May 23, 2018 - Board of Health Meeting

Sault Ste. Marie Community Rooms A

www.algomapublichealth.com

May 23, 2018 - Board of Health Meeting Book

Algoma Public Health Board of Health Meeting Table of Contents

Land Acknowledgement:

We would like to begin by acknowledging that we are in Robinson-Huron Treaty territory and that the land on which we are gathered is the traditional territory of the Anishnaabeg, specifically the Garden River and Batchewana First Nations, as well as Metis people.

We say 'meegwetch' to thank Indigenous peoples for taking care of this land from time immemorial.

We are called to treat this sacred land, its plants, animals, stories and its Peoples with honour and respect

We commit to the shared goal of reconciliation.

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
MAY 23, 2018 @ 5:00 PM - ROOM A, SSM
A*G*E*N*D*A

1.0 Meeting Called to Order — Mr. Ian Frazier, Board Chair
- **a. Land Acknowledgement**
- **b. Declaration of Conflict of Interest**

2.0 Adoption of Agenda Items — Mr. Ian Frazier, Board Chair

Resolution
THAT the agenda items dated May 23, 2018 be adopted as circulated.

3.0 Adoption of Minutes of Previous Meeting — Mr. Ian Frazier, Board Chair
- **a. April 25, 2018**

Resolution
THAT the Board of Health minutes for the meeting dated April 25, 2018 be adopted as circulated.

4.0 Delegations/Presentations — Mr. Chris Spooney Manager of Environmental Health
- **a.** Inspection Programs – Food Safety

5.0 Business Arising from Minutes
- **a.** APH BoH Annual Schedule - Updated — Mr. Ian Frazier

6.0 Reports to the Board
- **a. Medical Officer of Health and Chief Executive Officer Reports** — Dr. Marlene Spruyt, MOH/CEO
  - i. May 2018

Resolution
THAT the report of the Medical Officer of Health and CEO for the month of May 2018 be adopted as presented.

  - ii. Highlights of Changes to Ontario's Food Premises Regulation
  - iii. Highlights of Changes to Ontario's Public Pool and Public Spa Regulations
  - iv. Highlights of Changes to Ontario's Recreational Camps Regulation

- **b. Finance and Audit Committee Report** — Mr. Sergio Saccucci Committee Chair
  - i. Draft Financial Statements for the period ending March 31, 2018

Resolution
THAT the Draft Financial Statements for the period ending March 31, 2018 be approved as presented

7.0 New Business/General Business

8.0 Correspondence — Mr. Ian Frazier, Board Chair
- **a. Repeal of Section 43 of the Criminal Code**
  - i. Letter to the Minister of Justice from Peterborough Public Health dated April 23, 2018

b. Tobacco and Smoke-Free

i. Letter to Peterborough MPP from Peterborough Public Health dated May 3, 2018
ii. Letter to Haliburton-Kawartha Lakes-Brock MPP from Peterborough Public Health dated May 3, 2018
iii. Letter to Ontario Film Review Board from Peterborough Public Health dated May 3, 2018
iv. Letter to all Ontario Public Health Units from the Provincial Minister of Health dated May 3, 2018

9.0 Items for Information

a. Smoke-Free Ontario – The Next Chapter-2018
b. alPHa Resolutions for Consideration at June 2018 Annual General Meeting
c. Oral Health Report 2018 Update – Windsor – Essex County
d. Oral Health Report Recommendation – Amended Motion

10.0 Addendum

11.0 That The Board Go In-Camera — Mr. Ian Frazier, Board Chair

Resolution
THAT the Board of Health go in-camera

Agenda Items:

a. Adoption of previous in-committee minutes
b. Litigation or Potential Litigation
c. Labour Relations and Employee Negotiations

12.0 That The Board Go Into Open Meeting — Mr. Ian Frazier, Board Chair

Resolution
THAT the Board of Health goes into open meeting

13.0 Resolution(s) Resulting from In-Camera Session — Mr. Ian Frazier, Board Chair

14.0 Announcements:

Next Board Meeting: — Mr. Ian Frazier, Board Chair
June 27, 2018 @ 5:00pm
Sault Ste. Marie, Room A

Next Committee Meetings:
Governance Standing Committee
June 7, 2018 @ 4:30 pm
Prince Meeting Room, 3rd Floor

Finance and Audit Committee
June 13, 2018 @ 4:30 pm
Prince Meeting Room, 3rd Floor

15.0 That The Meeting Adjourn — Mr. Ian Frazier, Board Chair

Resolution
THAT the Board of Health meeting adjourn

ALGOMA PUBLIC HEALTH - BOARD OF HEALTH MEETING
MINUTES
APRIL 25, 2018 @ 5:00 pm
SAULT STE MARIE ROOM A 1ST FLOOR, APH SSM

PRESENT:	**Board Members**	**APH Executives**	
	Dr. Lucas Castellani	Dr. Marlene Spruyt	Medical Officer of Health/CEO
	Ian Frazier	Dr. Jennifer Loo	Associate Medical Officer of Health
	Debra Graystone	Justin Pino	Chief Financial Officer
	Sue Jensen	Antoniette Tomie	Director of HR and Corporate Services
	Lee Mason	Laurie Zeppa	Director of Health Promotion & Prevention
	Dr. Heather O'Brien	Sherri Cleaves	Director of Health Protection & Prevention
	Sergio Saccucci	Tania Caputo	Board Secretary
	Dennis Thompson		
	Adrienne Kappes		
	Dr. Patricia Avery		

REGRETS: Karen Raybould

1.0 Meeting Called to Order

Mr. Frazier called the meeting to order at 5:01 pm

a. Declaration of Conflict of Interest
Mr. Frazier called for conflicts of interest; none were declared.

2.0 Adoption of Agenda Items

2018-34 Moved: P. Avery
Seconded: L. Mason
THAT the Agenda items dated April 25, 2018, be adopted as amended;
CARRIED

3.0 Adoption of Minutes

2018-35 Moved: H. O'Brien
Seconded: D. Graystone
THAT the Board of Health minutes for the meeting dated March 28, 2018 be adopted as amended.
CARRIED

4.0 Delegations/Presentations

a. Communications
Mr. Leo Vecchio, Manager of Communications presented on the role of the department at Algoma Public Health. Discussion followed regarding the nature of the interactions with the public on the information we provide on forums. A copy of the presentation was provided in the Board agenda package.

5.0 Business Arising from Minutes

a. No business arising from previous minutes

6.0 Reports to the Board

a. Medical Officer of Health and Acting Chief Executive Officer Report

i. April 25, 2018

Dr. Spruyt spoke to her reports in the agenda package and provided an overview on the 2017 Sheela Basur Centre Don Low Communication Fellowhip, National Volunteer Week initiatives at APH and ongoing activities related to the 50th Anniversary Celebration. Also included were reports on Reducing Health Hazards and Optimizing the Health of Families in Sault Ste. Marie and a Human Resources and Corporate Services. Topics in the report are chosen based on feedback from Board members as well as items coming up in Public Health.

2018-36 Moved: L. Mason
Seconded: P. Avery

THAT the report of the Medical Officer of Health and CEO for the month of April 2018 be adopted as presented.

CARRIED

ii. Public Health Champion Award

Dr Spruyt recommended implementation of an award in honour of Algoma Public Health's 50 year milestone. The award would publicly recognize an individual or organization that has made an outstanding contribution to public health in the Algoma District

2018-37 Moved: H. O'Brien
Seconded: L. Castellani

THAT the Board of Health approves the creation of a Public Health Champion Award as a legacy initiative commemorating the 50th anniversary of Algoma Public Health.

