Board of Health Meeting

St. Thomas Location: 1230 Talbot Street, St. Thomas, Ontario
Talbot Boardroom
MS Teams Participation
Thursday, June 2, 2022
3:00 p.m.

AGENDA			
Item	**Agenda Item**	**Lead**	**Expected Outcome**
1.0 COVENING THE MEETING			
1.1	Call to Order, Recognition of Quorum • Introduction of Guests, Board of Health Members and Staff	Larry Martin	
1.2	Approval of Agenda	Larry Martin	Decision
1.3	Reminder to disclose Pecuniary Interest and the General Nature Thereof when Item Arises including any related to a previous meeting that the member was not in attendance for.	Larry Martin	
1.4	Reminder that Meetings are Recorded for minute taking purposes	Larry Martin	
2.0 APPROVAL OF MINUTES			
2.1	Approval of Minutes • May 5, 2022	Larry Martin	Decision
3.0 APPROVAL OF CONSENT AGENDA ITEMS			
4.0 CORRESPONDENCE RECEIVED REQUIRING ACTION			
5.0 AGENDA ITEMS FOR INFORMATION.DISCUSSION.ACCEPTANCE.DECISION			
5.1	Finance and Facilities Standing Committee's Report for June 2, 2022	Joe Preston	Acceptance
5.2	Chief Executive Officer's Report for June 2, 2022	Cynthia St. John	Acceptance
6.0 NEW BUSINESS/OTHER			
7.0 CLOSED SESSION			
8.0 RISING AND REPORTING OF THE CLOSED SESSION			
9.0 FUTURE MEETINGS & EVENTS			
9.1	September 1, 2022 at 3:00 p.m., location to be determined.	Larry Martin	Decision
10.0 ADJOURNMENT			

May 5, 2022

Board of Health Meeting

Minutes

The meeting of the Board of Health for Oxford Elgin St. Thomas Health Unit was held on Thursday, May 5, 2022 virtually through Zoom commencing at 3:00 p.m.

PRESENT:

Ms. L. Baldwin-Sands	Board Member
Mr. T. Comiskey	Board Member
Mr. G. Jones	Board Member
Mr. T. Marks	Board Member
Mr. L. Martin	Board Member (Chair)
Mr. D. Mayberry	Board Member
Mr. S. Molnar	Board Member
Mr. J. Preston	Board Member (Vice Chair)
Mr. L. Rowden	Board Member
Mr. D. Warden	Board Member
Ms. C. St. John	Chief Executive Officer
Dr. N. Tran	Acting Medical Officer of Health
Ms. A. Koning	Executive Assistant

GUESTS:

Mr. P. Heywood	Program Director
Mr. D. McDonald	Director, Corporate Services and Human Resources
Ms. M. Nusink	Director, Finance
Mr. D. Smith	Program Director
Ms. M Cornwell	Manager, Communications
Ms. C. Richards	Program Manager
Ms. S. Croteau	Data Analyst
Ms. W. Lee	Administrative Assistant
Ms. R. Perry	Woodstock Sentinel-Review
Mr. I. McCallum	My FM 94.1

1.1 CALL TO ORDER, RECOGNITION OF QUORUM

1.2 AGENDA

Resolution # (2022-BOH-0505-1.2)

Moved by L. Baldwin-Sands
Seconded by T. Comiskey

That the agenda for the Southwestern Public Health Board of Health meeting for May 5, 2022 be approved.

Carried.

1.3 Reminder to disclose Pecuniary Interest and the General Nature Thereof when Item Arises.

1.4 Reminder that Meetings are Recorded for minute-taking purposes.

2.0 APPROVAL OF MINUTES

Resolution # (2022-BOH-0505-2.1)
Moved by D. Mayberry
Seconded by G. Jones

That the minutes for the Southwestern Public Health Board of Health meeting for April 7, 2022 be approved.

Carried.

3.0 CONSENT AGENDA

Resolution # (2022-BOH-0505-3.0)
Moved by L. Baldwin-Sands
Seconded by L. Rowden

That the Board of Health for Southwestern Public Health receive and file consent agenda items 3.1 – 3.2.

Carried.

4.0 CORRESPONDENCE RECEIVED REQUIRING ACTION

None at this time.

5.0 AGENDA ITEMS FOR INFORMATION.DISCUSSION.DECISION

5.1 Indirect Health Impacts of COVID-19

D. Smith introduced S. Croteau, Data Analyst who will present the report. He noted that Carolyn Richards, Program Manager is also present to answer any questions.

S. Croteau provided an overview of the report.

S. Molnar asked if the report would inform the future work of SWPH. C. St. John confirmed that that this report will inform our program plans and service delivery for the next few years and will be re-evaluated on a regular basis. S. Molnar noted that there were positive outcomes of the pandemic and those should be highlighted as well, as well as the economic impacts of the pandemic. C. St. John agreed with S. Molnar's comments and noted that this would be considered for future reports.

L. Rowden noted that there seems to be issues with employers within the region being able to obtain employees, however there is an increase. S. Croteau noted that unemployment rates have resumed to pre-pandemic rates.

D. Mayberry asked what SWPH would do differently or what have we learned from the pandemic. S. Croteau noted that additional funding for mental health and addictions from the get-go would have been helpful. S. Croteau noted that the public health measures were put in place to save lives, which were critical and reduced the number of lives that were lost and reduced the burden on the health care system. D. Smith noted that SWPH will be conducting an after-action review which will inform the future actions of the pandemic. Dr. Tran noted that the field will be evaluating the pandemic response. T. Comiskey noted that an evaluation of international and national public health measures would inform what measures would be effective for future pandemic responses.

L. Baldwin-Sands noted that the report highlights the fact that women were disproportionately affected by the pandemic and asked Dr. Tran if he can comment on this. Dr. Tran noted that there are many social disparities that existed prior to COVID-19. He noted that there are root issues that are underlying social determinants of health, which were highlighted during the pandemic. He noted that COVID-19 has exposed us in many ways and our hope is that this informs what supports and infrastructure is needed.

S. Molnar asked how SWPH will be communicating this valuable information beyond the Board of Health meeting. C. St. John noted that our staff will continue to share this information with the Board and with our community. She noted that how we tailor our program and services in the coming years will be based on the information we have learned so it is shared this way as well..

D. Warden joined at 3:11 p.m.

Resolution # (2022-BOH-0505-5.1)
Moved by L. Baldwin-Sands
Seconded by L. Rowden

That the Board of Health for Southwestern Public Health accept the Indirect Health Impacts of COVID-19 report as information.

Carried.

5.2 Chief Executive Officer's Report for May 5, 2022

C. St. John reviewed her report.

C. St. John noted that SWPH received its 2022 funding letter from the Ministry of Health. She noted that we have been granted a 1% base budget increase. She noted that the letter and budget will be reviewed by the Finance and Facilities Standing Committee on May 26th in more depth and will follow-up with a report to the Board for our June meeting.

C. St. John noted that the Association of Local Public Health Agencies (alPHa) Election Primer has been developed and circulated as an additional item in her report. She noted that if the Board agrees, SWPH would use this to remind decision makers of public health's enduring value. There were no concerns with SWPH using the Primer as a foundation for meaningful dialogue with candidates and our community as we move into the provincial election campaign period.

L. Rowden asked about the time frame between the third and fourth dose of vaccine. C. St. John noted that the province encourages individuals who are eligible to obtain their fourth dose and that NACI recommends a five month interval and the Province of Ontario has indicated that eligible people can obtain their 4th dose as early as three months. Cynthia agreed with Lee that it can be confusing to people.

L. Rowden asked about the masking requirements within schools and why health units have not mandated masking. Dr. Tran noted that he and Dr. Summers, from Middlesex London Health Unit met with Thames Valley District School Board and advised that they would recommend masking indoors within schools. He noted that as the Medical Officer of Health of SWPH, he will continue to follow the mandates of the Chief Medical Officer of Health and not introduce a Section 22 order to mandate masking at this time. It was noted that an organization can introduce mandates over and above the Ministry, however that is their prerogative.

Resolution # (2022-BOH-0505-5.2)
Moved by S. Molnar
Seconded by T. Marks

That the Board of Health for Southwestern Public Health accept the Chief Executive Officer's report for May 5, 2022.

Carried.

5.2 Medical Officer of Health's Report for May 5, 2022

Dr. Tran reviewed his report.

Dr. Tran noted that he is looking forward to moving back to focusing on non covid-19 programs and services. He noted however, that given we are currently in our sixth wave, we need to continue to follow public health measures, such as obtaining vaccination and masking. He noted that we have a significant amount of our population that is eligible for a booster dose, however, those individuals have not yet received their eligible booster dose. He noted that Paxlovid has been a great tool to support members of our community and to protect them against COVID-19.

There were no questions for Dr. Tran.

Resolution # (2022-BOH-0505-5.3)
Moved by L. Baldwin-Sands
Seconded by G. Jones

That the Board of Health for Southwestern Public Health accept the Medical Officer of Health's report for May 5, 2022.

Carried.

6.0 NEW BUSINESS/OTHER

7.0 TO CLOSED SESSION

Resolution # (2022-BOH-0505-C7)

Moved by D. Mayberry
Seconded by T. Comiskey

That the Board of Health moves to closed session in order to consider one or more the following as outlined in the Ontario Municipal Act:

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

Other Criteria:

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

Carried.

8.0 RISING AND REPORTING OF CLOSED SESSION

Resolution # (2022-BOH-0505-C8)

Moved by T. Marks
Seconded by S. Molnar

That the Board of Health rise with a report.

Carried.

Resolution # (2022-BOH-0505-C3.1)

Moved by L. Baldwin-Sands
Seconded by J. Preston

That the Board of Health for Southwestern Public Health approve the Chief Executive Officer's Report for May 5, 2022.

Carried.

10.0 ADJOURNMENT

Resolution # (2022-BOH-0505-10)

Moved by T. Comiskey
Seconded by J. Preston

That the meeting adjourns at 4:21 p.m. to meet again on Thursday, June 2, 2022.

Carried.

Confirmed: _____

Finance & Facilities Standing Committee

REPORT

Open Session

MEETING DATE:	June 2, 2022
SUBMITTED BY:	Joe Preston, Chair, Finance and Facilities Standing Committee
SUBMITTED TO:	☒ Board of Health ☐ Finance & Facilities Standing Committee ☐ Governance Standing Committee ☐ Transition Governance Committee
PURPOSE:	☒ Decision ☐ Discussion ☒ Receive and File
AGENDA ITEM #	5.1
RESOLUTION #	2022-BOH-0602-5.1

The Finance and Facilities Standing Committee (FFSC) met on May 26, 2022, to consider several matters. A brief synopsis and applicable recommendations are below.

A. First Quarter Financial Statements

After review, the Committee is recommending the Board of Health approve the 1st Quarter financial statements for the period ending March 31, 2022. At the end of Q1, the health unit is underspent by approximately $3,021,000 or 16% of the overall budget. The underspending is due to Covid-19 staffing and resources, in particular our mass immunization clinics using a lot of our mandatory staffing and focus resulting in less regular program work occurring in the first quarter. Beyond the underspending and focus on covid-19, there is nothing remarkable about the revenue and expenses for Quarter 1.

MOTION: (2022-BOH-0602-5.1A)
That the Board of Health approve the first quarter financial statements for Southwestern Public Health.

B. 2022 Funding Grant and Accountability Agreement

The Committee reviewed the recently received 2022 Ministry of Health grant funding letter and associated amending agreement between the Ministry of Health and SWPH. The Committee discussed that:

- ✓ base funding included a 1% increase over the previous year.
- ✓ Ontario Senior Dental Care Program increased by 18% this year.
- ✓ Only 50% of Covid-19 General and Vaccine Funding was approved, and no provincial funding was approved for Covid-19 Recovery (similar across all PHUs).
- ✓ Four of the five one-time business cases were approved, albeit at less than requested for one of them, and they are funded 100% provincially. They are:
    - Public Health Inspector Practicum Program - $20,000
    - Space Needs Assessment - $30,000
    - Needle Exchange Program - $36,500 (requested $60,100)
    - Ontario Senior Dental Care Capital: new fixed site in Woodstock - $1,540,000

There were no material changes to the Amending Agreement.

The Committee discussed the fact that the Ministry noted in year requests for additional Covid expenditures will be considered however, that process could leave SWPH short on cashflow like last year.

MOTION: (2022-BOH-0602-5.1B)
That the Board of Health receive and file the Amending Agreement between the Ministry of Health and Southwestern Public Health.

C. Facilities Matters

The Committee discussed two facilities matters related to the potential future installation of Electric Vehicle Charging Stations and the current HVAC issue at the Talbot Street location.

MOTION: (2022-BOH-0602-5.1)
That the Board of Health for Southwestern Public Health accept the Finance & Facilities Standing Committee report for June 2, 2022.

