and Civility in the Workplace guide has been developed and all employees expected to sign off.
	h. Compensation policy;		Unionized staff wages and hours are negotiated through collective bargaining and the Collective Agreements is ratified by the Board. Policies have been approved for non-union benefits. BOH has approved a new non-union compensation policy to maintain salaries at the 50th percentile. This will be fully implemented by 2016. Contracts are negotiated with three bargaining units which outlines compensation. A board policy regarding procedure is being developed for the Governance Committee.
	i. Reporting relationships;		There is an organizational chart showing reporting relationships. An orientation module describing all committees and reporting relationships was created in 2013.
	j. Discipline and labour relation policies;		Discipline and labour relations policies are in place.
	k. Staff performance evaluation processes; and		There is a policy with directive for staff performance appraisals to be done annually, including re-signing confidentiality agreement.
	l. Succession planning.		Succession planning policy and procedure are covered above.
6.15 Staff development	The board of health shall ensure that the administration develops a workforce development plan which identifies the training needs of staff, including discipline specific and management training, and encourages opportunities for the development of core competencies and partnerships with academic institutions.	Mgmt. Team	Each supervisor develops a professional development plan with his or her employee and then seeks opportunities to have these needs met. Priorities for organizational training are established by Management Committee with input from HR and Standing Committees.
	The board of health shall ensure that the administration provides formal and informal opportunities for leadership development, such as educational programs, membership in professional associations, coaching and mentoring, for staff at all organizational levels and with consideration to equity and fairness.		Leadership development is being pursued by the Executive Committee as part of our succession planning. Acting non-union positions are offered when possible. Incentives are offered for staff to take online PHAC modules in epidemiology. Workshop and conference policies and procedures have been updated. A new fund has been established to assist employees with education. A mentorship policy has been developed and implemented. Placements will be supported. PEAK Leadership training is being offered and supported for staff.
	The board of health shall ensure that the administration fosters an interest in public health practice for future health professionals by supporting student placements.		Compliant. We offer a variety of student placements. Several educational agreements are in place.

Requirements	Details	Lead	Comments
6.16 Professional practice support	The board of health shall support a culture of excellence in professional practice for all regulated and unregulated health professions that ensures inter-professional collaboration and learning, and that staff are able to comply with professional regulatory body requirements where applicable. A range of models could be used, including the designation of professional practice leads.	PF	CNO has established a Nursing Practice Council and will develop a Professional Practice Council.
	Effective January 2013, boards of health are required to designate a Chief Nursing Officer (CNO) to be responsible for nursing quality assurance and nursing practice leadership.		Compliant. The Health Unit recruited a CNO in July 2012.