CARRIED

b. Finance and Audit Committee Report

i. Committee Chair Report for April 20182018
ii. Draft Audited Financial Statements for the Period ending December 31, 2017
iii. Draft Financial Statements for the period ending February 28, 2018

2018-38 Moved: L. Mason
Seconded: P. Avery

THAT the Finance and Audit Committee report for the month of April 2018 be adopted as presented; and

THAT the Draft Audited Financial Statements for the Period Ending December 31, 2017 be approved as presented; and

THAT the Financial Statements for the Period Ending February 28, 2018 be approved as presented.

CARRIED

iv. Building Conditions Assessment for Capital Asset Plan and Reserve Fund Planning

2018-39 Moved: H. O'Brien
Seconded: D. Graystone

THAT the Board of Health approves the 20 year Capital Reserve Expenditure schedule noted in the Building Conditions Assessment to be:
Adopted as a part of APH's Capital Asset Plan related to the 294 Willow Avenue Facility located in Sault Ste. Marie; and
Used as a tool to assist the Board of Health with contributions decisions related to the Reserve Fund and By-Law 15-01 - To Provide the Management of Property of the Board of Health be amended accordingly to reflect this.
CARRIED

v. Updates to Payroll software

2018-40 Moved: L. Castellani
Seconded: L. Mason

THAT the Board of Health approves the sole source procurement of Sage People HRMS upgrade.
CARRIED

vi. Approved Minutes February 13, 2018 **– *for information only***

c. Governance Standing Committee Report

i. **Committee Chair Report for April 2018**

2018-41 Moved: H. O'Brien
Seconded: S. Saccucci

THAT the Governance Standing Committee report for the month of April 2018 be adopted as presented.
CARRIED

ii. **02-05-000– Board of Directors**

iii. **02-05-045 - Attendance at Meetings Using Electronic Means**

2018-42 Moved: L. Mason
Seconded: A.Kappes

THAT the Board of Health approve the proposed changes to policies;
02-05-000 – Board of Directors
02-05-045 – Attendance at Meetings Using Electronic Means as amended
CARRIED

iv. 02-05-005 – Reports to the Board

2018-43 Moved: H. O'Brien
Seconded: L. Mason
THAT the Board of Health approves the proposal to archive policy 02-05-005 – Reports to the Board
CARRIED

v. **Approved Minute for February 15, 2018 – for information only**

7.0 New Business / General Business

a. Meeting Dates for Committees

2018-44 Moved: L. Mason
Seconded: L. Castellani
THAT the board approve the amended annual schedule as presented
CARRIED

8.0 Correspondence

All correspondence items were emailed to Board members previously, as well as, included in their Board packages.

a. Repeal of Section 43 of the Criminal Code
Letter to the Federal Minister of Justice from Grey Bruce Health Unit dated April 19, 2018

b. Tobacco and Smoke-Free Campuses
Letter to the CEO and President, Georgian College from Grey Bruce Health Unit dated April 19, 2018

c. Annual Service Plan and 2018 Budget
Letter to Provincial Minister of Health from Grey Bruce Health Unit dated April 19, 2018

d. Ontario Budget 2018
Letter to the Provincial Minister of Finance from the Association of Local Public Health Agencies dated April 3, 2018

e. Public Health Funding
Letter to all Ontario Public Health Units from the Provincial Minister Health

f. Cannabis Sales Revenue
Letter to the Premier of Ontario from the Hastings Prince Edward Public Health Unit dated March 28, 2018

9.0 Items for Information

a. News release announcing the merger of Oxford County and Elgin St. Thomas health unit – Southwestern Public Health

b. Northern Ontario Health Equity Strategy

c. alPHa Annual General Meeting & Conference – June 2018

10.0 Addendum

a. MOH Report with Health Indicators report included

11.0 That the Board Go Into Committee

2018-45 Moved: S. Jensen
Seconded: S. Saccucci
THAT the Board of Health goes into committee at 7:10 pm.
Agenda Items:

a. Litigation or Potential Litigation
b. Labour Relations and Employee Negotiations

CARRIED

12.0 That the Board Go Into Open Meeting

2018-46 Moved: L. Mason
Seconded: L. Castellani
THAT the Board of Health goes into open meeting at 7:26 pm
CARRIED

13.0 Resolution(s) Resulting from In-Committee Session

2018-47 Moved: L. Mason
Seconded: L. Castellani
THAT the Board of Health ratifies the memorandum of settlement between ONA and the Board of Health of the district of Algoma Health Unit as presented
CARRIED

14.0 Announcements:

Next Board Meeting:
May 23, 2018 @ 5:00pm
Sault Ste. Marie, Room A

15.0 THAT the Meeting Adjourn

2018-48 Moved: S. Saccucci
Seconded: L. Castellani
THAT the Board of Health meeting adjourns at 7:29 pm
CARRIED

_____ _____

Ian Frazier, Chair **Tania Caputo, Secretary**

_____ _____

Date **Date**

Food Safety Inspection Program

Name: Chris Spooney, Environmental Health Manager

Date: May 23, 2018

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Outline

- Why is food safety important?
- What is the goal of the food safety program?
- How do PHIs reach this goal?
- Legislation
- Algoma - geography of inspectors
- Completion rates of accountability indicators
- PHI food handler education
- Healthy Menu Choice's Act
- Consultation / Enforcement
- Collaborations
- Q&A

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Why is food safety important?

- Food Safety is a program listed under the Ontario Public Health Standards (OPHS).

- Improper food handling practices contribute to many illnesses, hospitalizations, and deaths each year.

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Why is Food Safety Important?

- Canada has a very safe food supply. However, food-borne bacteria, parasites and viruses still cause illnesses in Canada.
- According to Health Canada 2016, there are about 4 million (1 in 8) Canadians affected by a food-borne illness. Of these, there are about:

  - 11,600 hospitalizations

  - 238 deaths

- In Ontario, there are an estimated 100,000 food-borne cases each year (PHO, 2014).

  - Of these, only 3700 food-borne cases are reported each year (PHO, 2014).

Government of Canada (2015). Causes of Food Borne Illness in Canada

Why are the number of reported cases so low?

- Symptomatic individuals do not seek medical attention.
- Symptomatic individuals seek medical attention but a lab test is not ordered.
- A positive test result may not be reported to the health unit and entered in the tracking system.
- Cases may be entered in the tracking system but a link to food as the source of the illness may not be made.
- ITS OK NOT TO REPORT!

What is the goal of the Food Safety Program?

- Reduce Food-borne illnesses through surveillance, health protection, and health promotion.

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How do PHIs reach this goal?

- PHIs conduct their inspections in accordance with applicable legislation.
- Health Protection and Promotion Act – gives permission for the PHIs to enter a food premise and conduction inspections.
- Food Premises Regulation 493 – sets minimum health standards for all food premises in Ontario.

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How do PHIs reach this goal?

Geography of Inspectors in Algoma

- SSM – 9
- Wawa – 1
- Elliot Lake – 1
- Blind River – 2

- Disclosure: http://www.algomapublichealth.com/inspections-environment/food-safety/restaurant-inspection-reports

Risk Categorization of Premises

- RCAT – used to determine the level of risk within a food premises.
- The level of risk is used to determine the number of inspections a restaurant will receive each year.
  - Low risk premises = 1 inspection/year
  - Medium risk premises = 1 inspection/6 months
  - High risk premises = 1 inspection/4 months

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Types of Inspections

- Public Health Inspectors conduct many different types of inspections which include:

  - Routine Compliance Inspections
  - Food Safety Audits (HACCP)
  - Re-inspections
  - Complaints

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RESULTS

Risk Category	Total # of Premises	2016 inspections	Compliance %	2017 inspections	Compliance %	Complaints
High	110 (2016) 115 (2017)	331	92	345	93	47
Medium	187 (2016) 197 (2017)	373	95	393	95	15

Healthy Menu Choices Act

- Intended to allow the public to make healthier and informed food choices.
- Introduced January 1, 2017
- Applies to chains of food service premises (>20)
- 1 annual inspection
- In short, this act outlines the format and requirements for labelling calories on menus.