SOUTHWESTERN PUBLIC HEALTH

For the Three Months Ending Thursday, March 31, 2022

STANDARD/ PROGRAM	YEAR TO DATE ACTUAL	YEAR TO DATE BUDGET	YEAR TO DATE VAR	FULL YEAR BUDGET	FULL YEAR VAR	% VAR
Direct Program Costs						
Foundational Standards						
Emergency Management	$193	$16,547	$16,354	$66,187	$65,994	0.%
Effective Public Health Practise	28,122	114,603	86,481	458,413	430,291	6.%
Health Equity & CNO Nurses	0	103,976	103,976	415,903	415,903	0.%
Health Equity Program	0	625	625	2,500	2,500	0.%
Population Health Assessment	6,989	80,384	73,395	321,534	314,546	2.%
Foundational Standards Total	**35,304**	**316,135**	**280,831**	**1,264,537**	**1,229,233**	**3.%**
Chronic Disease Prevention & Well-Being						
Built Environment	0	64,140	64,140	256,560	256,560	0.%
Healthy Eating Behaviours	0	52,380	52,380	209,519	209,519	0.%
Healthy Menu Choices Act Enforcement	0	2,042	2,042	8,168	8,168	0.%
Physical Activity and Sedentary Behaviour	0	19,982	19,982	79,927	79,927	0.%
Substance Prevention	0	54,897	54,897	219,589	219,589	0.%
Suicide Risk & Mental Health Promotion	0	13,226	13,226	52,904	52,904	0.%
Chronic Disease Prevention & Well-Being Total	**0**	**206,667**	**206,667**	**826,667**	**826,668**	**0.%**
Food Safety						
Enhanced Food Safety - Haines Initiative	0	0	0	0	0	0.%
Food Safety (Education, Promotion & Inspection)	19,623	125,521	105,897	502,082	482,459	4.%
Food Safety Total	**19,623**	**125,521**	**105,897**	**502,082**	**482,459**	**4.%**
Healthy Environments						
Climate Change	0	31,837	31,837	127,347	127,347	0.%
Health Hazard Investigation and Response	5,950	89,557	83,607	358,228	352,278	2.%
Healthy Environments Total	**5,950**	**121,394**	**115,444**	**485,575**	**479,626**	**1.%**
Healthy Growth & Development						
Breastfeeding	25,841	78,117	52,276	312,469	286,628	8.%
Parenting	5,150	108,919	103,768	435,675	430,524	1.%
Reproductive Health/Healthy Pregnancies	3,545	128,233	124,687	512,931	509,386	1.%
Healthy Growth & Development Total	**34,536**	**315,269**	**280,732**	**1,261,075**	**1,226,538**	**3.%**
Immunization						
Vaccine Administration	32,263	23,768	-8,496	95,071	62,807	34.%
Vaccine Management	27,231	43,014	15,783	172,056	144,825	16.%
Community Based Immunization Outreach	6,909	19,252	12,342	77,006	70,096	9.%
Immunization Monitoring and Surveillance	6,108	8,272	2,164	33,086	26,978	18.%
Immunization Total	**72,511**	**94,306**	**21,793**	**377,219**	**304,706**	**19.%**
Infectious & Communicable Diseases						
Infection Prevention & Control	137,406	316,792	179,385	1,267,166	1,129,760	11.%
Infection Prevention and Control Nurses Initiation	0	0	0	0	0	0.%
Infectious Diseases Control Initiative	0	0	0	0	0	0.%
Needle Exchange	19,191	15,225	-3,966	60,900	41,709	32.%
Rabies Prevention and Control and Zoonotics	43,995	53,010	9,016	212,042	168,047	21.%
Sexual Health	151,484	227,749	76,265	910,997	759,512	17.%
Tuberculosis Prevention and Control	4,559	6,911	2,353	27,646	23,087	16.%
Vector-Borne Diseases	13,355	43,496	30,142	173,985	160,630	8.%
COVID-19 Pandemic	2,004,758	481,716	-1,523,042	1,926,863	-77,895	104.%
COVID-19 Mass Immunization	1,151,009	3,043,376	1,892,366	12,173,502	11,022,492	9.%
COVID-19 Backlog	151,865	235,280	83,415	941,120	789,255	16.%
COVID-19 Recovery	25,571	86,497	60,926	345,986	320,415	7.%
Infectious & Communicable Diseases Total	**3,703,193**	**4,510,052**	**806,859**	**18,040,207**	**14,337,012**	**21.%**
Safe Water						
Enhanced Safe Water Initiative	0	0	0	0	0	0.%
Small Drinking Water Systems	0	0	0	0	0	0.%
Water	9,126	71,083	61,957	284,332	275,205	3.%
Safe Water Total	**9,126**	**71,083**	**61,957**	**284,332**	**275,205**	**3.%**
School Health - Oral Health						
Healthy Smiles Ontario	194,776	214,536	19,760	858,143	663,367	23.%
School Screening and Surveillance	9,671	47,692	38,021	190,767	181,096	5.%
School Health - Oral Health Total	**204,447**	**262,228**	**57,781**	**1,048,910**	**844,463**	**19.%**
School Health - Vision						
Vision Screening	0	38,737	38,737	154,946	154,946	0.%
School Health - Immunization						
School Immunization	54,922	258,095	203,173	1,032,380	977,458	5.%
School Health - Other						
Comprehensive School Health	8,275	279,073	270,798	1,116,292	1,108,017	1.%
Substance Use & Injury Prevention						
Falls Prevention	0	30,411	30,411	121,642	121,642	0.%
Harm Reduction Enhancement	26,359	76,116	49,757	304,463	278,104	9.%
Road Safety	0	16,762	16,762	67,049	67,049	0.%
Smoke Free Ontario Strategy: Prosecution	4,329	118,325	113,996	473,301	468,972	1.%
Substance Misuse Prevention	9,184	40,926	31,741	163,702	154,518	6.%
Substance Use & Injury Prevention Total	**39,872**	**282,540**	**242,667**	**1,130,157**	**1,090,284**	**4.%**
TOTAL DIRECT PROGRAM COSTS	**4,187,759**	**6,881,100**	**2,693,336**	**27,524,379**	**23,336,615**	**15.%**
INDIRECT COSTS						
Indirect Administration	358,638	617,122	258,484	2,468,490	2,109,851	15.%
Corporate	28,010	58,398	30,388	233,592	205,582	12.%
Board	7,844	7,800	-44	31,200	23,356	25.%
HR - Administration	174,940	215,087	40,147	860,347	685,407	20.%

Premises	392,153	391,124	-1,030	1,564,491	1,172,338	25.%
TOTAL INDIRECT COSTS	**961,585**	**1,289,531**	**327,946**	**5,158,120**	**4,196,534**	**19.%**
TOTAL GENERAL SURPLUS/DEFICIT	**5,149,344**	**8,170,631**	**3,021,282**	**32,682,499**	**27,533,149**	**16.%**
100% MINISTRY FUNDED PROGRAMS						
MOH Funding	45,757	45,757	0	183,027	137,270	25.%
Senior Oral Care	219,190	225,325	6,135	901,300	682,110	24.%
TOTAL 100% MINISTRY FUNDED	**264,947**	**271,082**	**6,135**	**1,084,327**	**819,380**	**24.%**
One-Time Funding - April 1, 2021 to March 31, 2022						
OTF NEP	19,000	19,100	100	19,100	100	99.%
OTF Public Health Inspector Practicum	10,000	10,000	0	10,000	0	100.%
OTF Elgin-Oxford Merger Costs	400,000	400,000	0	400,000	0	100.%
OTF Mobile Dental Clinic	0	500,000	500,000	500,000	500,000	0.%
OTF IPAC HUB	685,000	685,000	0	685,000	0	100.%
OTF School Nurses	900,000	900,000	0	900,000	0	100.%
Total OTF	**2,014,000**	**2,514,100**	**500,100**	**2,514,100**	**500,100**	**100.%**
Programs Funded by Other Ministries, Agencies						
Healthy Babies Healthy Children	499,037	1,653,539	1,154,502	1,653,539	1,154,502	30.%
Pre and Post Natal Nurse Practitioner	139,000	139,000	0	139,000	0	100.%
School Nutrition Program	68,451	52,318	-16,133	209,270	140,819	33.%
Public Health Agency of Canada	196,999	213,900	16,901	213,900	16,901	92.%
Total Programs Funded by Other Ministries, Agencies	**903,487**	**2,058,757**	**1,155,270**	**2,215,709**	**1,312,222**	**75.%**

New Schedules to the Public Health Funding and Accountability Agreement

BETWEEN THE PROVINCE AND THE BOARD OF HEALTH

(BOARD OF HEALTH FOR THE OXFORD ELGIN ST. THOMAS HEALTH UNIT)

EFFECTIVE AS OF THE 1ST DAY OF JANUARY 2022

Issued May 2022

SCHEDULE "A"
GRANTS AND BUDGET

Board of Health for the Oxford Elgin St. Thomas Health Unit

DETAILED BUDGET - MAXIMUM BASE FUNDS (FOR THE PERIOD OF JANUARY 1ST TO DECEMBER 31ST, UNLESS OTHERWISE NOTED)	
Programs/Sources of Funding	**Approved Allocation ($)**
Mandatory Programs (70%)[1]	11,085,800
MOH / AMOH Compensation Initiative (100%)[2]	178,700
Ontario Seniors Dental Care Program (100%)[3]	1,061,100
Total Maximum Base Funds[4]	**12,325,600**

DETAILED BUDGET - MAXIMUM ONE-TIME FUNDS (FOR THE PERIOD OF APRIL 1, 2022 TO MARCH 31, 2023, UNLESS OTHERWISE NOTED)			
Projects / Initiatives			**2022-23 Approved Allocation ($)**
Cost-Sharing Mitigation (100%)[5]			1,498,900
Mandatory Programs: Needle Exchange Program (100%)			36,500
Mandatory Programs: Public Health Inspector Practicum Program (100%)			20,000
Capital: Space Needs Assessment (100%)			20,000
COVID-19: General Program (100%)[5]			963,500
COVID-19: Vaccine Program (100%)[5]			6,140,600
Infection Prevention and Control Hub Program (100%)			685,000
Ontario Seniors Dental Care Program Capital: New Fixed Site - Oxford County Dental Suite (100%)			1,540,000
School-Focused Nurses Initiative (100%)[6]	# of FTEs	**9**	672,000
Temporary Retention Incentive for Nurses (100%)			386,000
Total Maximum One-Time Funds[4]			**11,962,500**

MAXIMUM TOTAL FUNDS	**2022-23 Approved Allocation ($)**
Base and One-Time Funding	**24,288,100**

DETAILED BUDGET - MAXIMUM ONE-TIME FUNDS (FOR THE PERIOD OF APRIL 1, 2021 to MARCH 31, 2022, UNLESS OTHERWISE NOTED)	
Projects / Initiatives	**2021-22 Approved Allocation ($)**
Temporary Retention Incentive for Nurses (100%)	386,000
Total Maximum One-Time Funds[4]	**386,000**

2021-22 CARRY OVER ONE-TIME FUNDS[7] (CARRY OVER FOR THE PERIOD OF APRIL 1, 2022 to MARCH 31, 2023)		
Projects / Initiatives	**2021-22 Approved Allocation ($)**	**2022-23 Carry Over Amount ($)**
Ontario Seniors Dental Care Program Capital: Mobile Dental Clinic (100%)	550,000	500,000
Total Maximum One-Time Funds	**550,000**	**500,000**

NOTES:

(1) Base funding increase for Mandatory Programs is pro-rated at $82,350 for the period of April 1, 2022 to December 31, 2022; therefore, maximum base funding flowed for the period of January 1, 2022 to December 31, 2022 will be $11,058,350.

(2) Cash flow will be adjusted to reflect the actual status of current Medical Officer of Health and Associate Medical Officer of Health positions.

(3) Base funding increase for the Ontario Seniors Dental Care Program is pro-rated at $119,850 for the period of April 1, 2022 to December 31, 2022; therefore, maximum base funding flowed for the period of January 1, 2022 to December 31, 2022 will be $1,021,150.

(4) Maximum base and one-time funding is flowed on a mid and end of month basis, unless otherwise noted by the Province. Cash flow will be adjusted when the Province provides a new Schedule "A".

(5) Approved one-time funding is for the period of January 1, 2022 to December 31, 2022.

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

(7) Carry over of one-time funding is approved according to the criteria outlined in the provincial correspondence dated March 14, 2022.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***BASE FUNDING***

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

Mandatory Programs: Harm Reduction Program Enhancement

The scope of work for the Harm Reduction Program Enhancement is divided into three components:
1. Local Opioid Response;
2. Naloxone Distribution and Training; and,
3. Opioid Overdose Early Warning and Surveillance.

Local Opioid Response

Base funding must be used to build a sustainable community outreach and response capacity to address drug and opioid-related challenges in their communities. This includes working with a broad base of partners to ensure any local opioid response is coordinated, integrated, and that systems and structures are in place to adapt/enhance service models to meet evolving needs.

Local response plans, which can include harm reduction and education/prevention, initiatives, should contribute to increased access to programs and services, and improved health outcomes (i.e., decrease overdose and overdose deaths, emergency room visits, hospitalizations). With these goals in mind, the Board of Health is expected to:
- Conduct a population health/situational assessment, including the identification of opioid-related community challenges and issues, which are informed by local data, community engagement, early warning systems, etc.
- Lead/support the development, implementation, and evaluation of a local overdose response plan (or drug strategy). Any plan or initiative should be based on the needs identified (and/or gaps) in your local assessment. This may include building community outreach and response capacity, enhanced harm reduction services and/or education/prevention programs and services.
- Engage stakeholders – identify and leverage community partners to support the population health/situational assessment and implementation of local overdose response plans or initiatives. Community stakeholders, including First Nations, Métis and Inuit communities and persons with lived experience, should be meaningfully engaged in the planning and implementation of all initiatives, where appropriate.
- Adopt and ensure timely data entry into the Ontario Harm Reduction Database, including the Transition to the Ontario Harm Reduction Database and ensure timely collection and entry of minimum data set as per direction from the Province.

Naloxone Kit Distribution and Training

The Board of Health (or their Designate) must be established as a naloxone distribution lead/hub for eligible community organizations, as specified by the Province, which will increase dissemination of kits to those most at risk of opioid overdose.

Type of Funding	***BASE FUNDING***

To achieve this, the Board of Health is expected to:

- Order naloxone kits as outlined by the Province; this includes naloxone required by eligible community organizations distributing naloxone.
- Coordinate and supervise naloxone inventory, including managing supply, storage, maintaining inventory records, and distribution of naloxone to eligible community organizations, and ensuring community organizations distribute naloxone in accordance with eligibility criteria established by the Province.
- With the exception of entities (organizations, individuals, etc.) as specified by the Province:
  - Train community organization staff on naloxone administration, including how to administer naloxone in cases of opioid overdose, recognizing the signs of overdose and ways to reduce the risk of overdose. Board of Health staff would also instruct agency staff on how to provide training to end-users (people who use drugs, their friends and family).
  - Train community organization staff on naloxone eligibility criteria, including providing advice to agency staff on who is eligible to receive naloxone and the recommended quantity to dispense.
  - Support policy development at community organizations, including providing consultation on naloxone-related policy and procedures that are being developed or amended within the eligible community organizations.
  - Promote naloxone availability and engage in community organization outreach, including encouraging eligible community organizations to acquire naloxone kits for distribution to their clients.

