AMENDED - additions of 7.3c and 10.1a
(see end of package)

Board of Health for
Peterborough Public Health
AGENDA
Board of Health Meeting
Wednesday, May 8, 2019 – 5:30 p.m.
Curve Lake Health Centre / Oshkiigmong MnoBmaadziwin Gamiing
38 Whetung Street East, Curve Lake First Nation

Opening Prayer: Chief Phyllis Williams

1. **Call to Order**
   Kathryn Wilson, Chair

   Welcome and Opening Statement
   We respectfully acknowledge that Peterborough Public Health is located on the Treaty 20 Michi Saagiig territory and in the traditional territory of the Michi Saagiig and Chippewa Nations, collectively known as the Williams Treaties First Nations, which include: Curve Lake, Hiawatha, Alderville, Scugog Island, Rama, Beausoleil, and Georgina Island First Nations.

   Peterborough Public Health respectfully acknowledges that the Williams Treaties First Nations are the stewards and caretakers of these lands and waters in perpetuity, and that they continue to maintain this responsibility to ensure their health and integrity for generations to come. We are all Treaty people.

2. **Confirmation of the Agenda**

3. **Declaration of Pecuniary Interest**

4. **Consent Items to be Considered Separately**

   Board Members: *Please identify which items you wish to consider separately from section 9 and advise the Chair when requested. For your convenience, circle the item(s) using the following list: 9.1 9.2 a b c d e f g h i 9.3.1*

5. **Delegations and Presentations**

   5.1. Curve Lake First Nation Health Centre Update
   Robin Steed, Health & Family Services Manager
   Joanne Pine, Community Health Representative, Health & Family Services Department

- Cover Report

6. Confirmation of the Minutes of the Previous Meeting

- Cover Report

a. April 10, 2019

b. April 16, 2019

7. Business Arising From the Minutes

7.1. Request for Action Regarding the Legalization of Tailgating in Ontario
Dr. Rosana Salvaterra, Medical Officer of Health

7.2. Renewal of Sewage System Management Agreements Update
Dr. Rosana Salvaterra, Medical Officer of Health

7.3. Board of Health Budget Working Group Update
Dr. Rosana Salvaterra, Medical Officer of Health

- Cover Report

a. Briefing Note for MPP Smith

8. Staff Reports

8.1. Staff Presentation: Smoke is Smoke - Vaping and the Regulatory Landscape
Keith Beecroft, Health Promoter

- Cover Report

a. Presentation

9. Consent Items

9.1. Correspondence for Direction - Endorsement of the Children Count Task Force Recommendations, KFL&A Public Health

- Cover Report

a. KFL&A Letter

b. Children Count Task Force Summary

9.2. Correspondence for Information

- Cover Report

a. County Clerk – Sewage System Management Agreements
b. PFHT – Public Health Modernization
c. CMOH – Public Health Modernization
d. Premier Ford – Provincial Alcohol Strategy
e. Minister Elliott – Managed Opioid Programs
f. alPHa – 2019 Ontario Budget
g. alPHa – E-newsletter
h. alPHa – 2019 AGM and Conference Update
i. alPHa – Public Health Modernization

9.3. Staff Reports

9.3.1. Report: Q1 2019 Peterborough Public Health Activities
Donna Churipuy, Director of Public Health Programs
Larry Stinson, Director of Operations

- Cover Report

a. Q1 2019 Overall Compliance Status
b. Q1 2019 Communications and I.T. Report
c. Q1 2019 Social Media Report
d. Q1 2019 Finance Report

9.4. Committee Reports

10. New Business

10.1. Association of Local Public Health Agencies – 2019 Annual General Meeting Resolutions

- Cover Report

11. In Camera to Discuss Confidential Matters

12. Motions for Open Session

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

Wednesday, June 12, 2019, 5:30 p.m.
Training Room, Otonabee-South Monaghan Fire Department
21 Third Street, Keene

14. Adjournment

ACCESSIBILITY INFORMATION: Peterborough Public Health 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.

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 PPH Communications Manager or refer to the meeting summary issued shortly thereafter. Final motions are recorded in posted approved Minutes.

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**Presentation: Curve Lake First Nation Health Centre Update**
DATE:	**May 8, 2019**

PROPOSED RECOMMENDATIONS

That the Board of Health for Peterborough Public Health receive the following for information:
Presentation: Curve Lake First Nation Health Centre Update
Presenters: Robin Steed, Health & Family Services Manager
Joanne Pine, Community Health Representative, Health & Family Services Department

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**Meeting Minutes, April 10 & 16, 2019**
DATE:	**May 8, 2019**
PREPARED BY:	**Natalie Garnett, Board Secretary**
APPROVED BY:	**Dr. Rosana Salvaterra, Medical Officer of Health**

PROPOSED RECOMMENDATIONS

That the Board of Health for Peterborough Public Health approve the minutes of the meetings held on April 10 and 16, 2019.

ATTACHMENTS

Attachment A – Draft Minutes, April 10, 2019
Attachment B – Draft Minutes, April 16, 2019

Board of Health for
Peterborough Public Health
DRAFT MINUTES
Board of Health Meeting
Wednesday, April 10, 2019 – 5:30 p.m.
Dr. J.K. Edwards Board Room
Jackson Square, 185 King Street

In Attendance:

Board Members:	**Deputy Mayor Bonnie Clark**
	Councillor Henry Clarke (6:29 p.m.)
	Mr. Gregory Connolley
	Ms. Kerri Davies, Vice Chair
	Deputy Mayor Matthew Graham
	Mayor Andy Mitchell
	Ms. Catherine Praamsma
	Mr. Andy Sharpe
	Councillor Don Vassiliadis
	Mr. Michael Williams
	Councillor Kim Zippel
Regrets:	**Councillor Kathryn Wilson, Chair**
	Chief Phyllis Williams
Staff:	**Ms. Hallie Atter, Manager, Family and Community Health**
	Ms. Brittany Cadence, Manager, Communication Services
	Ms. Donna Churipuy, Director of Public Health Programs
	Ms. Patti Fitzgerald, Manager, Child Health Services
	Ms. Natalie Garnett, Recorder
	Ms. Alida Gorizzan, Executive Assistant
	Dr. Rosana Salvaterra, Medical Officer of Health
	Mr. Larry Stinson, Director of Operations

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1. Call to Order

Ms. Kerri Davies, Vice Chair called the meeting to order at 5:30 p.m.

2. Confirmation of the Agenda

MOTION:
That the agenda be amended by reversing the order of 5.1 and 5.2 and adding item 9.3.2.b.
Moved: Mr. Connolley
Seconded: Mr. Sharpe
Motion carried. (M-2019-052)

3. Declaration of Pecuniary Interest

There were no declarations of Pecuniary Interest.

4. Consent Items to be Considered Separately

MOTION:
That the following items be passed as part of the Consent Agenda: 9.2 a, c, e-f; 9.3.1, 9.3.2, 9.4.1a, and 9.4.2 a-d.
Moved: Councillor Vassiliadis
Seconded: Deputy Mayor Clark
Motion carried. (M-2019-053)

MOTION (9.2.a, c, e-f):
That the Board of Health for Peterborough Public Health receive the following for information:
a. Email dated March 13, 2019 from the Chief Medical Officer of Health regarding the release of the 2017 CMOH annual report.
c. Letter dated April 3, 2019 to Minister MacLeod from the Board Chair the Healthy Babies, Healthy Children program.
Correspondence from the Association of Local Public Health Agencies (alPHa):
e. Email dated March 20, 2019 regarding alPHa 2019 Winter Symposium proceedings.
f. E-newsletter dated March 26, 2019.
Moved: Councillor Vassiliadis
Seconded: Deputy Mayor Clark
Motion carried. (M-2019-053)

MOTION (9.3.1):
That the Board of Health for Peterborough Public Health receive the staff report, "Response to Notice of Intent – Potential Measures to Reduce the Impact of Vaping Products Advertising on Youth and Non-users of Tobacco Products", for information.
Moved: Councillor Vassiliadis
Seconded: Deputy Mayor Clark
Motion carried. (M-2019-053)

MOTION (9.3.2):
That the Board of Health for Peterborough Public Health approve the submission of the following draft resolution for the Association for Local Public Health Agencies (alPHa) Resolution Session (2019): Public Health Support for including Hepatitis A Vaccine in the School Immunization Program.
Moved: Councillor Vassiliadis
Seconded: Deputy Mayor Clark
Motion carried. (M-2019-053)

MOTION (9.4.1.a):
That the Board of Health for Peterborough Public Health receive meeting minutes of the Governance Committee from January 12, 2019, for information.
Moved: Councillor Vassiliadis
Seconded: Deputy Mayor Clark
Motion carried. (M-2019-053)

MOTION (9.4.2.a-d):
a. That the Board of Health for Peterborough Public Health receive meeting minutes of the Indigenous Health Advisory Circle from November 6, 2018, for information.
b. That the Board of Health for Peterborough Public Health receive meeting minutes of the Indigenous Health Advisory Circle from January 12, 2019, for information.
c. That the Board of Health for Peterborough Public Health approved 2-345 Indigenous Health Advisory Circle Terms of Reference (revised).
d. That the Board of Health for Peterborough Public Health approved 2-50 Land Acknowledgement (new).
Moved: Councillor Vassiliadis
Seconded: Deputy Mayor Clark
Motion carried. (M-2019-053)

5. Delegations and Presentations

5.2 Delegation: Changes to Provincial Autism Supports, Kristen Locklin

MOTION:
That the Board of Health for Peterborough Public Health receive the following for information: Delegation: Changes to Provincial Autism Supports, Kristen Locklin.
Moved: Deputy Mayor Graham
Seconded: Councillor Zippel
Motion carried. (M-2019-054)

5.1. Presentation: Health in All Policies

MOTION:
That the Board of Health for Peterborough Public Health receive the following for information: Presentation: Health in all Policies
Presenter: Ketan Shankardass, PhD.
Moved: Mayor Mitchell
Seconded: Mr. Williams
Motion carried. (M-2019-055)

6. Confirmation of the Minutes of the Previous Meetings

a. March 13, 2019

MOTION:
That the minutes of the Board of Health for the Peterborough Public Health meeting held on March 13, 2019 be approved as circulated.
Moved: Deputy Mayor Clark
Seconded: Deputy Mayor Graham
Motion carried. (M-2019-056)

7. Business Arising From the Minutes

7.1. Staff Report: 100% Ministry-Funded Program Shortfalls

MOTION:
That the Board of Health for Peterborough Public Health receive the staff report, "100% Ministry-Funded Program Shortfalls", for information.
Moved: Councillor Vassiliadis
Seconded: Ms. Praamsma
Motion carried. (M-2019-057)

8. Staff Reports

8.1. Staff Presentation: Oral Health Report - Highlights

Councillor Clarke arrived at 6:29 p.m.

MOTION:
That the Board of Health for Peterborough Public Health receive the following for information:
Staff Presentation: Oral Health Report - Highlights
Presenter: Patti Fitzgerald, Manager

Moved:	Deputy Mayor Clark
Seconded:	Mr. Williams
Motion carried.	(M-2019-058)

8.2. Staff Report: Expanding Opioid Substitution Treatment with Managed Opioid Programs

MOTION:
That the Board of Health for Peterborough Public Health:

- *receive the staff report, Expanding Opioid Substitution Treatment with Managed Opioid Programs, for information, and;*
- *send a letter to the Honourable Christine Elliott, Minister of Health and Long-Term Care, with copies to the Premier of Ontario, Ontario Chief Medical Officer of Health, Local MPPs, the Association of Local Public Health Agencies, and Ontario Boards of Health, urging the Ministry of Health and Long-Term Care to:*
  - *a. Improve response to the opioid poisoning crisis by immediately targeting operational and capital funding to support the implementation of managed opioid programs in Peterborough.*
  - *b. Take action to add managed opioid medications to the Ontario Drug Benefit Formulary at appropriate concentrations to treat opioid use disorder (i.e. 50 mg/mL and 100 mg/mL hydromorphone), as well as ensure managed opioid medications are accessible to all Ontarians requiring treatment for opioid use disorder.*
  - *c. Include diacetylmorphine (pharmaceutical-grade heroin) for use as a managed opioid program medication in Ontario by obtaining authority from Health Canada.*
  - *d. Address barriers to procuring, storing, and transporting diacetylmorphine (DAM) and/or mitigate its effects by collaborating with Health Canada and other necessary federal bodies to facilitate use of this managed opioid program medication.*

e. Ensure that managed opioid medication cost is not a barrier and that these medications are universally accessible to all Ontarians who could benefit from managed opioid programs.

Moved: Mayor Mitchell
Seconded: Mr. Connolley
Motion carried. (M-2019-059)

8.3. **Staff Report: Safe Sewage Disposal Program – Renewal of Sewage System Management Agreements with the County and City of Peterborough**

MOTION:
That the Board of Health for Peterborough Public Health:

- *receive the Safe Sewage Disposal Program – Renewal of Mandatory and Non-mandatory and Sewage System Re-inspection By-laws - County of Peterborough report for information;*
- *recommend to the County of Peterborough that Mandatory and Non-Mandatory Sewage System Re-inspection By-laws (with current fee schedule) be extended for up to one year;*
- *recommend that staff determine the future financial viability of maintaining the re-inspection programs; and*
- *that a working group be established with County of Peterborough staff to consider options for future program delivery.*

Moved: Mayor Mitchell
Seconded: Councillor Zippel
Motion carried. (M-2019-060)

The Board of Health recessed at 7:19 p.m. and resumed at 7:25 p.m.

9. Consent Items

9.1.a **Correspondence for Direction**

MOTION:
That the Board of Health for Peterborough Public Health receive the staff report, *Response to Notice of Intent – Potential Measures to Reduce the Impact of Vaping Products Advertising on Youth and Non-users of Tobacco Products,* for information.

Moved: Councillor Zippel
Seconded: Councillor Vassiliadis
Motion carried. (M-2019-061)

9.2.d **Correspondence for Information**

MOTION:
That the Board of Health for Peterborough Public Health receive the following for information:
Correspondence from the Association of Local Public Health Agencies (alPHa):
d. Email dated March 8, 2019 regarding the Ministry of Finance Round Tables on Alcohol Retail.

Moved:	Deputy Mayor Clark
Seconded:	Councillor Clarke
Motion carried.	(M-2019-062)

9.3.2.b **Asbestos**

MOTION:
That the Association of Local Public Health Agencies (alPHa) call on the federal government to make Canada "asbestos free" by establishing a federal asbestos agency based on the Australian model. The agency, in cooperation with Indigenous peoples, the provinces, territories and municipalities, would be mandated to develop a comprehensive Canadian asbestos strategy (see appendix A) and an implementation plan, while respecting the jurisdictions of each level of government;

And Further that the Chief Public Health Officer of Canada and the Ontario Public Health Association, be so advised.

Moved:	Deputy Mayor Clark
Seconded:	Mr. Williams
Motion carried.	(M-2019-063)

10. New Business

11. In Camera to Discuss Confidential Matters

MOTION:
*That the Board of Health for Peterborough Public Health in accordance with the **Municipal Act**, 2001, move In Camera to discuss one item under Section 239(2)(b), Personal matters about an identifiable individual, including Board employees, and one item under Section 239(2)(d), Labour relations or employee negotiations, at 7:33 p.m.*

Moved:	Deputy Mayor Graham
Seconded:	Mr. Williams
Motion carried.	(M-2019-064)

MOTION:
That the Board of Health for Peterborough Public Health rise from In Camera at 8:38 p.m.
Moved: Councillor Clarke
Seconded: Mr. Sharpe
Motion carried. (M-2019-065)

12. Motions from In Camera for Open Session

MOTION:
That staff undertake the adjustment of non-union salaries as directed.
Moved: Mayor Mitchell
Seconded: Councillor Clarke
Motion carried. (M-2019-066)

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

The next meeting will be held Wednesday, May 8, 2019 at the Curve Lake Health Centre, 38 Whetung St. E., Curve Lake First Nation, at 5:30 p.m.

14. Adjournment

MOTION:
That the meeting be adjourned.
Moved by: Councillor Clarke
Seconded by: Mr. Williams
Motion carried. (M-2019-067)

The meeting was adjourned at 8:40 p.m.

Chairperson

Medical Officer of Health

Board of Health for
Peterborough Public Health
DRAFT MINUTES
Special Board of Health Meeting
Wednesday, April 16, 2019 – 5:15 p.m.
Dr. J. K. Edwards Board Room, 3rd Floor
Jackson Square, 185 King Street, Peterborough

In Attendance:

Board Members:	**Deputy Mayor Bonnie Clark**
	Councillor Henry Clarke
	Mr. Gregory Connolley
	Ms. Kerri Davies, Vice Chair
	Deputy Mayor Matthew Graham
	Mayor Andy Mitchell
	Ms. Catherine Praamsma
	Mr. Andy Sharpe
	Councillor Don Vassiliadis
	Mr. Michael Williams
	Councillor Kathryn Wilson, Chair
	Councillor Kim Zippel
Regrets:	**Chief Phyllis Williams**
Staff:	**Ms. Brittany Cadence, Manager, Communication Services**
	Ms. Donna Churipuy, Director of Public Health Programs
	Ms. Alida Gorizzan, Executive Assistant (Recorder)
	Dr. Rosana Salvaterra, Medical Officer of Health
	Mr. Larry Stinson, Director of Operations

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1. Call to Order

Councillor Wilson, Chair called the meeting to order at 5:15 p.m.

2. Confirmation of the Agenda

MOTION:
That the agenda be approved as circulated.
Moved: Councillor Clarke
Seconded: Ms. Davies
Motion carried. (M-2019-068)

3. Declaration of Pecuniary Interest

There were no declarations of Pecuniary Interest.

4. Consent Items to be Considered Separately

5. Delegations and Presentations

6. Confirmation of the Minutes of the Previous Meeting

7. Business Arising From the Minutes

8. Staff Reports

8.1. Staff Report: Ontario 2019 Budget Announcements

MOTION:
That the Board of Health for Peterborough Public Health:

- *receive the staff report and presentation, Ontario 2019 Budget Announcements, for information; and,*
- *strike a working group to identify key messages for a local response and identify next steps for board and staff action.*

Moved: Deputy Mayor Clark
Seconded: Deputy Mayor Graham
Motion carried. (M-2019-069)

Membership for the Board of Health Working Group will be as follows: Mayor Mitchell, Ms. Davies, Ms. Praamsma, Deputy Mayor Graham, Dr. Salvaterra, Mr. Stinson, Mrs. Churipuy and Ms. Cadence.

It was recommended that members hold July 10 and August 14, 2019 as potential meeting dates for the Board of Health over the summer months should they be required.

9. Consent Items

10. New Business

11. In Camera to Discuss Confidential Matters

MOTION:
*That the Board of Health for Peterborough Public Health in accordance with the **Municipal Act**, 2001, move In Camera to discuss one item under Section 239(2)(b), Personal matters about an identifiable individual, including Board employees.*
Moved: Ms. Davies
Seconded: Councillor Vassiliadis
Motion carried. (M-2019-070)
MOTION:

That the Board of Health for Peterborough Public Health rise from In Camera at 6:46 p.m.
Moved: Councillor Clarke
Seconded: Ms. Davies
Motion carried. (M-2019-071)

12. Motions for Open Session

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

Wednesday, May 8, 2019, 5:30 p.m.
Curve Lake Health Centre, 38 Whetung St. E.,
Curve Lake First Nation

14. Adjournment

MOTION:
That the meeting be adjourned.
Moved by: Mr. Connolley
Seconded by: Ms. Praamsma
Motion carried. (M-2019-072)

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

Chairperson

Medical Officer of Health

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**Board of Health Budget Working Group Update**
DATE:	**May 8, 2019**
PREPARED BY:	**Alida Gorizzan, Executive Assistant**
APPROVED BY:	**Dr. Rosana Salvaterra, Medical Officer of Health**

PROPOSED RECOMMENDATIONS

That the Board of Health for Peterborough Public Health:

- receive the oral report, Board of Health Budget Working Group Update, for information; and,
- receive the briefing note for MPP Smith, dated May 1, 2019.

FINANCIAL IMPLICATIONS AND IMPACT

At its April 16 meeting, the Board of Health requested that a working group be struck in response to the 2019 Ontario Budget and the province's plans to modernize public health.

The group met on April 23 and 30, and will meet again on May 7, with additional dates to be scheduled as required. Membership includes board members (Mayor Mitchell, Cathy Praamsma, Kerri Davies and Deputy Mayor Graham) and staff (Dr. Salvaterra, Larry Stinson, Donna Churipuy and Brittany Cadence).

Arising from a working group request, a meeting was arranged with MPP Smith on May 3. Attendees for that meeting include: Mayor Therrien, Warden Jones, Mayor Mitchell, Chief Carr, Councillor Wilson and Dr. Salvaterra. Chief Williams was unable to attend. A briefing note (Appendix A) was developed for this meeting.

APPENDICES

Appendix A – Briefing Note for MPP Smith regarding the 2019 Ontario Budget

PETERBOROUGH PUBLIC HEALTH
BRIEFING NOTE

TO:	**MPP Dave Smith, Peterborough-Kawartha**
TITLE:	**Ontario 2019 Budget Announcements and Public Health**
DATE:	**May 1, 2019**
PREPARED BY:	**Dr. Rosana Salvaterra, Medical Officer of Health**

BACKGROUND

For 130 years, boards of health (BOHs) for Peterborough have provided proactive, timely and highly effective public health services which have saved lives and promoted the health and wellbeing of local residents. In 1965, the boards of the County and City amalgamated. In 1995, Curve Lake First Nation and Hiawatha First Nation signed agreements with the board which effectively included them as "obligated municipalities" under the Health Protection and Promotion Act (HPPA). In 2007, Hiawatha First Nation rejoined, after an absence of a few years.

WHAT WAS SHARED IN THE 2019 BUDGET:

The 2019 provincial budget contained the following announcements on page 119:

"Modernizing Ontario's Public Health Units
Ontario currently has 35 public health units across the province delivering programs and services, including monitoring and population health assessments, emergency management and the prevention of injuries. Funding for public health units is shared between the Province and the municipalities.

However, the current structure of Ontario's public health units does not allow for consistent service delivery, could be better coordinated with the broader system and better aligned with current government priorities. This is why Ontario's Government for the People is modernizing the way public health units are organized, allowing for a focus on Ontario's residents, broader municipal engagement, more efficient service delivery, better alignment with the health care system, and more effective staff recruitment and retention to improve public health promotion and prevention.

As part of its vision for organizing Ontario public health, the government will, as first steps in 2019–20:

- *Improve public health program and back-office efficiency and sustainability while providing consistent, high-quality services, be responsive to local circumstances and needs by adjusting provincial–municipal cost-sharing of public health funding; and*
- *Streamline the Ontario Agency for Health Protection and Promotion to enable greater flexibility with respect to non-critical standards based on community priorities.*

The government will also:

- *Establish 10 regional public health entities and 10 new regional boards of health with one common governance model by 2020–21;*
- *Modernize Ontario's public health laboratory system by developing a regional strategy to create greater efficiencies across the system and reduce the number of laboratories; and*
- *Protect what matters most by ensuring public health agencies focus their efforts on providing better, more efficient front-line care by removing back-office inefficiencies through digitizing and streamlining processes."*

On page 277:
"Modernizing public health units through regionalization and governance changes to achieve economies of scale, streamlined back-office functions and better coordinated action by public health units, leading to annual savings of $200 million by 2021–22;"

At a teleconference organized by the Chief Medical Officer of Health (CMOH), Dr. David Williams, on April 18th, Medical Officers of Health (MOHs) learned of the provincial plan to increase the municipal share of funding for public health, and to transfer currently 100% funded Ministry of Health programs over to the cost-shared budget as soon as 2019.

In a nutshell, these announcements translate to:

- Ontario's existing 35 health units would be replaced with 10 larger regional health units. So far, we know only that Toronto will be one of the ten. It is unclear where Peterborough would land in any larger amalgamation of health units.
- Total provincial funding for public health will be reduced by $200 million over the next two years. The province currently provides $743 million to local public health, so this represents a reduction, to the province, of almost 30%. Some of these "savings" would result from reductions in senior management staff and boards of health and other potential efficiencies secondary to amalgamations. The vast majority of savings will be achieved by shifting costs to municipal funders.
- Public Health Ontario and its laboratory services (PHL) will also be impacted. Although the wording in the budget is not completely clear, a reduction in PHL sites (currently there is a lab here in Peterborough that processes 40,000 to 45,000 water tests per year) has been announced.

What these announcements mean for public health in Peterborough is not clear yet, however it would be highly unlikely that the current BOH for the County-City of Peterborough with its own MOH would exist beyond March 2020. We can expect the new regional boards to be functional sometime after April 2020.