Results

- In 2017, there were 76 Premises inspected in regards to the Health Menu Choices Act.

- Tim Horton's, McDonald's Wendy's KFC, Subway, Casey's, etc.

Education

- Food handler training and certification is a priority to educate those who will be in direct contact with the public.

- 2016- 21 sessions hosted with 425 certified food handlers

- 2017- 22 sessions hosted with 429 certified food handlers

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Consultation / Enforcement

- Consultation - New premises, changes or alterations or premises, resource requests and special events.

- Enforcement – seize or destroy / issue a ticket / closure

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Collaborate

- **Canada Food Inspection Agency** (CFIA) – food recalls
- **Ontario Ministry of Agriculture, Food and Rural Affairs** (OMAFRA) – Joint Inspections
- **Public Health Ontario** (PHO) – Most current and updated science based practices
- **Municipal Chief Building Officials** (CBO) – Ontario Building Code
- **Municipal Fire Departments** – in regards to fire events that occur within food premise establishments
- **Public Utilities Commission** – in regards to water issues that arise and affect food premises establishments

Food Safety Matters

Thank you

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APH Board of Health - Annual Schedule

Grey = No meeting

Month	Major Event	Board of Health	Finance & Audit Committee	Governance Committee
JANUARY	▪ Chair and committee selection	**MEETING** ▪ MOH / CEO report	▪ Monthly statement	
FEBRUARY		**MEETING** ▪ MOH / CEO report - Quarterly data, previous year	**MEETING** ▪ Insurance review ▪ Monthly statement ▪ Auditor Engagement	
MARCH	▪ Insurance renewal	**MEETING** ▪ MOH / CEO Report	▪ Monthly statement	**MEETING** ▪ By-laws and policies ▪ Review Provincial appointees end dates
APRIL	▪ Provincial Budget ▪ Draft Audited Financial Statements	**MEETING** ▪ MOH / CEO Report – ▪ 1st Quarter Performance Indicators	**MEETING** ▪ Monthly statement ▪ Provincial Budget Impact	
MAY	▪ Amending agreement or accountability standards sign off of some sort	**MEETING** ▪ MOH / CEO Report	▪ Monthly statement	
JUNE	▪ Annual Reports ▪ Yearly Board Evaluation ▪ Accountability indicators	**MEETING** ▪ MOH / CEO Report	**MEETING** ▪ Monthly statement	**MEETING** ▪ By-laws and policies Review initiatives and progress
JULY			▪ Monthly statement	
AUGUST			▪ Monthly statement	
SEPTEMBER	▪ Staff planning for budget request ▪ Review Risk Management Model	**MEETING** ▪ MOH / CEO Report – 2nd Quarter Performance Indicators	▪ Monthly statement	**MEETING** ▪ By-laws and policies
OCTOBER	▪ Staff creating and collating budget	**MEETING** ▪ MOH / CEO Report	**MEETING** ▪ Monthly statement ▪ Budget presentation and questions	
NOVEMBER	▪ Budget Presentation and Approval ▪ Note chair changes if required ▪ *Election year - Last mo. for Municipal Reps. 2018	**MEETING** ▪ MOH / CEO Report – 3rd Quarter Performance Indicators ▪ Budget presentation	**MEETING** ▪ Monthly statement ▪ Final draft presentation and questions	**MEETING** ▪ By-laws and policies ▪ Monitor Board seat renewal for next year pre-election year.
DECEMBER				

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MEDICAL OFFICER OF HEALTH / CHIEF EXECUTIVE OFFICER
BOARD REPORT - MAY 23, 2018

Prepared by: Dr. Marlene Spruyt, Medical Officer of Health/CEO and the Leadership Team

alPHa Challenge 2018 – Employee Participation

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APH AT-A-GLANCE

After a very chilly April, it appears spring has arrived here in Algoma, or at least the southern parts of our district.

Bridges out of Poverty is a framework for understanding how systemic barriers and our personal attitudes make it more difficult for individuals living in poverty to utilize the services that may support them. During 3 days in May, we partnered with SSM District Social Services to provide this training to all of our APH staff along with many social services staff. They attended an all-day workshop and in addition, a half-day workshop was provided to other agencies in the community. We were fortunate to have the support of Wellington Dufferin Guelph Health Unit who shared with us their trained facilitators. Currently, we are training local facilitators to continue this work and will be able to extend delivery of this programming to other areas in the district as well as continuing to work with other community partners over the next few years. Bridges Out of Poverty is the community awareness component of a larger poverty reduction framework. Our eventual goal is to expand our partnership with other agencies to support delivery of other components of the framework ("Circles" provides support and coaching to individuals living in poverty)

As you are all aware we are in election mode in Ontario. After the writ drops and the Legislature is dissolved there is no direction from appointed Ministers to their respective Ministry portfolios as those individuals no longer hold that position. This also means that there is no direction and virtually no communication that occurs between the Ministry(s) and local public health. However in advance of this "silent period," we were deluged with many updated protocols and guidelines related to the new standards and to legislation that had recently been or was about to be implemented. You will see some fact sheets attached to this report explaining some of these changes.

Public health budgets were approved much earlier than ever before, (again because of election process) and we are pleased to share that we along with all other public health units in the province were provided with an increase to our base budget for mandatory cost-shared programs. In addition, we received funding for most of our one-time requests, one of which is to support the consultative work for the NE Collaborative project.

The Northeastern Collaborative Project:

- **The Northern Medical Officers of Health are a collaborative group that meets on a regular basis.**

- **Northern public health units share common experience and challenges and barriers that are unlike public health units in the south. Difficulties recruiting certain professionals, providing services over large geographic areas and inability to take advantage of economies of scale.**

- **As a result of the fiscal constraints, the northern public health units are exploring new and innovative ways to be as effective and efficient as possible in serving the northern communities.**

- **This "Northeastern Collaborative Project" is a project to identify novel opportunities to share services among northern health units.**

- **This project is not part of the Expert Panel's recommendations nor is it a "job cutting" measure. It is about working smarter together using limited resources.**

- **The northern public health units have engaged LBCG (formerly known as Lough Barnes Consulting Group) as consultants on this project. Their role is to understand our current practices and identify options for the northern health units to consider.**

- **The ultimate decision to change or share services will rest with each individual health unit.**

- **The initial touch down meeting with the consultants took place April 23, 2018 and the project report is expected to be completed by late fall.**

We have also been working on communication regarding public health issues that we feel are important to share with the voting public. Mental health and addictions (including opioid use) tobacco use and food insecurity are 3 areas of public health concern in Northern Ontario and in particular Algoma. We sharing our concerns about those issues with candidates from all parties and providing information to the voting public to engage them in these issues.

PROGRAM HIGHLIGHTS

"The District" Board Report

From: Sherri Cleaves, Director of Health Protection and Promotion
Laurie Zeppa, Director of Health Promotion and Prevention

Public Health Goal: To improve and protect the health and wellbeing of the population of Algoma and reduce health inequities.

Program Standard Requirements addressed in this report:
The Ontario Public Health Standards (OPHS) are delivered across the entire District of Algoma. All 9 OPHS Program Standards are addressed: Chronic Disease Prevention and Well-Being, Food Safety, Healthy Environments, Healthy Growth and Development, Immunization, Infectious and Communicable Diseases Prevention and Control, Safe Water, School Health, and Substance Use and Injury Prevention. In addition Algoma Public Health (APH) has the accountability to ensure the Community Programs, Community Mental Health, Community Drug and Alcohol Assessment, Genetics, Infant and Child Development Program, and Preschool Speech and Language Program are delivered across the District of Algoma.