Use of naloxone (NARCAN® Nasal Spray and injectable naloxone formulations)

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

- Its use of naloxone is entirely at its own risk. There is no representation, warranty, condition or other promise of any kind, express, implied, statutory or otherwise, given by her Majesty the Queen in Right of Ontario as represented by the Ministry of Health, including Ontario Government Pharmaceutical and Medical Supply Service in connection with naloxone.
- The Province takes no responsibility for any unauthorized use of naloxone by the Board of Health or by its clients.
- The Board of Health also agrees to:
  - Not assign or subcontract the distribution, supply or obligation to comply with any of these terms and conditions to any other person or organization without the prior written consent of the Province.
  - Comply with the terms and conditions as it relates to the use and administration of naloxone as specified in all applicable federal and provincial laws.
  - Provide training to persons who will be administering naloxone. The training shall consist of the following: opioid overdose prevention; signs and symptoms of an opioid overdose; and, the necessary steps to respond to an opioid overdose, including the proper and effective administration of naloxone.
  - Follow all provincial written instructions relating to the proper use, administration, training and/or distribution of naloxone.

Type of Funding	***BASE FUNDING***

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

Opioid Overdose Early Warning and Surveillance

Base funding must be used to support the Board of Health in taking a leadership role in establishing systems to identify and track the risks posed by illicit opioids in their jurisdictions, including the sudden availability of illicit synthetic opioids and resulting opioid overdoses. Risk based information about illicit synthetic opioids should be shared in an ongoing manner with community partners to inform their situational awareness and service planning. This includes:

- Surveillance systems should include a set of "real-time" qualitative and quantitative indicators and complementary information on local illicit synthetic opioid risk. Partners should include, but are not limited to: emergency departments, first responders (police, fire and ambulance) and harm reduction services.
- Early warning systems should include the communication mechanisms and structures required to share information in a timely manner among health system and community partners, including people who use drugs, about changes in the acute, local risk level, to inform action.

Mandatory Programs: Healthy Smiles Ontario Program

The Healthy Smiles Ontario (HSO) Program provides preventive, routine, and emergency and essential dental treatment for children and youth, from low-income families, who are 17 years of age or under.

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

- The Board of Health is responsible for ensuring promotional/marketing activities have a direct and positive impact on meeting the objectives of the HSO Program.
- The Board of Health is reminded that HSO promotional/marketing materials approved by the Province and developed provincially are available for use by the Board of Health in promoting the HSO Program.
- The overarching HSO brand and provincial marketing materials were developed by the Province to promote consistency of messaging, and "look and feel" across the province. When promoting the HSO Program locally, the Board of Health is requested to align local promotional products with the provincial HSO brand. When the Board of Health uses the HSO brand, it is required to liaise with the Ministry of Health's Communications and Marketing Division to ensure use of the brand aligns with provincial standards.
- The Board of Health is required to bill back relevant programs for services provided to non-HSO clients. All revenues collected under the HSO Program, including revenues collected for the provision of services to non-HSO clients such as Ontario Works adults, Ontario Disability Support Program adults, municipal clients, etc., must be reported as income in financial reports as per Schedule C of the Agreement.
- For the purposes of reporting and monitoring for the HSO Program, the Board of Health must use the following provincial approved systems or mechanisms, or other as specified by the Province.

Type of Funding	***BASE FUNDING***

  - Aggregate screening, enrolment, and utilization data for any given month must be submitted by the 15th of the following month to the ministry in the ministry-issued template titled Dental Clinic Services Monthly Reporting Template.
  - Client-specific clinical data must be recorded in either dental management software (e.g., ClearDent, AbelDent, etc.) or in the template titled HSO Clinic Treatment Workbook that has been issued by the ministry for the purposes of recording such data.
- The Board of Health must enter into Service Level Agreements with any partner organization (e.g., Community Health Centre, Aboriginal Health Access Centre, etc.) delivering services as part of the HSO Program. The Service Level Agreement must set out clear performance expectations, clearly state funding and reporting requirements between the Board of Health and local partner, and ensure accountability for public funds.
- Any significant change to previously approved HSO business models, including changes to plans, partnerships, or processes, must be approved by the Province before being implemented.
  Any contract or subcontract entered into by the Board of Health for the purposes of implementing the HSO Program must be conducted according to relevant municipal procurement guidelines.

Mandatory Programs: Nursing Positions

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

The Board of Health shall only employ a Chief Nursing Officer with the following qualifications:
- Registered Nurse in good standing with the College of Nurses of Ontario;
- Baccalaureate degree in nursing;
- Graduate degree in nursing, community health, public health, health promotion, health administration or other relevant equivalent OR be committed to obtaining such qualification within three years of designation;
- Minimum of 10 years nursing experience with progressive leadership responsibilities, including a significant level of experience in public health; and,
- Member of appropriate professional organizations (e.g., Registered Nurses' Association of Ontario, Association of Nursing Directors and Supervisors in Official Health Agencies in Ontario-Public Health Nursing Management, etc.).

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

The Board of Health shall only employ an Infection Prevention and Control Nurse with the following qualifications:
- The position is required to have a nursing designation (Registered Nurse, Registered Practical Nurse, or Registered Nurse in the Extended Class); and,
- Certification in Infection Control (CIC), or a commitment to obtaining CIC within three years of beginning of employment.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***BASE FUNDING***

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

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

Mandatory Programs: Smoke-Free Ontario

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

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

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

The Province provides the Board of Health with 100% of the additional base funding required to fund eligible Medical Officer of Health (MOH) and Associate Medical Officer of Health (AMOH) positions within salary ranges initially established as part of the 2008 Physician Services Agreement and continued under subsequent agreements.

Base funding must be used for costs associated with top-up for salaries and benefits, and for applicable stipends to eligible MOH and AMOH positions at the Board of Health and cannot be used to support other physicians or staffing costs. Base funding for this initiative continues to be separate from cost-shared base salaries and benefits.

The maximum base funding allocation in Schedule A of the Agreement does not necessarily reflect the cash flow that the Board of Health will receive. Cash flow will continue to be adjusted regularly by the Province based on up-to-date application data and information provided by the Board of Health during a funding year. The Board of Health is required to notify the Province if there is any change in the eligible MOH and/or AMOH(s) base salary, benefits, FTE and/or position status as this may impact the eligibility amount for top-up.

The Board of Health must comply and adhere to the eligibility criteria for the MOH/AMOH Compensation Initiative as per the *Policy Framework on Medical Officer of Health Appointments, Reporting, and Compensation*, including requirements related to minimum salaries to be eligible for funding under this Initiative.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***BASE FUNDING***

Ontario Seniors Dental Care Program (100%)

The Ontario Seniors Dental Care Program (OSDCP) provides comprehensive dental care to eligible low-income seniors to help reduce unnecessary trips to the hospital, prevent chronic disease and increase quality of life for seniors. The program is being implemented through a phased approach.

The government announced the launch and staged implementation of the OSDCP on November 20, 2019. During the first stage of implementation, dental services were available for eligible seniors through Boards of Health, participating Community Health Centres and Aboriginal Health Access Centres. Through Stage 1, dental care was initiated and provided to eligible low-income seniors through Boards of Health, participating Community Health Centres, and Aboriginal Health Access Centres based on increasing Board of Health operational funding and leveraging existing infrastructure. The second stage of the program, which began in winter 2020, expanded the program by investing in new dental clinics to provide care to more seniors in need. This included new dental services in underserviced areas, including through mobile dental buses and an increased number of dental suites in Boards of Health, participating Community Health Centres, and Aboriginal Health Access Centres. The second stage of the program will continue throughout 2022, with consideration being given to the ongoing implementation challenges presented by the COVID-19 response.

Program Enrolment

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

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

Program Delivery

The OSDCP is delivered through Boards of Health, participating Community Health Centres, and Aboriginal Health Access Centres across the province. These service delivery partners are well positioned to understand the needs of priority populations and provide high quality dental care to low-income seniors in their communities.

With respect to Board of Health service delivery under the OSDCP, the Board of Health may enter into partnership contracts with other entities/organizations or providers/specialists as needed (e.g., to address potential access issues) to provide services to enrolled clients in accordance with the OSDCP Schedules of Services for Dentist and Non-Dentist Providers on behalf of the Public Health Unit.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***BASE FUNDING***

Where OSDCP client service access issues exist, as evidenced by waiting lists, for example, the Board of Health must take prompt action as feasible to establish OSDCP partnership agreements to address these access issues, including engaging in outreach and consultation with local dental providers and in compliance with the Board of Health or municipal procurement processes.

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

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

As part of implementation, eligible expense categories under this Program also include:

- *Clinical service delivery costs*, which are comprised of:
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff of the Board of Health or local service delivery partner which provide clinical dental services for the Program.
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff of the Board of Health or local service delivery partner which undertake ancillary/support activities for the Program, including: management of the clinic(s); financial and programmatic data collection and reporting for the clinic(s); and, general administration (e.g., reception services) at the clinic(s).
  - Overhead costs associated with the Program's clinical service delivery such as: clinical materials and supplies; building occupancy costs; maintenance of clinic infrastructure; staff travel associated with clinical service delivery (e.g., portable clinics, mobile clinics, long-term care homes, if applicable); staff training and professional development associated with clinical staff and ancillary/support staff, if applicable; office equipment, communication, and information and information technology.
- *Oral health navigation costs*, which are comprised of:
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff engaged in: client enrolment assistance for the Program's clients (i.e., assisting clients with enrolment forms); program outreach (i.e., local-level efforts for identifying potential clients); and, oral health education and promotion to the Program's clients.
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff that undertake the following ancillary/support activities related to oral health navigation: management, financial and programmatic reporting, and general administration (if applicable).
  - Overhead costs associated with oral health navigation such as: materials and supplies; building occupancy costs incurred for components of oral health navigation; staff travel associated with oral health navigation, where applicable; staff training and professional development associated with oral health navigation and ancillary/support staff, if applicable; office equipment, communication, and information and information technology costs associated with oral health navigation.
  - Client transportation costs in order to address accessibility issues and support effective program delivery based on local need, such as where the enrolled OSDCP client would otherwise not be able to access dental services. Boards of Health will be asked to provide information on client

transportation expenditures through in-year reporting and should track these expenditures and the number of clients accessing these services accordingly.

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

- Staff recruitment incentives;
- Billing incentives; and,
- Costs associated with any activities required under the Ontario Public Health Standards, including the *Oral Health Protocol, 2018* (or as current), which are not related to the OSDCP.

Other Requirements

Marketing

- When promoting the OSDCP locally, the Board of Health is required to align local promotional products with the provincial Program brand and messaging. The Board of Health is required to liaise with the Province to ensure use of the brand aligns with provincial standards.

Revenue

- While priority must be given to clients eligible under this Program, the Board of Health may provide services to non-OSDCP clients using resources under this Program. If this occurs, the Board of Health is required to bill-back relevant programs for services provided to non-OSDCP clients using resources under this Program. All revenues collected under the OSDCP, including revenues collected for the provision of services to non-Program clients such as Ontario Works adults, Ontario Disability Support Program adults, Non-Insured Benefits clients, municipal clients, HSO clients, etc., with resources under this Program must be reported as an offset revenue to the Province. Priority must always be given to clients eligible under this Program. The Board of Health is required to closely monitor and track revenue from bill-back for reporting purposes to the Province.
- A client co-payment is required on new denture services. Co-payment amounts are specified by the Province in Appendix A of the OSDCP Denture Services Factsheet for Providers (Factsheet), which applies to both dentists and denturists. It is the Board of Health's responsibility to collect the client co-payment for the codes outlined in Appendix A of the Factsheet. The Board of Health may determine the best mechanism for collecting co-payments, using existing payment and administration processes at the local level, in collaboration with OSDCP service delivery partners (e.g., Community Health Centre, Aboriginal Health Access Centre), as needed. The remaining cost of the service, after co-payment, is to be absorbed by the Board of Health through its operating base funding for the OSDCP. The revenue received from client co-payments for OSDCP service(s) is to be used to offset OSDCP program expenditures. Co-payment revenues are to be reported as part of the financial reporting requirements to the Province.

Community Partners

- The Board of Health must enter into discussions with all Community Health Centres and Aboriginal Health Access Centres in their catchment area to ascertain the feasibility of a partnership for the purpose of delivering this Program.
- The Board of Health must enter into Service Level Agreements with any partner organization (e.g., Community Health Centres, Aboriginal Health Access Centres) delivering services under this Program. The Service Level Agreement must set out clear performance expectations, clearly state

Type of Funding	***BASE FUNDING***

funding and reporting requirements between the Board of Health and the local partner, and ensure accountability for public funds.

- The Board of Health must ensure that base funding is used to meet the objectives of the Program, with a priority to deliver clinical dental services to clients, while staying within the base funding allocation.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

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

Cost-Sharing Mitigation (100%)

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

Mandatory Programs: Needle Exchange Program (100%)

One-time funding must be used for extraordinary costs associated with delivering the Needle Exchange Program. Eligible costs include purchase of needles/syringes, associated disposal costs, and other operating costs.

Mandatory Programs: Public Health Inspector Practicum Program (100%)

One-time funding must be used to hire one (1) or more Public Health Inspector Practicum position(s). Eligible costs include student salaries, wages and benefits, transportation expenses associated with the practicum position, equipment, and educational expenses.

The Board of Health must comply with the requirements of the Canadian Institute of Public Health Inspectors Board of Certification for field training for a 12-week period; and, ensure the availability of a qualified supervisor/mentor to oversee the practicum student's term.