In the next few weeks, BOHs are expecting to receive our provincially approved 2019-2020 budgets. We expect to see a reduction in provincial funds and a requirement for local funders to increase from 25% cost share to 30%. In addition, we expect to see a shift of what have been

100% Ministry of Health funded programs into the cost-shared budget. By the 2021-2022 fiscal year, this ratio will further increase to a 40% cost to local councils in regions with over 1 million population. For the three regions with populations under 1 million, the ratio will remain at 70/30. This makes it appear that the regions have already been identified but not yet shared publicly.

WHAT WAS SHARED ON APRIL 29TH:

Late on Monday, April 29th, BOHs and MOHs received a letter from CMOH Dr. David Williams which reiterated the planned shifts in funding. In it, he confirms in writing:

"*It is important to note that the $200 million annual provincial savings target identified in the 2019 Ontario budget (by 2021-22) incorporates provincial savings related to the cost-sharing change, as well as savings from the proposed creation of 10 Regional Public Health Entities.*

As mitigation, and to support boards of health experiencing challenges during transition, the Ministry of Health and Long-Term Care will consider providing one-time funding to help mitigate financial impacts on municipalities and consider exceptions or "waivers" for some aspects of the Ontario Public Health Standards on a board by board basis. Implementation of these exceptions will ensure that critical public health (health protection and health promotion) programs and services are maintained for the protection for the public's health.

The proposed changes in both structure and cost-sharing are premised on the fact that essential public health program and service levels would be maintained and will remain local. The Ministry of Health and Long-Term Care will work with boards of health and public health units to manage any potential reductions in budgets, including encouraging public health units to look for administrative efficiencies rather than reductions to direct service delivery.

As a first step, we will be arranging calls with each of the Health Units over the next week to discuss the Annual Business Plan and Budget Submissions you have submitted, discuss the planned changes for this year and related mitigation opportunities, and ensure this next phase of planning supports your local needs and priorities."

Staff has used this information to calculate the impact of these changes on our yet to be released 2019 budget. **We have found that in 2019, the provincial changes will result in a gap of over $612,000 for the board of health.** If this is the case, this would result in significant increases, described in Appendix B.

WHY WE BELIEVE THE PUBLIC HEALTH MANDATE IS UNDER THREAT:

By downloading public health to municipal councils, the province is at risk of repeating the neglect of public health that was exposed by Ontario's inability to effectively predict and control the SARS outbreak in 2003. It was at this time that Hiawatha First Nation determined it could not afford the new cost-sharing ratio, making the decision to withdraw from its Section

50 agreement with the BOH. Both municipalities and First Nations have very limited ability to generate the revenues required to pay for health related services, hence the need for sustainable and predictable funding from the province.

Although public health is a municipal responsibility under the HPPA, the provincial Minister of Health mandates the programs and services that every BOH is required to deliver (Section 7). Recent comments made by Minister Elliott indicate that the non-health protection (healthy public policy, health promotion, healthy built and natural environment) components of the 2018 Ontario Public Health Standards (OPHS) may not be as valued. (Toronto Star, April 29, 2019, accessible at https://www.thestar.com/news/city_hall/2019/04/29/toronto-mayor-steps-up-pressure-on-pc-mpps-over-public-health-cuts.html)

In an April 28, 2019 opinion piece published in The Sun, former Peel Region MOH and former CMOH Dr. David Mowat wrote:

"*The benefits of many public health programs are often long-term. They may even be invisible in that, when they succeed nothing happens. You don't see headlines such as "Child does not die of meningitis," for example.*

Public health's long-term preventive perspective places it at risk of neglect by governments, which favour shorter-term, visible results.

But neglecting public health has consequences. Surely, we have not forgotten Walkerton or SARS. The federal and Ontario governments both commissioned reports on SARS.

The Naylor report found: "Public health is taken for granted until disease outbreaks occur, whereupon a brief flurry of lip service leads to minimal investments … This cycle must end."

The Walker Report called for a richer cost-sharing formula, with more provincial funding — the opposite of the recent announcement.

There is no lack of scientific evidence for public health's cost-effectiveness. A review (combining the results of many studies) in the U.S. in 2014 showed that a 10% increase in local public health spending was associated with a reduction in the death rate of between 1% and 6%-9%.

Another review, in 2017, showed a median cost-benefit ratio for public health programs of 8.3 – in other words, $8.30 benefit for each dollar invested.

The return on investment is even more favourable for the prevention of disease by means of policy actions (such as those limiting tobacco marketing and use, or the fluoridation of drinking water), or changes to the environment (such as building infrastructure for active transportation).

Local public health has been the leader in developing these approaches — progressively restricting smoking in public places, requiring calorie counts on menus and prohibiting minors from accessing tanning salons, for example.

Only later were these bylaws incorporated into provincial legislation. For these reasons, saving money by limiting public health's scope to the prevention of infectious diseases and other "health protection" issues would be a false economy.

Most of the burden of ill-health, and 85% of deaths, result from chronic disease such as cancer, heart disease and diabetes.

Obesity and diabetes are affecting ever more people of all ages. Posters, pamphlets, advertisements and programs have been used for years to get people to change their behaviours, with minimal results.

These conditions are becoming more prevalent, not because of ignorance or how people choose to behave, but because the environment in which we live, work and play makes eating well and being active just too difficult. We need to make the healthy choice the easy choice.

And that needs public health to continue effective, evidence-based efforts to prevent chronic diseases and injuries."

The PPH board is legally mandated to protect and promote the health of its communities and has a long track record of doing this. Examples are:

- Supporting community partners in mounting effective emergency responses against pandemics (Spanish Flu, H1N1);
- Preventing illnesses and deaths by mass vaccination against vaccine-preventable diseases such as polio, measles and more recently, H1N1 influenza;
- Successful advocacy for essential health-related resources such as Nurse Practitioners for Curve Lake FN and Keene, assisting with community-wide screening for workers and their families exposed to asbestos, accessing for provincial funding to support food-security interventions, and training close to 24,000 residents in safe food handling practices;
- High rates of immunization of children and youth which have prevented outbreaks being seen elsewhere in the province;
- Proactive work with communities and government partners on public awareness and guidance regarding historical and emerging health hazards present in air, water and land;
- Worked with the City of Peterborough to prohibit smoking in parks and on the hospital property five years before the province introduced similar smoke-free legislation;
- Early identification of opioid related harms and pro-active community mobilization, including early access to Naloxone for individuals at risk and support for hospital distribution.

A strategy to reduce hallway medicine that limits its scope from the hospital entrance to the long-term bed is doomed to fail. Part of the board of health's action plan must be to urge the provincial government recommit to investing in upstream prevention as the bedrock upon which to build a health care system. Returns on investment for strategies such as the prevention of exposure to second-hand smoke, immunization, fluoridation of drinking water, protection of drinking water and injury prevention are among the greatest returns ever realized by governments.

PROPOSING A 'MADE IN PETERBOROUGH' STRATEGY FOR STREAMLINING AND MODERNIZATION:

Peterborough Public Health (PPH) is not opposed to amalgamations that make sense. In 2006, amalgamation was explored and proposed, but not accepted by a neighbouring board of health. In response to the Expert Panel, PPH proposed to the province that local amalgamations be supported and funded (contrary to belief, amalgamations are costly, at least initially).

We believe that any future modernization of the public health system should be guided by the following principles:

1. **Maintain and build upon strong local connections** with municipal governments, First Nations, boards of education, primary health care providers, health system partners and First Nations. Any proposed amalgamation should consider input from existing boards, and align with geographic, historical and cultural groupings. Support amalgamations of boards of health that make sense to their communities and protect critical public health partnerships and connections.

2. **Build on sustainable and appropriate provincial funding.** Preserve a 75/25 provincial/ municipal ratio – or at minimum, ensure that Peterborough communities are held at a 70/30 ratio rather than being unfairly burdened with a 60/40 funding ratio. History has shown that municipalities are unable to shoulder the costs of downloaded public health services.

3. **Protect and maximize public health's contribution to prevent hallway healthcare** by ensuring upstream prevention efforts are sustained, comprehensive and effective. Any savings realized by efficiencies should be re-invested into public health.

4. **Maintain the full scope of mandated public health services and programs**, including those that address health inequities, health promotion and the prevention of chronic disease and injuries to ensure long term health benefits.

5. **Commit to funding both an immunization record and the digitization of public health services**, including the provision of electronic records to local public health agencies, as part of its strategy to "implement a digital first for health strategy that will increase the use of

virtual care and give the people of Ontario digital tools to access their own personal health information."

RESTRUCTURING:

PPH requests that local MPPs commit to engage with surrounding local councils and boards of health to identify the potential scope and boundaries for a new BOH to effectively serve the residents of Peterborough and the Kawarthas. See Appendix A.

A new regional BOH serving the Counties of Haliburton, Peterborough, Northumberland and the Cities of Kawartha Lakes and Peterborough, could maximize existing owned facilities in the City of Peterborough and still provide geographic access for the First Nations communities of Curve Lake, Hiawatha and, if interested, Alderville.

The population of this proposed region would be approximately 316,000 (2016 Census data), equivalent to the size being promoted for an Ontario Health Team. By 2041, the population is projected to grow to 372,625.

The following table highlights the rationale for a Four County regional public health unit and BOH:

Size matters	A Peterborough and the Kawartha Lakes board would service a geographic area that could be serviced from a rational combination of existing owned assets and municipal/FN spaces. Travel time for service delivery and for access by communities and clients would be minimized.
Local governance is enhanced	A Peterborough and Kawartha Lakes board would be close enough and accessible enough to local councils and their communities to preserve the vital connections that allow boards to be proactive, timely, responsive and accountable. This would ensure that the board is still seen as local and relevant.
Unique characteristics preserved	A Peterborough and Kawartha Lakes board comprised of smaller urban centres, rural communities and First Nations living in the Kawartha Lakes region would be served by a dedicated BOH.
Natural alignment with partners is maintained	Many current partners (boards of education, health and social service providers, potential new Ontario Health Team, Treaty #20 and Williams Treaty nations) align along the proposed boundaries. This would preserve those partnerships and relationships.
30/70 Funding would be appropriate	All of the communities within the proposed regional boundaries share a common residential/ commercial mix of the municipal tax base, making them more appropriate for a 30/70 funding ratio.

RECOMMENDATIONS BEING PROPOSED TO MPP DAVE SMITH:

As local leaders, we ask whether our MPP is willing to speak on behalf of his constituents. Specifically,

- ⇒ **What will you do to help us address the projected $612,000 shortfall for public health programs and services this year?**
- ⇒ **Will you champion a local proposal for a regional public health unit and board that makes sense for your constituents?**
- ⇒ **Will you ensure that the municipalities and First Nations located in your riding will have proper representation on any future regional board of health (say for pay)?**

The BOH will be discussing the results and any follow-up from the May 3rd meeting with MPP Smith at its upcoming public meeting on May 8th.

APPENDICES:

Appendix A – Four County Map
Appendix B – Estimates of Impact of Budget Announcements on Local Share of Public Health

APPENDIX A

Haliburton County - 18,062
City of Kawartha Lakes - 75,423
City of Peterborough – 81,032
County of Peterborough – 55,800
Northumberland County - 85,598
Total: 315,915

Curve Lake First Nation – 1,059
Hiawatha First Nation – 362
Alderville First Nation – 495

Source: Statistics Canada Census Data (2016)

APPENDIX B - Estimates of Impact of Ministry of Health and Long-Term Care Budget Announcements on Local Share of Public Health

The changes in the funding formula proposed by the provincial government impacts both the cost-shared and 100% MOHLTC-funded programs. Below the impact on each for the 3 years of implementation is outlined.

Cost-Shared Budgets

2019 Assumptions:

- 2019 Budget Total as approved by the Board of Health at $8,434,560
- Budget includes the use of $130,441 of reserves and has been retained for the purposes of calculations
- To move from a 25/75 split to a 30/70 split for the period of April 1 to December 31, 2019, the additional local share required would be $301,590
- Given that local partners already agreed to an increased contribution (beyond the 75/25 funding ratio), the shortfall for 2019 is **$152,617**

2020 Assumptions:

- Cost of living increase of 1.0% in the budget (to retain current staffing/service levels) would lead to total budget of: $8,518,906
- Cost shared at 70/30 for entire 12 months, so provincial contribution would have to increase by 1.0% as well
- No reserves to be used to balance the budget
- Local share increase from the 2019 total would be: **$130,339**

2021 Assumptions:

- Cost of living increase of 1.0% in the budget (to retain current staffing/service levels) would lead to a total budget of $8,604,095
- Cost shared at 60/40 for entire 12 months, so provincial contribution would have to increase by 1.0% as well
- No reserves to be used to balance the budget
- Local share increase from the 2020 total would be: **$885,966**

Current 100% Funded Programs

General Assumptions:

- All programs continue at existing funding levels (no annual increase)
- Total budget cost = $2,043,100
- HBHC, ITDP, and Safe Sewage not included

For 2019, 30% cost for April – December = **$459,698**
For 2020, 30% cost for 12 months = **$612,930**
For 2021, 40% cost for 12 months = **$817,240**

Total Additional Costs:

	2019	2020	2021
Cost-Shared	**$152,617**	**$130,339**	**$885,966**
Current 100%	**$459,698**	**$612,930**	**$817,240**
Total	**$612,315**	**$743,269**	**$1,703,206**

The total increased cost to local funders for the three years is $3,058,790. Based on current allocation formula, the individual contributions would increase by:

	2019	2020	2021	Total
City of Peterborough	$357,102	$433,475	$993,309	$1,783,886
County of Peterborough	$249,028	$302,288	$692,694	$1,244,010
Curve Lake First Nation	$4,351	$5,500	$12,604	$22,636
Hiawatha First Nation	$1,653	$2,007	$4,599	$8,259

These numbers reflect the additional costs in each year of the transition to the 60/40 province/local funding formula. This cumulative increase will need to be maintained in the following years.

Estimates based on information available as of April 29, 2019.

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**Staff Presentation: Smoke is Smoke – Vaping and the Regulatory Landscape**
DATE:	**May 8, 2019**
PREPARED BY:	**Keith Beecroft, Health Promoter**
APPROVED BY:	**Dr. Rosana Salvaterra, Medical Officer of Health**

PROPOSED RECOMMENDATIONS

That the Board of Health for Peterborough Public Health receive the following for information:
Staff Presentation: Smoke is Smoke – Vaping and the Regulatory Landscape
Presenter: Keith Beecroft, Health Promoter

ATTACHMENTS

Attachment A – Presentation

Smoke is Smoke

Vaping and the Regulatory Landscape

Keith Beecroft
Health Promoter, Family and Community Health
(705) 743-1000, ext. 238
kbeecroft@peterboroughpublichealth.ca

Peterborough Public Health

Agenda

- Vaping 101
- What has changed since October 17th, 2018?
- What does the science say about vaping?
- PPH approach to tobacco-wise/smoke-free living
- Federal, provincial, and municipal regulation
- Questions

Peterborough Public Health

E-Cigarettes: The Basics

- **What's in a name?**
  - Whatever you call it or whatever it looks like each device operates under the same premise and is designed to deliver vapour into the users' lungs.

Peterborough Public Health

E-Cigarettes: The Basics

- **What is in e-juice?**
  - Generally, e-juice (the liquid substance put in an e-cigarette or vape) contains these main ingredients: vegetable glycerin, propylene glycol, flavours, and nicotine.

Peterborough Public Health

Why We're Worried About Vapes

- In our last sample, 2015-16, 24.1% of students in local high schools had tried vaping (that number is likely much higher today)
- Altria (a cigarette company) just spent $13B on a 35% stake of JUUL (America's largest e-cigarette company)
- The US Surgeon General has declared e-cigarette use by youth an epidemic

Peterborough Public Health

What about the science?

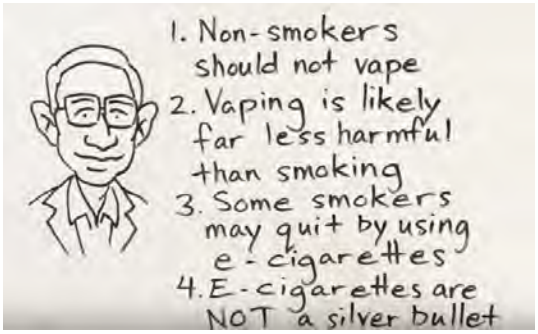
- Occasionally a single study will show that vapes may support cessation attempts

The National Academies of SCIENCES ENGINEERING MEDICINE

Peterborough Public Health

What about the science?

- Take home message:



Peterborough Public Health

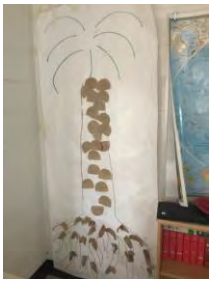
The Smoke-Free Ontario Act

- What has changed since October 17th, 2018?
  - E-cigarettes, cannabis (recreational and medicinal), conventional cigarettes are now included in the Act
  - Restrictions are harmonized re: purchase and places of use

Peterborough Public Health

Tobacco-Wise/Smoke-Free Living

- Prevention:
  - Love My Life



Peterborough Public Health

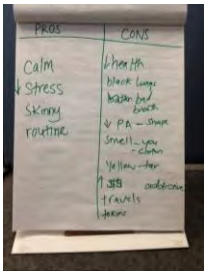
Tobacco-Wise/Smoke-Free Living

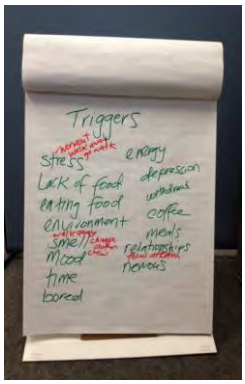
- Prevention:
  - Parent Action on Drugs
  - Scoop on Smoke

Peterborough Public Health

Tobacco-Wise/Smoke-Free Living

- Cessation
  - Connect, Change, Connect
  - Choose to Be Smoke-Free
  - 1:1





Peterborough Public Health

Regulatory Framework


Government of Canada Gouvernement du Canada

MENU

Consultation - Reducing Youth Access and Appeal of Vaping Products: Potential Regulatory Measures

From Health Canada

Current status: Open

Opened on April 11, 2019 and will close on May 25, 2019.

This consultation offers interested parties the opportunity to provide comments to inform the development o regulatory measures that aim to reduce youth access and appeal of vaping products.

- Specific to the **devices and products** themselves
- aIPHa resolution before you tonight

- Specific to the **marketing and advertising** of vapour products
- Staff report was received by the BOH at the last meeting


Government of Canada Gouvernement du Canada

MENU

Notice of Intent – Potential Measures to Reduce the Impact of Vaping Products Advertising on Youth and Non-users of Tobacco Products

Tobacco and Vaping Products Act

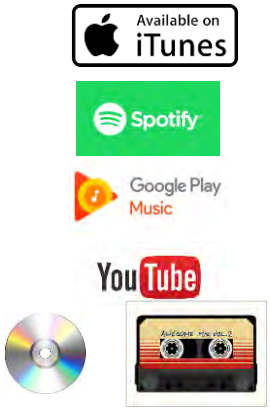
Notice of Intent - Potential Measures to Reduce the Impact of Vaping Products Advertising on Youth and Non-users of Tobacco Products

This notice offers interested parties the opportunity to provide comments on regulatory measures under consideration

Peterborough Public Health

Conclusion

- ✓ Vaping basics
- ✓ October 17th, 2018
- ✓ Understanding the science
- ✓ PPH approach
- ✓ Regulatory environment
- ? Questions



Peterborough Public Health

Thank you!

www.peterboroughpublichealth.ca/vaping

Keith Beecroft
Health Promoter, Family and Community Health
(705) 743-1000, ext. 238
kbeecroft@peterboroughpublichealth.ca

Peterborough Public Health

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**Correspondence for Direction – Endorsement of the Children Count Task Force Recommendations, KFL&A Public Health**
DATE:	**May 8, 2019**
PREPARED BY:	**Carolyn Doris, Manager, Family and Community Health**
APPROVED BY:	**Dr. Rosana Salvaterra, Medical Officer of Health**

PROPOSED RECOMMENDATIONS

That the Board of Health for Peterborough Public Health:

- receive for information, the letter dated April 25, 2019 from the Board of Health for Kingston, Frontenac and Lennox & Addington (KFL&A) regarding the Children Count Task Force Recommendations; and,
- support their position and communicate this support to Premier Ford, with copies to Minister Elliott, Minister Thompson (Education), Minister McLeod (MCCSS & Responsible for Women's Issues), Dr. David Williams, Chief Medical Officer of Health local MPPs, the Association of Local Public Health Agencies, Ontario Boards of Health and the Children Count Task Force.

BACKGROUND

Correspondence from Kingston, Frontenac, Lennox & Addington Public Health (KFL&A) was forwarded to all Ontario Boards of Health on April 25, 2019.

The Children Count Task Force, comprised of leaders from local public health agencies, boards of education, non-governmental organizations, academics, federal and provincial government agencies and ministries, convened in the spring of 2017 to identify opportunities to improve the monitoring and assessment of health and well-being of children and youth in Ontario. Through the nine-month intensive collaboration, members contributed a range of perspectives, knowledge and expertise, and identified recommendations and avenues for this work.

The Children Count Task Force Recommendations focused on the monitoring and assessment of health and well-being of children and youth in Ontario (See attachment). The recommendations focus on improving and streamlining the monitoring and assessment infrastructure for the health and well-being of Ontario's children and youth, particularly at the local level. These recommendations are relevant to the current mandates of the Ministry of Children, Community and Social Services, Ministry of Education and Ministry of Health and Long-Term Care.

Peterborough Public Health staff have been aware of this work and support the KFL&A PH endorsement. The recommendations support the work of evidence-informed decision making of Peterborough Public Health.

APPENDICES

Attachment A: KFL&A PH letter
Attachment B: Children Count Task Force Recommendations Summary

April 25, 2019

VIA: Electronic Mail (doug.ford@pc.ola.org)

Honourable Doug Ford
Premier of Ontario
Premier's Office
Room 281
Legislative Building, Queen's Park
Toronto, ON M7A 1A1

Dear Premier Ford:

RE: Endorsement of the Children Count Task Force Recommendations

The Kingston, Frontenac and Lennox & Addington (KFL&A) Board of Health passed the following motion at its April 24, 2019 meeting:

That the KFL&A Board of Health endorse the Children Count Task Force Recommendations and send correspondence to:

1) **The Honourable Doug Ford, Premier of Ontario**
2) **The Honourable Christine Elliott, Minister of Health and Long-Term Care, Deputy Premier**
3) **The Honourable Lisa Thompson, Minister of Education**
4) **The Honourable Lisa MacLeod, Minister of Children, Community and Social Services and Minister Responsible for Women's Issues**
5) **Ian Arthur, MPP Kingston and the Islands**
6) **Randy Hillier, MPP Lanark-Frontenac-Kingston**
7) **Daryl Kramp, MPP Hastings-Lennox and Addington**
8) **Loretta Ryan, Association of Local Public Health Agencies**
9) **Ontario Boards of Health**

At present, there are approximately 50 federal programs collecting health data on the Canadian population, many of which include school age children and youth. Notwithstanding the number of sources, data collected from these surveys are not always collected in a way that provides representative results at the regional and local levels. As such, Ontario needs a coordinated and cost-effective system for measuring the health and well-being of children and youth to inform local, regional and provincial programming. Such a system will enable stakeholders at all levels (local, regional and provincial) to effectively measure the health and well-being of our kids, and in turn, the return on investment in relevant programs.

To address this gap, the Children Count Task Force has made one overarching recommendation, which is to create a secretariat responsible for overseeing the implementation of the systems, tools, and resources required to improve the surveillance of child and youth health and well-being in Ontario. To further support this secretariat, the task force made an additional five recommendations:

- **Recommendation 1**: Create an interactive web-based registry of database profiles resulting from child and youth health and well-being data collection in Ontario schools.
- **Recommendation 2**: Mandate the use of a standardized School Climate Survey template in Ontario schools and a coordinated survey implementation process across Ontario.
- **Recommendation 3**: Develop and formalize knowledge exchange practice through the use of centrally coordinated data sharing agreements.
- **Recommendation 4**: Develop and implement a centralized research ethics review process to support research activities in Ontario school boards.
- **Recommendation 5**: Work with the Information and Privacy Commissioner (IPC) of Ontario to develop a guideline for the interpretation of privacy legislation related to student health and well-being data collection in schools.

The KFL&A Board of Health urges the Government of Ontario to act on the recommendations from the Children Count Task Force.