2015-2020 Strategic Priorities addressed in this report:
- Improve Health Equity
- Collaboration
- Be accountable
- Enhance Employee Engagement

Key Messages:
- 1/3 of Algoma's population is located outside of the City of Sault Ste. Marie.
- APH staff in District offices possess and utilize a broad knowledge base and skillset.
- Local partnerships play a critical role in delivery of programs
- Management and program re-structure supports District-wide program planning, implementation and evaluation.

Introduction:
"The District" includes the entire catchment area of APH outside of the City of Sault Ste. Marie (SSM), and it includes 20 municipalities and unincorporated communities. The APH District offices are situated in the municipalities of Elliot Lake, Blind River and Wawa. These office locations provide onsite public health services, community meeting spaces, and staff office accommodations. Additionally, many District programs are planned and delivered at out-of-office outreach locations, such as schools, homes, and workplaces.

Population Health Snapshot:

The District of Algoma spans an area of about 49,000 square kilometers and over 114, 000 residents live, work and play in this area.[1] Over one third of these residents live outside the City of SSM, representing District residents. The large geography that the District covers provides both challenges (e.g., travel) and opportunities (e.g., partnerships) for public health program delivery.

APH Intervention:

District programing addresses the foundational standards by using a population health approach, which considers social determinants of health unique to the communities, a focus on health equity, and evidence-based guidance in order to promote healthy behaviours and build healthy communities. Key areas that highlight the District's unique structure include:

- Resources (focus on staff compliment)
- Program planning and delivery (focus on health equity)
- Local partnerships

Resources:

Each District office has core public health and community program staff. Currently, across the District there are: 4 Public Health Inspectors, 9 Public Health Nurses, 6 Clerical, 2 Parent Child Advisors, 3 Family Support Workers, and 5 Community Mental Health and Addictions staff.

Resourcing the District requires an assessment of community needs, planning, and consideration of District staff competencies. In order to meet the diversity of needs in their communities, District staff possess competencies that span multiple programs, requiring them to be flexible and responsive to changing community needs and public health issues.

Additional public health resource capacity for program delivery is provided from the SSM office. Public Health Dieticians and the Youth Engagement Coordinator travel to the District to support and deliver programs. The Genetics program staff work centrally from SSM, and receive referrals from the District. District staff are also supported by SSM staff when specialized knowledge and referral is required, such as reporting infectious diseases including measles and tuberculosis. In other instances, certain program requirements such as Tobacco Enforcement and Oral Health require staff to travel from SSM to ensure the delivery of these requirements in the District.

Program Planning and delivery:

Program Managers are responsible for the planning, implementation, and evaluation of programs for all District offices. Technology such as teleconferencing and video capabilities have allowed for better administrative and program support. APH management has embraced "managing at a distance," as managers regularly communicate with and support staff and community partners throughout the District. For example, the Environmental Health Program Manager regularly meets with District staff

[1] Statistics Canada. 2017. *Focus on Geography Series, 2016 Census*. Statistics Canada Catalogue no. 98-404-X2016001. Ottawa, Ontario. Data products, 2016 Census

and community partners to ensure that community needs are being met and effectively responded to (e.g., matters concerning small drinking water systems).

Health equity is a foundational lens through which all APH offices plan and delivers programs. Some health equity challenges specific to the Algoma District include: access to transportation, adequate housing, and food insecurity.[2] An example of how District staff have responded to these issues includes collaboration with the North Channel Poverty Network, which works to address issues related to poverty in rural Algoma communities.

Additionally, APH values accessibility for all clients, and having District offices is another way in which APH can improve and protect the health and wellbeing of all Algoma residents who do not live close to SSM.

Local Partnerships:

Partnerships are particularly important when leveraging limited resources in rural settings.[3] APH District staff have developed strong working relationships with community partners in their respective communities. The relative ease in developing local partnerships is due in part to small communities, and the fact that there are fewer organizations delivering health and social services, compared to larger cities such as SSM.

APH has recently partnered with Alamos Island Gold Mine to increase support for mine employees who are interested in quitting smoking. In Elliot Lake APH is working with the City's Community Services Department to plan and implement healthier food choices for menus at local recreation centres such as the local arena and pool. Also in Elliot Lake, APH staff recently provided breastfeeding education to St. Joseph's Hospital staff, with the aim of increasing breastfeeding promotion among hospital nurses. The breastfeeding support was well-received by hospital nurses, and APH staff plan to return to the hospital in the fall to review and reinforce the breastfeeding training.

Evaluation and Next Steps:

Evidence that focuses on advancing healthy public policy in rural settings speaks clearly for the need to critically asses evidence for success in urban centres, consider a variety of intervention settings, explore the economic impact of such policies, and recruit local champions.[4] With the launch of the new Ontario Public Health Standards and the re-structuring of management and programs, APH has an opportunity to collaborate effectively to enhance the planning cycle, prioritize healthy public policy, and improve and protect the health and wellbeing of Algoma's District population.

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[2] Algoma Public Health. (2011). Community Picture Report: Healthy Community Fund Partnership- Algoma District. *Algoma Public Health*. Available from: http://www.algomapublichealth.com/media/1301/2011-community-profile-report.pdf

[3] Calanice, L., Leeman, J., Pitts, S., Khan, L., Fleischhacker, S., Evenson, K., Schreiner, M., Byker, C., Owens, C., McGuirt, J., Barnidge, E., Dean, W., Johnson, D., Kolodinsky, J., Piltch, E., Pinard, C., Quinn, E., Whetstone, L. and Ammerman, A. (2015). Nutrition-Related Policy and Environmental Strategies to Prevent Obesity in Rural Communities: A Systematic Review of the Literature, 2002-2013. *Preventing Chronic Disease,* 12. Available from: https://www.cdc.gov/pcd/issues/2015/14_0540.htm

Baby Friendly Initiative (BFI) Annual Report

From: Leslie Wright, Healthy Growth and Development
Laurie Zeppa, Health Promotion and Prevention

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

Program Standard Requirements addressed in this report:

Healthy Growth and Development

- **Collect and analyze relevant data** to monitor trends over time, emerging trends, priorities, and health inequities related to healthy growth and development
- Develop and implement a program of public health interventions using a **comprehensive health promotion approach**

2015-2020 Strategic Priorities addressed in this report:

- Improve Health Equity
- Collaborate Effectively

Key Messages

- Breastfeeding has many benefits to mothers, children, families, and the community; yet breastfeeding rates in Algoma have been decreasing.
- APH interventions are becoming more comprehensive as a way to improve healthy growth and development for Algoma families.

Introduction

The Baby Friendly Initiative (BFI) originally began as the Baby Friendly Hospital Initiative (BFHI) in 1991; a program developed by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), with the purpose of motivating facilities that provide maternal and newborn services to better support breastfeeding.[1] Best practice guidelines recommend breastfeeding within the first hour of childbirth and exclusively for the first six months of life and continued, alongside supplementary foods, until two years and beyond.[1]

In infants and children, breastfeeding is strongly associated with lower incidence of gastrointestinal and respiratory tract infections and child survival.[2] Breastfeeding has been shown to be protective against obesity and type 2 diabetes,[3] and it's also associated with improved cognitive development.[4] Breastfeeding mothers benefit from a reduced risk of postpartum hemorrhage, ovarian and breast cancer, and type 2 diabetes.[5] Additionally, breastfeeding benefits extend beyond mother and child to families, who incur cost savings associated with not purchasing formula, and to the greater community who benefits from less waste production and used resources.[1]

Public health values the promotion of healthy growth and development via breastfeeding. Algoma Public Health (APH) received its BFI designation in 2010, and became re-designated in 2016. To date, the designation has complimented staff's abilities to optimize breastfeeding education and support for mothers in the Algoma District at critical healthy growth stages, including prenatal, birth, and beyond.