Capital: Space Needs Assessment (100%)

One-time funding must be used by the Board of Health to hire a consultant/architect to review its return to work policy to understand the impact on future space needs; to review dental programs currently running in several locations to determine how much space is required and where; and, to review Woodstock office spaces to capture the current space being utilized and to prepare an estimate of how much space would be required should the organization relocate all services in Woodstock to a single location in a new leased space. Eligible costs include items identified in the Board of Health's one-time funding request.

Other requirements of this one-time funding include:

- Any changes to the scope of the project, including anticipated timelines, require, prior review and approval by the Province.
- One-time funding is provided with the understanding that no additional operating funding is required, nor will it be made available by the Province, as a result of the completion of this project.
- The Board of Health must ensure that any goods and services acquired with this one-time funding should be procured through an open and competitive process that aligns with municipal and provincial procurement directives to the greatest extent possible.
- The Board of Health must ensure that this project is compliant with associated legislated standards (i.e., Building code/associated Canadian Standards Association requirements) and infection prevention and control practices as appropriate to the programs and services being delivered within the facility.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

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

COVID-19: General Program (100%)

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

Eligible costs include, but are not limited to:

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

Other requirements of this one-time funding include:

- The Board of Health must ensure that any goods and services acquired with this one-time funding are procured through an open and competitive process that aligns with municipal and provincial procurement directives to the greatest extent possible.
- The Board of Health must enter into a Memorandum of Understanding / Service Level Agreement (or other similar arrangement) with any partner organization delivering services under this program (this includes services provided by a municipality of which a Public Health Unit is a part of). The Memorandum of Understanding / Service Level Agreement must set out clear performance expectations, clearly state funding and reporting requirements between the Board of Health and the local partner, and ensure accountability for the funds (value for money). Funding included as part of a Memorandum of Understanding / Service Level Agreement must NOT exceed those that would

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

The following are examples of non-admissible expenditures:

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

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

COVID-19: Vaccine Program (100%)

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

Eligible costs include, but are not limited to:

- Staffing – salaries and benefits, inclusive of overtime, for existing staff or redeployed Board of Health staff (including management staff directly engaged in COVID-19 activities); staff redeployed from associated regional governments; new temporary or casual staff; and, salaries and benefits associated with overtime worked by indirect staff (e.g., finance, human resources, legal, communications, etc.) and management staff (where local Board of Health policies permit such arrangements) that have not been redeployed directly to COVID-19, but have incurred overtime due to working on COVID-19 related activities. Activities include providing assistance with meeting provincial and local requirements for COVID-19 surveillance and monitoring (including vaccine safety surveillance, adverse events and number of people vaccinated), administering the COVID-19 vaccine, managing COVID-19 Vaccine Program reporting requirements, and planning and deployment of immunization/ vaccine clinics.
- Travel and Accommodation – for staff delivering COVID-19 Vaccine Program services away from their home office location, including transporting vaccines, and transportation/accommodation for staff of mobile vaccine units.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

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

- Supplies and Equipment – supplies and equipment associated with the storage and handling of the COVID-19 vaccines (including vaccine refrigerators, freezers, coolers, etc.), small equipment and consumable supplies (including personal protective equipment) not already provided by the Province, supplies necessary to administer the COVID-19 vaccine (including needles/syringes and disposal, sterile gauze, alcohol, bandages, etc.) not already provided by the Province, information and information technology upgrades related to tracking COVID-19 immunization not already approved by the Province.
- Purchased Services – service level agreements for services/staffing with community providers and/or municipal organizations, professional services, security services, cleaning services, hazardous waste disposal, transportation services (e.g., courier services, transporting clients to vaccination clinics), data entry or information technology services for reporting COVID-19 data related to the Vaccine Program to the Province from centres in the community that are not operated by the Board of Health or increased services required to meet pandemic reporting demands, outside legal services, and additional premises leased or rented by the Board of Health.
- Communications – language interpretation/translation services, media announcements, public and provider awareness, signage, and education materials regarding COVID-19 immunization outreach.
- Other Operating – recruitment activities, staff training.

Other requirements of this one-time funding include:

- The Board of Health must ensure that any goods and services acquired with this one-time funding are procured through an open and competitive process that aligns with municipal and provincial procurement directives to the greatest extent possible.
- The Board of Health must enter into a Memorandum of Understanding / Service Level Agreement (or other similar arrangement) with any partner organization delivering services under this program (this includes services provided by a municipality of which a Public Health Unit is a part of). The Memorandum of Understanding / Service Level Agreement must set out clear performance expectations, clearly state funding and reporting requirements between the Board of Health and the local partner, and ensure accountability for the funds (value for money). Funding included as part of a Memorandum of Understanding / Service Level Agreement must NOT exceed those that would have been paid if the transaction was at "arm's length" (and is subject to provincial audit or assessment). Copies of these agreements must be provided to the Province upon request.

The following are examples of non-admissible expenditures:

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

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

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

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

Infection Prevention and Control Hub Program (100%)

One-time funding must be used by the Infection Prevention and Control (IPAC) Hubs to enhance IPAC practices in congregate living settings in the Board of Health's catchment area. Congregate living settings include, but are not limited to, long-term care homes, retirement homes, hospices, residential settings for adults and children funded by Ministry of Children, Community and Social Services (MCCSS), shelters, supportive and residential housing funded by the Province.

The IPAC Hub will be required to provide IPAC supports and services to congregate living settings in its catchment. The type, amount, and scheduling of services provided by the IPAC Hub to congregate living settings will be based on the need, as identified by any of the following: the congregate living settings, the IPAC Hub, and IPAC Hub networks. The IPAC Hub will conduct an assessment to determine the allocation and priority of services. These services include provision of the following IPAC services supports either directly or through partnership with Hub Partners (other local service providers with expertise in IPAC):

- Education and training;
- Community/ies of practice to support information sharing, learning, and networking among IPAC leaders within congregate living settings;
- Support for the development of IPAC programs, policy, and procedures within sites;
- Support of assessments and audits of IPAC programs and practice;
- Recommendations to strengthen IPAC programs and practices;
- Mentorship for those with responsibilities for IPAC within congregate living settings;
- Support for the development and implementation of outbreak management plans (in conjunction with public health partners and congregate living settings); and,
- Support for congregate living settings to implement IPAC recommendations.

At all times, the congregate living organization will retain responsibility and accountability for their organization's IPAC program unless otherwise stated through a supplemental agreement with another partner. Supplemental agreements may be made with an organization operating an IPAC Hub.

Eligible one-time funding must be used for the provision of IPAC expertise, education, and support to congregate care settings and be subject to review by the Province. Allocation of funding must be used at the discretion of the Board of Health (the Hub), in conjunction with direction from the Province, and in consultation with the Ontario Health West Region, and with support from Public Health Ontario in service delivery. As appropriate to the jurisdiction, other health partners may also be engaged such as Ontario Health Teams.
In addition, the Board of Health (Hub) will be required to:

- Provide status reports, per the requirements in Schedule C.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

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

Ontario Seniors Dental Care Program Capital: New Fixed Site - Oxford County Dental Suite (100%)

As part of the OSDCP, capital funding is being provided to support capital investments in Boards of Health, Community Health Centres and/or Aboriginal Health Access Centres across the province for enhancing infrastructure to increase clinical spaces and capacity to deliver dental care services for eligible seniors.

One-time funding must be used to retrofit a fixed clinical space in Oxford County to create a four (4) operatory dental clinic. Eligible costs include dental equipment, waiting room, storage, Panorex, and digital radiography.

Other requirements of this capital funding include:

- Any changes to the scope of the project, including anticipated timelines, require, prior review and approval by the Province.
- Capital funding is provided with the understanding that no additional operating funding is required, nor will it be made available by the Province, as a result of the completion of this project.
- The Board of Health must ensure that any goods and services acquired with this Capital funding should be procured through an open and competitive process that aligns with municipal and provincial procurement directives to the greatest extent possible.
- The Board of Health must ensure that this project is compliant with associated legislated standards (i.e., Building code/associated Canadian Standards Association requirements) and infection prevention and control practices as appropriate to the programs and services being delivered within the facility.

School-Focused Nurses Initiative (100%)

The School-Focused Nurses Initiative was created to support additional nursing FTE capacity in every Board of Health to provide rapid-response support to school boards and schools, child care, and camps in facilitating public health preventative measures related to the COVID-19, including screening, testing, tracing, vaccination, education and mitigation strategies.

The school-focused nurses continue to contribute to the following activities in support of school boards and schools:

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

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

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

The initiative is being implemented with the following considerations:

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

Qualifications required for these positions are:

- Current registration with the College of Nurses of Ontario (i.e., Registered Nurse, Registered Practical Nurse, or Registered Nurse in the Extended Class).

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

Temporary Retention Incentive for Nurses (100%)

Nurses are critical to the province's health workforce and its ongoing response to COVID-19. Across the province, nurses have demonstrated remarkable dedication, professionalism, and resilience. Ontario has introduced a temporary financial incentive to support nursing retention and stabilize the current nursing workforce during this critical time.

Through the Temporary Retention Incentive for Nurses, the Province is providing a lump sum payment of up to $5,000 for eligible full-time nurses and a prorated payment of up to $5,000 for eligible part-time and casual nursing staff across the province. The payment will be paid by employers, including Boards of Health, in two (2) installments, with the first payment made in Spring 2022 and second payment made in September 2022.

The eligibility period for the program is related to work performed between **February 13, 2022 to April 22, 2022**. To receive the first payment, nurses must be in employment as a practicing nurse on **March 31, 2022**. To receive the second payment, nurses must be in employment as a practicing nurse on **September 1, 2022**.

All those employed as practicing nurses (Registered Nurses, Registered Practical Nurses, Nurse Practitioners) are eligible for the incentive, except for:

- Those in private duty nursing.
- Those employed by schools / school boards.
- Those employed by postsecondary institutions.
- Nursing executives (i.e., Chief Nursing Officer).

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

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

In addition:

- Hours worked in any of the "excluded" areas are not eligible.
- Hours worked for Temporary Staffing Agencies are not eligible.
- Nurses are not eligible to receive any payment if they retire or leave employment prior to March 31, 2022.
- Nurses are only eligible to receive one payment if they retire or leave employment as a nurse prior to September 1, 2022.

One-time funding must be used to support implementation of the Temporary Retention Incentive for Nurses in accordance with the *Temporary Retention Incentive for Nurses Program Guide for Broader Public Sector Organizations*, and any subsequent direction provided by the Province. The Board of Health is required to consider various factors, including those identified in the Guide, to determine the appropriate implementation and eligibility of the program at its Public Health Unit.

The Board of Health is required to monitor the number of full-time employees receiving the incentive as well as the number of eligible part-time/casual hours. The Board of Health is also required to create and maintain records of payments and records must include the following details for each eligible worker:

- Number of work hours eligible for pandemic hourly pay.
- Gross amount of paid out to eligible workers.
- Number of statutory contributions paid by employers because of providing pay to eligible workers (applicable to part-time/casual workers).
- Completed employee attestations.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***OTHER***

Infectious Diseases Programs Reimbursement

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

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

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

Leprosy

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

Tuberculosis

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

Vaccine Programs Reimbursement

Funding on a per dose basis will be provided to the Board of Health for the administration of influenza, meningococcal, and human papillomavirus (HPV) vaccines.

In order to claim the vaccine administration fees, the Board of Health is required to submit, as part of the Standards Activity Reports or other reports as requested by the Province, the number of doses administered. Reimbursement by the Province will be made on a quarterly basis based on the information.

The Board of Health is required to ensure that the vaccine information submitted on the Standards Activity Reports, or other reports requested by the Province, accurately reflects the vaccines administered and reported on the Vaccine Utilization database.

Influenza

- The Province will continue to pay $5.00/dose for the administration of the influenza vaccine.
- All doses administered by the Board of Health to individuals aged 6 months or older who live, work or attend school in Ontario.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***OTHER***

Meningococcal

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

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

Human Papillomavirus (HPV)

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

SCHEDULE "C"

REPORTING REQUIREMENTS

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

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

Name of Report	Reporting Period	Due Date
1. Annual Service Plan and Budget Submission	For the entire Board of Health Funding Year	March 1 of the current Board of Health Funding Year
2. Quarterly Standards Activity Reports		
Q2 Standards Activity Report	For Q1 and Q2	July 31 of the current Board of Health Funding Year
Q3 Standards Activity Report	For Q3	October 31 of the current Board of Health Funding Year
Q4 Standards Activity Report	For Q4	January 31 of the following Board of Health Funding Year
3. Annual Report and Attestation	For the entire Board of Health Funding Year	April 30 of the following Board of Health Funding Year
4. Annual Reconciliation Report	For the entire Board of Health Funding Year	April 30 of the following Board of Health Funding Year
5. COVID-19 Expense Form	For the entire Board of Health Funding Year	As directed by the Province
6. Infection Prevention and Control Hub Program Reports	For the period of April 1, 2022 to March 31, 2023	As directed by the Province
7. MOH / AMOH Compensation Initiative Application	For the entire Board of Health Funding Year	As directed by the Province

Name of Report	Reporting Period	Due Date
8. Temporary Retention Incentive for Nurses Reporting	For the entire Board of Health Funding Year	June 1 of the current Board of Health Funding Year October 3 of the current Board of Health Funding Year
9. Other Reports and Submissions	As directed by the Province	As directed by the Province

Definitions

For the purposes of this Schedule, the following words shall have the following meanings:
"Q1" means the period commencing on January 1st and ending on the following March 31st.

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

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

"Q4" means the period commencing on October 1st and ending on the following December 31st.

Report Details

Annual Service Plan and Budget Submission

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

Quarterly Standards Activity Reports

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

Annual Report and Attestation

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

Annual Reconciliation Report

- The Board of Health shall provide to the Province an Annual Reconciliation Report for funding provided for public health programs governed under the Accountability Agreement.
- The Annual Reconciliation Report must contain: Audited Financial Statements; and, Auditor's Attestation Report in the Province's prescribed format.
- The Annual Reconciliation Report shall be signed on behalf of the Board of Health by an authorized signing officer.