Yours truly,

Denis Doyle, Chair
KFL&A Board of Health

Copy to: The Honourable Christine Elliott, Minister of Health and Long-Term Care, Deputy Premier
The Honourable Lisa Thompson, Minister of Education
The Honourable Lisa MacLeod, Minister of Children, Community and Social Services and Minister Responsible for Women's Issues
Ian Arthur, MPP Kingston and the Islands
Randy Hillier, MPP Lanark-Frontenac-Kingston
Daryl Kramp, MPP Hastings-Lennox and Addington
Loretta Ryan, Association of Local Public Health Agencies
Ontario Boards of Health

CHILDREN COUNT: TASK FORCE
RECOMMENDATIONS SUMMARY

CHILDREN COUNT

REVISED **JANUARY 2019**

Ontario needs a coordinated and cost-effective system for measuring the health and well-being of children and youth. Such a system will enable stakeholders at all levels (local, regional and provincial) to effectively measure the health and well-being of our kids, and in turn, the return on investment in relevant programs.

Without a coordinated assessment and monitoring system in Ontario, the ability to inform public health planning for child and youth well-being at the local level is hindered. Monitoring, often referred to as 'surveillance' in the public health field, includes the systematic collection and analysis of health data for the purpose of planning, implementing and evaluating effective public health programs in local communities. In order to appropriately understand health behaviours of children and youth that influence well-being, and to properly measure health program investments over time, good quality assessment and monitoring data are needed at local levels. Good quality data are accessible, reliable, accurate, consistent and comparable. In particular, it is important that sample sizes are large enough and representative enough to allow for valid analysis at local levels, ensure ethical standards for privacy and to draw solid conclusions to inform decision making.

Based on the recommendation of the Children Count Report, a provincial task force of key stakeholders was convened in the spring of 2017. This task force included representation from boards of education, local public health units, government, researchers, and non-governmental organizations in Ontario. The aim of the task force was to identify next steps for improving assessment and monitoring of child and youth health and well-being in Ontario. The following recommendations of the Children Count Task Force represent next steps and actions needed to coordinate and connect the current data collection systems that exist in Ontario.

OVERARCHING RECOMMENDATION

Suggested lead Ministries:
Ministry of Education, Ministry of Health and Long-Term Care, Ministry of Children, Community and Social Services

Create a secretariat responsible for overseeing the implementation of the systems, tools and resources required to improve the monitoring of child and youth health and well-being. The secretariat shall be so enabled to:

1. Guide the implementation of the five recommendations of the task force that are contained in this report.
2. Develop a process to ensure that assessment and monitoring systems remain effective and relevant over time by addressing emerging issues and data gaps.

RECOMMENDATION 1

Suggested Lead Ministries: Ministry of Education, Ministry of Health and Long-Term Care
Supporting Ministry: Ministry of Children, Community and Social Services

Create an interactive web-based registry of database profiles resulting from child and youth health and well-being data collection in Ontario schools.

RECOMMENDATION 2

Suggested Lead Ministry: Ministry of Education
Supporting Ministries: Ministry of Health and Long-Term Care, Ministry of Children, Community and Social Services

Mandate the use of a standardized School Climate Survey template and a coordinated process across Ontario.

RECOMMENDATION 3

Suggested Lead Ministries: Ministry of Education, Ministry of Health and Long-Term Care
Supporting Ministry: Ministry of Children, Community and Social Services

Develop and formalize knowledge exchange practices through the use of centrally coordinated data sharing agreements.

RECOMMENDATION 4

Suggested Lead Ministry: Ministry of Education
Supporting Ministries: Ministry of Health and Long-Term Care, Ministry of Children, Community and Social Services

Develop and implement a centralized research ethics review process to support research activities in Ontario school boards.

RECOMMENDATION 5

Suggested Lead Ministries: Ministry of Health and Long-Term Care, Ministry of Education
Supporting Ministry: Ministry of Children, Community and Social Services

Work with the Information and Privacy Commissioner (IPC) of Ontario to develop a guideline for the interpretation of privacy legislation related to student health and well-being monitoring data collection in schools.

For a complete list of recommendations and their associated actions see the full report at ***www.wechu.org/reports/ldcp-task-force-recommendation.***

THE CHILDREN COUNT TASK FORCE RECOMMENDATIONS WILL LEAD TO:

- Better Data
- More Efficient Data Collection
- Reduced Costs
- Healthier Children and Youth

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**Correspondence for Information**
DATE:	**May 8, 2019**
PREPARED BY:	**Alida Gorizzan, Executive Assistant**
APPROVED BY:	**Dr. Rosana Salvaterra, Medical Officer of Health**

PROPOSED RECOMMENDATIONS

That the Board of Health for Peterborough Public Health receive the following for information:

a. Letter dated April 18, 2019 from Dr. Salvaterra to Lynn Fawn, County Clerk, regarding sewage system management agreements.

b. Letter dated April 24, 2019 from the Peterborough Family Health Team Board of Directors to Minister Elliot regarding public health modernization.

c. Letter dated April 29, 2019 from the Chief Medical Officer of Health regarding public health modernization.

d. Letter dated May 1, 2019 to Premier Ford from the Board Chair regarding a provincial alcohol strategy.

e. Letter dated May 3, 2019 to Minister Elliott from the Board Chair regarding managed opioid programs.

Correspondence from the Association of Local Public Health Agencies (alPHa):

f. Letter dated April 11, 2019 regarding the 2019 Ontario Budget.

g. E-newsletter dated April 24, 2019.

h. Email dated May 1, 2019 regarding the 2019 alPHa Annual General Meeting and Conference. *(Dr. Salvaterra and Mayor Mitchell will be attending).*

i. Letter dated May 3, 2019 regarding public health modernization.

Please note that alPHa has created an online resource page which houses communications related to public health modernization, including correspondence from local public health agencies and other stakeholders. Additional materials can be found here: ***https://www.alphaweb.org/page/PHR_Responses***

Peterborough Public Health

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

April 18, 2019

County of Peterborough
c/o Lynn Fawn, Clerk
470 Water Street
Peterborough, ON K9H 3M3
lfawn@ptbocounty.ca

Dear Ms. Fawn,

RE: Sewage System Management Agreement

In 2014, the County of Peterborough entered into a Sewage System Management Agreement with Peterborough Public Health for a five year term. That agreement expires in May 2019.

Under Part IV of the Clean Water Act, the principal authority is required to conduct maintenance inspections also known as mandatory re-inspections of on-site sewage systems located in "vulnerable areas" as outlined in source protection plans. Peterborough Public Health conducts these inspections as per the Mandatory and Non-mandatory and Sewage System Re-inspection By-laws - County of Peterborough which also require renewal.

On Wednesday, April 10, 2019, the Board of Health for Peterborough Public Health approved a motion to recommend to the County of Peterborough that:

- the current sewage system management agreement (with current fee schedule) be extended for up to one year;
- the Mandatory and Non-Mandatory Sewage System Re-inspection By-laws (with current fee schedule) be extended for up to one year; and,
- it strike a working group with Peterborough Public Health on this matter.

Your consideration of this request is appreciated.

Sincerely,

Original signed by

Rosana Salvaterra, MD, MSc, CCFP, FRCPC
Medical Officer of Health

/ag

Peterborough
FAMILY HEALTH TEAM

April 24, 2019

The Honourable Christine Elliott
Minister of Health and Long Term Care
Hepburn Block, 10th Floor, 80 Grosvenor St
Toronto, ON M7A 1E9

Response to Ontario Government Announcement - Funding Cuts to Public Health

Peterborough Family Health Team (PFHT) is one of the first Family Health Teams in Ontario. We are deeply rooted in the City and County of Peterborough as a trusted source for family medicine and the delivery of comprehensive primary care. We provide a team-based approach to patient care through our responsive and caring staff. In our model of care, we support the family physicians working within the Family Health Organizations (FHO). Our patients receive care at the clinics that are part of one of our five (5) FHOs.

Our team collectively cares for over 115,000 patients at various offices located throughout Peterborough County. Our team is comprised of 94 family physicians, 12 medical residents and over 80 allied health care providers. In addition, the Partners in Pregnancy Clinic (PIPC) is also part of PFHT. PIPC provides low risk team based obstetrical care to women and their families from 20 weeks' gestation to six weeks postpartum.

PFHT, who works closely with Peterborough Public Health strongly opposes the proposed funding cuts to Public Health, including the possibility of losing the local Medical Officer of Health, Dr. Salvaterra who has been an excellent leader for our community. In our experience as primary care physicians who are leaders in our region, it is inarguable that public health, delivered locally, is the most effective model, both from a safety, and from a cost perspective.

Yours in health on behalf of the PFHT Board of Directors,

Dr. Marta Wesolowski
Chair of the Board / Family Physician
Peterborough Family Health Team

Dr. Kaetlen Wilson
Medical Director / Family Physician
Peterborough Family Health Team

Peterborough
FAMILY HEALTH TEAM

Cc: Helen Angus, Deputy Minister of Health and Long Term Care

Patrick Dicerni, Assistant Deputy Minister, Strategic Policy and Planning

Dr. David Williams, Chief Medical Officer of Health, Public Health, Office of Chief Medical Officer of Health, Public Health

Melanie Fraser, Associate Deputy Minister, Health Services

Phil Graham, Director, Primary Health Care

Nadia Surani, Director, Primary Health Care

David Smith, Peterborough-Kawartha, Member Provincial Parliament

France Gelinas, Nickle Belt, (NDP) Member Provincial Parliament, Critic Health Care, Chief Opposition Whip

Ontario

Ministry of Health and Long-Term Care

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

Telephone: (416) 212-3831
Facsimile: (416) 325-8412

Ministère de la Santé et des Soins de longue durée

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April 29, 2019

TO: Chairpersons, Boards of Health
Medical Officers of Health, Public Health Units
Chief Executive Officers, Public Health Units

RE: Public Health Modernization

As you are aware, the Ontario government released its Budget on April 11, 2019. The government is taking a comprehensive approach to modernize Ontario's health care system which includes a coordinated public health sector that is nimble, resilient, efficient, and responsible to the province's evolving health needs and priorities.

While the broader health care system undergoes transformation, a clear opportunity has emerged for us to transform and strengthen the role of public health and its connectedness to communities. Modernizing and streamlining the role of public health units across the province will better coordinate access to health promotion and disease prevention programs at the local level, ensuring that Ontario's families stay safe and healthy.

As you know well, public health is a uniquely placed sector that must evolve to better meet ever-changing community needs. To that end, the Ministry of Health and Long-Term Care (the "ministry") has been working to define what a more resilient, modernized public health sector will look like, and also how it can contribute to the patient experience and better align to the new Ontario Health Agency, local Ontario Health teams, and the health system at large.

Notably, with respect to the public health sector, the ministry is proposing the following:

- Changing the cost-sharing arrangement with municipalities that would reflect an increased role for municipalities within a modernized public health system beginning 2019-20. The ministry will graduate the cost-sharing changes slowly over the next 3 years and will vary the final ratios by population size of the new Regional Public Health Entities. This is being done to recognize the variation across the province (i.e., geography, disbursement of populations, etc.). The cost-sharing changes, which will also apply to all 100% provincial programs funded by MOHLTC (except for the unorganized territories grant provided to northern public health units, and the new seniors dental program) are planned as follows:

  - **2019-20 (April 1, 2019):** 60% (provincial) / 40% (municipal) for Toronto; and, 70% (provincial) / 30% (municipal) for all other public health units.
  - **2020-21 (April 1, 2020):** 60% (provincial) / 40% (municipal) for the Toronto Regional Public Health Entity; and, 70% (provincial) / 30% (municipal) for all other Regional Public Health Entities.
  - **End State 2021-22 (April 1, 2021):** 50% (provincial) / 50% (municipal) for the Toronto Regional Public Health Entity; 60% (provincial) / 40% (municipal) for 6 larger Regional Public Health Entities with populations over 1 million; and, 70% (provincial) / 30% (municipal) for 3 smaller Regional Public Health Entities with populations under 1 million.

- Creating 10 Regional Public Health Entities, governed by autonomous boards of health, with strong municipal and provincial representation. Realigning the public health sector at a regional level provides for enhanced system capacity, consistent service delivery and greater coordination to support health system planning. The role of municipalities are core aspects of public health that the ministry wants to preserve in this new model and will do so by maintaining a local public health presence in communities.

- Modernizing Public Health Ontario to reflect changes in the health and public health landscape.

- Introducing a comprehensive, publicly-funded dental care program for low-income seniors. The program aims to prevent chronic disease, reduce infections, and improve quality of life, while reducing burden on the health care system.

It is important to note that the $200 million annual provincial savings target identified in the 2019 Ontario budget (by 2021-22) incorporates provincial savings related to the cost-sharing change, as well as savings from the proposed creation of 10 Regional Public Health Entities.

As mitigation, and to support boards of health experiencing challenges during transition, the Ministry of Health and Long-Term Care will consider providing one-time funding to help mitigate financial impacts on municipalities and consider exceptions or “waivers” for some aspects of the Ontario Public Health Standards on a board by board basis. Implementation of these exceptions will ensure that critical public health (health protection and health promotion) programs and services are maintained for the protection for the public’s health.

The proposed changes in both structure and cost-sharing are premised on the fact that essential public health program and service levels would be maintained and will remain local. The Ministry of Health and Long-Term Care will work with boards of health and public health units to manage any potential reductions in budgets, including encouraging public health units to look for administrative efficiencies rather than reductions to direct service delivery.

As a first step, we will be arranging calls with each of the Health Units over the next week to discuss the Annual Business Plan and Budget Submissions you have submitted, discuss the planned changes for this year and related mitigation opportunities, and ensure this next phase of planning supports your local needs and priorities.

Further details on the 2019 Ontario Budget can be found on the government's website at: http://budget.ontario.ca/2019/contents.html.

As previously noted, there is a significant role for public health to play within the larger health care system and it will continue to be a valued partner. I look forward to your input and collaboration as we work to modernize the public health sector.

Thank you for your ongoing support as the ministry continues to build a modern, sustainable and integrated health care system that meets the needs of Ontarians.

Sincerely,

Original signed by

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

c: Business Administrators, Public Health Units
Executive Director, Association of Municipalities of Ontario
City Manager, City of Toronto
Executive Director, Association of Local Public Health Agencies

Peterborough Public Health
1889-2019 LOCAL & STRONG

Jackson Square, **185 King Street**, Peterborough, ON K9J 2R8
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peterboroughpublichealth.ca

May 1, 2019

The Honourable Doug Ford
Premier of Ontario
Legislative Building, Queen's Park
Toronto, ON M7A 1A1
Sent via e-mail: doug.ford@pc.ola.org

Dear Premier Ford:

Re: Urgent provincial action needed to address the potential health and social harms from the ongoing modernization of alcohol retail sales in Ontario

On behalf of the Peterborough Public Health (PPH) Board of Health, I am writing to call on the Government of Ontario to develop a comprehensive, province-wide strategy to minimize alcohol-related harm and support safer consumption of alcohol in the province.

Alcohol is a legal psychoactive substance, not a regular commodity. As with other psychoactive substances, alcohol causes changes in perception and behaviour and its use exists on a spectrum from beneficial, to problematic, to chronic dependence. Recent statistics show that approximately 21% of Ontarians who drink exceed the low-risk alcohol drinking guidelines[1], a key modifiable risk factor of chronic diseases and injuries and their associated health care costs.

The costs of alcohol are significant. In 2014, Ontario spent $5.3 billion on alcohol-related harms; more than any other substance including tobacco, cannabis and opioids.[2] In the same year net revenue from alcohol amounted to only $3.9 billion, representing a net annual loss of over $1.4 billion.[3] Since 2015, alcohol use has contributed to more than 43,000 emergency room visits and 66 hospitalizations per day, a significant and avoidable burden on Ontario's healthcare system.[4]

It is well established that increasing access to alcohol is related to a subsequent increase in alcohol use[5], which in turn increases the potential for rising harms and costs. A comprehensive provincial alcohol strategy can help support a culture of moderation and mitigate the potential harms and costs of alcohol use. Such a strategy should include:

- Strong policies to minimize the potential health and social harms of alcohol consumption;
- Strategies to enhance alcohol treatment and harm-reduction programs;
- An improved monitoring system to track alcohol-related harms;
- Rigorous enforcement of alcohol marketing regulations, and;
- Public education and awareness campaigns aimed at changing attitudes and social norms around consumption.

The Ontario Government has committed to putting more money in people's pockets, and cutting hospital wait times and ending hallway healthcare as part of the 2019 Ontario Budget.[6] Given the significant costs associated with alcohol consumption, which are shouldered by both individual taxpayers and government systems, these commitments risk being undermined by recent and anticipated changes to provincial alcohol policy, including: reducing the minimum retail price of beer to $1.00, halting the annual inflation-indexed increase in the beer tax, extending the hours of sale for alcohol retail outlets, permitting municipalities to designate public areas for consumption of alcohol, advertising happy hour, and creating a tailgating permit for eligible sporting events including post-secondary events.

We echo the call from the Canadian Centre for Substance Use Research which, in the 2019 review of alcohol policies across Canada, identified that "in light of the on-going expansion of alcohol availability in Ontario the development and implementation of an alcohol-specific government-endorsed strategy should be given high priority".[7] In doing so, Ontario would join Alberta, Nova Scotia, and Nunavut as leaders in this important domain of alcohol policy.[8]

We believe it is possible to create a healthy alcohol culture in Ontario that balances interests in public health, government revenue, economic development, and consumer preferences without sacrificing the health of Ontarians. We support both the Council of Ontario Medical Officers of Health and Association of Local Public Health Agencies' request to ensure such a balance, and we thereby encourage the government to develop a provincial alcohol strategy that incorporates health goals. Now is the time for Ontario to take leadership and address the harms of alcohol use in our province.

Thank you for your consideration.

Sincerely,

Original signed by

Councillor Kathryn Wilson
Chair, Board of Health

/ag

cc: Hon. Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care
Hon. Vic Fedeli, Minister of Finance
Ken Hughes, Special Advisor for the Beverage Alcohol Review
Dr. David Williams, Chief Medical Officer of Health for Ontario
Local MPPs
Association of Local Public Health Agencies
Ontario Boards of Health

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[1] Canadian Tobacco, Alcohol and Drugs Survey. (2017). Table 18 Alcohol Indicators by province 2017. Accessed from: https://www.canada.ca/en/health-canada/services/canadian-tobacco-alcohol-drugs-survey/2017-summary/2017-detailed-tables.html#t18
[2] Canadian Centre for Substance Use and Addiction. (2019). Canadian substance Use Costs and Harms. Accessed from: https://csuch.ca/
[3] Canadian Institute for Substance Use Research. (2019). Reducing Alcohol-Related Harms and Costs in Ontario: A Policy Review.
[4] Ontario Public Health Association. (2018) The Facts: Alcohol Harms and Costs in Ontario.

[5] Popova, S., Giesbrecht, N., Bekmuradov, D. & Petra, J. (2009) Hours and days of sale and density of alcohol outlets: Impacts of alcohol consumption and damage: A systematic review. Alcohol and Alcoholism, 44(5), 500-516.
[6] Province of Ontario. (2019). 2019 Ontario Budget: Protecting What Matters Most. Accessed from: http://budget.ontario.ca/2019/foreword.html#section-0
[7] Canadian Institute for Substance Use Research. (2019). Reducing Alcohol-Related Harms and Costs in Ontario: A Policy Review.
[8] Canadian Institute for Substance Use Research. (2019). Canadian Alcohol Policy Evaluation (CAPE). Accessed from: https://www.uvic.ca/research/centres/cisur/projects/active/projects/canadian-alcohol-policy-evaluation.php

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May 3, 2019

The Honourable Christine Elliott
Minister of Health and Long-Term Care
Hepburn Block, 10th Floor
80 Grosvenor St.
Toronto, ON M7A 1E9
christine.elliott@pc.ola.org

Dear Minister Elliott:

Re: Urgent provincial action needed to expand opioid substitution treatment with Managed Opioid Programs (MOPs) to address the increased and immense number of opioid-related preventable deaths in Ontario

On behalf of the Board of Health for Peterborough Public Health, I am writing to call on the Government of Ontario to enhance its current response to the opioid poisoning crisis by providing operational and capital funding to support the implementation of Managed Opioid Programs (MOPs) in Peterborough.

Canada's current crisis with opioids continues to devastate communities nationwide and is affecting people from all demographics, age groups, and socio-economic backgrounds. The Peterborough community, including the City, the County, and both Curve Lake and Hiawatha First Nations, is no exception. Between 2013- 2016, Peterborough had the fourth highest rate of opioid-related deaths in Ontario.[1] In 2017, Peterborough ranked among the top 3 cities in Ontario per census metropolitan area for opioid poisoning emergency department visits.[2] Since January 2019, there have already been 17 suspected opioid poisoning fatalities in Peterborough, almost a three-fold increase over the same time period last year (preliminary findings, yet to be confirmed with Coroner data). The introduction of fentanyl and other toxic substances into the illicit drug supply has contributed considerably to the number of opioid poisoning fatalities in Ontario. In the first half of 2018, 72% of accidental overdose deaths involved fentanyl-related substances.[3]

To save lives and improve health outcomes for people who use drugs, we believe that there is a critical need to rapidly expand treatment options to include MOPs. MOPs provide patients with oral or injectable hydromorphone or diacetylmorphine (pharmaceutical heroin), along with methadone or slow release oral morphine for overnight relief. Used as a second line treatment option, managed opioid medications are prescribed by a physician in a clinic setting. Clients take the prescribed medications under medical supervision reducing the risk of drug-related harms from toxic street use. Through the provision of a clean, non-toxic drug supply, MOPs are cost-saving, provide a gateway for clients to access health and social support services, and is an effective form of treatment for people suffering chronic opioid use who have been unsuccessful with conventional forms of treatment, such as methadone.[4]

MOPs have a proven track record of increasing client participation in treatment, reducing the use of street drugs, and decreasing illegal activities associated with the drug trade.[5] MOPs reduce the prevalence of acute

opioid poisonings in the growing opioid-dependent population by providing safer alternatives to illicit drugs in a supervised and controlled environment. In Europe, six randomized control trials occurring over 15 years, demonstrated that prescribed supervised injectable heroin (SIH) treatment reduced crime and heroin use in the public.[6] Patients also led more meaningful lives with improved social functioning, such as acquiring stable housing, enhancing family functioning and increasing rates of employment.[7] The cost to deliver SIH treatment in Europe is higher than oral methadone treatment, however, this higher cost was offset by significant savings in the criminal justice system.[8]

The Province of Ontario recently announced a $102 million funding agreement with the federal government for drug treatment, and MOP's, which have demonstrated effectiveness in other Canadian regions as a treatment option, have potential to be an impactful tool under this agreement for communities such as Peterborough if appropriately resourced.

Peterborough's Board of Health is urging the Ministry of Health and Long-Term Care to:

- enhance the provincial response to the opioid poisoning crisis by immediately identifying operational and capital funding to support the implementation of managed opioid programs in communities like Peterborough, where appropriate;
- take action to add medications that could be used in a managed program to the Ontario Drug Benefit Formulary at appropriate concentrations to treat opioid use disorder (i.e. 50 mg/mL and 100 mg/mL hydromorphone), as well as ensure managed opioid medications are accessible to all Ontarians requiring treatment for opioid use disorder;
- include diacetylmorphine (pharmaceutical-grade heroin) for potential use as a managed opioid program medication in Ontario by obtaining authority from Health Canada;
- address barriers to procuring, storing, and transporting diacetylmorphine and/or mitigate its effects by collaborating with Health Canada and other necessary federal bodies to facilitate use of this managed opioid program medication; and
- ensure that the cost of managed opioid medications is not a barrier and that these medications are universally accessible to all Ontarians who could benefit from managed opioid programs.

Tragically, the majority of opioid poisoning deaths are accidental. To combat the large number of preventable deaths occurring in the province, urgent expansion of treatment options geared to reducing consumption of toxic street drugs is a public health priority. We urge you as our Minister of Health to make this the time for Ontario to take a progressive, evidence-based approach in addressing the opioid crisis through the expansion of treatment options that include MOPs.