Population Health Snapshot

Rates of exclusive breastfeeding at hospital discharge have been decreasing in the Algoma District compared to Ontario rates, which have remained relatively stable. The following table displays the overall per cent of infants fed breastmilk only, in both Algoma District (APH) and Ontario (ON) for the years of 2013-2015.[6]

Infants fed breastmilk only, overall per cent[6]

Year	Algoma	Ontario
2013	74.3%	62.5%
2014	72.2%	61.5%
2015	64.3%	62.3%

As a component of the BFI designation, local infant feeding surveillance seeks to capture major trends regarding breastfeeding at birth, as well as post-natal intervals of 48 hours, 2 weeks, and 6 weeks. Public Health Nurses (PHNs) offer continued breastfeeding education and support to mothers and their families during these intervals.

APH Program or Intervention

APH interventions have focused on staff competencies, breastfeeding-friendly policy, client services, and external partnerships. Program staff at APH educate and support mothers and families on breastfeeding initiation and continuation. APH supports the WHO's International Code of Marketing of Breast-milk Substitutes,[7] and therefore does not accept or advertise free formula, bottles, or products produced by formula companies. Client services include a baby friendly room at the Sault Ste. Marie office, as well as an array of services including prenatal classes, education and support at birth, follow-up phone calls, home visits and parenting classes. Additionally, in 2017 APH partnered with the Sault Area Hospital, St. Joseph's General Hospital in Elliot Lake, and the Wawa Family Health Team to launch a poster campaign geared to increase awareness, about the benefits of breastfeeding for Algoma mothers.

Evaluation or Next Steps

APH is committed to supporting and promoting a culture of breastfeeding, which ultimately affects healthy growth and development for Algoma families. Interventions that support and extend beyond the BFI will remain a focal point for the Healthy Growth and Development program moving forward. One example of this is the current evaluation of the Sault Area Hospital poster campaign. This specific hospital was chosen for evaluation because the majority of births in the Algoma District occur in Sault Ste. Marie.

Service delivery will continue in the form of individual visits, telephone calls, on site clinic visits, and group classes. Additional activities related to breastfeeding will be considered as the program performs an annual review and develops a 2019 program plan. This will likely include a scan of community indicators, outcomes, and needs, which will inform a comprehensive health promotion approach for APH's Healthy Growth and Development program.

Respectfully submitted,

Dr. Marlene Spruyt

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Highlights of Changes to Ontario's Food Premises Regulation

Effective July 1st 2018 the Food Premises Regulation R.R.O. 1990, Reg. 562 will be revoked and replaced with the Food Premises Regulation O. Reg. 493/17. This summary document has been prepared for public health and industry stakeholders to raise awareness about the upcoming changes and assist with implementation of the new requirements.

Background

The new regulation follows many other provinces and territories who have adopted outcome-based regulations and have removed many prescriptive requirements. Outcome-based regulations focus on the intended end result of food protection and food safety practices.

Here are some of the key changes:

Posting requirements of inspection results

Many public health units have existing public disclosure programs, some of them require on-site posting to raise awareness of the availability of inspection results to the public. Under the new regulation food premise operators will be required to post the results of inspections conducted by a public health inspector in accordance with the inspector's request.

Food handler training

The new regulation requires every operator of a food premise to ensure that there is at least one food handler or supervisor on the premise who has completed food handler training during every hour of operation. Completed training, under *The Operational Approaches to Food Safety Guidelines (2018)*, requires a 70% pass on food safety training examination and issuance of a food handler certificate that expires after 5 years. Currently in Ontario, more than 64% of food premises meet this requirement as a result of existing local by-laws and the promotion of training by the public health inspector.

Ontario

Remove prescriptive requirements throughout the regulation by replacing them with outcome-based requirements in areas including

Protection of food from contamination and adulteration, maintenance of rooms and sanitary facilities, sanitary garbage management and requirements relating to convenient hand washing stations for food handlers.

Amend requirements related to temperature control, food handling, and cleaning and sanitizing

- Allow potentially hazardous food items to be in the temperature danger zone for no more than two hours during periods of time necessary for the preparation, processing and manufacturing of the food.
- Prescriptive internal cooking temperatures for specific food items has been replaced with an emphasis on utilizing safe food handling and processing procedures, including temperature control, to ensure food is safe to eat.
- Removal of double strength sanitizer concentration requirement when sanitizing large equipment that cannot be washed in a sink or mechanical dishwasher.
- Supporting innovation by recognizing NSF standard for mechanical equipment and expanding the use of sanitizing agents permitted in a food premises.

While this is a brief review of highlights in the new Food Premises Regulation 439/17, the requirements are intended to move Ontario toward increased transparency, consistency, and strengthen food safety practices based on outcomes that will protect the public.

More Information

It is recommended to work with your public health inspector to learn more about the requirements and how to maintain compliance with the Food Premises Regulation.

To contact your local public health unit, visit:
http://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx

Contact

Ministry of Health and Long-Term Care
Population and Public Health Division
Health Protection Policy and Programs Branch
Environmental Health Policy and Programs
EnvironmentalHealth@ontario.ca

Ontario

Highlights of Changes to Ontario's Public Pool and Public Spa Regulations

Effective July 1, 2018, the Public Pools Regulation R.R.O. 1990, Reg. 565 will include requirements for public spas, wading pools, spray/splash pads and waterslide receiving basins. As such, Ontario Regulation 428/05- Public Spas has been revoked. This summary document has been prepared for public health and industry stakeholders to raise awareness and assist with implementation of the new requirements.

Background

Reg. 565 Public Pools, had not received a comprehensive review since coming into effect in 1944. When Reg. 428/05 Public Spas was introduced in 2005, many requirements for opening, operating and maintaining a public spa were taken from Reg. 565. Updating and modernizing these regulatory requirements involved consultations with public health and industry stakeholders, consideration of the United States Centres for Disease Control's Model Aquatic Health Code, and coroner recommendations.

Here are some of the key changes:

Posting requirements of inspection results

Many public health units have existing public disclosure programs, some of them require on-site posting to raise awareness of the availability of inspection results to the public. Under the amended regulation, operators will be required to post the results of public health inspections, in accordance with the inspector's request.

The addition of Class C facilities

Public splash and spray pads, wading pools, and water slide receiving basins, known collectively as Class C facilities, are now regulated under Reg. 565, which contains requirements for notification, general maintenance, supervision and disinfection.

Lifeguard and assistant lifeguard certification

"Lifeguard certificate" and "assistant lifeguard certificate" now includes certificates issued by the Lifesaving Society, Canadian Red Cross or other organization that provides equivalent training in lifeguarding and that is approved by the Minister of Health and Long-Term Care for that purpose.

Ontario

Admission standards:

- Class A pools (i.e., lifeguard supervised) are now required to have a process in place to ensure guardian supervision of children under 10 years of age, to improve the ability of lifeguards to provide overall pool bather supervision.
- Pool operators are encouraged to continue using existing admission policies that meet the regulatory requirements such as those recommended by the Chief Coroner of Ontario. Operators may also consult with industry experts on best practices (e.g., swim tests) to meet the requirements of the regulation at their facility.