COVID-19 Expense Form

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

Infection Prevention and Control Hub Program Reports

- The Board of Health shall provide to the Province status reports for one-time funding provided for the Infection Prevention and Control (IPAC) Hub Program in addition to identifying concerns and emerging issues to Ontario Health West in a timely way and contribute to shared problem solving. Reports will include:
  - Operational targets and progress;
  - Description and explanation of changes in strategy;
  - Communication strategies; and,
  - Changes in human resources within the IPAC Hub.

MOH / AMOH Compensation Initiative Application

- The Board of Health shall complete and submit an annual application in order to participate in this Initiative and be considered for funding.
- Supporting documentation such as employment contracts must be provided by the Board of Health, as requested by the Province.
- Application form templates and eligibility criteria/guidelines shall be provided by the Province.

Temporary Retention Incentive for Nurses

- The Board of Health will be required to monitor and report on the number of full-time employees receiving the incentive, as well as the number of eligible part-time / casual hours. Key reporting timelines, which are subject to change, are as follows:
  - **June 1, 2022:** status update on progress of first payments to be provided to the

Province.

- **October 3, 2022:** status update on progress of second payments to be provided to the Province.

SCHEDULE "D"

BOARD OF HEALTH FINANCIAL CONTROLS

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

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

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

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

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

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

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

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

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

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

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

   Examples of potential controls include, but are not limited to:
   - Policy in place to define dollar limit for paying cash versus cheque.
   - Cheques are sequentially numbered and access is restricted to those with authorization to issue payments.
   - All cancelled or void cheques are accounted for along with explanation for cancellation.
   - Process is in place for accruing liabilities.
   - Stale-dated cheques are followed up on and cleared on a timely basis.
   - Bank statements and cancelled cheques are reviewed on a regular and timely basis by a person other than the person processing the cheques / payments.
   - Bank reconciliations occur monthly for all accounts and are independently reviewed by someone other than the person authorized to sign cheques.

Ministry of Health

Office of the Deputy Premier
and Minister of Health

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Ministère de la Santé

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Ontario

May 2, 2022

eApprove-72-2022-381

Mr. Larry Martin
Chair, Board of Health
Oxford Elgin St. Thomas Health Unit
1230 Talbot Street
St. Thomas ON N5P 1G9

Dear Mr. Martin:

I am pleased to advise you that the Ministry of Health will provide the Board of Health for the Oxford Elgin St. Thomas Health Unit up to $269,600 in additional base funding for the 2022-23 funding year, up to $386,000 in one-time funding for the 2021-22 funding year, and up to $9,481,600 in one-time funding for the 2022-23 funding year, to support the provision of public health programs and services in your community.

Dr. Kieran Moore, Chief Medical Officer of Health, will write to the Oxford Elgin St. Thomas Health Unit shortly concerning the terms and conditions governing the funding.

Thank you for the important service that your public health unit provides to Ontarians, and your ongoing dedication and commitment to addressing the public health needs of Ontarians.

Sincerely,

Christine Elliott

Christine Elliott
Deputy Premier and Minister of Health

c: Cynthia St. John, Chief Executive Officer, Oxford Elgin St. Thomas Health Unit
Dr. Ninh Tran, Medical Officer of Health (A), Oxford Elgin St. Thomas Health Unit
Dr. Kieran Moore, Chief Medical Officer of Health
Alison Blair, Associate Deputy Minister, Pandemic Response and Recovery, MOH

Ministry of Health

Office of Chief Medical Officer of Health, Public Health
Box 12,
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Tel.: 416 212-3831
Fax: 416 325-8412

Ministère de la Santé

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Ontario

eApprove-72-2022-381

May 2, 2022

Ms. Cynthia St. John
Chief Executive Officer
Oxford Elgin St. Thomas Health Unit
1230 Talbot Street
St. Thomas ON N5P 1G9

Dear Ms. St. John:

Re: Ministry of Health Public Health Funding and Accountability Agreement with the Board of Health for the Oxford Elgin St. Thomas Health Unit (the "Board of Health") dated May 1, 2018, as amended (the "Agreement")

This letter is further to the recent letter from the Honourable Christine Elliott, Deputy Premier and Minister of Health, in which she informed your organization that the Ministry of Health (the "ministry") will provide the Board of Health with up to $269,600 in additional base funding for the 2022-23 funding year, up to $386,000 in one-time funding for the 2021-22 funding year, and up to $9,481,600 in one-time funding for the 2022-23 funding year, to support the provision of public health programs and services in your community.

This will bring the total maximum funding available under the Agreement for the 2022-23 funding year to up to $23,603,100 ($12,325,600 in base funding and $11,277,500 in one-time funding). Please find attached to this letter a new Schedule A (Grants and Budget), Schedule B (Related Program Policies and Guidelines), Schedule C (Reporting Requirements), and Schedule D (Board of Health Financial Controls) that, pursuant to section 3.4 of the Agreement, shall replace the existing schedules. All terms and conditions contained in the Agreement remain in full force and effect.

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

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

…/2

Ms. Cynthia St. John

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

Yours truly,

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

Attachments

c: Larry Martin, Chair, Board of Health, Oxford Elgin St. Thomas Health Unit
Dr. Ninh Tran, Medical Officer of Health (A), Oxford Elgin St. Thomas Health Unit
Monica Nusink, Director of Finance, Oxford Elgin St. Thomas Health Unit
Alison Blair, Associate Deputy Minister, Pandemic Response and Recovery, MOH
Peter Kaftarian, Assistant Deputy Minister, Hospitals and Capital Division, MOH
Jim Yuill, Director, Financial Management Branch, MOH
Jeffrey Graham, Director, Fiscal Oversight and Performance Branch, MOH
Dianne Alexander, Director, Health Promotion & Prevention Policy & Programs, MOH
James Stewart, Director, Health Capital Investment Branch, MOH
Elizabeth Walker, Director, Accountability and Liaison Branch, MOH
Brent Feeney, Manager, Accountability and Liaison Branch, MOH

2022 Funding Letter Summary

	2022 Amount	2021 Amount	Increase per funding letter	% Increase	* ** Cash flowed in 2022	2022 BOH Budget	Above budgeted amounts	Cash flow % Increase
Mandatory Programs (70%) *	$ 11,085,800	$ 10,976,000	$ 109,800	1%	$ 11,058,350	$ 11,057,222	$ 1,128	0.75%
MOH Compensation Initiative (100%)	$ 178,700	$ 178,700	$ -	0%	$ 178,700	$ 178,700	$ -	
Ontario Senior Dental Care Program (100%) **	$ 1,061,100	$ 901,300	$ 159,800	18%	$ 1,021,150	$ 901,300	$ 119,850	9.14%
TOTAL	**$ 12,325,600**	**$ 12,056,000**	**$ 269,600**		**$ 12,258,200**	**$ 12,137,222**	**$ 120,978**	

* Mandatory Base funding is pro rated at $82,350 for the period of April 1, 2022 to December 31, 2022. Therefore cash actually flowing for 2022 will be $11,058,350

** OSDCP funding is pro rated at $119,850 for the period of April 1, 2022 to December 31, 2022. Therefore cash actually flowing for 2022 will be $1,021,150

One Time Funding (April 1, 2022 to March 31 ,2023)	2022 Amount	2021 Amount	Amount budgeted (ASP)	Difference to 2022 BOH Budget
Mitigation Funding (100%)	$ 1,498,900	$ 1,498,900	$ 1,498,900	$ -
Mandatory Programs: Needle Exchange Program (100%)	$ 36,500	$ 19,100	$ 60,100	-$ 23,600
Public Health Inspector Practicum Program (100%)	$ 20,000	$ 10,000	$ 20,000	$ -
Capital: Space Needs Assessment (100%)	$ 20,000	$ -	$ 20,000	$ -
COVID-19: General Program (100%)	$ 963,500	$ 5,242,300	$ 1,926,863	-$ 963,363
COVID-19: Vaccine Program (100%)	$ 6,140,600	$ 3,121,800	$ 12,173,502	-$ 6,032,902
Ontario Senior Dental Care Capital New Fixed Site -Oxford County (100%)	$ 1,540,000	$ -		$ 1,540,000
School Focused Nurses Initiative (100%) April to Dec 2022	$ 672,000	$ 900,000		$ 672,000
Temporary Retention Incentive for Nurses (100%)	$ 386,000	$ -		$ 386,000
Infection Prevention and Control Hub Program (100%)	$ 685,000	$ 685,000	685000	$ -
Supervised Consumption Site	$ -	$ -	$ 30,000	-$ 30,000
Covid-19 Recovery	$ -	$ -	$ 1,287,106	-$ 1,287,106
TOTAL	**$ 11,962,500**	**$ 11,477,100**	**$ 17,701,471**	**-$ 5,738,971**

TOTAL 2022 Ministry Funding	**$ 24,288,100**

Carry Over OTF Funding

Ontario Senior Dental Care Program Capital: Mobile Bus	$ 500,000	$ 550,000	$ 500,000	$ -

CEO REPORT

Open Session

MEETING DATE:	June 2, 2022
SUBMITTED BY:	Cynthia St. John, CEO (written as of May 27, 2022)
SUBMITTED TO:	☒ Board of Health ☐ Finance & Facilities Standing Committee ☐ Governance Standing Committee ☐ Transition Governance Committee
PURPOSE:	☒ Decision ☐ Discussion ☒ Receive and File
AGENDA ITEM #	5.2
RESOLUTION #	2022-BOH-0602-5.2

1. Update regarding Covid-19 Funding, Expenses and Cashflow (Receive and File**)**:

At the May 26, 2022 Finance and Facilities Standing Committee, the Committee discussed the potential impacts associated with the shortage of funding that was requested for our COVID-19 response. Given the shortage of funding, the Committee discussed concerns that SWPH may experience cashflow concerns, like that in 2021. Like 2021, a line of credit has been established again, which you approved at April's board meeting and like 2021, the last resort would be seeking additional funds from municipalities until such time as the Ministry reimbursement is received. Staff produce regular cashflow forecasts, which I receive and review on a regular basis. The members discussed that I would continue to keep the Committee and Board informed of forecasted financial pressures associated with not receiving timely funding for the payment of COVID-19 expenses. If the Board wishes to write to the Ministry of Health expressing its concerns on this matter, I can work with the Chair of the Finance Committee to develop and send that.

2. Association of Local Public Health Agencies (alPHa) Annual Meeting (Decision**)**:

In June, Board member Lee Rowden, myself, and Dr. Tran will be attending the alPHa 2022 Annual General meeting held virtually this year. As members of this Association, SWPH carries four (4) votes in total that may be cast for annual meeting business. As part of the agenda, the attached resolutions will be presented for consideration and approval by the attendees. Dr. Tran and I have reviewed the resolutions and we are supportive of all of them. To ensure that we vote in accordance with the Board of Health's wishes, we would appreciate knowing whether the Board is supportive of these resolutions as presented. A summary of the resolutions:

- *Resolution #A22-1 – Race Based Inequities in Health*
  This is in response to evidence showing that racialized populations and low-income groups have suffered disproportionate harm related to COVID-19. alPHa calls on the Ministry of Health to work with stakeholders and communities to explore methods, supports, and resources to more systematically collect socio-demographic data including race, within the provincial health services and to make this data routinely available to local Public Health Units for assessment and planning, to ensure that we are deploying resources to the populations with the greatest need, supporting culturally safe public health services and preserving the capacity of the health care system.

- *Resolution #A22-2 – Public Health Modernization & Covid-19*
  This is in response to the previous public health modernization consultation that was underway when COVID-19 arrived. The resolution suggests that alPHa send a letter to the Government of Ontario requesting that a new round of consultation with local public health agencies (LPHAs), alPHa, AMO and others and that any amalgamation of existing public health units be set up as groups that have similar communities of interest, and that any reform include a local governance model. Further, it suggests that the Ontario Public Health Standards not be altered in order to achieve budget reduction targets, that the Province of Ontario continue to support local public heath units with adequate and predictable funding, that municipalities not be required to increase their % of municipal contribution to meet Standards, that the funding cost-shared arrangement return to 25/75, that the Province reassume the 100% provincially funded programs, and that COVID-19 recovery funding be made available.

- *Resolution #A22-3 – Provincial Cooling Tower Registry for the Public Health Management of Legionella Outbreaks*
  This asks alPHa to write to the Minister of Municipal Affairs and Housing to recommend the creation of a province-wide mandatory cooling tower registration system and mandating a risk management plan for cooling towers to operate. This is in response to the fact that most non-healthcare associated Legionellosis deaths are attributable to the spread of Legionella from cooling towers by aerosolization.

- *Resolution #A22-4 – Priorities for Provincial Action on the Drug/Opioid Poisoning Crisis in Ontario (late resolution)*

  This asks alPHa to endorse nine (9) priorities (noted in detail in the resolution) to support a provincial multi-sector response, that this endorsement be communicated to various Ministry agencies, and that these agencies collaborate on an effective, well-resourced, and comprehensive multi-sectoral approach using these nine priorities. This is in response to the fact that the ongoing drug/opioid poisoning crisis has affected every part of Ontario with the COVID-19 pandemic further exacerbating the issue.

3. SWPH Program Updates (Receive and File):

To keep the Board apprised of the current and planned public health program and service offerings, below is an update for your information.

3.1 Infectious Diseases Prevention and Control Program

a. Outbreaks and Case Management

Outbreaks in congregate settings and hospitalizations due to COVID-19 are decreasing. The provincial workforce (PWF) deployed staff continue to manage all community cases of COVID-19 in our region except for hospitalized cases. I am pleased to report that we are reaching all cases within 24 hours of notification, and we have added information to the calls about eligibility and access to anti-viral treatment.

b. Infection Prevention and Control (IPAC) Hub

In addition to the one-time funding for the IPAC HUB work noted in the finance committee report, we learned that the Ministry of Health has hired a consulting firm to evaluate the IPAC HUB model across the province. This work has started, and it is expected to be completed in September of this year.