Sincerely,

Original signed by

Councillor Kathryn Wilson
Chair, Board of Health

cc: Hon. Doug Ford, Premier of Ontario
Dr. David Williams, Chief Medical Officer of Health for Ontario
Local MPPs
Association of Local Public Health Agencies
Ontario Boards of Health

[1] Gomes T, Pasricha S, Martins D, et al. *Behind the prescriptions: A snapshot of opioid use across all Ontarians.* Toronto: Ontario Drug Policy Research Network; 2017

[2] Canadian Institute for Health Information. Opioid-related harms in Canada. https://secure.cihi.ca/free_products/opioid-related-harms-report-2018-en-web.pdf Published December 2018. Accessed March 12, 2019

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[4] Jesseman R, Payer D. Decriminalization: Options and evidence. Canadian Centre on Substance Use and Addiction. http://www.ccsa.ca/Resource%20Library/CCSA-Decriminalization-Controlled-Substances-Policy-Brief-2018-en.pdf. Published June 2018. Accessed May 1, 2019

[5] Leece P, Tenenbaum M. *Effectiveness of supervised injectable opioid agonist treatment (SiOAT) for opioid use disorder.* Toronto, ON: Public Health Ontario; 2017: 1-8. https://www.publichealthontario.ca/-/media/documents/eb-effectiveness-sioat.pdf?la+en Accessed May 1, 2019

[6] Strang J, Groshkova T, Metrebian N. *EMCDDA insights: New heroin-assisted treatment.* Lucembourg: European Monitoring Centre for Drugs and Addiction; 2012: 11-23

[7] Jesseman R, Payer D. Decriminalization: Options and evidence. Canadian Centre on Substance Use and Addiction. http://www.ccsa.ca/Resource%20Library/CCSA-Decriminalization-Controlled-Substances-Policy-Brief-2018-en.pdf. Published June 2018. Accessed May 1, 2019

[8] Strang J, Groshkova T, Metrebian N. *EMCDDA insights: New heroin-assisted treatment.* Lucembourg: European Monitoring Centre for Drugs and Addiction; 2012: 11-23

alPHa
Association of Local
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Dear alPHa Members,

Re: 2019 Ontario Budget, Protecting what Matters Most

Unlike previous recent budgets, the 2019 Ontario Budget contains a section devoted specifically to Modernizing Ontario's Public Health Units, so the traditional chapter-by-chapter summary of other items of interest to alPHa's members will be delayed as our immediate focus will be need to be on the significant changes that are being proposed for Ontario's public health system.

It appears that the Government intends to create efficiencies through streamlining back-office functions, adjusting provincial-municipal cost-sharing, and reducing he total number of health units and Boards of Health from 35 to 10 in a new regional model. As details about how they will do this are scarce, verbatim excerpts from the two areas that are directly relevant are reproduced here (*comments added in italics*):

VERBATIM EXCERPT FROM CHAPTER 1, A PLAN FOR THE PEOPLE: MODERNIZING ONTARIO'S PUBLIC HEALTH UNITS (P. 119)

"Ontario currently has 35 public health units across the province delivering programs and services, including monitoring and population health assessments, emergency management and the prevention of injuries. Funding for public health units is shared between the Province and the municipalities.

However, the current structure of Ontario's public health units does not allow for consistent service delivery, could be better coordinated with the broader system and better aligned with current government priorities. This is why Ontario's Government for the People is modernizing the way public health units are organized, allowing for a focus on Ontario's residents, broader municipal engagement, more efficient service delivery, better alignment with the health care system and more effective staff recruitment and retention to improve public health promotion and prevention.

As part of its vision for organizing Ontario public health, the government will, as first steps in 2019-20:

- Improve public health program and back-office efficiency and sustainability while providing consistent, high-quality services, be responsive to local circumstances and needs by adjusting provincial-municipal cost-sharing of public health funding (*ed. Note: what this means is not spelled out, i.e. it is not clear how such an adjustment would contribute to efficiency and if they are considering a change to the relative share, they have not revealed what it will be*).

- Streamline the Ontario Agency for Health Protection and Promotion to enable greater flexibility with respect to non-critical standards based on community priorities (*ed. Note: again, not spelled out*).

The government will also:

- Establish 10 regional public health entities and 10 new regional boards of health with one common governance model by 2020-20 (*based on the excerpt from chapter 3 below, it is likely that this means consolidation and not the establishment of another regional layer*);

- Modernize Ontario's public health laboratory system by developing a regional strategy to create greater efficiencies across the system and reduce the number of laboratories; and

- Protect what matters most by ensuring public health agencies focus their efforts on providing better, more efficient front-line care by removing back-office inefficiencies through digitizing and streamlining processes.

VERBATIM EXCERPT FROM CHAPTER 3, ONTARIO'S FISCAL PLAN AND OUTLOOK (HEALTH SECTOR INITIATIVES, P. 276-7):

Health Sector expense is projected to increase from $62.2B in 2018-19 to $63.5B in 2021-22, representing an annual average growth rate of 1.6% over the period…Major sector-wide initiatives will allow health care spending to be refocused from the back office to front-line care. These initiatives include:

- Modernizing public health units through regionalization and governance changes to achieve economies of scale, streamlined back-office functions and better-coordinated action by public health units, leading to annual savings of $200M by 2021-22.

Gordon Fleming and Pegeen Walsh (ED, OPHA) were able to ask a couple of questions of clarification of Charles Lammam (Director, Policy, Office of the Deputy Premier and Minister of Health and Long-Term Care), and he mentioned that strong local representation and a commitment to strong public health standards will be part of the initiative, and the focus of the changes is more on streamlining the governance structure. He also indicated that many of the details (including the cost-sharing model) will need to be ironed out in consultation with municipal partners and hinted that there is a rationale behind the proposed number of health units though he couldn't share that level of detail at this time.

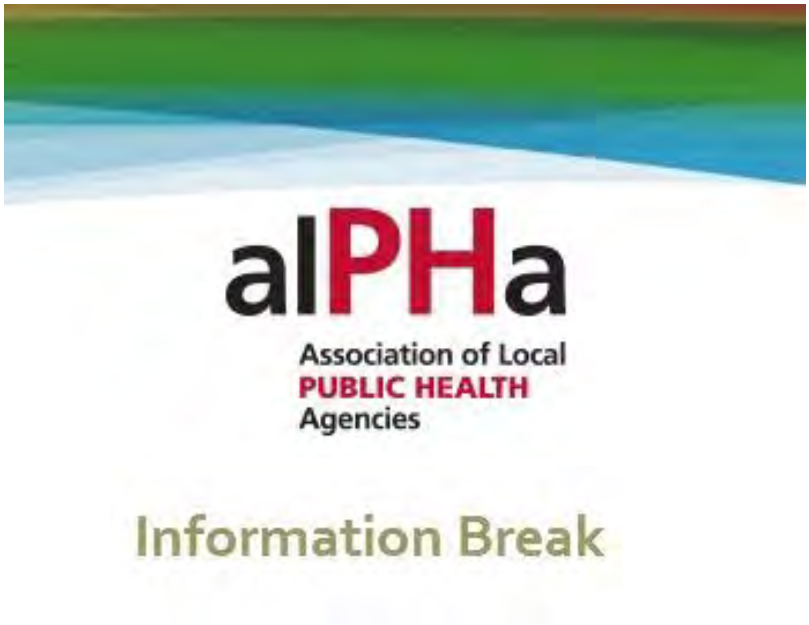
Please click here for the portal to the full 2019 Ontario Budget, which includes the budget papers, Minister's speech and press kits.

alPHa's Executive Committee will be holding a teleconference at 9 AM on Friday April 12 to begin the formulation of a strategic approach to obtaining further details about the foregoing and responding to the proposals. As always, the full membership will be consulted and informed at every opportunity.

We hope that you find this information useful.

Loretta Ryan,
Executive Director

From: info@alphaweb.org [mailto:info@alphaweb.org]
Sent: Wednesday, April 24, 2019 1:09 PM
To: Alida Gorizzan <agorizzan@peterboroughpublichealth.ca>
Subject: alPHa Information Break - April 24, 2019



April 24, 2019

This update is a tool to keep alPHa's members apprised of the latest news in public health including provincial announcements, legislation, alPHa activities, correspondence and events.

alPHa Action on Public Health Budget Announcements

During the 2019 budget release on April 11, the province announced sweeping changes to the Ontario public health system. The government will reduce the number of health units from the current 35 to 10, and install regional boards to oversee their governance by 2020/21. The province also plans to cut $200M across the local public health system by 2021/22. It will further streamline Public Health Ontario and regionalize the public health lab system. The changes appear to be a part of the government's move to make the broader health sector more efficient by achieving economies of scale, streamlining and digitizing processes, and improving coordination across entities. alPHa has summarized the public health changes below.
Read the full 2019 Ontario Budget here
View the alPHa summary of the 2019 Ontario Budget here

In response, alPHa's leadership and membership have launched a campaign to make Ontarians aware of significant concerns over these unprecedented changes and their potential negative impact on front-line public health programs and services. Many health units, including alPHa, have written news releases and met with media to highlight concerns that the proposals will put even more pressure on an already-lean system that effectively prevents disease and protects health. Today, a position statement (see below) was also released by the Association in light of last week's funding details.

Read alPHa's news release on the Budget here
Read alPHa's position statement of April 24, 2019
(podcast) Listen to alPHa president's interview on CBC Radio's Metro Morning here
Read about CBC news coverage on the interview here
Go to alPHa's Twitter account to view health units' media outreach

alPHa's member bodies and Executive held emergency meetings over the past week to discuss strategy and next steps. alPHa's Board of Directors will be meeting on April 26. Outcomes from these discussions and others will be shared with the membership, so keep an eye out for email updates as details about the changes become available. In the meantime, visit alPHa's dedicated web page on Public Health Restructure communications and resources from the Association and members (link below).
Go to alPHa's Public Health Restructure web page
Speaking Notes - Toronto Board of Health Meeting, April 15
Post Election Flyer to Municipal Representatives
alPHa Pre-Budget Submission 2019
Submission - Expert Panel on Public Health
alPHa Promotional Brochure
alPHa Video, What is public health?

Important News: 2019 Annual Conference Program

Due to the recent provincial budget announcements, alPHa is considering a major revamp of its June conference program. We will have more program and registration details next week, so please stay tuned and many thanks for your patience.
Learn more about alPHa's 2019 Annual Conference here

Last Call for Resolutions: April 26

Health units and their boards have until April 26, 2019 to submit resolutions to alPHa for consideration at the June annual conference.
View the 2019 Call for Resolutions here

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alPHa Fitness Challenges

This is a reminder to members to gear up for this year's annual alPHa Fitness Challenges for health unit employees and boards of health. Health units are challenged to involve all staff in 30 minutes of physical activity on May 9. Boards of health are encouraged to get their members to participate in 30 minutes of physical activity as well during April and May. Health units and boards of health with the highest participation rate will be recognized at the upcoming June conference.
Learn more about the health unit employee Fitness Challenge
Learn more about the Fitness Challenge for boards of health

Government News Round Up

Ontario amends Mandatory Blood Testing Act - 2019/04/16

Health Canada launches consultations to reduce youth vaping - 2019/04/11

Council of Chief MOHs statement on youth vaping - 2019/04/11

Ontario to launch public sector compensation consultations - 2019/04/04

Province releases guidance document for Ontario Health Teams - 2019/04/03

Auditor General's office assumes new environmental responsibilities - 2019/04/01

Ontario names Consumption & Treatment Services sites - 2019/03/29

Upcoming Event - Mark your calendars!

June 9, 10 & 11, 2019 - Annual General Meeting & Conference, Kingston, Ontario. Co-hosted with KFL&A Public Health. Four Points by Sheraton, 285 King St. E., Kingston, Ontario. View the Notice of AGM and calls. Registration details coming soon!

From: Susan Lee [mailto:susan@alphaweb.org]
Sent: Wednesday, May 01, 2019 12:28 PM
To: All Health Units <AllHealthUnits@lists.alphaweb.org>
Subject: Registration Now Open for 2019 alPHa Annual Conference, June 9-11, Kingston

ATTENTION:
All Board of Health Members
All Senior Public Health Directors & Managers
****

alPHa is pleased to announce that registration is now open for the 2019 Annual General Meeting and Conference, June 9-11, at the Four Points by Sheraton in downtown Kingston. In light of the recent news on public health restructuring, the conference has been retitled **Moving Forward with Public Health** and the two afternoon plenary panel discussions have been changed (all other sessions, including Dr. Theresa Tam's presentation, will remain the same in terms of timing and format).

The first panel on June 10 will feature **Drs. David Mowat** (past Interim Chief Medical Officer of Health) and **David Walker** (Expert Panel on SARS and Infectious Disease Control) as well as **Cynthia St. John**, CEO, Southwestern Public Health, who will speak to the Impacts of (Dis)Investment and understanding the cyclical nature of support for public health. This will be followed by a second panel, The Future State of Public Health, that will focus on the critical elements for Ontario's public health system as we move forward in these times of significant change. Click on the links below to learn more and to register:

2019 alPHa Annual Conference Home Page
Updated June 2019 Program
June 2019 Registration Information

An Early Bird registration rate is available, and will end **May 21, 11:59 PM. Click here to register.**

Note: The guest room block at the Four Points by Sheraton have sold out as of this writing, but please call the hotel directly at (613) 544-4434 for availability due to cancellations. Alternate nearby accommodations include Holiday Inn Kingston Waterfront and Delta Hotels by Marriott Kingston Waterfront.

Reminder:
May 31, 2019 – Deadline to submit a BOH nomination to the 2019-2021 alPHa Board of Directors

Hope to see you in June!

Susan Lee
Manager, Administrative & Association Services
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Hon. Christine Elliott
Minister of Health and Long-Term Care
10th Flr, 80 Grosvenor St,
Toronto, ON M7A 2C4

May 3, 2019

Dear Minister Elliott,

Re: Modernizing Ontario's Health Units

On behalf of the Association of Local Public Health Agencies (alPHa) and its member Medical Officers of Health, Boards of Health and Affiliate organizations, I am writing today to seek clarity on several aspects of the government's proposed steps towards reorganizing public health in Ontario, as announced in the 2019 Ontario Budget.

We are supportive of focusing on Ontario's residents, broader municipal engagement, more efficient service delivery, better alignments with the health care system, improved staff recruitment and retention, and improved public health promotion and prevention. We are ready and willing to assist you in meeting those goals, but in order to do so, we will need to be equipped with more information.

Our most immediate concern is related to public health funding. We appreciated receiving the memo from the Chief Medical Officer of Health on April 29th, which outlined the changes to the cost-sharing arrangement over the next three years. While this change is characterized as gradual, the municipalities' share of the cost of public health funding envelope will increase to varying degrees, effective immediately. Given that local budgets have already been set for the year, this will represent an unforeseen additional expense that will be difficult to absorb. Additionally, we have concerns about the decision to implement this change prior to finalizing the new public health governance structure that will ultimately be responsible for it. We are therefore looking forward to our upcoming calls with the Chief Medical Officer of Health for more specific and detailed descriptions of the Province's plans to ensure that any immediate local shortfalls are covered and that the total investment in local public health does not decrease over time.

We would also welcome the opportunity to draw on the wealth of expertise that currently exists within local public health to provide informed advice on the proposed replacement of Ontario's 35 public health units with 10 regional entities governed by new boards under a common governance model. We believe that our input will be vital to ensuring that all governance and operational aspects of the proposed transition are considered and that it can be achieved effectively and on time.

From a system standpoint, we eagerly anticipate more details about the plans to "streamline the Ontario Agency for Health Protection and Promotion to enable greater flexibility with respect to non-critical standards based on community priorities." Also known as Public Health Ontario, this agency is an essential partner to local public health and a most valuable resource for making the evidence-based decisions that are at the root of efficient and effective public health practice.

Finally, we would welcome a conversation about the status of the recently modernized Ontario Public Health Standards (OPHS), Protocols, and Guidelines within the Government's vision of a modernized public health system. For over three decades, population health in Ontario has benefitted from detailed mandatory health programs and services as itemized in Sections 5 through 9 of the Health Protection and Promotion Act, which include the enabling authority for the OPHS. Taken together, these form a comprehensive blueprint for addressing the public health needs of every Ontarian in every community. If changes are being considered, it is imperative that these be communicated and subject to inclusive and reciprocal stakeholder consultation.

We support modernizing the public health system in a way that improves population health. We find that the magnitude of the changes being proposed and achieving this within less than one year exceptionally ambitious given the intricacies of public health services and their deliberate and appropriate variation among communities. The pace and breadth of these changes will cause significant disruptions in every facet of the public health system. It is essential that attendant risks are mitigated, and Ontario's front-line public health professionals continue to have the local and provincial support that they require to carry out their essential duties to keep Ontarians healthy during this time of transition.

We also acknowledge the important contributions that such modernization can make to ensuring the province's fiscal health by identifying efficiencies and, more importantly, keeping Ontarians healthy. We look forward to learning more from the discussions that the Chief Medical Officer of Health has scheduled with each of Ontario's Boards of Health.

As the organization that represents the public health system's Medical Officers of Health, Boards of Health and Affiliate organizations, we would like to request a meeting with you to discuss opportunities for input into the design and implementation of these changes. To schedule a meeting, please contact alPHa Executive Director, Loretta Ryan, at loretta@alphaweb.org or 647-325-9594.

Yours sincerely,

Dr. Robert Kyle,
alPHa President

COPY: Helen Angus, Deputy Minister, Ministry of Health and Long-Term Care
Dr. David Williams, Chief Medical Officer of Health
Dr. Peter Donnelly, President and CEO, Public Health Ontario
Pat Vanini, Executive Director, Association of Municipalities of Ontario
Chris Murray, City Manager for Toronto

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH – REPORT

TITLE:	**Q1 2019 Peterborough Public Health Activities**
DATE:	**May 8, 2019**
PREPARED BY:	**Management Staff**
APPROVED BY:	**Donna Churipuy, Director of Public Health Programs** **Larry Stinson, Director of Operations** **Dr. Rosana Salvaterra, Medical Officer of Health**

PROPOSED RECOMMENDATION

That the Board of Health for Peterborough Public Health receive *report, Q1 2019 Peterborough Public Health Activities, for information.*

ATTACHMENTS

Attachment A – Q1 2019 Overall Compliance Status
Attachment B – Q1 2019 Communications and I.T. Report
Attachment C – Q1 2019 Social Media Report
Attachment D – Q1 2019 Finance Report

PETERBOROUGH PUBLIC HEALTH
Quarter 1 2019 Status Report - January 1 – March 31, 2019
Overall Compliance Status

Ontario Public Health Standard Mandated Programs	# Requirements Compliant
Program Standards	
Chronic Disease Prevention and Well-Being	3/4
Food Safety	5/5
Healthy Environments	4/10
Healthy Growth and Development	2/3
Immunization	10/10
Infectious and Communicable Diseases Prevention and Control	21/21
Safe Water	8/8
School Health	7/10
Substance Use and Injury Prevention	2/4
Foundational Standards	
Population Health Assessment	5/7
Health Equity	4/4
Effective Public Health Practice	7/9
Emergency Management	1/1
Non-OPHS Mandated Programs	
Infant and Toddler Development	ME
Safe Sewage Disposal	ME

ME: Meeting Expectations PME: Partially Meeting Expectations

Link to Ontario Public Health Standards

Chronic Disease Prevention and Well-Being
Hallie Atter/Carolyn Doris, Managers, Family and Community Health

Program Compliance
Requirement #2: Due to gaps in staffing, interventions will be planned and prioritized but not all implemented in 2019.

Foundational Standards
Jane Hoffmeyer, Manager, Foundational Standards

Program Compliance – Population Health Assessment:
Requirement #2 & 4: The recently hired Health Promoter for the FS division begins working at PPH later in April. This role will increase PPH's capacity to analyze, interpret, report and disseminate population health information. Limited progress has been made on the development of the preferred early warning and surveillance system due to financial barriers to paramedic data and the priority placed on staff time needed to respond to elevated opioid poisonings experienced by the community in the first quarter.

Program Compliance – Effective Public Health Practice:

Requirement #2: The development of a new Strategic Plan for PPH will support the ability of programs to identify priorities for program evaluation and surveillance. Newly developed evidence-informed decision-making tools for the Family and Community Health division may be expanded across the organization after managers are consulted in the second quarter. PPH's policy and procedures for Evidence Generating Activities will be revised and updated in the second quarter. PPH continues to be engaged in the Ministry's process to create a common set of program outcome indicators (specific to health protection indicators).

Requirement #5: The recently hired Health Promoter for the Foundational Standards division begins working at PPH later in April. In addition to data management responsibilities, this role will also support PPH's increased use of effective knowledge translation/exchange practices across the organization.

Healthy Environments

Manager, Environmental Health
Hallie Atter and Carolyn Doris, Managers, Family and Community Health

Program Compliance:

Requirement 2: Due to new planning process, due to limited staffing capacity, a full assessment of needs is still being completed.

Requirement3: Due to limited staffing capacity, the adaptation plan has been started but not completed.

Requirement 4 to 7: Due to limited staffing, only some interventions will be planned and implemented in 2019.

Healthy Growth and Development

Hallie Atter/Carolyn Doris, Managers, Family and Community Health

Program Compliance:

Requirement 2: Due to new planning process and limited staffing capacity, only some interventions will be planned and implemented in 2019. Further assessment of local needs is required.

School Health

Patti Fitzgerald, Manager, Child Health Services
Hallie Atter/Carolyn Doris, Managers, Family and Community Health

Program Compliance:

Requirement 2 to 4: Due to new planning process, as well as gaps in staffing, only some interventions will be planned and implemented in 2019.

Requirement 7: Vision screening began this quarter. PPH is on track to complete all Catholic and Public schools (not previously screened by Lion's Club by end of current school year, which is end of the second quarter).

Requirement 9: Due to new planning process, as well as gaps in staffing, only some interventions will be planned and implemented in 2019.

Substance Use and Injury Prevention
Hallie Atter/Carolyn Doris, Managers, Family and Community Health

Program Compliance:
Requirement 2: Due to new planning process and limited staffing capacity, only some interventions will be planned and implemented in 2019.

PETERBOROUGH PUBLIC HEALTH

Communications – Q1 2019

Brittany Cadence, Manager, Communications & IT Services

Media Relations

Activity	Q1 comparison	
	2019	2018
Total media products produced (news releases, audio files, letters to the editor, monthly Examiner and PTW columns, op eds, BOH meeting summaries, etc.)	45	36
Number of media interviews	27	11
Number of media stories captured directly covering PPH activities	166	73

Activity	Yearly Totals				
	2019 (YTD)	2018	2017	2016	2015
Press releases/media products issued	45	131	181	158	165
Media interviews	27	77	86	92	82
Number of media stories directly covering PPH activities	166	465	329	340	540
Communications tickets	198	649	680	n/a	n/a

Communications Highlights:

- Hosted February 9th, "Back to the Future" event promoting 130 years of public health in the Peterborough area.
- Four frostbite alerts issued.

Information Technology - 2019 Q1

<u>Note:</u> this report is provided from the Information Technology (IT) team and is intended to summarize major projects and provide a snapshot of the overall health of PPH systems.

System Status This Quarter:

Service Description	Planned Outage - % downtime of total	Unplanned Outage - % downtime of total	Total Uptime
MS Exchange Email server	0.14%	0%	99.86%
Phone server	0.14%	0%	99.86%
File server	0.14%	0%	99.86%
Backup server	0.0%	0.0%	99.86%

Total Number of Helpdesk Tickets Served:

Activity	Yearly Totals				
	2019 (YTD)	2018	2017	2016	2015
IT Tickets (IT in Q1)	308	1696	1426	1277	945

IT Highlights:

- Completion of IT Quarterly Maintenance on March 1, 2019.
- Deployed 21 new monitors.

Peterborough Public Health

Follow us @Ptbohealth

SOCIAL MEDIA Q1 REPORT

Jan 1 - Mar 31/19

Breadth… How many people are connecting with us on our social media channels?

Twitter: In Q1 our followers grew

2.4%

to **2246**

+56

154 tweets

Instagram was launched in Q1:

428

Current # of followers

6%↑

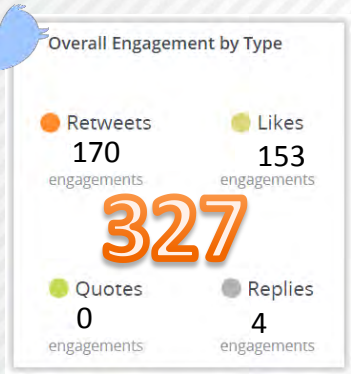
1003 fans

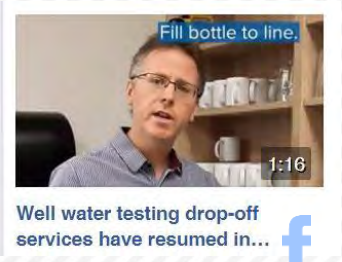
61,793

webpage views

+9.34%

Direct Engagement… How did people interact with us on social media?





most popular share
1071 views

209%
Increase
In FB engagement

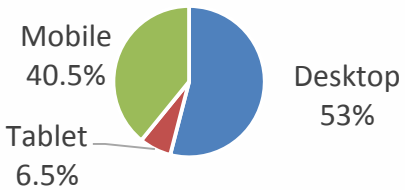
Depth… How are people reaching us and what are they looking for?