Modernized Requirements:

- Where appropriate, requirements for pool and spa operators have been aligned. For example, operator training required under the former public spas regulation, has been expanded to public pool operators; the daily inspection and recording frequencies for pH and sanitizer residual are now the same for pool and spa operators, and are dependent on whether an automatic sensing device is present; and first aid kit supplies aligned and fixed quantities replaced with requirement for sufficient quantities to reflect the needs of each facility.
- Upper limits have been added for various water chemistry parameters, make-up water per bather has been reduced, and the ground fault circuit interrupter inspection frequency adjusted.
- Unsupervised class B pools with a slope of greater than 8% are required to have a buoy line.

While this is a brief review of highlights in Reg. 565 Public Pools, the requirements are intended to move Ontario toward increased transparency, consistency, and bather safety based on outcomes that will protect the public.

More Information

It is recommended to work with your public health inspector to learn more about the requirements and how to maintain compliance with the Public Pools Regulation.

To contact your local public health unit, visit:
http://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx

Contact

Ministry of Health and Long-Term Care
Population and Public Health Division
Health Protection Policy and Programs Branch
Environmental Health Policy and Programs
EnvironmentalHealth@ontario.ca

Ontario

Highlights of Changes to Ontario's Recreational Camps Regulation

Effective July 1, 2018 the Recreational Camps Regulation R.R.O. 1990, Reg. 568 will be revoked and replaced with the Recreational Camps Regulation O. Reg. 503/17. This summary document has been prepared for public health and industry stakeholders to raise awareness about the upcoming changes and assist with implementation of the new requirements.

Background

The new regulation focus on the protection and safety of persons attending a recreational camp who are under eighteen years of age or who have special needs. The regulation adopts an outcome-based perspective and many prescriptive requirement have been removed.

Here are some of the key changes:

Posting requirements of inspection results

Many public health units have existing public disclosure programs, some of them require on-site posting to raise awareness of the availability of inspection results to the public. Under the new regulation recreational camp operators will be required to post the results of inspections conducted by a public health inspector in accordance with the inspector's request.

Definition of Recreational Camps

The new definition of recreational camps focuses on protecting the safety of children, youth and persons who have special needs. The definitions for class A and B recreational camps have been removed along with the occupancy time of 5 or more days to ensure proper health and safety measures are in place for camps with short durations. The number of participants using a recreational camp has also been changed from 10 to 5 or more to ensure health and safety requirements apply to smaller locations.

Notifications

In the new regulation, operator are required to notify the Medical Officer of Health (MOH) or Public Health Inspector (PHI) of the operators name, contact information and camp location prior to operating or closing/abandoning a camp. Additionally, the operator must immediately notify the MOH or PHI of an outbreak for suspected outbreak of any communicable disease at the camp.

Ontario

Camp Safety

In addition to the requirement that there is to be at least one adult supervisor on the premise at all times, this supervisor is now required to have a current first aid certificate. The new requirement for a camp safety plan is a proactive approach for each camp operator to develop safety and emergency response plans based on the camp's activities and needs. The regulation outlines the minimum requirements that the operator must consider in writing and maintaining their camp safety plan.

The camp safety plan must include supervision ratios for campers based on the age and needs of the campers. Additionally, any land-based and water-based activities at the camp must include supervision procedures if appropriate, this could include additional supervision for high risk activities such as horseback riding or zip lining courses. Camp operators may opt to choose ratios based on industry standards, legislation, or best-practice guidelines recommended by industry experts (e.g. Ontario Camps Association guidelines, O. Reg. 137/15 under the Child Care and Early Years Act, 2014).

Waterfront Supervision

Operators of recreational camps with a waterfront area that is used for aquatic activities are required to ensure that bathers in the designated swimming area of the waterfront are under the supervision of a lifeguard who is at least 16 years of age and who holds a lifeguard certificate (as defined in O. Reg. 565, Public Pools) obtained within the past two years, and in accordance with the ratios set out in section 24 (2).

With respect to boating activities such as canoeing and kayaking, operators will need to establish a process or continue to use appropriate safety protocols and best-practice guidelines recommended by industry experts (e.g., Ontario Camps Association, Lifesaving Society, Canadian Red Cross). Details of the safety protocols would be captured in the Camp Safety Plan.

While this is a brief review of highlights in the new Recreational Camps Regulation 503/17, the requirements are intended to move Ontario toward increased transparency, consistency, and strengthen public safety practices based on outcomes that will protect the public.

More Information

It is recommended to work with your public health inspector to learn more about the requirements and how to maintain compliance with the Recreational Camps Regulation. To contact your local public health unit, visit: http://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx

Contact

Ministry of Health and Long-Term Care
Population and Public Health Division
Health Protection Policy and Programs Branch
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EnvironmentalHealth@ontario.ca

Ontario

Algoma Public Health
(Unaudited) Financial Statements March 31, 2018

Algoma Public Health
Statement of Operations
March 2018
(Unaudited)

	Actual YTD 2018	Budget YTD 2018	Variance Act. to Bgt. 2018	Annual Budget 2018	Variance % Act. to Bgt. 2018	YTD Actual/ YTD Budget 2018
Public Health Programs						
Revenue						
Municipal Levy - Public Health	$ 875,545	$ 875,545	$ 0	$ 3,502,179	0%	100%
Provincial Grants - Cost Shared Funding	1,827,300	1,827,300	-	7,309,200	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	745,300	749,239	(3,939)	2,996,950	-1%	99%
Fees, other grants and recovery of expenditures	100,070	182,141	(82,071)	699,214	-45%	55%
Provincial Grants - Funding for Prior Yr Expenses	0	0	-	-		
Total Public Health Revenue	$ 3,548,215	$ 3,634,224	$ (86,010)	$ 14,507,543	-2%	98%
Expenditures						
Public Health Cost Shared	$ 2,788,629	$ 2,927,229	$ 138,600	$ 11,510,592	-5%	95%
Public Health 100% Prov. Funded Programs	645,336	743,089	97,753	2,996,951	-13%	87%
Total Public Health Programs Expenditures	$ 3,433,965	$ 3,670,318	$ 236,353	$ 14,507,543	-6%	94%
Excess of Rev. over Exp. Cost Shared Funding	$ 14,286	$ (42,243)	$ 56,529	$ 2		
Excess of Rev. over Exp. 100% Prov. Funded	99,964	6,150	93,814	(2)		
Provincial Grants for Prior Yr Expenses	-	-	-	-		
Total Rev. over Exp. Public Health	$ 114,250	$ (36,094)	$ 150,343	$ (0)		
Healthy Babies Healthy Children						
Provincial Grants and Recoveries	$ 267,000	267,003	3	1,068,011	0%	100%
Expenditures	254,335	265,952	(11,618)	1,068,011	-4%	96%
Excess of Rev. over Fiscal Funded	12,665	1,050	11,615	(0)		
Public Health Programs - Fiscal 17/18						
Provincial Grants and Recoveries	$ 164,324	164,324	-	164,324		
Expenditures	158,818	164,324	(5,506)	164,324		
Excess of Rev. over Fiscal Funded	5,506	-	5,506	-		
Community Health Programs						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	$ -	$ -	$ -	$ -		
Municipal, Federal, and Other Funding	76,875	83,125	(6,250)	332,500	-8%	92%
Total Community Health Revenue	$ 76,875	$ 83,125	$ (6,250)	$ 332,500	-8%	92%
Expenditures						
Child Benefits Ontario Works	759	6,125	5,366	24,500	-88%	12%
Algoma CADAP programs	67,902	77,000	9,098	308,000	-12%	88%
One-Time Funding programs	0	0	-	-	#DIV/0!	#DIV/0!
Total Calendar Community Health Programs	$ 68,661	$ 83,125	$ 14,464	$ 332,500	-17%	83%
Total Rev. over Exp. Calendar Community Health	$ 8,214	$ (0)	$ 8,214	$ 0		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	$ 5,580,858	$ 5,597,693	$ (16,835)	$ 5,597,693	0%	100%
Municipal, Federal, and Other Funding	817,037	830,468	(13,431)	830,468	-2%	98%
Other Bill for Service Programs	58,799		58,799			
Total Community Health Revenue	$ 6,456,693	$ 6,428,161	$ 28,532	$ 6,428,161	0%	100%
Expenditures						
Brighter Futures for Children	120,389	120,388	(0)	120,388	0%	100%
Infant Development	640,513	640,434	(80)	640,434	0%	100%
Preschool Speech and Languages	623,405	623,406	1	623,406	0%	100%
Nurse Practitioner	139,753	139,753	0	139,753	0%	100%
Genetics Counseling	466,885	367,805	(99,079)	367,805	27%	127%
Community Mental Health	3,417,306	3,452,498	35,192	3,452,498	-1%	99%
Community Alcohol and Drug Assessment	705,980	724,157	18,177	724,157	-3%	97%
Healthy Kids Community Challenge	202,067	223,000	20,933	223,000	-9%	91%
Stay on Your Feet	107,445	107,445	-	107,445	0%	100%
Bill for Service Programs	54,852	-	(54,852)	-		
Misc Fiscal	24,545	29,274	4,729	29,274		
Total Fiscal Community Health Programs	$ 6,503,138	$ 6,428,160	$ (74,978)	$ 6,428,160	1%	101%
Total Rev. over Exp. Fiscal Community Health	$ (46,445)	$ 1	$ (46,446)	$ 1		