3.2 Vaccine Update

a. Covid Vaccine Update

We continue to vaccinate all eligible people for first, second, and booster doses for Covid-19 protection. We continue to use a number of different methods for vaccination delivery including mobile, pop up, fixed clinic, and GOVAXX bus.

b. Vaccine Preventable Diseases

The importance of robust personal and community immunization coverage to protect against serious diseases and illnesses has never been more important. While COVID19 has consumed

all resources across the world, the time is now to refocus on the prioritization of routine immunization for children living in Oxford County, Elgin County, and the City of St. Thomas.

The Immunization of School Pupils Act (ISPA) is the law in Ontario that requires children and adolescents under the age of 18 to receive certain vaccinations to attend primary and secondary school unless a valid exemption (includes medical, religious and exemptions of conscience) is provided. The team continues to be very busy catching up on our backlog of work. Thousands of record reviews were completed this month and vaccination offerings occurred in both school based and community based settings. We will continue this work over the summer months to protect as many children as possible.

3.3 Electronic Medical Record (EMR) Update – We're Live!

Following weeks of intense preparations, the Sexual Health Program has successfully launched its new QHR Accuro electronic medical record (EMR). The EMR replaces the previous, error-prone, and inefficient, paper-based documentation system.

The introduction of the EMR will help us improve client care through better healthcare provider communication, improved laboratory result availability and medication error alerts. With standardized and consistent data entry, the EMR will provide valuable clinic utilization information, which will be used to make optimal staffing and care decisions and will inform annual program plans. The EMR is a cost-effective solution which will support organizational strategy and operational needs for the foreseeable future.

3.4 School Health

Over the course of May, staff have focused on re-building relationships and resuming school health-related programming in school settings. One of the initiatives staff have worked on is "Mental Health May (MHM)" - a four-week program focused on promoting mental health literacy, resiliency, and coping skills in children in elementary schools. It consists of activities, school announcements, mental health teachings, book and video recommendations. MHM was designed to be scaled to the needs, skills and abilities of the children involved and offers opportunities for student leadership.

Schools reported that the content was relevant, and that turn out to MHM activities was high. Most schools asked our staff to return for repeat visits following MHM activities. MHM has proven to be an effective tool for engaging children in mental health literacy, resiliency, and coping skills. Going forward, we plan on expanding the MHM offering to a full mental health series which would span the entire school year. Each offering would tackle a new mental health topic and reflect key messages from the School Boards. Expanding the offering allows for consistency of mental health promotion, which is a proven success factor in mental health interventions.

3.5 Chronic Disease and Injury Prevention (CDIP)

The staff team have been focused on planning and re-engagement with community partners given the significant pause in this work over the past two years. Staff have also been actively collecting data and other information to assess the current needs of our communities and prioritizing actions for the remainder of 2022.

Additionally, the Elgin Community Drug and Alcohol Strategy has completed their community consultations and the final strategy report is on track to be finished in late June.

3.6 Foundational Standards

It is program planning season. The program planning process is critically important to how we function as an organization. It informs the budget, the allocation of human resources and it requires us to make thoughtful and informed decisions about the needs of our community and the data we have to support service delivery.

The 2023 program planning cycle kicked off this month and will be completed by the end of the year to support the 2023 draft budget. This year, we will be undertaking the full program planning process (as opposed to the past two-years' condensed version).

3.7 Environmental Health

"Demand work" in responding to complaints and concerns remains the team's number one priority. Seasonal demands this time of year includes vector borne disease program work, safe water inspections, animal bite investigations, and supporting the community for special events and farmers' market requests.

Climate change work is underway, following the 2022 program plan, with our heat alert response system and vulnerability assessment taking the lead. The Health Inspect program is being reviewed with the support of a Health Informatics student with the intention of increasing the quality control and determining an auditing process.

3.8 Communications

a. "We do that, too" Strategy

COVID-19 emphasized the role of public health in infectious disease management and vaccination delivery. While our community may now be more familiar with our organization due this work, we know that we do much more than COVID-19 response.

As part of our recovery from COVID-19, we have an opportunity to articulate our full suite of programs and services to show the breadth and value of local public health. The team has developed a strategy to reintroduce Southwestern Public Health to the community through an integrated marketing communication initiative.

Titled “We do that, too”, this strategy will highlight core programs and services offered through public health. The message comes with a logo that will be added to staff email signatures, shared on social media and our website, included on 2022 program materials, and communicated via key messages in media, in already-planned advertisements, and in storytelling about our staff experts.

b. Messages of Appreciation

Also in May, we launched the external ‘thank you’ to all the external stakeholders who supported the pandemic effort using a variety of methods including this video. In addition, internally, a video message was created and shared with all staff that was accompanied by a certificate with a message of appreciation signed by me and the Board Chair. I encourage you to check out both videos!

4. Quarterly Board Meeting Evaluation (Receive and File):

Per Board policy, the Board is required to evaluate its meetings on a quarterly basis. Evaluation is a core element of public health work and the information obtained is used to improve the design and delivery of meetings, systems, and processes. Results from each quarterly Board of Health meeting evaluation will be tabulated and shared with the Board.

Please click here to access the quarterly meeting evaluation form for June 2022. Board members are asked to complete this evaluation following the June Board meeting and no later than June 10, 2022.

MOTION: 2022-BOH-0602-5.2
That the Board of Health for Southwestern Public Health accept the Chief Executive Officer’s Report for June 2, 2022.

To:	Chairs and Members of Boards of Health Medical Officers of Health and Associate Medical Officers of Health alPHa Board of Directors Presidents of Affiliate Organizations
From:	Loretta Ryan, Executive Director
Subject:	***alPHa Resolutions for Consideration at the June 14, 2022 Annual General Meeting***
Date:	May 17, 2022

Please find enclosed a package of the resolutions to be considered at the Resolutions Session taking place following the 2022 Annual General Meeting (AGM) and important information on voting procedures.

Three resolutions were received prior to this year's April 22 deadline, and these have been reviewed by the alPHa Executive Committee and recommended to go forward for discussion at the Resolutions Session. One late resolution was received prior to the assembly of this package and is included here for your review.

NOTES ON LATE RESOLUTIONS:

Late resolutions are not reviewed by the Executive Committee and are subject to additional procedures for consideration of late resolutions. Please note that any further late resolutions received by alPHa will be added to the online version of the attached Resolutions for Consideration document as they come in to allow for review in advance.

Late resolutions will only be debated at the AGM if time allows and if delegates agree to consider these by a two-thirds majority vote. Please be reminded that such resolutions are otherwise subject to the same criteria as all other submitted resolutions, including the requirement that it be sponsored by a recognized alPHa Committee and not an individual acting alone. Please see the "Procedural Guidelines for alPHa Resolutions" for more details.

Due to the technical requirements of online voting, we must impose a deadline for late resolutions and cannot accept introduction of new ones during the meeting. To have a late resolution considered this year, it must be submitted in writing to loretta@alphaweb.org by 4:30 pm on Tuesday, June 7, 2022.

IMPORTANT NOTE FOR VOTING DELEGATES:

Members must register to vote at the Resolutions Session by filling out the attached registration form, wherein member Health Units must indicate who they are designating as voting delegates and which delegates will require a proxy vote.

Eligible voting delegates include Medical Officers of Health, Associate Medical Officers of Health, Acting Medical Officers of Health, members of a Board of Health and senior members in any of alPHa's Affiliate Member Organizations. Each delegate will be voting on behalf of their health unit and only one proxy vote is allowed per person, up to the maximum total allocated per health unit (please see the table below).

The completed registration form must be received by Lindsay Koch (lKoch@nwhu.on.ca) no later than 4:30 pm on June 7, 2022.

Delegates who are voting will receive special log in instructions for voting purposes shortly before the conference.

If you have any questions on the above, please contact Loretta Ryan, Executive Director, 416-595-0006, x 222.

Enclosures:
Resolutions Voting Registration Form
Number of Resolutions Votes Allocated per Health Unit
2022 Resolutions for Consideration

Association of Local PUBLIC HEALTH Agencies

480 University Avenue
Suite 300
Toronto ON M5B 1J3Tel:
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E-mail: info@alphaweb.org

Providing leadership in public health management

2022 alPHa Annual General Meeting
Resolutions Session
REGISTRATION FORM FOR VOTING

Health Unit _____

Contact Person & Title _____

Phone Number & E-mail _____

Name(s) of Voting Delegate(s):

Name and email address	**Proxy*** (Check this box if the person requires a proxy voting card. Only one proxy is allowed per delegate.)	**Is this person registered to attend the alPHa Annual Conference? (Y/N)**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please email this form to lKoch@nwhu.on.ca by 4:30 pm on June 7, 2022 .

* Each voting delegate may carry their own vote plus one proxy vote for an absent delegate. For any health unit, the total number of regular plus proxy votes cannot exceed the total number of voting delegates allotted to that health unit.

alPHa RESOLUTIONS
NUMBER OF VOTES ALLOCATED PER HEALTH UNIT

HEALTH UNIT	VOTING DELEGATES
Toronto*	**20**
POPULATION OVER 400,000	**7**
Durham	
Halton	
Hamilton	
Middlesex-London	
Niagara	
Ottawa	
Peel	
Simcoe-Muskoka	
Waterloo	
York	
POPULATION OVER 300,000	**6**
Windsor-Essex	
POPULATION OVER 200,000	**5**
Eastern Ontario	
Kingston, Frontenac, Lennox and Addington	
Wellington-Dufferin-Guelph	
POPULATION UNDER 200,000	**4**

Algoma	North Bay-Parry Sound
Brant	Northwestern
Chatham-Kent	Oxford
Elgin-St.Thomas	Perth
Grey Bruce	Peterborough
Haldimand-Norfolk	Porcupine
Haliburton, Kawartha, Pine-Ridge	Renfrew
Hastings-Prince Edward	Sudbury
Huron	Thunder Bay
Lambton	Timiskaming
Leeds, Grenville and Lanark	

* total number of votes for Toronto endorsed by membership at 1998 Annual Conference

Health Unit population statistics taken from: Statistics Canada. 2016 Census. *Census Profile*

Resolutions for Consideration
2022

Resolutions Session
2022 Annual General Meeting
Tuesday, June 14, 2021
Online

LATE RESOLUTIONS: Resolutions received after the deadline may still be considered, but the onus is on the sponsor to submit them along with supporting materials to the alPHa office as soon as possible after the deadline for review and advance distribution to the membership. Late resolutions will only be debated at the AGM if time allows and if delegates agree to consider these by a two-thirds majority vote. Late Resolutions will be added below in order of date of receipt and the most up-to-date version of this document will be available on the conference landing page.

DRAFT alPHa RESOLUTION A22-01

TITLE: **Race-Based Inequities in Health**

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

WHEREAS the goal of public health is to reduce health inequities and improve the health of the whole population; and

WHEREAS this goal is mandated in the Ontario Public Health Standards; and

WHEREAS pre-existing health, social and economic disparities have been highlighted and deepened by the pandemic; and

WHEREAS evidence shows that racialized populations and low-income groups have suffered disproportionate harm related to COVID-19; and

WHEREAS alPHa denounces systemic racism and discrimination in all its forms and, instead, embrace diversity, in all its dimensions, as an asset and seek to promote respect for all; and

WHEREAS Ontario's anti-racism strategic plan includes the development of a disaggregated race data collection framework and guidelines to understand and address the adverse impacts of systemic racism; and

WHEREAS local public health agencies strive for equity and inclusion in our work environment in order to effectively deliver services to the communities we serve; and

WHEREAS local public health agencies have demonstrated the utility of systematic collection of sociodemographic data and its successful use to inform public health action so as to improve health outcomes and reduce inequities (for example, in the recent COVID-19 vaccination efforts);

THEREFORE BE IT RESOLVED THAT alPHa call on the Ministry of Health to work with stakeholders and communities to explore methods, supports, and resources to more systematically collect socio-demographic data including race, within the provincial health services and to make this data routinely available to local Public Health Units for assessment and planning, to ensure that we are deploying resources to the populations with the greatest need, supporting culturally safe public health services and preserving the capacity of the health care system.

DRAFT alPHa RESOLUTION A22-2

TITLE: **Public Health Modernization & COVID-19**

SPONSOR: **Peterborough Public Health**

WHEREAS the Province of Ontario has indicated its intention to "modernize" the process of public health delivery in Ontario; and

WHEREAS the consultations led by Mr. Jim Pine on behalf of the Province were interrupted by the emergence of the COVID-19 pandemic; and

WHEREAS public health has been significantly impacted both in the short and long term by the COVID-19 pandemic; and

WHEREAS there is a need to close the program deficit created during the last 28 months addressing COVID-19; and

WHEREAS there are significant lessons to be learned from addressing COVID-19; and

WHEREAS there is a need to engage municipal partners in any proposed financial changes to funding public health;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) send formal correspondence to the Premier of Ontario, the Minister of Health of Ontario, and the Chief Medical Officer of Health of Ontario insisting that, prior to continuing with any renewal initiatives and/or implementing lessons learned from COVID-19, a new round of consultation with local public health agencies (LPHAs), alPHa, the Association of Municipalities of Ontario (AMO), the Ministry of Health and other relevant parties be conducted, and

AND FURTHER THAT alPHa take the position that the Ontario public health mandate as currently outlined in the Ontario Public Health Standards not be altered or diminished in an effort to achieve budget reduction targets, and that the Province continues to financially support LPHAs, in an adequate and predictable manner, to implement the Standards and not require municipalities to increase the percentage of their contribution, and

AND FURTHER THAT alPHa promote the following principles as fundamental to addressing modernization and COVID-recovery activities:

- That the recommendations, as outlined in the January 2022 aLPHa Public Health Resilience in Ontario be given full consideration by the provincial government;

- That the current mitigation funding be continued until such time as the cost-shared arrangement is reset to 75/25 for all cost-shared programs and that the Province once again assumes 100%

funding for those programs identified as such in the public health budget for 2018-19.