TOP 10

pages: peterboroughpublichealth.ca

Homepage: 10344
Employment: 6408
Contact Us: 2138
Sexual Health Clinic: 2125
Clinics & Classes: 2001
For professionals: 1856
Food Handler Course: 1732
Your Health: 1396
Reports & Data: 1087
About Us: 906

website visitors by device



Click throughs from tweet/post to our website

230

174

Loyalty… How are we doing at keeping our visitors engaged?

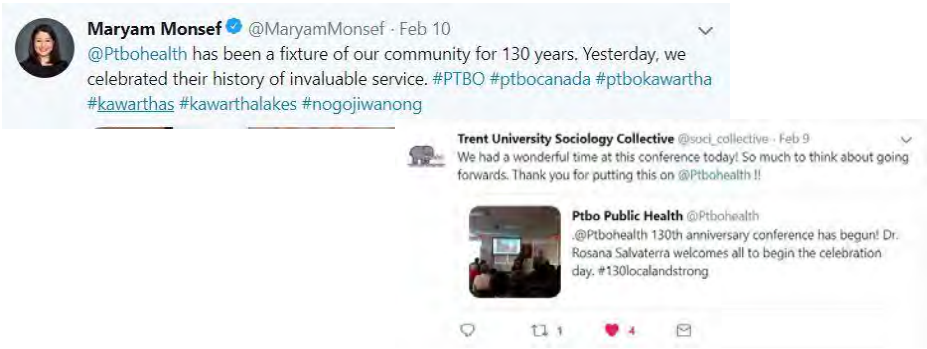
Our visitors are following us on our newest platform, Instagram

www.peterboroughpublichealth.ca

Customer Experience… What are people saying about us on social media?

@MENTIONS

143



Campaigns… How did our coordinated social projects perform?

Ad Campaigns – We did not run any paid advertising this quarter

Glossary… What do these social media terms mean?

Engagements Total number of times a user interacted with a Tweet.

Engagement rate: Number of engagements divided by impressions

Impression: Times a user is served a Tweet in timeline or search results

Promoted Tweet: Are ordinary Tweets purchased by advertisers who want to reach a wider group of users to spark engagement

Impression: Times a user is served a Tweet in a timeline or search results

Handle: another word for username specific to Twitter and represented by an @ symbol (e.g. @Ptbohealth)

Mention: A Tweet that contains another user's @handle anywhere in the body of the Tweet. Used to "call out" to someone and will land in their notifications timeline.

Financial Update Q1 2019 (Finance: Dale Bolton)

Programs Funded January 1 to December 31, 2019									
	Funding Type	2019 Submission	Approved by Board	Approved $ by Province	YTD Budget $ Based on 2019 Submission (100%)	Year To Date Expenditures to Mar. 31	Year to Date % of Budget Submission	Year to Date Variance Under/(Over)	Comments
Mandatory Public Health Programs	MOHLTC Cost Shared (CS)	8,137,186	14-Nov-18	Awaiting approval	2,034,297	1,885,874	23.2%	148,423	Operating within budget submission.
Small Drinking Water Systems	CS	90,800	08-Nov-17	Awaiting approval	22,700	23,503	25.9%	(803)	Operated just above budget submission. Anticipate being within budget by end of year.
Vector- Borne Disease (West Nile Virus)	CS	76,133	14-Nov-18	Awaiting approval	19,033	3,009	4.0%	16,024	Operating within budget submission. West Nile Virus program measures and students begin in May.
Infectious Disease Control	100%	222,300	14-Nov-18	Awaiting approval	55,575	58,341	26.2%	(2,766)	Operating above budget submission. Anticipate being within budget by end of year.
Infection Prev. & Control Nurses	100%	90,100	14-Nov-18	Awaiting approval	22,525	23,601	26.2%	(1,076)	Operating above budget submission. Anticipate being within budget by end of year.
Healthy Smiles Ontario (HSO)	100%	763,100	14-Nov-18	Awaiting approval	190,775	170,514	22.3%	20,261	Operating within budget submission. Program over past few years has been underspent.

	Funding Type	2019 Submission	Approved by Board	Approved $ by Province	YTD Budget $ Based on 2019 Submission (100%)	Year To Date Expenditures to Mar. 31	Year to Date % of Budget Submission	Year to Date Variance Under/(Over)	Comments
Enhanced Food Safety	100%	25,000	14-Nov-18	Awaiting approval	6,250	6,229	24.9%	21	Operated within budget submission.
Enhanced Safe Water	100%	15,500	14-Nov-18	Awaiting approval	3,875	1,201	7.7%	2,674	Operated within approved budget. Student position will begin in next quarter.
Needle Exchange Initiative	100%	57,000	14-Nov-18	Awaiting approval	14,250	4,790	8.4%	9,460	Operating well within budget submission. Additional supplies purchased at end of 2018 resulting in reduced spending in Q1.
Harm Reduction Enhancement	100%	150,000	14-Nov-18	Awaiting approval	37,500	45,810	30.5%	(8,310)	Operating above budget submission due to additional Epi services in 1st quarter.
Social Determinants of Health Nurses Initiative - Nurses Commitment	100%	180,500	14-Nov-18	Awaiting approval	45,125	46,204	25.6%	(1,079)	Operating just above budget submission. Anticipate being within budget by end of year.
Chief Nursing Officer Initiative	100%	121,500	14-Nov-18	Awaiting approval	30,375	32,267	26.6%	(1,892)	Operating just above budget submission. Anticipate being within budget by end of year.
Smoke Free Ontario (SFO) - Control	100%	100,000	14-Nov-18	Awaiting approval	25,000	25,536	25.5%	(536)	Operated just above budget submission.
SFO - Enforcement	100%	202,100	14-Nov-18	Awaiting approval	50,525	46,580	23.0%	3,945	Operating within budget submission.

	Funding Type	2019 Submission	Approved by Board	Approved $ by Province	YTD Budget $ Based on 2019 Submission (100%)	Year To Date Expenditures to Mar. 31	Year to Date % of Budget Submission	Year to Date Variance Under/(Over)	Comments
SFO - Youth Prevention	100%	80,000	14-Nov-18	Awaiting approval	20,000	20,648	25.8%	(648)	Operating just above budget submission. Anticipate being within budget by end of year.
SFO - Prosecution	100%	6,700	14-Nov-18	Awaiting approval	1,675	-	0.0%	1,675	Operating within budget based on program demand.
Electronic Cigarettes Act - Protection & Enforcement	100%	29,300	14-Nov-18	Awaiting approval	7,325	7,306	24.9%	19	Operating within budget submission.
Medical Officer of Health Compensation	100%	51,054	NA		12,764	12,764	25.0%	-	Operating within prior year budget approval. Have not submitted to Ministry as waiting for template.
Healthy Babies, Healthy Children	100% MCYS	928,413	06-Mar-19	Awaiting approval	232,103	226,082	24.4%	6,021	Operating within prior year budget approval. Budget has not been submitted to Ministry at this time as no template available.
Total - Ministry Funded - 2019		**11,326,686**			**2,831,672**	**2,640,259**	**23.31%**	**191,413**	

One-Time Programs Funded April 1, 2018 to March 31, 2019									
	Funding Type	2018 Submission	Approved by Board	Approved $ by Province	YTD Budget $ (100%)	Year To Date Expenditures to Mar. 31	% of Budget	Year to Date Variance Under/(Over)	Comments
Menu Labelling	100%	111,947	11-Apr-18	12,500	12,500	12,500	100.0%	-	Operated within budget.
PHI Practicum	100%	10,000	11-Apr-18	10,000	10,000	10,000	100.0%	-	Operated within budget.
Vaccine Refrigerators	100%	50,000	11-Apr-18	45,800	45,800	44,082	96.2%	1,718	Operated within approved budget. Purchase of 4 vaccine fridges, installation and service.

Recreational Beaches Predictive Model	100%	30,000	11-Apr-18	30,000	30,000	30,000	100.0%	-	Operated within budget.

Programs funded April 1, 2018 to March 31, 2019

	Funding Type	2018 - 2019	Approved by Board	Approved $ by Province/Other	YTD Budget $ (100%)	Year To Date Expenditures to Mar. 31	% of Budget	Year to Date Variance Under/(Over)	Comments
Infant Toddler and Development Program	100%	242,423	06-Mar-19	242,423	252,423	252,423	104.1%	-	Operated within approved amended budget. Additional funding of $10,000 provided in 4th quarter for staffing costs to enhance program services. Final audit of program to be completed.
Speech	100% FCCC	12,670	Annual Approval	12,670	12,670	12,670	100.0%	-	Operated within budget.

Funded Entirely by User Fees January 1 to December 31, 2019

	Funding Type	2019	Approved By Board	2019 Budget	YTD Revenue $ (100%)	Year To Date Expenditures to Mar. 31	% of Budget	Year to Date Variance Under/(Over)	Comments
Safe Sewage Program	Fee for Service	413,009	NA	413,009	48,065	93,252	22.6%	(45,187)	Program funded entirely by user fees. Expenditures are within budget, however revenue from User Fees are below budget resulting in a deficit of $45,187. Building activity slower in first quarter of the year, however anticipate increase in revenues as building season commences to offset deficit.
Mandatory and Non-Mandatory Re-inspection Program	Fee for Service	97,500	NA	97,500	-	4,058	4.2%	(4,058)	Program funded entirely by fees. Revenue will be collected in next quarter when property inspections commence.
Total - All Programs Programs		**12,294,235**		**863,902**	**3,243,130**	**3,099,244**	**25.21%**	**143,886**	

PETERBOROUGH PUBLIC HEALTH
BOARD OF HEALTH

TITLE:	**alPHa 2019 Annual general Meeting Resolutions**
DATE:	**May 8, 2019**

Resolutions for the Association of Local Public Health Agencies (alPHa) 2019 Annual General Meeting & Resolutions Session (scheduled for Monday, June 8) were not circulated at the time the agenda package was finalized. These are expected the week of May 6, and will be shared with the Board once they are available, for consideration on May 8.

Wednesday, May 8, 2019

Dear MPP Smith,

Thank you for meeting with the delegation from Peterborough on May 3rd, at the Douro-Dummer municipal building. We appreciated the opportunity to propose to you our made-in-Peterborough solution for the modernization of the public health system.

We understood from our meeting that you were expecting to find out shortly about the planned consultations. We would appreciate hearing from your office so that we can ensure our fulsome participation. We were glad to learn that you appreciated the principles and recommendations put forward in our briefing note. Thank you for sharing your intention to advocate that Peterborough NOT be grouped with areas that are not like us. You are correct in your assertion that we are in a unique situation and that "one of the biggest advantage (for PPH) is that we have a facility that can deliver high quality public health services to Northumberland and the City of Kawartha Lakes in less time than it takes to get to some communities in the County."

You may recall hearing from the delegation that we are concerned about the size of any regional board being so big as to dilute and weaken the voice of rural Peterborough and the First Nations communities that have been members of our board since 1995.

Thank you for agreeing to have an informal discussion with the board of health once you have more information on this matter. We are prepared to organize a subsequent meeting as soon as you indicate your readiness and availability.

Of course, we remain concerned about the cuts in the 2019 budget that you confirmed to us. Although we did not get to it during our conversation, the board is looking to you to advocate that in the long term, the funding formula for our municipalities remain at the 70%provincial/30%municipal cost ratio, as being proposed for smaller communities like ours.

We are concerned about the nature and the timing of this planned policy change. We wish to work collaboratively with your government to ensure that public health remains a protected and adequately funded investment. It would be our recommendation that changes be paused to allow for more consultation and input from the impacted communities, municipalities, First Nations, boards of health and partners.

June 2019

RESOLUTIONS for CONSIDERATION

Resolutions Session
2019 Annual General Meeting
Monday, June 10, 2019
Ballroom, Four Points by Sheraton
285 King Street East
Kingston, Ontario

alPHa
Association of Local PUBLIC HEALTH Agencies

CONTENTS

DRAFT RESOLUTIONS FOR CONSIDERATION
at June 2019 alPHa Annual General Meeting

TITLE: **Climate Change and Health in Ontario: Adaptation and Mitigation**

SPONSOR: **Council of Ontario Medical Officers of Health**

WHEREAS the "*Lancet Countdown: Tracking Progress on Health and Climate Change*", a global, interdisciplinary research collaboration between 27 academic institutions and inter-governmental organizations, describes climate change as the biggest global health threat of the 21st century and tackling climate change is described as potentially the greatest health opportunity[1]; and

WHEREAS there is clear evidence that, like the rest of Canada, Ontario's climate has experienced warming, as well as more frequent events of extreme temperature, wind and precipitation[2-4]; and

WHEREAS the current environmental health harms borne by the people of Ontario are significant, and include

- Four excess deaths per day for each 5°C change in daily temperature in warm seasons[5]
- 560 cancer cases per year attributable exposure to fine particulate matter air pollution[6]
- Vector borne disease including 138 cases of West Nile virus disease and 612 cases of Lyme disease in 2018[7]
- 67 deaths, 6,600 hospitalizations, and 41,000 emergency department visits per year related to foodborne illness[8]
- 73 deaths, 2,000 hospitalizations, and 11,000 emergency department visits per year related to waterborne disease[9]
- Community evacuations as a result of flooding or forest fires, with First Nation and northern Ontario communities particularly affected[10-12]; and

WHEREAS national and provincial projections indicate that ongoing climate change will lead to increased health harms from extreme weather, floods, drought, forest fires, heat waves, air pollution, and changing patterns of infectious disease[3,13-17]; and

WHEREAS just as all sectors of the economy are facing increasing impacts and financial costs due to climate change[4], the increasing health harms to the people of Ontario may be associated with increased health care utilization and health care costs; and

WHEREAS the health harms and costs of climate change will continue to have a disproportionately worse impact on certain groups and regions of Ontario, including people who are elderly, infants and young children, people with chronic diseases, people who are socially disadvantaged, Indigenous people, and residents of northern Ontario and rural Ontario[4,13]; and

WHEREAS climate change adaptation and mitigation actions, such as increasing active transport and reducing greenhouse gas emissions, can have powerful health benefits which include improved cardiovascular and mental health, and decreasing air pollution-related deaths, respectively[1]; and

WHEREAS there is broad support among Canadian physicians and public health professionals for specific, evidence-informed actions on climate change and health, as demonstrated by the seven recommendations of the "*Lancet Countdown 2018 Report: Briefing for Canadian Policymakers*" co- developed by the Canadian Medical Association and the Canadian Public Health Association[1]

WHEREAS the Ontario Public Health Standards articulate a general goal to improve and protect the health and well-being of the population of Ontario and reduce health inequities, and a specific goal to reduce exposure to health hazards and promote the development of healthy built and natural environments that support health and mitigate existing and emerging risks, including the impacts of a changing climate[18]; and

WHEREAS as part of a made-in-Ontario environment plan, the Government of Ontario has committed to undertake a provincial impact assessment to identify where and how climate change is likely to impact Ontario's communities, critical infrastructure, economies and natural environment, as well as impact and vulnerability assessments for key sectors, such as transportation, water, agriculture and energy distribution[4];

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies write to the provincial Minister of the Environment, Conservation and Parks and the Minister of Health and Long-Term Care to support the Ontario government's commitment to undertake provincial level climate change impact and vulnerability assessments;

AND FURTHER that the Association of Local Public Health Agencies recommend that health and health sector impacts borne by the full diversity of Ontario communities be included in provincial climate change impact and vulnerability assessments;

AND FURTHER that the Association of Local Public Health Agencies recommend that the provincial government's approaches to the health impacts of climate change be aligned with the recommendations of the *Lancet Countdown 2018 Report: Briefing for Canadian Policymakers*;

AND FURTHER that copies be sent to the Chief Medical Officer of Health of Ontario.

Supplementary information attached (1 page)

References

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7. Public Health Ontario. *Monthly Infectious Diseases Surveillance Report January to December 2018*: Public Health Ontario; April 8, 2019 2019.
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9. Drudge C, Fernandes R, Greco S, Kim J, Copes R. Estimating the Health Impact of Waterborne Disease in Ontario: A Key Role for Pathogens Inhaled from Plumbing Systems. *The Ontario Public Health Convention (TOPHC)*. Toronto2019.
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alPHa
Association of Local PUBLIC HEALTH Agencies

DRAFT alPHa RESOLUTION A19-2

TITLE: **Affirming the Impact of Climate Change on Health**

SPONSOR: **Kingston, Frontenac, and Lennox & Addington Public Health**

WHEREAS climate change is defined as a shift in long-term worldwide climate phenomena associated with changes in the composition of the global atmosphere[1]; and

WHEREAS the World Health Organization states climate change to be the greatest global health threat of the 21st century[2]; and

WHEREAS the United Nations Intergovernmental Panel on Climate Change concludes that human influence on climate change is clear and is extremely likely that human influence is the dominant cause[3]; and

WHEREAS climate change impacts the health of all people through temperature-related morbidity and mortality, extreme weather events, poor air quality, food and water contamination, altered exposure to ultraviolet rays, increasing risk of vector-borne infectious diseases, food security and indirectly impacts people by affecting labour capacity and population migration and displacement[4–6]; and

WHEREAS climate change disproportionately affects vulnerable populations such as children, seniors, low income and homeless people, those who are chronically ill, Indigenous peoples, and rural and remote residents[7,8]; and

WHEREAS the City of Kingston, the City of Hamilton, and the City of Ottawa declared a climate emergency for the purposes of naming, framing, and deepening commitment to protecting the economy, the ecosystem, and the community from climate change; and

WHEREAS tackling climate change requires political commitment by international, federal, provincial, and municipal stakeholders in acknowledging climate change as a public health issue

NOW THEREFORE BE IT RESOLVED THAT the Association of Local Public Health Agencies (alPHa) affirm the anthropogenic cause of climate change and its adverse impact on health in all people;

AND FURTHER will call upon strategic and provincial partners including the Ontario Ministry of Health and Long-Term Care, Ministry of Environment, Conservation and Parks, Ministry of Labour, Association of Municipalities of Ontario, Ontario Public Health Association, etc. to support climate change mitigation and adaptation measures in local communities.

Supplementary information attached (1 page)

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DRAFT alPHa RESOLUTION A19-3

TITLE: **Public Health Approach to Drug Policy**

SPONSOR: **Toronto Public Health**

WHEREAS governments around the world are considering different approaches to drugs, including the decriminalization of drug use and possession and legal regulation, including here in Canada for non-medical cannabis; and

WHEREAS a growing number of health officials and boards of health are calling for changes to our approach to drugs, especially in the midst of the opioid poisoning crisis in which the contaminated, unregulated supply of illegal drugs is the main contributor to the crisis; and

WHEREAS decisions about the legal status of drugs in Canada, including alcohol, were not based on scientific assessments of their potential for harm, but on moral judgements and racist ideas about people and the drugs they were using; and

WHEREAS laws that criminalize people simply for using and possessing drugs have resulted in serious health and social harms, including forcing people into unsafe spaces and high-risk behaviours leading to HIV and HCV infection, resulting in criminal records that make it difficult to obtain employment and housing, and reinforcing negative stereotypes and judgements about people who use drugs; and

WHEREAS some groups are more impacted by our drug laws than others, including people who are homeless and/or living in poverty, people with mental health and substance use issues, people from racialized groups, Indigenous people, women and youth; and

WHEREAS a public health approach to drugs would be based on principles and strategies that have been shown to support healthy individuals, families and communities; and

WHEREAS countries that have decriminalized personal drug use and possession and invested in public health interventions have seen results, including decreases in HIV and overdose, decreases in costs to the criminal justice system, and improved police/community relationships; and

WHEREAS the evidence on the health and social harms of our current criminalization approach to illegal drugs as well as that of alternative approaches such as decriminalization and legal regulation strongly support the need to shift to a public health approach to drugs in Canada;

NOW THEREFORE BE IT RESOLVED that the federal government be urged to decriminalize the possession of all drugs for personal use, and scale up prevention, harm reduction and treatment services.

Cont'd

AND FURTHER that the federal government convene a task force, comprised of people who use drugs, family members, and policy, research and program experts in the areas of public health, human rights, substance use, mental health, and criminal justice, to explore options for the legal regulation of all drugs in Canada, based on a public health approach.

TITLE: **Asbestos-Free Canada**

SPONSOR: **Peterborough Public Health**

WHEREAS the adverse health effects associated with exposure to asbestos exposure have been well established: Epidemiological, clinical, and laboratory studies have shown that asbestos is capable of causing lung cancer, mesothelioma, and a range of asbestos-related diseases (International Agency for Research on Cancer [IARC], 1987); and

WHEREAS asbestos is one of the most important occupational carcinogens causing about half of all deaths from occupational cancer. Currently, about 125 million people in the world are exposed to asbestos in the workplace, and at least 90,000 people die each year from lung cancer, mesothelioma, and asbestosis resulting from occupational exposures (Driscoll et al., 2005); and

WHEREAS it is believed that thousands of deaths each year can be attributed to other asbestos-related diseases as well as to non-occupational exposures, and the global burden of disease is still rising (World Health Organization [WHO], 2006); and

WHEREAS Canada was the fourth largest producer of chrysotile asbestos, exporting to more than 70 countries, even after introducing strict restrictions on its use in 1985, 1999 and 2004. In 2001, the World Trade Organization ruled against Canada's challenge to national asbestos bans. Canada went on to oppose the addition of chrysotile asbestos to the Rotterdam Convention, an international treaty regulating the environmentally-sound use of hazardous materials, in 2004 and 2006. In 2008, Canada abstained; and

WHEREAS Canada reached a historic milestone on December 30, 2018. On that date, after 130 years as a leading exporter of asbestos, Canada finally banned its use, import and export; and

WHEREAS we can take inspiration from other countries' experiences in eliminating the impact of asbestos on people and the environment. The most successful efforts have taken place in countries with comprehensive strategies, coordinated by a transparent and accountable institutional framework. The European Union has a lot to teach us, but the most impressive example is the Australian Agency for Asbestos Safety and Eradication (ASEA). https://www.asbestossafety.gov.au/;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) call on the federal government to make Canada "asbestos free" by establishing a federal asbestos agency based on the Australian model. The agency, in cooperation with Indigenous peoples, the provinces, territories and municipalities, would be mandated to develop a comprehensive Canadian asbestos strategy (see appendix A) and an implementation plan, while respecting the jurisdictions of each level of government.

Cont'd

AND FURTHER that the Chief Public Health Officer of Canada and the Ontario Public Health Association, be so advised.

Supplementary information attached (1 page)

BACKGROUNDER: A19-4

From April 7th to 13th, 2019, a delegation from the Italian city of Casale Monferrato visited Peterborough, Sarnia and Toronto – communities in Ontario with a legacy of occupational disease related to asbestos. Ten percent of Casale's population has died from occupational and environmental exposure to asbestos, used in a cement factory that operated there until 1986. Chrysotile asbestos, mined in Canada, was also used in the plant. Today, forty years after plant closure, there are still mesothelioma cases being diagnosed in young adults, at a rate of 50 new cases per year.

Despite the fact that asbestos was a known carcinogen and health hazard, Canada continued to export asbestos until December 30, 2018. Now that the government has taken definitive action, it is time to ensure that a comprehensive approach to reduce the harm and risk experienced by exposed and future populations be undertaken.

This alPHa resolution builds on a position paper produced in 2010 by the Public Health Physicians of Canada. The devastating tragedy of Casale Monferrato reminds us that asbestos is an ongoing threat that can persist for decades, and that Canada, as a major producer and exporter of asbestos has a health protective mandate to address this legacy.