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months
and variances of 10% and $10,000 occurring in the final 6 months

Algoma Public Health
Revenue Statement
For the Three Months Ending March 31, 2017
(Unaudited)

	Actual YTD 2018	Budget YTD 2018	Variance Bgt. to Act. 2018	Annual Budget 2018	Variance % Act. to Bgt. 2018	YTD Actual/ YTD Budget 2018	Comparison Prior Year: YTD Actual 2017	YTD BGT 2017	Variance 2017
Levies Sault Ste Marie	606,441	606,441	0	2,425,762	0%	25%	605,743	605,743	0
Levies Vector Bourne Disease and Safe Water	14,858	14,858	0	59,433	0%	25%	14,858	14,858	0
Levies District	254,246	254,246	0	1,016,984	0%	25%	250,595	250,595	0
Total Levies	**875,545**	**875,545**	**0**	**3,502,179**	**0%**	**25%**	**871,197**	**871,197**	**0**
MOH Public Health Funding	1,782,725	1,782,725	0	7,130,900	0%	25%	1,782,724	1,782,725	(1)
MOH Funding Vector Borne Disease	27,175	27,175	0	108,700	0%	25%	27,175	27,175	0
MOH Funding Safe Water	17,400	17,400	0	69,600	0%	25%	17,400	17,400	0
Total Public Health Cost Shared Funding	**1,827,300**	**1,827,300**	**0**	**7,309,200**	**0%**	**25%**	**1,827,299**	**1,827,300**	**(1)**
MOH Funding Needle Exchange	12,675	16,175	(3,500)	64,700	-22%	20%	12,675	12,675	0
MOH Funding Haines Food Safety	6,150	6,150	0	24,600	0%	25%	6,150	6,150	0
MOH Funding Healthy Smiles	192,475	192,475	0	769,900	0%	25%	192,476	192,475	1
MOH Funding - Social Determinants of Health	45,125	45,125	0	180,500	0%	25%	45,125	45,125	(0)
MOH Funding - MOH / AMOH Top Up	31,180	31,613	(433)	126,451	-1%	25%	0	0	0
MOH Funding Chief Nursing Officer	30,375	30,375	0	121,500	0%	25%	30,375	30,375	0
MOH Enhanced Funding Safe Water	3,875	3,875	0	15,500	0%	25%	3,875	3,875	0
MOH Funding Unorganized	132,600	132,600	0	530,400	0%	25%	128,775	128,775	0
MOH Funding Infection Control	78,100	78,100	0	312,400	0%	25%	78,100	78,100	0
MOH Funding Diabetes	37,500	37,500	0	150,000	0%	25%	37,500	37,500	0
MOH Funding Northern Ontario Fruits & Veg.	29,345	29,344	1	117,400	0%	25%	0	0	0
Funding Ontario Tobacco Strategy	108,400	108,407	(7)	433,600	0%	25%	108,400	108,400	0
MOH Funding Harm Reduction	37,500	37,500	0	150,000	0%	25%	0	0	0
One Time Funding	0	0	0	0		0%	0	0	0
Total Public Health 100% Prov. Funded	**745,300**	**749,239**	**(3,939)**	**2,996,951**	**-1%**	**25%**	**643,451**	**643,450**	**1**
Funding for Prior Yr Expenses	**0**	**0**	**0**	**0**		**0%**	**0**	**0**	**0**
Recoveries from Programs	2,515	19,950	(17,435)	27,450	-87%	9%	0	0	0
Program Fees	56,234	59,441	(3,207)	237,764	-5%	24%	4,279	2,515	1,764
Land Control Fees	5,860	40,000	(34,140)	160,000	-85%	4%	59,181	62,436	(3,254)
Program Fees Immunization	26,769	46,250	(19,481)	185,000	-42%	14%	8,425	40,000	(31,575)
HPV Vaccine Program	298	7,000	(6,703)	20,000	0%	1%	46,336	44,875	1,461
Influenza Program	0	0	0	25,000	0%	0%	0	300	(300)
Meningococcal C Program	77	1,000	(924)	10,000	0%	1%	0	1,100	(1,100)
Interest Revenue	8,318	3,500	4,818	14,000	138%	59%	0	300	(300)
Other Revenues	0	5,000	(5,000)	20,000	0%	0%	3,287	2,668	619
Total Fees, Other Grants and Recoveries	**100,070**	**182,141**	**(82,071)**	**699,214**	**-45%**	**14%**	**121,509**	**154,194**	**(32,685)**
Total Public Health Revenue Annual	**$ 3,548,215**	**$ 3,634,225**	**$ (86,010)**	**$ 14,507,544**	**-2%**	**24%**	**$ 3,463,456**	**$ 3,496,140**	**$ (32,685)**
Public Health Fiscal									
Panorama	74,100	74,100	0	74,100	0%	100%	74,600	74,600	0
Smoke Free Ontario NRT	30,000	30,000	0	30,000	0%	100%	30,000	30,000	0
Practicum	10,000	10,000	0	10,000	0%	100%	10,000	10,000	0
Other One Time Fiscal Funding	50,224	50,224	0	50,224	0%	100%	28,900	28,900	0
Total Provincial Grants Fiscal	**$ 164,324**	**$ 164,324**	**$ -**	**$ 164,324**	**0%**	**100%**	**$ 143,500**	**$ 143,500**	**$ -**

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months and variances of 10% and $10,000 occurring in the final 6 months

Algoma Public Health

Expense Statement- Public Health

For the Three Months Ending March 31, 2017

(Unaudited)