- That COVID recovery be supported by 100% one-time funding from the Province to assist LPHAs in addressing non-COVID program deficits.

- That any amalgamation of existing public health units group units together that have similar communities of interest.

- That any reform of public health includes a local governance model.

- That the unique challenges of rural and urban communities be distinctly incorporated in any re-organization or modernization initiatives.

- That any re-organization, modernization or recovery initiatives be implemented with the meaningful participation of First Nations and Indigenous peoples.

DRAFT alPHa RESOLUTION A22-3

TITLE: **Provincial Cooling Tower Registry for the Public Health Management of Legionella Outbreaks**

SPONSOR: **Simcoe Muskoka District Health Unit Board of Health**

WHEREAS Legionella can cause fatal disease and cases of Legionellosis remain underreported in the province of Ontario;

WHEREAS The burden of Legionellosis is increasing and is expected to continue to increase in the context of climate change;

WHEREAS Most non-healthcare-associated Legionellosis deaths are attributable to spread of Legionella from cooling towers by aerosolization;

WHEREAS Public health units must search for and identify cooling towers for environmental sampling and possible remediation in the context of community Legionella outbreaks, which delays remediation actions and causes considerable resource expenditure by public health units;

WHEREAS Legionella outbreak investigation and control could be streamlined if a province-wide cooling tower registry existed, yet no such registry exists;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) write to the Minister of Municipal Affairs and Housing recommending the creation of a province-wide mandatory cooling tower registration system and mandating a risk management plan for cooling towers to operate;

AND FURTHER that the Minister of Health, the Minister of Environment Conservation and Parks, and the Chief Medical Officer of Health of Ontario be copied.

BACKGROUND:

PROVINCIAL COOLING TOWER REGISTRY FOR THE PUBLIC HEALTH MANAGEMENT OF LEGIONELLA OUTBREAKS

1. The burden of Legionella

Legionella bacteria are gram-negative aerobic bacilli that are ubiquitous in freshwater environments such as ponds, rivers, and lakes (1). Their ability to survive in biofilm and to reproduce within certain protozoa makes them resistant to chlorination and other traditional water disinfection protocols, enabling replication within plumbing systems (2), hence their designation as opportunistic premise plumbing pathogens. Most human infections are caused by Legionella pneumophilia serogroups, though other legionellae species have been involved in human disease (3).

Legionella infection occurs primarily through inhalation of aerosolized water droplets and manifests as two distinct clinical syndromes in humans (1). Pontiac fever is generally mild in nature, self-resolving, involving febrile illness and muscle aches. Symptoms generally begin within 24 to 72 hours post exposure (4). Legionnaire's disease is a type of pneumonia that often manifests with overlapping systemic symptoms and can be severe. Hospitalization is common, and up to 10% of community-acquired cases (non-healthcare associated) are fatal (4). Risk factors for severe disease include age over 50, smoking, chronic lung disease, immunize system compromise, malignancy, or other chronic illness such as diabetes, renal failure, or hepatic failure (5). Cases of Legionnaire's disease are underreported because symptoms are non-specific, overlap significantly with those of other bacterial pneumonias, and Legionella testing is not performed routinely (6,7).

Transmission of Legionella is determined by the presence or absence of conditions that promote growth of Legionella, aerosol generation, and human exposure to aerosolized water (8). Aerosolization of contaminated water particles may occur through potable water systems (e.g., shower), cooling towers, whirlpool spas, or through other water sources such as decorative fountains, sprinkler systems, safety showers and eyewash stations, humidifiers, and nebulizers (2). Water stagnation, temperatures between 25°C and 45°C, and plastic and rubber plumbing materials favor the colonization and growth of Legionella (2).

Sources of Legionella infections can be difficult to determine, but cooling towers have been identified as significant contributors to the burden of Legionella. A cooling tower is an evaporative heat transfer device that places warm water from a building water system into direct contact with atmospheric air. The water is cooled upon contact, and the heat rejected into the atmosphere via evaporation (8). Legionella bacteria present in the cooling tower can be aerosolized via this process and spread to distances of over six kilometers away (9). In a large database that compiles published Legionella outbreaks worldwide, an infectious source for Legionella outbreaks was identified 68% of the time. While potable water systems account for a greater proportion of outbreaks (63%) relative to cooling towers (34%), the overall number of cases attributable to cooling towers is larger than the number of cases attributable to potable water systems (10). A separate review attributed 60% of Legionella outbreak-related deaths to cooling towers (11).

The reported incidence of Legionnaire's disease has been increasing provincially. From 2015 to 2019, the annual incidence rate for Legionellosis in Ontario more than doubled, from 0.9 cases per 100 000 population in 2015 to 2.6 cases per 100 000 in 2019 (12). Rates in Simcoe Muskoka have also increased in recent years and have exceeded provincial rates. In 2019, Simcoe Muskoka reported 3.5 cases per 100, 000 population. There have been two recent Legionella outbreaks in the Simcoe Muskoka region. On September 4, 2019, the Simcoe Muskoka District Health Unit (SMDHU) received a report of a confirmed case of Legionellosis in the City of Orillia. This single case was later associated with a cluster of cases. In

all, ten confirmed cases of Legionellosis were identified, with symptom onset ranging from August 9, 2019 to October 2, 2019. The investigation was completed on November 19, 2019. All ten cases required hospitalization and one death was reported. Thirty-nine locations were investigated for cooling towers within the Orillia area. Ten cooling towers in eight different locations were identified and sampled for Legionella. Of these, three cooling towers tested positive for Legionella, but only one of these samples matched the genetic sequence of Legionella found in two of the confirmed cases. As the cluster investigation in Orillia was being finalized, SMDHU received a report of a confirmed case of Legionellosis in the City of Barrie. Five cases were identified, with symptom onset between November 9, 2019 and December 12, 2019. All five cases required hospitalization, and two required admission to the intensive care unit. Twenty-eight cooling tower locations were identified by the SMDHU team as potential sources for the cases. Ultimately, ten cooling towers from 8 distinct locations were sampled for Legionella. Of the ten cooling towers sampled, three tested positive for Legionella spp. Further laboratory analysis with genomic sequencing showed no relation between the Legionella samples from the three cooling towers and confirmed cases.

Both clusters highlight the challenging nature of Legionella investigations. A necessary and time-consuming step in both investigations was the identification of operational cooling towers within a defined geographic area. A significant amount of time was spent in the search for potential cooling tower sites through a variety of means (including field assessments), which caused considerable delay in sampling of the potential sources of aerosolized Legionella and remediating towers with contamination.

The threat of Legionella is likely to increase in the context of climate change (13). Several empirical studies investigating the relationship between sporadic, community acquired Legionnaires Disease (LD) and meteorological variables were identified (14, 15, 16, 17, 18, 19, 20, 22, 23). Overwhelmingly, these studies found that increases in temperature, humidity, and precipitation increased the incidence of LD. Furthermore, Beaute et al. (2016) suggest that higher temperatures are linked with behaviours that can increase the risk of potentially hazardous sources of Legionnaires (22). For example, higher outdoor temperatures are linked to increase use of air conditioning, taking showers, and using fountains (and air conditioning units, shower heads, and fountains are all potential sources of Legionnaires).

Finally, the COVID-19 pandemic may increase the risk of Legionella. Many buildings have been closed or have reduced their water usage in the past year in the context of public health measures, creating stagnant water conditions favorable to Legionella. The Ministry of the Environment, Conservation and Parks (23), Public Services and Procurement Canada (24), and the Canadian Water and Wastewater Association (25) have all issued statements to alert of or provided guidance to mitigate risks linked to Legionella in the context of building re-opening. The staged nature of our provincial re-opening plan and the increase in remote work arrangements mean these risks are likely to persist through 2021 and into next year.

2. Mitigating risks of Legionella outbreaks from cooling towers: Rapid review of the literature

SMDHU performed an environmental scan of jurisdictions in early 2020 to determine existing policies used to mitigate the risk of Legionellosis in buildings. It is useful to organize findings by jurisdictional level, namely national, provincial, and municipal.

The Federal role in mitigating the risk of Legionella is outlined in a joint 2018 report by the National Research Council of Canada (NRC), Health Canada, and Public Services and Procurement Canada (PSPC). The NRC publishes the National Model Construction Codes with oversight by the Canadian Commission on Building and Fire Codes. Included in the National Model Construction Codes are the National Building Code of Canada and the National Plumbing Code of Canada. Each contain provisions specific to the

control of Legionella in building systems to be implemented in the design and construction of cooling towers (26).

After construction, responsibility for mitigating Legionella risk at the Federal level is shared between Health Canada, the Treasury Board of Canada Secretariat (TBS), and PSPC. Health Canada creates drinking water guidelines, and Legionella is mentioned in its guidance document on waterborne bacterial pathogens, though the section on treatment technologies for Legionella offers a review of evidence for the relative effectiveness of various agents and technologies rather than firm recommendations (27). TBS indirectly mandates requirements for the investigation, risk assessment and control of Legionella as it relates to the health of federal employees (27). PSPC is responsible for mitigating the risk of Legionella on Government of Canada property and has developed the MD-15161 Control of *Legionella* in Mechanical Systems standard. Chapter 3 of the standard outlines design, construction, maintenance, and sampling requirements for mitigating the risk of Legionella in all crown-owned buildings (28). Different maintenance requirements are mandated on a weekly, monthly, and annual basis. Readers are directed to table 3.1 of the standard for a summary of mandated maintenance and testing requirements and to Appendix D for detailed cooling tower bacterial test protocols.

Finally, the Public Health Agency of Canada supports provinces by providing a national case definition for Legionellosis and by aggregating surveillance data (26).

Provinces and territories are responsible for development of their own protocols to prevent, investigate, and control Legionella-related outbreaks (26). The Ontario Public Health Standards (OPHS) Infectious Diseases Protocol puts forth high level principles for the prevention and control of Legionellosis. Section 6.2 of the disease-specific chapter on Legionellosis recommends implementation of a preventive maintenance program with hazard control measures, making specific reference to the American Society of Heating, Refrigeration and Air-Conditioning Engineers (ASHRAE) Standard 188-2015 – Legionellosis: Risk Management for Building Water (29).

The British Columbia Center for Disease Control guidelines for the management of Legionella outbreak investigation and control offer more comprehensive prevention recommendations (30). These include i) minimizing risk via design and installation recommendations, operational considerations, water temperature control and flushing, and regular disinfection protocols; and ii) implementation of a monitoring plan that may include testing routine parameters with heterotrophic plate count, weekly dipslide count, and testing at start of season and after disinfection (30).

Quebec has imposed the most stringent requirements for the control of Legionella. These include mandatory registration of all cooling towers with the Régie du bâtiment du Quebec. Cooling tower operators must also provide the name of third-party professionals hired for implementation of a maintenance program, and the name and contact details of the laboratory to whom routine samples are sent for analysis (31).

Several municipalities in Canada have adopted local strategies for mitigating the risk of Legionellosis. The City of Hamilton, Ontario, passed the Cooling Tower Registry By-Law in 2011 that requires all cooling towers to be registered with the city with an accompanying risk management plan (32). The City of Vancouver, BC, has enacted a similar by-law mandating operating permits for cooling towers, decorative water features, alternate water systems, and building water treatment systems (33). The Middlesex-London Health Unit (MLHU) has also identified cooling tower registration as a key risk mitigation strategy for Legionella. The MLHU Cooling Tower Registration Project allows voluntary registration of cooling towers and assists cooling tower operators with their risk management plans.

The environmental scan also identified 13 guidelines for mitigating the risk of Legionella in cooling towers. The content of the guidelines was variable, though most (nine of the 13 guidelines) recommend a risk management plan. One of the more comprehensive guidelines is the ASHRAE Standard 188-2018, recently supplemented with Guidelines 12 (8), which offers operational considerations specific to cooling towers for implementing components of a risk management plan as outlined in Standard 188. Basic elements of a risk management plan include, but are not limited to (8):

- Documented system maintenance requirements, including scheduled inspection
- Specified routine water treatment protocols, including chemical treatment or other specialized treatment equipment. The goals of a water management plan are to extend equipment life, minimize energy consumption, minimize water consumption, and maintain a safe environment.
- System standby and shutdown protocols
- Disinfection protocols to remedy deviations from expected standards on routine monitoring, including when disinfection is urgently required
- Contingency response plan in the event of known or suspected cases of Legionellosis

Other risk mitigation strategies discussed in the guidelines include recommendations specific to risk assessment, testing, reporting and remediation actions. Auditing was only mentioned in two guidelines, and cooling tower registries was only mentioned in the BCCDC guideline. It is beyond the scope of this document to provide an in-depth review of the relative merits of each guideline.

The environmental scan also identified two synthesis documents that review control strategies for Legionella in plumbing systems. The first was produced by the US Environmental Protection Agency (EPA) and focuses exclusively on potable water plumbing systems (34). The second review was authored by Public Health Ontario (PHO), is more general in scope, and follows a question-and-answer format (2). The overarching findings from both documents were largely overlapping. In both documents, the challenges posed by Legionella's ability to survive in amoeba and biofilms is highlighted. Techniques for reducing Legionella contamination are extensively discussed, particularly in the EPA review. There is consensus that thermal control is effective, but that temperatures are hard to regulate consistently in complex water systems. The reviews identify monochloramine and chlorine dioxide as superior to chlorine for Legionella-containing biofilm penetration, but optimal concentrations of all chemical biocides are difficult to determine and depend on several system-specific variables including water pH, temperature, pipe material and condition, water turnover rate and turbidity. Moreover, chemical biocides may compromise integrity of the water system and come with a risk of disinfection by-products. Non-chemical biocides such as UV disinfection and ozone appear effective a decreasing Legionella counts that are associated with biofilms and amoebae but must be used in conjunction with other agents or techniques given their lack of a residual effect.