TITLE: **Public Health Support for including Hepatitis A Vaccine in the School Immunization Program**

SPONSOR: **Peterborough Public Health**

WHEREAS hepatitis A is a viral liver disease that can cause mild to severe illness, and according to the World Health Organization (2018), epidemics that can be difficult to control and cause substantial economic loss[1]; and

WHEREAS recent hepatitis A outbreaks have been reported in Ontario and through-out North America, related to infected food handlers and to food products (strawberries, scallops, pomegranate seeds, organic berries)[2] ; amongst men who have sex with men; people who use illicit drugs, and people experiencing homelessness[2]; and

WHEREAS hepatitis A is one of the most common vaccine preventable diseases in travellers. Protection against hepatitis A is recommended for all travellers to hepatitis A endemic countries[3]; and

WHEREAS recovery from hepatitis A infection may take months, with about 25% of adult cases requiring hospitalization, resulting, in Ontario (2016/2017) with potential hospital stays costing is over $5300 per person[4]; and

WHEREAS in 2018, 12 million Canadians reported travel to overseas countries[5]; and

WHEREAS studies estimate that 44% to 55% of reported HA cases in Canada are linked to travel with low-budget travellers, volunteer humanitarian workers, and Canadian-born children of new Canadians returning to their country of origin to visit friends and relatives being at highest risk[6]; and

WHEREAS immunization is a cost-effective health intervention that reduces the burden on the health care system and offsets the high costs of doctor visits, trips to the emergency room, hospitalizations, medication therapy and outbreak management[6]; and

WHEREAS pre-exposure hepatitis A immunization is at least 90% to 97% effective with protective concentrations of hepatitis A antibody likely persisting for at least 20 years, possibly for life, following immunization with 2 doses of hepatitis A-containing vaccine[7]; and

WHEREAS increasing access to publicly funded vaccinations such as those offered in school clinics improves health equity and reduces disparities in immunization coverage across communities; and

WHEREAS combined vaccines result in fewer injections, fewer office visits, more convenience for clients, simplified logistics and increased compliance[8]; and

Cont'd

WHEREAS a combined hepatitis A/B vaccine could easily be implemented in the existing school-based clinic schedule provided in conjunction with the human papillomavirus (HPV) vaccine at 0 and 6 months[9]; and

WHEREAS there is no increase in adverse events with the combined hepatitis A/B vaccine when compared with the hepatitis A vaccine given alone or concomitantly with the hepatitis B vaccine[10]; and

WHEREAS the logistics and the related costs to adding a combined vaccine would be nil or minimal for the current Ontario school-based vaccine program and would further be reduced through bulk purchasing; and

WHEREAS the process of obtaining consent for the combined hepatitis A/B vaccine may be easy to update given that information on hepatitis is already included in the current package and thus, would require minimal modification; and

WHEREAS a goal of the Ministry of Health and Long-Term Care's Immunization 2020 – Modernizing Ontario Publicly Funded Immunization Program (2015), is to improve access to immunizations by offering additional vaccines and catch-up immunizations for school-aged children and adolescents through school-based immunization clinics[9].

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) endorse the replacement of the hepatitis B vaccine in the school-based program with the combined hepatitis A/B vaccine.

AND FURTHER that alPHa request that the provincial Government include the combined hepatitis A/B vaccine in the provincially funded immunization program as a way to reduce vaccine-preventable diseases and promote the health of all Ontarians.

AND FURTHER that the Premier of Ontario, the Chief Medical Officer of Health for Ontario, the Ontario Public Health Association and the Ministry of Health and Long-Term Care be so advised.

Supplementary information attached (2 pages)

BACKGROUNDER: A19-5

Peterborough Public Health is recommending the combined hepatitis A/B vaccine replace the single antigen hepatitis B vaccine in the publicly-funded school-based vaccine program.

Currently, in Ontario, the hepatitis B vaccine is offered free of charge to all Grade 7 students. In addition to the Grade 7 students, the hepatitis A vaccine in Ontario is also offered free of charge to those considered at high risk for the disease (men who have sex with men, intravenous drug users, and those with chronic liver disease (including hepatitis B and C).

Recently, the Centres for Disease Control and Prevention recommended adding homelessness as a risk factor for receiving the hepatitis A vaccine in the United States.[11] In Ontario, there were 120 outbreak cases reported from June 1, 2017 to November 30, 2018 which were linked to recent outbreaks in Europe and the United Kingdom primarily among men who have sex with men[12]. Given that it is difficult to reach these groups when exposures occur, pre-exposure vaccinating would be a more cost-effective and pro-active approach.

The cost of managing hepatitis A cases involves public health rapidly mobilizing staff to conduct product recalls, case/contact management, public and health care consultations, teleconferences and a d-hoc vaccination clinics to prevent outbreaks. In this day and age, food is distributed from many countries across Ontario and Canada. It is consumed in the home before products are recalled therefore when a foodborne outbreak occurs, many public health agencies must mobilize in an effort to protect the public. This comes at a very high cost for affected local public health agencies to manage the case and related risk of spread to susceptible exposed community members. Integrating routine hepatitis A vaccination pre-exposure into our publicly funded vaccine schedule can reduce the size of the at-risk population over time and thereby reducing the risk for large-scale outbreaks.

The combined vaccine has been available for many years. It is safe and effective. It can be easily interchanged logistically into the current school-based vaccine program as seen in Quebec. Quebec already offers both hepatitis A and hepatitis B vaccinations in a school-based program (NOTE: This program offers 1 dose of the combined vaccine and one dose of hepatitis B vaccine in Grade 4.[13])

[1] World Health Organization (2018). Available from: https://www.who.int/news-room/fact-sheets/detail/hepatitis-a

[2] Public Health Ontario (2019). Monthly Infectious Diseases Surveillance Report (February 2019). Available from: https://www.publichealthontario.ca/-/media/documents/surveillance-reports/surveillance-report-infectious-diseases-jan-dec-2018.pdf?_cldee=YXRhbm5hQHBjY2h1LmNh&recipientid=contact-4b1b4f0d4ab1e411bbf30050569e0009-e8e486622bdd4328a78300abe0c2ad02&esid=cbd675d2-bb24-e911-ab0a-0050569e0009

[3] Canadian Immunization Guide. Part 4 active vaccines: Hepatitis A vaccine https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-4-active-vaccines

[4] Canadian Institute for Health Information (2019) Available from: https://yourhealthsystem.cihi.ca/hsp/inbrief?lang=en#!/indicators/015/cost-of-a-standard-hospital-stay/;mapC1;mapLevel2;provinceC5001;trend(C1,C5001);/

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[8] Bakker, M et al. (2016) Immunogenicity, effectiveness and safety of combined hepatitis A and B vaccine: a systematic literature review, Expert Review of Vaccines, 15:7, 829-851.

[9] Ministry Health of Health and Long Term Care Publicly Funded Immunization Schedules for Ontario – December 2016. Available from: http://www.health.gov.on.ca/en/pro/programs/immunization/docs/immunization_schedule.pdf

[10] Canadian Immunization Guide. Part 4 active vaccines: Hepatitis B vaccine https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-4-active-vaccines/page-7-hepatitis-b-vaccine.html#a10

[11] Centres for Disease Control and Prevention (2019). Recommendations of the Advisory Committee on Immunization Practices for Use of Hepatitis A Vaccine for Persons Experiencing Homelessness. Available from: https://www.cdc.gov/mmwr/volumes/68/wr/mm6806a6.htm

[12] Public Health Ontario (2019). Public health responses to recent hepatitis A outbreaks: Spotlight on San Diego County, California and Middlesex-London, Ontario: Introduction. Available from: https://www.publichealthontario.ca/-/media/documents/presentations/grand-rounds-january-15-2019.pdf?la=fr

[13] Quebec Immunisation Program: https://www.quebec.ca/en/health/advice-and-prevention/vaccination/hepatitis-a-and-b-vaccine/

TITLE: **No-Fault Compensation for Adverse Effects Following Immunization (AEFI)**

SPONSOR: **Kingston, Frontenac, and Lennox & Addington Public Health**

WHEREAS routine immunization programmes are a significant part of public health practice and an important tool to protect the health of the public from the incidence and severity of vaccine-preventable diseases; and

WHEREAS serious adverse events following immunizations are much less likely to occur than similar adverse events following infection with vaccine preventable diseases, but will rarely occur after approximately 1 in 1,000,000 immunizations; and

WHEREAS in Canada, few individuals will bear the burden of serious adverse events for the communal benefit of the population; and

WHEREAS serious adverse events occur in spite of best practices being followed by health care providers and vaccine manufacturers; and

WHEREAS the Canadian legal system lacks an appropriate mechanism to provide individuals with compensation and this does not meet the ethical principle of reciprocity; and

WHEREAS no-fault compensation programs are increasingly regarded as a component of a successful vaccination program as an expression of community solidarity in which members of a community do not bear the risks of vaccination alone; and

WHEREAS Canada stands alone among the G7 countries as the only jurisdiction without a national publicly administered no-fault vaccine compensation program; and

WHEREAS Quebec is the only province or territory in Canada that has no-fault compensation for AEFIs; and

WHEREAS providing access to a fair reasonable process for compensation of serious adverse events weakens the argument against vaccination; and

WHEREAS no-fault compensation programs can quickly, effectively, and consistently make awards that are proportional to the serious adverse event;

NOW THEREFORE BE IT RESOLVED THAT the Association of Local Public Health Agencies (alPHa) call upon the Chief Medical Officer of Health of Ontario and the Minister of Health and Long-Term Care to institute a program of no-fault compensation for adverse outcomes following immunization.

AND FURTHER that the Association of Local Public Health Agencies (alPHa) call upon the Chief Medical Officer of Health of Ontario and the Minister of Health and Long-Term Care to call upon their counterparts across Canada as well as their Federal counterparts to institute a National system of no-fault compensation for adverse outcomes following immunization.

Cont'd

AND FURTHER that the Minister of Health and Long-Term Care, and the Chief Medical Officer of Health for Ontario, as well as the provincial, territorial, and federal Ministers of Health and Chief Medical Officers of Health be so advised.

Supplementary information attached (1 page)

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1. Duclos, P, Okwo-Bele, JM, Gacic-Dobo, M, and Cherian, T. Global immunization: status, progress, challenges and future. BMC Int Health Hum Rights. 2009; 9: S2
2. Law, B., et al. "Canadian Adverse Events Following Immunization Surveillance System (CAEFISS): Annual report for vaccines administered in 2012." Canada communicable disease report= Releve des maladies transmissibles au Canada 40.Suppl 3 (2014): 7-23.

Appendix:

Vaccination is among public health's greatest achievements in terms of reducing morbidity and mortality worldwide. Vaccines are safe, effective, and a powerful tool of public health to protect the public from preventable disease. According to the WHO, immunization is estimated to save the lives of 2.5 million worldwide people each year.

The number of individuals who experience adverse events as a result of vaccination is exceedingly low. Unfortunately, these individuals bear the burden of adverse events following immunization in the service of a public good – the pursuit of community immunity for the population. These events occur in spite of best practices followed by both health care providers and vaccine manufacturers. As a result of the legal system requiring fault be demonstrated in order for a compensatory award to be granted, there is no means by which individuals adversely affected in the course of receiving immunizations can be appropriately compensated. Several justices presiding in our courts have remarked that the system lacks an appropriate mechanism to compensate those who experience adverse events when receiving vaccines and that this oversight should be corrected.

No-fault compensation programmes are one means by which compensation could be accomplished. The implementation of the *Immunization of School Pupils Act* behooves us as a society to compensate individuals for adverse effects that may occur. There is an ethical imperative for a no-fault approach that would bring the mechanism for compensation outside the existing legal system. In jurisdictions where these approaches have been employed, resolution is generally quick, effective, and more consistently applied than via traditional legal channels. Canada stands alone among the G7 countries as the only country without a national publicly administered compensation system for those injured in the course of receiving immunizations. Quebec is the only province or territory in Canada that has no-fault compensation for AEFIs. Lessons learned from other jurisdictions' successful implementation of no-fault AEFI compensation could be applied to create a similar system in Ontario.

TITLE: **Considering the Evidence for Recalling Long-Acting Hydromorphone**

SPONSOR: **Kingston, Frontenac, and Lennox & Addington Public Health**

WHEREAS data from 2017 estimates 1,250 Ontarians died from opioid-related causes, representing a 246% increase in mortality from 2003 (Public Health Ontario, 2019); and

WHEREAS one in three people who died from an opioid-related cause had an active prescription for an opioid (Gomes, 2018); and

WHEREAS the harms associated with long-acting and high-dose formulations of opioids are well-characterized and include accidental overdose, cognitive impairment, falls, depression, and physical dependence (Bohnert, et al., 2011) (Juurlink, 2017); and

WHEREAS there is emerging evidence that long-acting hydromorphone is able to sustain HIV infectiousness due to the microcrystalline cellulose component of the drug and can infect people who inject drugs as a result of sharing equipment (Ball, et al., 2019); and

WHEREAS there is evidence that HIV persisted in long-acting hydromorphone residuals which may be used in "serial washes", where the non-solubilized drug from an initial preparation for injection is reused; and

WHEREAS there is additional evidence that long-acting hydromorphone prescribing patterns are associated with an increased incidence of infective endocarditis among people who inject drugs (Weir, et al., 2019); and

WHEREAS the federal Minister of Health has the power under the Food and Drug Act to recall drugs that pose serious or imminent risk to health (Government of Canada, 1985); and

WHEREAS the known harms of opioids coupled with new evidence of additional risk of infectious disease uniquely associated with long-acting hydromorphone meet the threshold for action from the federal Minister of Health;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) petition the federal Minister of Health and Health Canada to review the scientific literature and other available data regarding potential harms associated with long-acting hydromorphone, particularly with respect to the risk it poses for the spread of infectious diseases among people who inject drugs.

AND FURTHER that if evidence of serious or imminent risk to health is found, that the federal Minister of Health and Health Canada consider recalling or restricting prescribing of long-acting hydromorphone.

AND FURTHER that the Federal Minister of Health, the Minister of Health and Long-Term Care, the Chief Medical Officer of Health for Ontario, the Chief Coroner for Ontario, the CEO of Public Health Ontario, the Chief Medical Officer of Health for Canada, and all Chief Medical Officers of Health across all Provinces and Territories be so advised.

Supplementary information attached (1 page)

References

Ball, L. et al., 2019. Heating injection drug preparation equipment used for opioid injection may reduce HIV transmission associated with sharing equipment.

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Weir, M. A. et al., 2019. The risk of infective endocarditis among people who inject drugs: a retrospective, population-based time series analysis. *CMAJ,* Volume 191, pp. 93-9.

TITLE: **Preventing Mental Illness through Early Childhood Development Programming**

SPONSORS: **Northwestern Health Unit**
Thunder Bay District Health Unit
Middlesex-London Health Unit

WHEREAS one in five Canadians are affected by mental illness or an addiction issue every year, and the burden of illness is more than 1.5 times the burden of all cancers and 7 times the burden of all infectious diseases; and

WHEREAS suicide is the second leading cause of mortality among young Canadians aged 10-24 and suicide accounted for 24% of all deaths among youth 15 to 24 years old from 2009-2013; and

WHEREAS there were more than 9,000 deaths in Canada from 2016 to 2018 and more than 1,250 deaths in Ontario in 2017 related to opioids; and

WHEREAS the annual economic burden of mental illness is approximately 51 billion in Canada with a substantial impact on emergency room departments and hospitals; and

WHEREAS 70% of mental health and substance use problems begin in childhood; and adverse childhood experiences, such as poor attachment to parents, child abuse, family conflict and neglect, have been clearly linked to risk for mental illness and addiction later in life; and

WHEREAS programming that enhances the early childhood experience has proven benefits in IQ levels, educational achievements, income levels, interactions with the criminal justice system and utilization of social services; and

WHEREAS every $1 invested in early childhood development can save $9 in future spending on health, social and justice services; and

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 the child's transition to school) who are at risk of physical, cognitive, communicative, and/or psychosocial problems have access to effective, consistent, early intervention services; and

WHEREAS the HBHC program provides home visiting services and home visiting programs have demonstrated effectiveness in enhancing parenting skills and promoting healthy child development in ways that prevent child maltreatment; and

WHEREAS the HBHC program supports the early childhood experience and development of resiliency by enhancing the parent-child attachment, parenting style, family relationships, and financial instability and addressing parental mental illness and

substance misuse, child abuse or neglect thereby reducing the risk of subsequent mental illness and addictions; 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 with the exception of increased base funding in 2012 for an increase in public health nursing positions for Healthy Babies Healthy Children program as part of the 9,000 Nurses Commitment; and

WHEREAS fixed costs such as salaries and benefits, travel, supplies, equipment and other operational costs have increased the costs of operating the HBHC program, and

WHEREAS operating the HBHC program with the existing funding has become increasingly more challenging and will result in reduced services for high-risk families if increased funding is not provided;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) actively engage with the Ministry of Children, Community and Social Services, the Ministry of Health and Long term Care, and the Premier's Council on Improving Health Care and Ending Hallway Medicine to support investments in early childhood development as a strategy to enable health and resiliency throughout life, promote mental health and reduce mental illness and addictions.

AND FURTHER that alPHa engage with the Ministry of Children, Community and Social Services, the Ministry of Health and Long term Care, and the Premier's Council on Improving Health Care and Ending Hallway Medicine to urgently support adequate funding (including staffing and operational costs) of the Healthy Babies Healthy Children program as a strategic immediate action to enhance the early childhood experience and address mental illness and addictions in Ontario.

AND FURTHER that the Chief Medical Officer of Health of Ontario, Ontario Public Health Association, Centre for Addictions and Mental Health and other relevant partner agencies be so advised.

Supplementary information attached (6 pages)

Northwestern Health Unit
www.nwhu.on.ca

Preventing Mental Illness through Early Childhood Development Programming

The Issue

The Mental Health Commission of Canada (MHCC) states that 1 in 5 Canadians are affected by a mental illness or addiction issue every year; 70% of mental health and substance use problems begin in childhood. [i]

The Cost

Mental illness and addiction-related harms are costly to Ontarians, both financially and socially. Costs are incurred at every level, including healthcare, law enforcement, the judiciary system, the social system, the workforce, and premature deaths.

- The burden of mental illness and addictions in Ontario is more than 1.5 times the burden of all cancers, and 7 times the burden of all infectious diseases. [ii]
- There is a national opioid overdose crisis with more than 9,000 deaths in Canada between January 2016 and June 2018 related to opioids; [iii] In 2017, more than 1,250 Ontarians died from opioid-related causes. [iv]
- The annual economic burden of mental illness (costs of health care utilization, absenteeism form work, and declined quality of life) is about $51 billion in Canada. [v]
- 72% rise in emergency department visits and a 79% spike in hospitalizations for children and youth seeking help for mental health and substance use problems from 2006-

What Can Be Done

Mental health and addictions are complex issues with multiple causes and contributing factors across the lifespan. A comprehensive strategy includes mental health promotion, treatment and harm reduction, healthy public policy and addressing social factors.

Mental Health Promotion includes increasing protective factors and reducing risk factors for mental illness and addictions. Improvements in these factors promote positive mental health, reduces the likelihood of mental illness and addictions and may support recovery and treatment from mental illness and addictions. There are a broad range of protective and risk factors many of which apply to the prenatal and early childhood period: Maternal education, parental employment status, parental mental illness, parental substance misuse, physical health in infancy, single parent household, parent-child attachment and relationship, parenting style, family relationships and harmony, child abuse or neglect, self-esteem and resiliency, childhood poverty, food insecurity, adequate housing, sense of safety in the neighbourhood and social support or exclusion for the family. [vi]

Adverse childhood experiences, such as poor attachment to parents, child abuse, family conflict, and neglect, have been clearly linked as risks for mental illness and addiction later in

life. [vii] Substance use and substance use disorders during pregnancy are becoming more common and can lead to multiple social and health problems for both mother and child. [viii]

The Importance of Early Childhood Experiences

The prenatal and early childhood period is a critical period for neurological development with broad reaching consequences for the rest of the child's life. Brain development starts soon after conception and during early childhood, neurological development is rapid and greatly influenced by the social environment such as interactions with caregivers, nurturing engagement or neglect, and stressors created by the socioeconomic circumstances of the family. The extent to which the early childhood experience is supported by the social and family setting has a well-established effect on physical health, cognition, language, behavior, emotional and social development, and mental health. This subsequently impacts readiness to start school, school success and achievement, post-secondary educational attainment and likelihood of employment in adulthood. [ix]

Return on Investment

Programming that has focused on supporting children and families during early childhood and enhancing the early childhood experience have proven benefits in IQ levels, educational achievements, income levels, interactions with the criminal justice system, and reduced utilization of social services. Every $1 invested in early childhood development can save $9 in future spending on health, social and justice services. [x] Investing in the early years can save the system nearly 25% in publicly funded services per person[xi] Improving a child's mental health from moderate to high can lead to lifetime savings of $140,000. [xii]

HBHC

While there are a variety of programs that focus on the early childhood experience, this background paper focuses on a prominent program currently implemented provincially: Healthy Babies Healthy Children.

Healthy Babies Healthy Children (HBHC) is a prevention/early intervention initiative designed to ensure that all Ontario families with children (prenatal to the child's transition to school) who are at risk of physical, cognitive, communicative, and/or psychosocial problems have access to effective, consistent, early intervention services. HBHC is a free, voluntary program funded by the Ministry of Children, Community and Social Services (MCCSS) (formerly the Ministry of Children and Youth Services (MCYS)) and is delivered through Public Health Units across Ontario. HBHC was introduced in 1998 as a mandatory program under the Health Protection and Promotion Act (HPPA).

The HBHC program was created to improve outcomes for families experiencing challenges, to help children to get a healthy start in life and be supported to achieve their full potential. Program components of the HBHC program are:

- Screening and assessment to identify strengths and risks
- Home visiting and support services to families identified with risk
- Planning and coordination of services to families
- Referrals to community programs and resources to address key issues and support families
- Integration of service within a larger system of supports

- Evaluation and research of activities of the HBHC program

The home visiting component of the HBHC program uses a strength based approach to supporting pregnant women and their families, and families with children from birth to their transition to school. Evidence-based tools are used to assess the needs and strengths of families in areas such as:

- Continued education/employment
- Independent life skills
- Effective settlement and cultural adaptation
- Financial stability
- Healthy nutrition and food security
- Safe environment
- Housing stability
- Effective breastfeeding maintenance
- Positive support network
- Optimal growth and development
- Optimal prenatal health
- Optimal parental health
- Healthy relationships
- Healthy attachment
- Effective management of addiction/dependency

Interventions are designed to improve outcomes in many areas including social and emotional development, parent child interaction, help parents learn about and respond to baby's cues, foster infant attachment, increase parenting confidence and skills and support and have a positive effect on maternal health outcomes. [xiii]

The HBHC program has a unique opportunity to provide services in the home environment where typical parent-child interactions take place in order to observe for the emergence of parent-infant dyadic challenges. The HBHC program is a relationship based program which increases parent relational competence by teaching families about the importance of serve and return type interactions that are supportive of creating a safe base and secure haven for infants and children. Home visiting provides protective therapeutic relationship opportunities by role modeling regulated, attentive, and attuned interactions with both parents and children which counteract the effects of early childhood adversities consistent with neglect, maltreatment and otherwise impoverished environments. Without foundational nurturing experiences during infancy and early childhood, children are at high risk for developmental, relational, and behavioral difficulties and are at an increased risk for mental illness. [xiv]

The HBHC Program supports the development of safe, nurturing relationships between the parent/caregiver and their children.[xv] Home visiting programs have demonstrated effectiveness in enhancing parenting skills and promoting healthy child development in ways that prevent child maltreatment. [xvi]

HBHC staff provide direct care for women with perinatal mood disorder and addictions which consists of screening, assessment, education and referrals to primary care, counselling and community supports. Supporting women suffering with mental health disorders or addictions provides protective interventions aimed at diminishing the impact of adversity on children by decreasing vulnerability to stress and creating supportive environments for families.

The period between conception and transition to school is the most critical period of a child's growth and development. Experiences during these early years can have health and social effects that last a lifetime. The HBHC program provides important and necessary services and

supports to children and families at a critical period in time to supports healthy child development, effective parenting and to help children to achieve their full potential.

BUDGETARY IMPACT

In 1997 the province committed to funding the Healthy Babies Healthy Children program at 100%. Although fixed costs for salaries, benefits and overall operational costs are ever-increasing, funding for the HBHC program has remained static. In October 2012, MCYS announced the addition of base funding for 36 new full time equivalents (FTE) public health nursing positions for Healthy Babies Healthy Children program as part of the 9,000 Nurses Commitment. This funding supported salaries, benefits and operational costs associated with the HBHC Screening Liaison role. With the exception of this new funding, MCCSS base funding for HBHC has not increased.

Costs associated with operating the HBHC program continue to increase with no consideration of an increase in base funding to offset this pressure. The capacity for public health units to continue to offer high quality home visiting in a frequency and intensity of support that will have greatest impact is compromised by the budgetary conditions. Operating the HBHC program with the existing funding shortfall has become increasingly more challenging and will result in reduced services for high-risk families if increased funding is not provided.

CONCLUSION

Poor mental health, mental illness and addictions have a substantial burden of illness in Ontario and nationally with subsequent costs to the health care system, social services. Addressing this problem must include strategic investments in mental health promotion particularly as it applies to early childhood experiences. Healthy Babies Healthy Children is a prominent program that targets high risk families and enhances protective factors and tackles risk factors to prevent mental illness and addictions. This program has been chronically underfunded for the past decade which threatens its ability to sustain service and meet the needs of families and young children.