Both reviews also highlighted existing knowledge gaps concerning routine environmental sampling, and the large variation seen in guidelines recommending routine sampling. The PHO review cautions that interpretation of Legionella culture results can be challenging and lead to underestimation of risk. Culture of the organism, which is considered the gold standard for identification purposes, can be difficult on standard culture media and competing microorganisms may mask Legionella growth. Furthermore, Legionella contained within an amoeba host will not show up on culture (2).

Similarly, an evidence-based threshold of Legionella counts for remediation has not yet been determined. Some standards suggest using numerical cut offs based on colony-forming units per water volume. Others suggest a relative trigger for remediation, whereby remediation is performed when a sample exceeds average counts from historical samples by a certain margin. Neither are based in evidence.

To supplement the environmental scan, a rapid review of the evidence for various mitigation strategies to reduce the risk of spread of Legionella from cooling towers was performed. Seven observational studies

met inclusion criteria. Of these, one was discarded due to poor methodological quality. Two reports were from the province of Quebec, where a province-wide mandatory cooling tower registry, documentation of mechanical maintenance and water treatment programs and regular cooling tower sampling and culture were implemented following a significant outbreak in Quebec City in 2012. A decreasing trend in the number of samples exceeding a threshold of 10 000 colony-forming units per litre (cfu/L) was reported, though the level of significance for this observation was not clear and the association to human-cases of Legionella not discussed (35, 36). Similarly, France has required mandatory registration of all cooling towers since 2004 (also following a substantial outbreak), with obligatory sampling every two years. Findings from a cross sectional study suggest a decreasing trend in the number of Legionella cases since 2005 (37). A decrease in the number of yearly outbreaks was also reported (37).

The impact of routine sampling of plumbing systems and cooling towers was also described in Greece, where routine monitoring for Legionella was introduced in preparation for the Athens 2004 Olympic games. Greek authorities selected a threshold of 10 000 cfu/L for cooling towers and water distribution systems to trigger remediation. In hospitals specifically, a significant decrease in the contamination of potable plumbing systems was noted over the monitoring period, but no decrease in the proportion of cooling towers requiring remediation was noted (38). In community settings where the same measures were introduced, an inverse association was noted between Legionella contamination levels and the presence of a risk assessment and management plan with trained staff (39). The impact on Legionella cases was not discussed.

Finally, one mixed-methods study based in Texas investigated the impact of a requirement for owners of multi-family dwellings with cooling towers to perform annual testing for Legionella (40). Qualitative findings suggest that the testing requirement was effective in raising awareness of the potential risks of Legionella and enhancing overall controls, a finding that was also reported in Racine, 2019 (35). The low cost of testing (and possible remediation) was also identified as enabling by study participants. During the ten-year observation period from 2005 to 2015, the proportion of cooling towers with samples positive for Legionella decreased significantly. Trends in human cases were not noticeably different.

3. Policy options

To articulate policy recommendations, it is useful to discuss the expected real-world effects of the various risk mitigation strategies discussed above, while also accounting for implementation considerations.

The effectiveness of a mandatory cooling tower registry, and specifically, the impact of having a cooling tower registry on the number of human cases of Legionellosis, is difficult to assess because this intervention was never applied in isolation in the cross sectional studies we encountered in our rapid literature review. Mandatory registration was most often accompanied by routine sampling requirements and reporting. While the effectiveness of this intervention in reducing the burden of Legionella, therefore, cannot be commented on, there are several anticipated operational benefits to such a policy. First, having such a registry would improve the comprehensiveness and speed of public health response in the context of a suspected Legionella outbreak linked to a cooling tower. If a comprehensive list of cooling towers in each geographic area is readily available for reference by public health unit investigators, the task of identifying cooling tower locations is eliminated, and shutdown and remediation of potential sources of the outbreak can occur more rapidly, potentially saving lives. Procedures and processes that enable rapid detection and risk assessment during suspected Legionella outbreaks are essential (6) and SMDHU's own experience attests to this. Moreover, the human resources and other costs involved in a cooling tower outbreak response would also be diminished, because field investigations (for identification of potential cooling tower sites specifically) would be significantly reduced. Finally, mandatory registration of cooling towers would be necessary for other risk mitigation

strategies such as routine environmental sampling, reporting, and auditing to be effectively implemented.

The primary disadvantage of mandating cooling tower registration is the additional costs for multiple stakeholders. First, cooling tower operators will need to cover the cost of operating permits, though these are generally low (frequently under $100 per annum) and some jurisdictions have provided operating permits at no cost in the initial phases of roll-out (41). Moreover, the processing of operating permit applications and maintenance of a cooling tower database will require administrative and technical staff support in government agencies at the local and provincial levels.

Implementation of a cooling tower registry can be done via various legal channels. While the examples of Hamilton and Vancouver demonstrate that cooling tower registries can be enacted through municipal by-laws, this approach is impractical for public health units who have jurisdiction over several distinct municipalities, as each would require its own by-law. A provincial approach, such as the one adopted in Quebec, could be implemented much more rapidly and with considerable savings (both in time and labour) for municipalities and their associated public health units across the province.

The cross-sectional articles we identified in our rapid review largely focused on frequent sampling and remediation. The overall impact on human cases of Legionella was largely equivocal. The benefits of routine sampling in a non-outbreak context remain unclear given the uncertain link between Legionella counts and likelihood of dissemination and human disease. Moreover, given the knowledge gaps that persist about interpretation of culture results and altogether arbitrary thresholds recommended in various guidelines, the effect of implementing a sampling protocol is difficult to forecast. In addition, a frequent sampling process imposes additional human resource demands on cooling tower operators and laboratories tasked with sample analysis. Therefore, a case for strong recommendation of routine sampling cannot be made at this time. Additional strategies, such as mandated reporting and preventive remediation would rely on routine environmental sampling being in place, and therefore cannot be recommended.

Most of the guidelines encountered in the environmental scan recommended implementation of a risk management plan, as described in the previous section. While the literature is equivocal on the association between implementation of a risk management plan and reduction of human cases of Legionellosis, the general principles of a risk management plan align with current understanding of factors that promote the growth of Legionella and how to mitigate these. A properly implemented risk management plan should decrease the presence of biofilm, monitor for, and remediate the presence of disinfectant residual, and control water age and water temperature. How to best achieve control of these factors, however, depends on a host of factors that may be unique to each facility. These include average temperature water, water replacement rate, plumbing system materials, turbidity level, and pH. Therefore, generalizable recommendations on the use of specific chemical biocides, their concentration, and potential supplementation with other effective decontamination techniques such as ozone or UV disinfection, are difficult to make. Instead, these decisions should be made by cooling tower owners for their specific system in consultation with manufacturers or third-party experts as they design their risk management plan and consider the potential for unwanted effects of various technologies including damage to plumbing infrastructure. Cooling tower operators should be directed to well-established guidelines for the formulation of risk management plans, such as the ASHRAE standard 188 (2018) and Guideline 12-2020 supplement, and the CDC Controlling Legionella in Cooling Towers resource. If testing is being considered by a cooling tower operator, Appendix D of the Mechanical design 15161-2013 control of Legionella in mechanical systems produced by the PSPC can be referenced (42).

4. Conclusion

The burden of Legionella is underestimated and rising. To protect Ontarians from potentially fatal disease, strategies mitigating the risk of Legionella spread from cooling towers must be adopted. Given operational considerations and the knowledge gaps that persist in the literature, the implementation of a province-wide mandatory cooling tower registry is recommended as a first step towards improving the control of Legionella in the province. Additional provisions could be made for cooling tower operators to have a risk management plan in place, though beyond general principles, decisions on the use of chemical biocides or other techniques should be made by cooling tower operators in consultation with experts familiar with the unique characteristics of their water system. Additional risk mitigation strategies, such as sampling, reporting, and auditing, could be added to the registration requirement if stronger evidence of their effectiveness becomes available. Finally, new technologies providing alternatives to wet cooling towers that would remove the risk of Legionella aerosolization entirely should be considered in the construction of new buildings.

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LATE alPHa RESOLUTION A22-4

TITLE: **Priorities for Provincial Action on the Drug/Opioid Poisoning Crisis in Ontario**

SPONSOR: **Council of Ontario Medical Officers of Health (COMOH)**

WHEREAS the ongoing drug/opioid poisoning crisis has affected every part of Ontario, with the COVID-19 pandemic further exacerbating the issue, leading to a 73% increase in deaths from opioid-related toxicity from 2,870 deaths experienced in the 22 months prior to the pandemic (May 2018 to February 2020) to 4,951 deaths in the 22 months of available data since then (March 2020 to December 2021); and

WHEREAS the burden of disease is particularly substantial given the majority of deaths that occurred prior to the pandemic and the increase during the pandemic have been in young adults, in particular those aged 25-44, and the extent of the resulting trauma for families, front line responders, and communities as a whole cannot be overstated; and

WHEREAS the membership previously carried resolution A19-3, asking the federal government to decriminalize the possession of all drugs for personal use based on broad and inclusive consultation, as well as supporting robust prevention, harm reduction and treatment services; and

WHEREAS the membership previously carried resolution A21-2, calling on all organizations and governmental actors to respond to the opioid crisis with the same intensity as they did for the COVID-19 pandemic; and

WHEREAS the Association of Local Public Health Agencies (alPHa) has identified that responding to the opioid crisis is a priority area for local public health recovery in their *Public Health Resilience in Ontario* publication (Executive Summary and Report); and

WHEREAS recognizing that any responses to this crisis must meaningfully involve and be centred-around people who use drugs (PWUDs), inclusive of all backgrounds, and must be founded not only on evidence- and trauma-informed practices but also equity, cultural safety, anti-racism as well as anti-oppression; and

WHEREAS COMOH's Drug / Opioid Poisoning Crisis Working Group has recently identified nine provincial priorities for a robust, multi-sector response that is necessary in response to this crisis (see Appendix A); and

WHEREAS local public health agencies are well positioned, with additional resourcing, to play an enhanced role in local planning, implementation and coordination of the following priority areas: harm reduction, substance use prevention and mental health promotion, analysis, monitoring and reporting of epidemiological data on opioid and other substance-related harms, health equity and anti-stigma initiatives, efforts towards healthy public policy related to substance use including but not limited to decriminalization, and providing and mobilizing community leadership; and

WHEREAS this work of local public health agencies aligns with the Substance Use and Harm Reduction Guideline (2018) and the Health Equity Guideline (2018) under the Ontario Public Health Standards;

NOW THEREFORE BE IT RESOLVED that alPHa endorse the nine priorities for a provincial multi-sector response;

AND FURTHER that the noted provincial priorities and areas of contribution by local public health agencies be communicated to the Premier, Minister of Health, Associate Minister of Mental Health & Addictions, Attorney General, Minister of Municipal Affairs & Housing, Minister of Children, Community & Social Services, Chief Medical Officer of Health, Chief Executive Officer (CEO) of Ontario Health and CEO of Public Health Ontario;

AND FURTHER that alPHa urge the above-mentioned parties to collaborate on an effective, well-resourced and comprehensive multi-sectoral approach, which meaningfully involves and is centred-around PWUDs from of all backgrounds, and is based on the nine identified provincial priorities.

A22-4 Appendix A – Priorities for a Provincial Multi-Sector Response

The following was developed by the Drug / Opioid Poisoning Crisis Working Group of COMOH, and shared with the COMOH membership for review at its general meeting on April 27th, 2022:

1. Create a **multi-sectoral task force**, including people with lived experience of drug use, to guide the development of a robust, integrated provincial drug poisoning crisis response plan. The plan should ensure necessary resourcing, health and social system coordination, policy change, and public reporting on drug-related harms and the progress of the response. An **integrated approach** is essential, to address the overlap between the use of various substances, to integrate aspects of the response such as treatment and harm reduction, and to ensure a common vision for addressing health inequities and preventive opportunities.

2. Expand access to **harm reduction** programs and practices (e.g. Consumption and Treatment Service (CTS) sites, Urgent Public Health Needs Sites (UPHNS), drug checking, addressing inhalation methods as a key route of use and poisonings, and exploring the scale up of safer opioid supply access).

3. Enhance and ensure sustainability of support for substance use **prevention** and mental health promotion initiatives, with a focus from early childhood through to adolescence.

4. Expand the collection, analysis and reporting of timely integrated **epidemiological data** initiatives, to guide resource allocation, frontline programs and services, and inform healthy public policy.

5. Expand access to **treatment** for opioid use disorder, including opioid agonist therapy in a range of settings (e.g., mobile outreach, primary care, emergency departments) and a variety of medication options (including injectable). To support the overall health of PWUDs, also connect with and expand access to care for other substances, for mental illness and trauma as key risk factors for drug use, and for comprehensive medical care for PWUDs.

6. Address the structural **stigma**, discrimination and related harms that create systemic barriers for PWUDs, through re-orienting systems for public health, first responders, health care, and social services, to address service provider and policy-level stigma, normalize services for drug use, and better meet the needs of PWUDs. Also, support community and community leadership conversations to address drug use stigma and its societal consequences.

7. Advocate to and support the Federal government to **decriminalize** personal use and possession of substances, paired with increased investments in health and social services and a focus on health equity at all levels. These efforts aim to address the significant health and social harms of approaches that criminalize PWUDs, including Black, Indigenous and other racialized communities.
8. Acknowledge and address **socioeconomic determinants of health**, **systemic racism**, and their intersections that are risk factors for substance use and substance use disorders, and pose barriers to accessing supports. This includes a need for more affordable and supportive **housing** for PWUDs, and efforts to further address **poverty** and **unemployment/precarious employment**.

9. Provide funding and other supports to enable consistent **community leadership** by PWUDs and by community organizations, including engagement with local drug strategies. People who bring

their lived experience should be paid for their knowledge contribution and participation at community tables.