RECOMMENDATIONS

1. That the Association of Local Public Health Agencies (alPHa) actively engage with the Ministry of Children, Community and Social Services, the Ministry of Health and Long term Care, and the Premier's Council on Improving Health Care and Ending Hallway Medicine to support investments in early childhood development as a strategy to enable health and resiliency throughout life, promote mental health and reduce mental illness and addictions

2. that alPHa engages with the Ministry of Children, Community and Social Services, the Ministry of Health and Long term Care, and the Premier's Council on Improving Health Care and Ending Hallway Medicine to urgently support adequate funding (including staffing and operational costs) of the Healthy Babies Healthy Children program as a strategic immediate action to enhance the early childhood experience and address mental illness and addictions in Ontario.

PREVIOUS ALPHA RESOLUTIONS

There are a number of previous alPHa resolutions related to funding for Healthy Babies Healthy Children and Early Childhood development:

- 2001: Healthy Babies, Healthy Children Program Funding
- 2008: Poverty Reduction Strategy Linked to Healthy Babies Healthy Children Program Base Funding
- 2011: Public Health Supporting Early Learning and Care
- 2016: Healthy Babies Healthy Children 100% Funding

This resolution differs from previous resolutions as it positions early child development programs and Healthy Babies Healthy Children as an effective, cost-saving strategic direction for programming and services to address the pervasive health problem of mental illness and addictions.

ACKNOWLEDGEMENTS

This backgrounder was developed in consultation with the following health units:

- Thunder Bay District Health Unit
- Simcoe Muskoka District Health Unit
- Middlesex-London Health Unit
- Niagara Region Public Health
- Ottawa Public Health
- Peel Public Health

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TITLE: **Public Health Support for Accessible, Affordable, Quality Licensed Child Care**

SPONSOR: **Simcoe Muskoka District Health Unit**

WHEREAS the Ontario Public Health Standards indicate the child care sector is an important setting for Public Health interventions, related to the Standards for Health Equity, Healthy Growth and Development, Immunization, Institutional Outbreak Management, Infection Prevention, Food Safety and others; and

WHEREAS supporting families and healthy early childhood development is a core part of the mandate of public health; and

WHEREAS early childhood experiences and socioeconomic status (SES) are important social determinants of health, and are supported by affordable, accessible, quality child care; and

WHEREAS the positive effects of high quality child care and early learning programs can last a lifetime and are associated with immediate and long-term positive outcomes for children, particularly for children from lower socioeconomic backgrounds; and

WHEREAS the current number of licensed child care spaces across Ontario can accommodate less than 1 in 4 (23%) children from ages 0-4; and

WHEREAS Ontario has the highest child care costs provincially, with parents spending $750-$1700 per month for licensed child care, totalling between $9,000-$20,000+ per year for each child; and

WHEREAS public investment in child care demonstrates positive economic benefits; in Ontario, the return on investment is $2.27 for every dollar invested; and

WHEREAS the Ontario government's plan for a refundable tax credit for child care costs will not improve access to quality licensed child care spaces, requires initial out of pocket expenses by families, and may thereby increase health inequities; and

WHEREAS Ontario has the lowest rate of women's workforce participation nationally; recognizing income is a key social determinant of health for Canadian families; and

WHEREAS no provincial standard or definition for quality of child care exists; most of Ontario's municipalities have a quality assurance coordinator, however only half are using a measurement tool to assess quality of child care; and

WHEREAS there is a shortage of Registered Early Childhood Educators in Ontario, in part due to the low compensation they receive.

Cont'd

NOW THEREFORE BE IT RESOLVED that alPHa will endorse the importance of an accessible, affordable, quality child care and early learning system, for improved health equity for families and enhanced child development outcomes.

AND FURTHER that alPHa will advocate to the provincial and federal governments to maintain their commitment to ensuring a more affordable child care system, and to expand access to quality, licensed child care services for all Ontario families, including access for families with diverse needs (eg. 24 hour care, weekend care, part time care).

AND FURTHER that alPHa will advocate to the province to maintain its commitment towards creating a provincial definition of quality, including establishing an early years and child care workforce strategy, to ensure child care professionals are adequately qualified and compensated.

AND FURTHER that alPHa will support local public health agencies to:

- enhance their knowledge and transfer knowledge to decision-makers and the general public about the health impacts of the current state of the child care system and the importance of progressing towards an increasingly accessible, affordable, quality child care system; this could be initiated at an upcoming alPHa forum.
- build capacity to support the child care sector, by sharing examples of best practices for public health programming in child care environments and useful approaches for creating and enhancing partnerships with child care providers; this could be initiated through professional development opportunities in collaboration with partner organizations.

Supplementary information attached (7 pages)

BACKGROUNDER: A19-9

Public Health Support for Accessible, Affordable, Quality Licensed Child Care

ISSUE:

The 2018 Ontario Public Health Standards (OPHS) has identified child care as an important setting for public health intervention. Shortages of affordable, accessible, high quality child care contribute to child poverty and are an impediment for healthy child growth and development.

CURRENT FACTS:

The demand for child care is high given the labour market participation rates of parents. It is estimated that 89.5% of men and 81.4% of women ages 24 to 49, living in Ontario, are employed either part or full-time.[(1)] In 2015, 74% of couples who had at least one child under age six were dual-earner couples. The number of families with two parents working full year, full time, doubled between 1980 and 2005, mostly stabilizing since the early 2000s.[(1)]

As many of Ontario's young children require non-parental care, it is important that child care settings are accessible, affordable, and of high quality. The social and physical environment and the quality of care that young children receive in child care settings influences their growth and development during this critical life period. Young children who are exposed to nurturing care, a safe environment and positive social interactions in a child care setting can have improved cognitive, language, and social outcomes, are more likely to complete higher levels of education, and have improved health and wellbeing in adulthood compared to their peers who did not experience high quality child care.[(2,3,4,5)]

Access to and affordability of child care can also enable parents, especially mothers who are often the primary caregivers, to pursue educational and/or employment opportunities.[(5)] This can lead to higher income and improved socioeconomic status (SES), which are strongly associated with better health outcomes for children.[(6)]

Currently, child care is addressed through various provincial and federal policies. Federal policies that support young families include maternity/parental leave benefits, the enhanced Canada Child Benefit[(7)] and the Federal/Provincial *Multilateral Early Learning and Child Care Framework*[(8)] that includes bi-

lateral funding agreements for the provinces/territories, active until 2020. Current provincial/territorial policy approaches include funding for subsidies for low to moderate income families, capital funding to build child care locations, funding to support professional development of ECE and wage equity for ECEs working in the licensed child care sector.[8] Despite these approaches, Canada is still spending much less on early childhood education and care (ECEC) than the minimum level (i.e. 1% of annual GDP) recommended by the OECD.[9]

The 2018 Ontario Public Health Standards - Healthy Growth and Development Guideline identifies child care as an important stakeholder and setting for public health interventions. Public Health Units have a longstanding history of working with the child care sector through participation on regional advisory committees, inspections, outbreak management, monitoring immunization status and providing health promotion information, specifically related to the Standards of Health Equity, Healthy Growth and Development, Immunization, Institutional Outbreak Management, Infection Prevention, Food Safety and others.

Public Health is well positioned to further this work through supporting and collaborating with the child care sector to advance a comprehensive child care system as a strategy to reduce child poverty, address health and income inequities and enhance children's health and development.

ACCESSIBILITY

There are over 5,300 licensed child care centres in Ontario with over 406,000 spaces for children 0-12 years. Approximately 40% of these centre spaces are for infants, toddlers and preschoolers 0-4 year of age; nearly 25% of these spaces are specifically for preschool age children. There are also 124 licensed home child care agencies, which oversee 7,600 family homes and have spaces for 16,000 children.[5]

The current number of licensed spaces (in childcare centres and licenced home childcare settings) across Ontario can accommodate only one out of every 4 (23%) children from birth to age 4 years,[5,10] making many regions in Ontario "child care deserts". A "child care desert" is a postal code catchment area where there are three or more children per licensed space, resulting in inadequate access to licensed spaces, regardless of fees.[11] If spaces were available and affordable, it's estimated that 45-50% of children ages 0-4 would be using licensed child care.[10]

For families who cannot access limited licensed child care spaces, children are often placed in alternative care arrangements including family/friends or unlicensed child care arrangements, where neither quality nor safety can be guaranteed.[6,12]

In addition, when working families cannot find licensed child care, parents- most often mothers- can be forced to take time off work, reduce their working hours, work opposite shifts, seek jobs that accommodate the child care's schedule, or leave the workforce entirely to care for their children.[12,13] Therefore, it is no coincidence that Ontario has the lowest rate of women participating in the workforce in Canada.[10]

Rural access, transportation barriers, lack of part time child care opportunities, care for children with special needs, lack of parent awareness of available child care subsidies, and the limited availability of child care during non-traditional hours such as early mornings/ evenings/ weekends/ overnights are additional factors that further limit child care options for families.[5,13]

AFFORDABILITY

Ontario has the highest child care costs compared to all other provinces and territories in Canada. Ontario families with young children spend a significant portion of their household income on fees associated with child care. Provincially, the average parent with young children spends $750 -$1700 per month for licensed child care, totalling between $9,000 -$20,000+ per year for each child. These costs are estimated to rise steadily at about twice the rate of inflation.[5] Licensed childcare in Ontario remains expensive despite provincial and federal efforts such as the child care expansion investments, provincial subsidy programs, child care tax credits, and the Canada Child Benefit.

In Simcoe Muskoka, median-income families with two children age 3 and under can spend an estimated 29% of their after-tax household income on child care alone. A family with two minimum wage earners could spend upwards of 45% of their income on child care. The Ontario Child Care Subsidy program is available for low to moderate income families based on income sliding scales; subsidies are restricted to licensed home and centre based child care spaces, of which there is a shortage.[14] Currently, a family's income must be under $20,000 to qualify to receive the full subsidy; this threshold has not been updated since 2005. Therefore, licensed child care affordability may be limited to higher income families, despite the goal of the subsidy system to make licensed child care affordable for low-income families.[5]

In Ontario, families with at least one child aged 0-4 years could spend nearly one quarter (23.5%) of their after tax family income on child care, or just over two thirds (67%) of the net income of the main caregiving parent.[5] These costs are far above the 10% threshold of household spending that is used to define affordable child care.[5] According to the Family Income Affordability Measure, and Caregiving Parent Affordability Measure, fewer than 22% of families find licensed child care affordable.[5] When families are able to afford child care, they are 63% more likely to use licensed child care over informal care.[5] Public investment in child care and the early years has a multiplying or "ripple" effect in positive economic benefits. In Ontario, the multiplying effect is approximately 2.27, meaning that every dollar invested in child care results in an economic output of $2.27.[10]

In some regions, up to 80% of children attend unlicensed child care; as an estimated 35% of unlicensed caregivers provide receipts,[13] many of these families are not able to access tax return incentives.[13] While most families access the new Canada Child Benefit, low income, Indigenous, immigrant and newcomer families are less likely to access the benefit.[15] Thus, inequity of access to the licensed child care system is further exacerbated for families who are in greatest need.

QUALITY

High quality child care can enhance children's development.[5] The improvement in developmental outcomes of children enrolled in high quality licensed child care is greater for children from lower socioeconomic backgrounds.[2,3,4] Low quality child care arrangements can have the reverse effect,[16] demonstrating poorer developmental outcomes for children.[16] Thus, the social determinants of health that are directly relevant for young children, such as early childhood experiences and household economic status, can be addressed by quality child care.

In Ontario, minimum standards for quality licensed and unlicensed child care are set out in the Child Care and Early Years Act, 2014[17] including ratios of providers to children, caregiver qualifications, physical space and equipment, safety, nutrition and programming. Additional quality standards are outlined in the Government of Ontario's pedagogy for the early years, *How does learning happen?.*[18] Despite the existence of these minimum standards, there is no provincial definition or standardized quality assessment tool which makes it challenging for licensed childcare operators to create a high quality childcare environment,[15] and for parents to evaluate the quality of the child care they utilize.[15] Further, as many parents are working non-traditional hours, and as quality licensed spots are not

typically available for these hours, parents may be forced to choose *any* available child care arrangement that meets their schedule over a higher quality child care setting.[13]

Across Ontario, regional districts and municipalities operationalize "quality" for their local licensed childcare sector. Most have hired quality assurance coordinators, provide professional development and mentoring programs, and are working with the community to improve quality in their programs; about half of all regions are using a quality assessment tool to measure quality.[5]

Guided by Ontario's pedagogical framework that includes the foundations of belonging, well-being, engagement, and expression, child care providers influence and contribute to young children's social and emotional development.[18] Unfortunately, there is currently a shortage of Registered Early Childhood Educators (ECEs) in Ontario. Workforce issues such as inadequate compensation and competition with other settings interfere with staff retention[5] leading licensed centres to limit the number of available spots due to low staffing.

The current Government of Ontario has not ruled out replacing kindergarten teachers with ECEs in full-day kindergarten classrooms. Full-day kindergarten is unique to Ontario, with certified teachers and Registered ECEs working collaboratively to deliver play-based learning.[19] If this proposal was enacted and implemented, it would worsen the already critical ECE shortage that further threatens the quality of the early education provided in child care centres.[20] This could also impact the benefits of the current full day kindergarten policy. Evaluation of this policy initiative has shown full-day kindergarten increases language and cognitive development scores of junior kindergarten students, increases social competency scores (SK), and increases communication skills and general knowledge (SK) compared to children who did not attend full-day kindergarten. Students who participated in full-day kindergarten were also more likely to achieve academic success in Grade 1.[21]

For children ages 0-6 years, early experiences have profound and long-lasting influence on their development and on the kind of learner they become; thus, it is critical that child care and early learning opportunities, including full day kindergarten, be of high quality.

CONCLUSION

There is a shortage of licensed, high quality child care in Ontario. Only one of every four children ages 0-4 years has access to licensed childcare settings. Families who cannot access licensed child care must resort to unlicensed options where the safety and quality of services cannot be assured.

Licensed childcare is also unaffordable as families with young children spend a significant portion of their household income on fees associated with child care. Families with higher SES are more likely to afford and access licensed child care compared to families with lower SES, thus creating an inequity of access for Ontario parents. Public investment in child care and the early years has a multiplying effect in positive economic benefits. In Ontario, the multiplying effect is approximately 2.27, meaning that every dollar invested in child care results in an economic output of $2.27.[10]

Quality child care exposure has been associated with improved short and long term developmental and health related outcomes for young children, especially those from low social-economic status households. However, quality remains undefined provincially, and is interpreted and operationalized with variability at the local level.

There is a widespread shortage of qualified Early Childhood Educators in licensed child care settings, partly due to the low compensation they receive, despite their crucial contribution to high quality child care.

Given the critical importance of the early years of life, and that the 2018 Ontario Public Health Standards has identified child care as an important setting for intervention, it is crucial that Public Health leaders acknowledge the importance and impact of shortages of affordable, accessible, and high quality child care. Public Health practitioners are well positioned to advocate for a comprehensive, high quality, licensed early child care system as part of an approach to reduce child poverty and income inequality and improve children's health and development.

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DRAFT alPHa RESOLUTION A19-10

TITLE: **Children Count Task Force Recommendations**

SPONSOR: **Windsor-Essex County Board of Health**

WHEREAS boards of health are required under the Ontario Public Health Standards (OPHS) to collect and analyze health data for children and youth to monitor trends overtime; and

WHEREAS boards of health require local population health data for planning evidence-informed, culturally and locally appropriate health services and programs; and

WHEREAS addressing child and youth health and well-being is a priority across multiple sectors, including education and health; and

WHEREAS Ontario lacks a single coordinated system for the monitoring and assessment of child and youth health and well-being; and

WHEREAS there is insufficient data on child and youth health and well-being at the local, regional and provincial level; and

WHEREAS the Children Count Task Force recommendations build upon years of previous work and recommendations, identifying gaps and priorities for improving data on child and youth health and wellbeing;

NOW THERFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) endorse the recommendations of the Children Count Task Force.

AND FURTHER that alPHa request the provincial government establish a mechanism to oversee the implementation of the systems, tools, and resources required to improve the monitoring and assessment of child and youth health and well-being and ensure:

1. The implementation of the five recommendations of the task force.
2. A process is developed so that assessment and monitoring systems remain effective and relevant over time by addressing emerging issues and data gaps.

AND FURTHER that the Premier of Ontario, the Deputy Premier of Ontario and Minister of Health, the Minister of Children, Community and Social Services, the Minister of Education, the Chief Medical Officer of Health for Ontario, the Association of Municipalities of Ontario, the Council of Directors of Education for Ontario be so advised.

Supplementary information attached (20 pages)

Windsor-Essex County Board of Health

RECOMMENDATION/RESOLUTION REPORT – Children Count Task Force Recommendations

February 21st, 2019

ISSUE

The behaviours initiated in youth create a foundation for health through the life course (Toronto Public Health, 2015). Enabling Ontario's children and youth to reach their full potential and reduce the current and future burden of disease, is a vision shared across multiple sectors including health and education. Addressing the health of this age group requires a comprehensive approach, involving strategies built upon evidence that includes local population health data. Collecting, analyzing and reporting these data at the local level is essential for planning, delivering and evaluating effective and efficient services that meet the unique needs of children and youth and to ensure the responsible public stewardship of the resources allocated to these services (Windsor-Essex, 2017).

At present, there are approximately 50 federal programs collecting health data on the Canadian population, many of which include school age children and youth (Public Health Agency of Canada, 2013). Notable programs operating in Canada include the National Longitudinal Survey of Children and Youth (NLSCY) (Statistics Canada, 2010), the COMPASS study (Leatherdale et al., 2014), the McMaster University Ontario Child Health Study (OCHS) (Statistics Canada, 2015), the Ontario Student Drug Use and Health Survey (OSDUHS) (Centre for Addiction and Mental Health, 2013), the Canadian Student Tobacco, Alcohol and Drugs Survey (CSTADS) (University of Waterloo, 2017), and the Health Behaviour in School Age Children (HBSC) survey. Notwithstanding the number of sources, data collected from these surveys are not always collected in a way that provides representative results at the regional and local levels, thus creating challenges for public health units and related stakeholders to generate meaningful information on their specific population of interest. This often results from insufficient sample sizes at the sub-provincial level, and the prohibitive cost of purchasing additional local data (i.e. oversamples) from national or provincial sources (Windsor-Essex County Health Unit, 2017). Understanding trends and differences at the local level is a necessary foundation on which to build tailored intervention strategies that improve health and well-being outcomes.

The lack of a well-coordinated system for monitoring of child and youth health in Ontario at the local and regional level contributes to disorganization, duplication of efforts and inefficiency of population health assessment initiatives created to fill these gaps (Windsor-Essex County Health Unit, 2017). These issues not only affect local public health units, but other stakeholders as well, including provincial-level government institutions, schools, researchers, and end-users of data due

to a lack of interface or forum for stakeholder to communicate and collaborate (PHO, 2013; PHO, 2015; Windsor-Essex County Health Unit, 2017).

Further coordination and improvement of Ontario's system for child and youth health monitoring would deliver:

- Greater impact and use of public funds
- Improved evidence in decision-making at all levels (local, regional, provincial)
- Better efficiency, accountability, and collaboration between sectors
- Improved health and well-being of children and youth

BACKGROUND

The Ontario Public Health Standards (OPHS) require that Boards of Health collect and analyze health data for the purpose of monitoring trends over time and informing programs and services tailored to local needs (OPHS, 2018). The results of the 2017 report, Children Count: Assessing Child and Youth Surveillance Gaps for Ontario Public Health Units, which surveyed 34 of 36 health units and over 377 professionals and key informants, found that public health units (PHU) need better local data on mental health, physical activity and healthy eating for children and youth (Windsor-Essex County Health Unit, 2017). Key stakeholders in education, academia and government validated these data needs. Additionally, the 2017 Annual Report of the Ontario Auditor General acknowledged that children and youth are a public health priority population, and that epidemiological data on children are not readily available to public health units for planning and measuring effective programming for this population (Office of the Auditor General of Ontario, 2017).

The 2017 Children Count report recommended expanding or augmenting existing monitoring efforts, and improving collaboration on child and youth health monitoring between public health, education and academic sectors (Windsor-Essex County Health Unit, 2017). This recommendation included the development of a task force, comprised of key stakeholders from across Ontario and sectors who were able to identify tangible next steps for system improvements for monitoring child and youth health and well-being in Ontario.

With modest funding from Public Health Ontario, the Children Count research team established the Children Count Task Force with leaders from public health, education, non-governmental organizations (NGOs), government agencies, academia and provincial ministries. The Children Count Task Force met four times from June 2017 to January 2018 to: 1) review and discuss the 2017 Children Count report findings and recommendations; 2) review current systems and assess opportunities to find and improve system-wide efficiencies; and 3) construct and refine recommended actions that would improve monitoring of children and youth health and well-being in Ontario.

The Children Count Task Force recommendations were released in spring 2018 to key Ministry representatives and provincial stakeholder groups, such as the Council of Directors of Education (CODE) and Council of Medical Officers of Health (COMOH). In fall 2018; following consultation with the Children Count Task Force, recommendations were re-released with further minor revisions in January 2019. The five recommendations of the Task Force are:

Overarching Recommendation: Create a secretariat responsible for overseeing the implementation of the systems, tools, and resources required to improve the surveillance of child and youth health and well-being. The secretariat shall be enabled to:

1. Guide the implementation of the five recommendations of the task force.
2. Develop a process to ensure that assessment and surveillance systems remain effective and relevant over time by addressing emerging issues and data gaps.

Recommendation 1: Create an interactive web-based registry of database profiles resulting from child and youth health and well-being data collection in Ontario schools.

Recommendation 2: Mandate the use of a standardized School Climate Survey template in Ontario schools and a coordinated survey implementation process across Ontario.

Recommendation 3: Develop and formalize knowledge exchange practise through the use of centrally coordinated data sharing agreements.

Recommendation 4: Develop and implement a centralized research ethics review process to support research activities in Ontario school boards.

Recommendation 5: Work with the Information and Privacy Commissioner (IPC) of Ontario to develop a guideline for the interpretation of privacy legislation related to student health and well-being data collection in schools.

The Children Count Task Force recommendations represent key steps to improving the system of data collection and assessment for child and youth well-being in Ontario. The recommendations will better enable public health units, boards of education and related stakeholders to improve the planning, implementation and evaluation of local programs and services that meet the diverse and unique needs of children and youth across the province.

PROPOSED MOTION

Whereas, boards of health are required under the Ontario Public Health Standards (OPHS) to collect and analyze health data for children and youth to monitor trends overtime, and

Whereas, boards of health require local population health data for planning evidence-informed, culturally and locally appropriate health services and programs, and

Whereas, addressing child and youth health and well-being is a priority across multiple sectors, including education and health, and

Whereas, Ontario lacks a single coordinated system for the monitoring and assessment of child and youth health and well-being, and

Whereas, there is insufficient data on child and youth health and well-being at the local, regional and provincial level, and

Whereas, the Children Count Task Force recommendations build upon years of previous work and recommendations, identifying gaps and priorities for improving data on child and youth health and wellbeing,

Now therefore be it resolved that the Windsor-Essex County Board of Health receives and endorses the recommendations of the Children Count Task Force, and

FURTHER THAT, the Windsor-Essex County Board of Health urges the provincial government to take steps to improve the ways in which population health data for children and youth is currently collected and reported in Ontario.

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REVISED JANUARY 2019

CHILDREN COUNT: TASK FORCE
RECOMMENDATIONS

CHILDREN COUNT

Acknowledgment

The Children Count Task Force would like to thank Public Health Ontario (PHO) funding received through the knowledge exchange grant opportunity that enabled the convening of the task force. The views expressed in this publication are the views of the Children Count Task Force and do not necessarily reflect those of PHO.

Introduction

Health seeking behaviors and risks for disease outcomes that occur later in life are often developed in youth and become harder to change over time. In order to make significant differences in chronic disease outcomes for a population, upstream approaches are needed that influence behaviours and the environment surrounding children and youth (Healthy Kids Panel, 2013). Focusing on children and youth and preventing or reducing poor health behaviours and risks before they start is the most direct way to improve overall population health and well-being (Cancer Care Ontario, Public Health Ontario, 2012).

Enabling children and youth to reach their full potential and reduce the burden of chronic diseases is a goal shared across multiple sectors including health and education. In their recent report, *Achieving Excellence* (Ministry of Education, 2014), the Ontario Ministry of Education (EDU) acknowledged the important interrelationship between health, well-being and educational outcomes. As well, the Ontario Ministry of Health and Long-Term Care (MOHLTC), in their release of the Ontario Public Health Standards (OPHS) (2018), underscored the importance of this connection with the inclusion of a School Health Standard that directly addresses health and well-being within the school environment. As such, Public Health Units in Ontario have a legislated responsibility for assessment and monitoring of child and youth health.

Addressing population health requires a comprehensive approach involving strategies built upon evidence and monitoring data. Monitoring, often referred to as 'surveillance' in the public health field, includes the systematic collection and analysis of health data for the purpose of planning, implementing and evaluating effective public health programs in local communities. In order to appropriately understand health behaviours of children and youth that influence well-being, and to properly measure health program investments over time, high quality assessment and monitoring data are needed at local levels. High quality data is accessible, reliable, accurate, consistent and comparable. In particular, it is important that sample sizes are large enough and representative enough to allow for valid analysis, ensure ethical standards for privacy and to draw solid conclusions to inform decision making.

The lack of a coordinated provincial system for the assessment and monitoring of child and youth health and well-being that meets local health assessment needs has been the focus of many reports, including: *Youth Population Health Assessment Visioning* (Public Health Ontario, Propel Centre for Population Health Impact, 2013) and *Child and Youth Health Sources Project* (Public Health Ontario, 2015). In a recent report to the Ministry of Education, *Unlocking Student Potential Through Data: Final Report (Quan, 2017),* the authors identify that improving monitoring of health and well-being for children and youth across systems would enable limited resources to be efficiently targeted to allow for the largest benefit to those most at risk of poor outcomes. Ontario's Chief Medical Officer of Health has also highlighted the importance of local data for planning and evaluating effective programs and services in the release of his report *Mapping Wellness: Ontario's Route to Healthier Communities* (The Chief Medical Officer of Health for Ontario, 2015).

Furthermore, the 2017 Annual Report of the Ontario Auditor General recognized that children are a public health priority population and that epidemiological data on children are not readily available to public health units for planning and measuring effective programming for this population (Office of the Auditor General of Ontario, 2017). Work must be done to coordinate and maximize resources that currently exists such that a cohesive approach can be developed to best capture and share information to enhance child and youth health and well-being that is accountable and fiscally responsible.

Improving Ontario's assessment and monitoring system would allow for:

- Greater impact and use of publicly funded dollars.
- Improved evidence in decision making at all levels (local, regional, provincial).
- Better efficiency, accountability, and collaboration between sectors.
- Improved health and wellbeing of children and youth.

Children Count LDCP

Building upon previous work, in the spring of 2017 the population health assessment and surveillance LDCP team released the results of its year of research in the report *Children Count: Assessing Child and Youth Surveillance Gaps for Ontario Public Health Units.* This report examined information gaps from the viewpoint of Ontario's public health units that were undocumented by earlier publications. The knowledge gained from public health units was further validated through stakeholder engagement with boards of education, federal and provincial government representatives, and child and youth health researchers in Ontario. The work of the LDCP resulted in key recommendations necessary for improving the assessment and monitoring of child and youth health and well-being in Ontario, as well as identifying priority health areas for action including physical activity, mental health and healthy eating.

This report is the outcome of the First Recommendation of the Children Count report to:

Establish a provincial task force: *The task force should include membership representing key stakeholders and leaders, with the aim to identify next steps for improving assessment and surveillance of child and youth health and well-being in Ontario.*

With continued support and funding through PHO, the Children Count LDCP team established the task force populated with leaders from public health units, non-governmental Organizations (NGO), education, government agencies, ministries, and researchers in this field. Invitations were sent in the spring of 2017 to identified stakeholders and organizations. The task force met four times (three in person and once via teleconference) from June 2017 to January 2018. Meetings of the task force included review and in-depth discussion of the Children Count reports recommendations and findings, review of current systems and their potential for monitoring in Ontario, and the crafting and refining of actions that need to be taken to improve assessment and monitoring of children and youth health and well-being.

The recommendations and action steps outlined in this report aim to improve the current state of health and well-being monitoring and assessment for children and youth in Ontario.

These recommendations are made specifically to the Ministry of Education, Ministry of Health and Long-Term Care and Ministry of Children, Community and Social Services; however, they will need to be applied with flexibility and a proper understanding of provincial and local conditions and capacities. Although the intended key stakeholders for these recommendations are the Minister of Education, Minister of Health and Minister of Children, Community and Social Services collectively, it is recognized that some recommendations may be directed to one Minister.

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RECOMMENDATIONS & ACTION STEPS

OVERARCHING RECOMMENDATION

Create a secretariat responsible for overseeing the implementation of the systems, tools and resources required to improve the monitoring of child and youth health and well-being. The secretariat shall be so enabled to:

1. **Guide the implementation of the five recommendations of the task force that are contained in this report.**
2. **Develop a process to ensure that assessment and monitoring systems remain effective, efficient, and relevant over time by addressing emerging issues and data gaps.**

Suggested Lead Ministries: Ministry of Children, Community and Social Services, Ministry of Education, Ministry of Health and Long-Term Care

The monitoring of health and well-being for children and youth is a shared priority of these three Ministries. In order to put children and youth at the forefront and ensure that programs and services are informed by local evidence based on high quality assessment and monitoring data, a secretariat is required. The secretariat should be formally enabled to work across Ministries to implement the following five recommendations.

Recommendation 1. Create an interactive web-based registry of database profiles resulting from child and youth health and well-being data collection in Ontario schools.

Suggested Lead Ministries: Ministry of Education, Ministry of Health and Long-Term Care
Suggested Supporting Ministry: Ministry of Children, Community and Social Services

Rationale: There is no coordinated or centralized system for data collection on the health and well-being of children and youth in Ontario schools. Instead, child and youth health and well-being is assessed by multiple data collection systems with a variety of methods, survey content, target populations, and purposes. A provincial registry of these systems would be an important step towards better and more consistent knowledge about the existence of child and youth health and well-being data across Ontario. The registry should document the data collection systems already in existence in Ontario to identify and reduce duplications to improve efficiencies that can increase the value of the information already collected, and ease the process of identifying knowledge gaps.

1.1 Identify and assign responsibility to a lead institution for the creation and maintenance of an electronic, interactive, and searchable registry.

1.2 Establish inclusion criteria for the registry, recognizing the large variability in size and quality of the data collected over time in Ontario schools, that will help optimize its value. The inclusion criteria may be based on principles related to:

- Collecting data in publicly-funded schools in Ontario
- Focusing on data regarding student health and/or well-being
- Determining a minimum sample size of study that should be included so that the data collected yield at a minimum, regionally representative estimates of student health and well-being indicators

1.3 Determine the database characteristics and meta-data to be collected in the registry. The registry should provide a minimum set of publicly available information. The elements may include:

- Name, description, and purpose of the data collection system/survey
- The owner/administrator or principal investigator
- Methodological description (study design, sampling and data collection methods, consent process, etc.)
- Target student population description, (i.e., by age, sex, grade, school board, etc.)
- Geographic coverage, such as by school board or public health region and whether the system extends beyond Ontario (i.e., other provinces/territories or international)
- Data collection time period(s)
- Status of the database (active versus inactive)
- Survey content themes
- Detailed survey questions and response items, including socio-demographics and content relating to health and well-being
- Description of data quality, accuracy, and limitations
- Links to publicly reported results, as available
- Data release and access
- Contact information for the data

Recommendation 1. Create an interactive web-based registry of database profiles resulting from child and youth health and well-being data collection in Ontario schools. *CONTINUED*

1.4 Establish the necessary levels of user access and a process by which users can attain access to the registry database. As noted, there should be a minimum set of information for the registry that is publicly accessible; however, some elements (e.g., detailed survey questions) may not be appropriate for public access.

1.5 Secure agreement from the lead Ministries on the resources to establish and maintain the registry including the rules requiring monitoring activities involving Ontario publicly-funded schools to be included in the registry going forward.

Recommendation 2. Mandate the use of a standardized School Climate Survey template and a coordinated process across Ontario.

Suggested Lead Ministry: Ministry of Education

Suggested Supporting Ministries: Ministry of Children, Community and Social Services, Ministry of Health and Long-Term Care

Rationale: Monitoring of children and youth health and well-being is not well coordinated and the resulting reports/data are not or cannot always be shared, creating barriers for developing programs for children and youth. Mandating the use of a single School Climate Survey template for publicly-funded school boards would ensure that a standard set of data focused on health and well-being are collected regularly and consistently across the province. This standard template should include, at a minimum, the topics of mental health, healthy eating, and physical activity and be developed with appropriate stakeholder engagement and include space for individual school boards to ask questions on topics of local interest. Additionally, a coordinated reporting system that includes data sharing with public health units and other child service providers would improve coordination efforts with other data collection projects such as COMPASS, Health Behaviour in School-aged Children (HBSC), and the Ontario Student Drug Use and Health Survey (OSDUHS), and will increase the sharing of results with public health units, facilitated through the Ministry of Education.

2.1 Standardize frequency of School Climate Survey administration.

2.2 Consult with the Ministry of Health and Long-Term Care to coordinate concepts, terms and wording for standardized questions including, at minimum the topics of mental health, healthy eating and physical activity to ensure alignment with public health needs and definitions.

2.3 Coordinate with other large data collection projects such as COMPASS, HBSC and OSDUHS to use standardized health and well-being questions and to balance timing of all data collection systems (see 2.1) in Ontario publicly funded schools.

2.4 Require all school level data from the School Climate Surveys to be shared annually with Ministry of Education.

2.5 Coordinate the sharing of School Climate Survey data with public health agencies (e.g., via the Ministry of Health and Long-Term Care and Public Health Ontario) through appropriate data sharing mechanisms.

Recommendation 3. Develop and formalize knowledge exchange practices through the use of centrally coordinated data sharing agreements.

Suggested Lead Ministries: Ministry of Education, Ministry of Health and Long-Term Care
Suggested Supporting Ministry: Ministry of Children, Community and Social Services

Rationale: In 2015, Public Health Ontario's Child and Youth Data Sources Project Report identified over 25 data sources for Ontario. While these sources (e.g., Canadian Community Health Survey, Ontario Student Drug Use and Health Survey, and the Kindergarten Parent Survey, etc.) cover different aspects of child and youth health and well-being the results are not always readily disseminated or made available to school boards, public health units, or other organizations due to perceived privacy and legislation restrictions. The lack of coordinated data sharing practices and knowledge exchange between key stakeholders and decision-makers creates a barrier to the development of evidence-based programs and services to improve the health and well-being of children and youth in Ontario communities.

3.1 Establish a formal requirement mandating that all data collection systems (that meet the inclusion requirements of the registry) used in publicly-funded schools and school boards be registered through the central web-based data registry.

3.2 The Ministry of Education should develop and require a Memorandum of Understanding (MOU) between the Ministry and each data collection organization. These MOUs should support sharing of data between:

- Publicly-funded schools and school boards
- Publicly-funded school boards and the Ministry of Education
- Publicly-funded school boards and local public health units
- The Ministry of Education and Ministry of Health and Long-Term Care (in support of requirements for local public health units).

Recommendation 4. Develop and implement a centralized research ethics review process to support research activities in Ontario school boards.

Suggested Lead Ministry: Ministry of Education

Suggested Supporting Ministries: Ministry of Health and Long-Term Care, Ministry of Children, Community and Social Services

Rationale: The Task Force recognizes the significant barrier that a de-centralized and non-standardized research ethics review model poses to external researchers and public health authorities attempting to collect health data on students in schools across Ontario, as described in the *Children Count Report* (Population Health Assessment LDCP Team, 2017). The Task Force supports a more streamlined approach to the current patchwork of ethical review processes and a consistent model for determining appropriate consent (active versus passive) practices. These streamlined ethical review processes should consider The OCAP principles of Ownership, Control, Access and Possession for research involving Indigenous communities. This approach can be monitored by the proposed registry in Recommendation 1. To this end, the following sub-actions are required.

4.1 Adopt definitions and interpretations of research and surveillance in compliance with the Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (pre.ethics.gc.ca/pdf/eng/tcps2-2014/TCPS_2_FINAL_Web.pdf) that are acceptable across publicly-funded school boards.

4.2 Raise awareness across Ontario publicly-funded school boards, public health units and other child service agencies about the difference between research and public health monitoring as it applies to data collection activities, such as the School Climate Survey.

4.3 Develop a streamlined approach to the current patchwork of ethical review processes. Streamlined ethics process should be considered for all surveys following criteria set out for the data registry (action 1.2).

4.4 Develop a consistent model for determining appropriate consent (active versus passive) practices that is acceptable across the publicly-funded school system that facilitates data collection across all age groups.

Recommendation 5. Work with the Information and Privacy Commissioner (IPC) of Ontario to develop a guideline for the interpretation of privacy legislation related to student health and well-being data collection in schools.

Suggested Lead Ministries: Ministry of Education, Ministry of Health and Long-Term Care.

Suggested Supporting Ministry: Ministry of Children, Community and Social Services

Rationale: Monitoring activities in schools are important for shaping policies, programs and services to improve student health and well-being, yet monitoring generates legitimate concerns across stakeholders charged with safeguarding the information. Information collected from students can be for public health monitoring purposes or can be for strictly research purposes. In public health monitoring, health and well-being related data are regularly collected and analyzed to monitor the frequency and distribution of health outcomes in the defined population to inform health service planning. It is a subtle, and therefore confusing, nuance. Often the distinction between public health monitoring and research is not well understood and this can have implications for scope of responsibility, methods for data collection and analysis, and most importantly on where and how privacy regulations apply. There is a need to ensure all health and education stakeholders understand this difference and they acknowledge that monitoring activities may be developed to comply with Ontario privacy legislation.

5.1 Integrate specific privacy best practices and legislative requirements in the guideline to assist educators and partners legislated to conduct monitoring activities in schools.

5.2 Establish consistent, clear interpretation of privacy legislation for Ontario publicly-funded school boards and public health units in the guideline.

5.3 Address and clarify issues related to the consent process for collecting health and well-being monitoring data in the guideline.

5.4 Establish knowledge processes between stakeholders, including school boards and public health units to ensure the guideline is understood and implemented.

The findings of the Children Count report and subsequent work of the provincial task force were validated in the recently released 2017 Report of the Ontario Auditor General which recognized children as a public health priority population and that epidemiological data on children (and other populations) are not readily available to public health units for planning and measuring efficient and effective programming. This finding led to a recommendation that the Ontario Ministry of Health and Long-Term Care identify areas in which relevant data are not consistently available to all public health units, such as data on children and youth, and develop and implement a process to gather needed data. (Office of the Auditor General of Ontario, 2017). The report also contained recommendations related to:

- The coordinated, efficient and effective delivery of health promotion initiatives to children and youth through efforts by the Ministry of Health and Long-Term Care and Ministry of Education to form partnerships between school boards and public health units
- Avoiding duplication in program planning and research for effective, evidence based public health interventions by coordinating and sharing research
- Properly measuring public health unit performance in delivering health promotion programs and services by establishing indicators linked to the new Ontario Public Health Standards

The recommendations developed by this task force can help to advance action in these areas and foster inter-ministry collaboration for establishing and monitoring meaningful indicators. These indicators can be used across all three Ministries, local school boards and public health units to guide actions that sustain and promote the health and well-being of Ontario's children and youth.

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Suggested citation:
Children Count Task Force. (2019). *Children Count: Task Force Recommendations.* Windsor, ON: Windsor-Essex County Health Unit.

For more information please contact: ChildrenCount@wechu.org

GLOSSARY OF TERMS

Active consent - In an active consent procedure, the introductory letter explains the nature of the study and provides a method to document permission. Active consent requires parents or guardians to sign and return a consent form if they consent for their child to participate in an activity.

Assessment - The action or an instance of making a judgment about something. In relation to child and youth health data, assessment is the evaluation of health status of children and youth.

Locally-Driven Collaborative Projects (LDCP) The LDCP program brings public health units (PHUs) together to develop and run research projects on issues of shared interest related to the Ontario Public Health Standards. Working collaboratively on an LDCP helps PHUs build partnerships with each other and with students, academics, and organizations that are doing related work. As public health unit staff develop and lead projects, they strengthen their skills in research and project management, and ensure that the results of these projects are directly relevant to the work of Ontario's PHUs.

Knowledge exchange - In this report, knowledge exchange is defined as "a dynamic and iterative process that includes the synthesis, dissemination, exchange and ethically sound application of knowledge to help educators understand and apply privacy legislation related to student health and well-being monitoring activities in schools". This definition is adapted from Canadian Institutes of Health Research.

Passive Consent - A passive consent procedure typically involves distributing a letter to the children's parents or guardians explaining the nature of the study and providing a method to retract permission. Passive consent procedure assumes that the parent or guardian has consented unless some action is taken.

Registry - Registry of data sources for health and well-being of children and youth in publicly-funded schools in Ontario: an official platform and catalog for registering data collection systems that collect health and well-being data among students in publicly-funded schools in Ontario.

Research - An undertaking intended to extend knowledge through a disciplined inquiry and/or systematic investigation.

Student - Children and youth attending schools in Ontario (grade 1 to 12).

Monitoring/Surveillance - According to World Health Organization (WHO) and United States Centers for Disease Control and Prevention (CDC), surveillance or as this report identifies "monitoring" is the continuous, systematic collection, analysis, interpretation, and dissemination of data needed for the purposes of program planning, implementation, and evaluation. In this report, data collected through surveillance activities are health-related among students in Ontario and the ultimate goal of monitoring/surveillance is to improve health and well-being.

Well-being - According to Ontario's Well-Being Strategy for Education, well-being is a positive sense of self, spirit and belonging that is felt when our cognitive, emotional, social and physical needs are being met. Well-being in early years and school settings is about helping children and students become resilient, so that they can make positive and healthy choices to support learning and achievement both now and in the future.


CHILDREN
COUNT

DRAFT alPHa RESOLUTION A19-11

TITLE: **Public Health Funding for Local Project Managers to Support Healthy Weights and Prevention of Childhood Obesity**

SPONSOR: **Chatham-Kent Public Health Unit**

WHEREAS almost 30% of Ontario Children are overweight or obese; and

WHEREAS children and youth who are overweight or obese are more likely to become obese adults; and

WHEREAS children who are obese also have a higher risk of chronic disease and premature death as adults; and

WHEREAS previous funding through the Healthy Kids Community Challenge provided 45 communities with the ability to hire a local project manager as part of an evidence-based EPODE model and best practice in childhood overweight and obesity prevention; and

WHEREAS local project managers can enhance community capacity to plan, implement and evaluate sustainable local health interventions; and

WHEREAS the function of local project managers works to assist in facilitating community collaboration and coordination of community programming through multi-sectoral partnerships; and

WHEREAS the Healthy Kids Community Challenge has concluded and the subsequent role and funding of local project managers no longer exists;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) call upon the Ministry of Health and Long-Term Care to provide funding to Ontario Health Units for the hiring of local project managers to support childhood overweight and obesity prevention efforts in all Ontario communities.

Supplementary information attached (4 pages)

Municipality Of Chatham-Kent

Community Human Services

Public Health Unit

To: Board of Health

From: Chris Sherman, Health Educator

Date: April 3, 2019

Subject: Healthy Kids Community Challenge Funding

Recommendation

It is recommended that:

1. A resolution be submitted to the Association of Local Public Health Agencies (alPHa) Annual General Meeting in support of urging the provincial government to provide funding for local project managers to support healthy weights and the prevention of childhood obesity.

Background

The Healthy Kids Community Challenge (HKCC) was Ontario's initiative to support the health of children aged 0 to 12 years. This was a community-led program in 45 communities across Ontario, including Chatham-Kent. The HKCC involved collaboration between sectors and various local partners, with the common goal of promoting children's health through physical activity and healthy eating, and preventing childhood obesity. This program was based on the Ensemble Prévenons l'Obesité des Enfants - Together Let's Prevent Childhood Obesity (EPODE) model which has been recognized as a best practice in childhood obesity prevention by the World Health Organization.

Almost 30 percent of Ontario children and youth are overweight or obese.[1] Data on overweight and obese children aged 0 to 12 is limited at the local level, however it is estimated that 41 percent of youth between the ages of 12 and 17 in Chatham-Kent are overweight or obese.[2] Children and youth who are overweight or obese are more likely to become obese adults. In one study, overweight two to five year-olds were four times more likely to be overweight as adults.[3] Children who are obese also have a higher risk of chronic disease and premature death as adults. Obese adults are more likely to have

[1] Ministry of Health and Long-Term Care. Water Does Wonders: Fact Sheet – Background and Evidence. Ontario: Queen's Printer; ND.
[2] Chatham-Kent Public Health Unit. 2017 CK Health Status Report: Risk Factors for Chronic Disease. Chatham, ON: Chatham-Kent Public Health Unit; October 2017.

coronary artery disease, a stroke, high blood pressure, breast and colon cancer, type 2 diabetes, gall bladder disease, and osteoarthritis.[3]

In Chatham-Kent, chronic disease rates are typically higher than the provincial average. Every year, cardiovascular disease results in 1,556 hospitalizations and 364 deaths; there are 631 new cases of cancer and 300 cancer-related deaths; and 157 hospitalizations and 44 deaths occur due to diabetes.[4]

The Ministry of Health and Long-Term Care provided the Municipality of Chatham-Kent (the Municipality) $962,500 over the course of three and half years, from April 1, 2015 to October 31, 2018, to implement new and emerging projects and initiatives. The selection and development of projects and initiatives was guided by different themes of the HKCC; and was informed by knowledge on best and promising practices, consultations with community partners, and the community needs assessment (CNA) conducted at the beginning of the program. Within the funding structure of the HKCC community grants, the Ministry provided 50% of one full-time equivalent position ($50,000 annually) towards a local project manager. The responsibility of this role was to coordinate and monitor the planning and implementation of collaborative community activities at the local level.

A final report of the progress and activities undertaken through the local HKCC, referred to as Super Kids CK, was previously received by the Board of Health in December 2018.

Upon completion of the program in 2018 funding to support a local program coordinator no longer exists within the participating communities, including Chatham-Kent.

At the December, 2018 Board of Health meeting, the Board received a report on the HKCC and requested that administration prepare a resolution for the Association of Local Public Health Agencies (alPHa) Annual General Meeting.

Comments

Provincial funding to support a local project manager for the duration of the HKCC helped to increase local community capacity to plan, implement and evaluate sustainable local health interventions. It also worked to improve community collaboration and enhance coordination of programming through the development of multi-sectoral partnerships. Many opportunities were also provided for children in Chatham-Kent to access low-barrier or barrier-free program and recreation opportunities that they may otherwise have not had the opportunity to participate in. This type of approach also aligns with the EPODE model and evidence on the

[3] Ministry of Health and Long-Term Care. Water Does Wonders: Fact Sheet – Background and Evidence. Ontario: Queen's Printer; ND.
[4] Chatham-Kent Public Health Unit. Chronic Diseases in Chatham-Kent: Leading Causes of Death, Disability and Health Care Costs. Chatham, ON: Chatham-Kent Public Health Unit; May 2018.

effectiveness of centrally-coordinated, community-based interventions to improve healthy weights.

Upon completion of the HKCC, the subsequent loss of a local project manager has negatively impacted the ability of the existing partnership tables to continue their coordinated efforts and could hinder progress and gains made over the past four years to enhance community mobilization.

As part of the final project activity report for the HKCC in Chatham-Kent the local steering committee identified the role of a local project manager as an essential component to ensuring sustainability and continuing efforts to address childhood obesity and related health behaviours following the conclusion of the challenge.

Areas of Strategic Focus and Critical Success Factors

The recommendation in this report supports the following areas of strategic focus:

☐ Economic Prosperity:
Chatham-Kent is an innovative and thriving community with a diversified economy

☒ A Healthy and Safe Community:
Chatham-Kent is a healthy and safe community with sustainable population growth

☐ People and Culture:
Chatham-Kent is recognized as a culturally vibrant, dynamic, and creative community

☐ Environmental Sustainability:
Chatham-Kent is a community that is environmentally sustainable and promotes stewardship of our natural resources

The recommendation in this report supports the following critical success factors:

☐ Financial Sustainability:
The Corporation of the Municipality of Chatham-Kent is financially sustainable

☐ Open, Transparent and Effective Governance:
The Corporation of the Municipality of Chatham-Kent is open, transparent and effectively governed with efficient and bold, visionary leadership

☐ Has the potential to support all areas of strategic focus & critical success factors

☐ Neutral issues (does not support negatively or positively)

Consultation

There was no consultation required to produce this report.

Financial Implications

There are no financial implications resulting from the recommendation in this report.

Prepared by:

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General Manager
Community Human Services

Attachment: Draft Resolution for alPHa Annual General Meeting

This report supports the following rights of the Chatham-Kent Children's Charter of Rights:

6. The Right to Play; 12. The Right to Equal Access

This report addresses the following requirement(s) of the Ontario Public Health Standards:

Chronic Disease Prevention and Well-Being Requirement 2.