	Actual YTD 2018	Budget YTD 2018	Variance Act. to Bgt. 2018	Annual Budget 2018	Variance % Act. to Bgt. 2018	YTD Actual/ YTD Budget 2018	*Comparison Prior Year:* YTD Actual 2017	YTD BGT 2017	Variance 2017
Salaries & Wages	$ 2,023,760	$ 2,208,938	$ 185,179	$ 8,868,131	-8%	23%	$ 1,872,190	$ 2,104,243	$ 232,053
Benefits	530,850	525,951	(4,899)	2,105,552	1%	25%	507,591	495,269	(12,322)
Travel - Mileage	13,717	29,915	16,198	120,775	-54%	11%	13,737	31,965	18,229
Travel - Other	26,085	18,750	(7,335)	75,000	39%	35%	14,604	19,486	4,882
Program	106,636	161,754	55,118	669,715	-34%	16%	101,332	165,740	64,409
Office	33,634	29,227	(4,407)	116,909	15%	29%	24,592	33,437	8,845
Computer Services	182,161	168,970	(13,191)	700,881	8%	26%	134,677	174,880	40,202
Telecommunications	74,214	75,826	1,612	303,304	-2%	24%	65,411	61,699	(3,713)
Program Promotion	37,331	40,973	3,641	167,223	-9%	22%	13,691	42,699	29,009
Facilities Expenses	198,044	198,750	706	795,000	0%	25%	204,755	200,087	(4,668)
Fees & Insurance	117,390	122,113	4,722	228,450	-4%	51%	96,297	131,774	35,477
Debt Management	115,225	115,225	0	460,900	0%	25%	115,225	115,225	0
Recoveries	(25,083)	(26,074)	(991)	(104,297)	-4%	24%	(25,584)	(17,102)	8,481
	$ 3,433,965	$ 3,670,318	$ 236,353	$ 14,507,543	-6%	24%	$ 3,138,518	$ 3,559,402	$ 420,884

Explanations will be provided for variances of 15% and $15,000 occurring in the first 6 months and variances of 10% and $10,000 occurring in the final 6 months

Notes to Financial Statements – March 2018

Reporting Period

The March 2018 financial reports include three months of financial results for Public Health and the following calendar programs; Healthy Babies & Children, Child Benefits Ontario Works, and Algoma CADAP programs. All other programs are reporting twelve month results from operations year ended March 31st, 2018.

Statement of Operations (see page 1)

Summary – Public Health and Non Public Health Programs

As of March 31st, 2018, Public Health programs are reporting a $150k positive variance.

Total Public Health Revenues are indicating a negative $86k variance. This is a result timing of receipts of Fees, Other Grants & Recoveries. Recoveries from Programs, Land Control Fees and Program Fees Immunization are driving this negative variance. APH typically captures the bulk of its fees between the spring and fall months.

There is a positive variance of $236k related to Total Public Health expenses being less than budgeted. Salary and Wages expense is driving this positive variance. A Communications Coordinator position was budgeted for the full calendar year. Recruitment for this position was completed at the end of April 2018 with an anticipated start date in May. Furthermore, due to recent changes in the Ontario Public Health Standards, Management is in the process of aligning resources according to the new Standards. In total, there are 2.5 Public Health FTE positions that have been budgeted but have yet to be filled. These positions will be filled once all internal staff moves have taken place. These vacancies are the primary contributor of the positive variance associated with Salary and Wages.

***NOTE**: On May 7th, 2018 Algoma Public Health received the 2018-19 Public Health funding approval letter from the Ministry of Health and Long-Term Care. APH will receive up to $214,000 in additional base funding and up to $227,700 in one-time funding for the 2018-19 funding year to support the provision of public health programs and services in the communities the Board serves. APH Public Health budget will be revised as of May 2018 as funding approval letters were received in May.*

Notes Continued…

One-time funding requests and approvals are summarized below:

One-Time Request	Amount BoH Requested ($)	2018 Approved Allocation ($)
Infectious Diseases: Legal Cost Policy Item	56,302	56,400
Smoke-Free Ontario Expanded Smoking Cessation Programming for Priority Populations	30,000	-
Public Health Inspector Practicum Program (2)	24,000	10,000
New Purpose-Built Vaccine Refrigerators	13,063	13,100
Mandatory Programs: Northeastern Collaboration/Shared Services Project (100%)*	134,651	141,700
Healthy Growth/School Health: School Vision Screening Assessment	6,500	6,500
Total One Time Funding	**264,516**	**227,700**

Note: * Submission was on behalf of the Northeastern Collaborative with funds to be proportionately shared

Community Health Calendar programs are operating within budget.

APH's Community Health Fiscal Programs are twelve months into the fiscal year.

Genetics Counseling is showing a negative $99k variance. APH management is utilizing deferred revenue associated with the program by increasing the program FTE compliment by 0.2; by Public Health increasing the charges associated with the Genetics program for general administration support to more accurately reflect actual usage; and by hiring the successful candidate for a retiring employee prior to the retirement date as a means of fostering training and mitigating risk to the program delivery.

The Community Mental Health and Community Alcohol and Drug Assessment LHIN funded programs end the fiscal year slightly under budget. This results in minimal funds to be returned to the Ministry.

All other Community Health Fiscal Programs operated within budget.

Notes Continued...

Public Health Revenue (see page 2)

Public Health funding revenues are showing a negative $86k variance.

The municipal levies are within budget.

Cost Shared Funding is within budget.

Fees, Other Grants & Recoveries are showing a negative variance of $82k. Recoveries from Programs are showing a negative $17k variance as a result of timing of fees received. Land Control Fees are showing a negative $34k variance. In addition, Program Fees Immunization is showing a $19k negative variance. APH typically captures the bulk of its fees between the spring and fall months.

Public Health Expenses (see page 3)

Salary & Wages
The $185k positive variance associated with Salary and Wages expense is a result of the time lag in filling vacant positions within the agency. Specifically, a Communications Coordinator position was budgeted for the full calendar year. Recruitment for this position was completed at the end of April 2018 with an anticipated start date in May. Furthermore, due to recent changes in the Ontario Public Health Standards, Management is in the process of aligning resources according to the new Standards. In total, there are 2.5 Public Health FTE positions that have been budgeted to but have yet to be filled. These positions will be filled once all internal staff moves have taken place.

Travel
Travel expense is indicating a positive $16k variance. As the year progresses this positive variance is expected to reduce.

Program
Program expense is indicating a positive $55k variance. This is a result of timing of expenses not yet incurred.

Computer Services
Computer Services is showing a negative $13k variance. As noted in the Board approved 2018 Operating Budget, APH is utilizing an additional MicroAge resource to help with IT requests. As projected, the size of the variance is decreasing relative to last month.

Financial Position - Balance Sheet (see page 7)

APH's liquidity position continues to be stable and the bank has been reconciled as of March 31st, 2018. Cash includes $525k in short-term investments.

Notes Continued…

Long-term debt of $5.41 million is held by TD Bank @ 1.95% for a 60 month term (amortization period of 180 months) and matures on September 1, 2021. $316k of the loan relates to the financing of the Elliot Lake office renovations with the balance related to the financing of the 294 Willow Avenue facility located in Sault Ste. Marie.

There are no material collection concerns for accounts receivable.

Algoma Public Health

Statement of Financial Position

(Unaudited)

Date: As of March 2018	**March 2018**	December 2017
Assets		
Current		
Cash & Investments	$ **2,931,427**	$ 2,931,699
Accounts Receivable	**367,993**	489,631
Receivable from Municipalities	**153,797**	30,769
Receivable from Province of Ontario		
Subtotal Current Assets	**3,453,217**	3,452,099
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,656,996**	1,436,721
Payable to Gov't of Ont/Municipalities	**193,960**	543,083
Deferred Revenue	**549,237**	512,747
Employee Future Benefit Obligations	**2,704,275**	2,704,275
Term Loan	**5,554,992**	5,554,992
Subtotal Current Liabilities	**10,659,460**	10,751,817
Net Debt	**-7,206,243**	-7,299,718
Non-Financial Assets:		
Building	**22,732,421**	22,732,421
Furniture & Fixtures	**1,911,323**	1,911,323
Leasehold Improvements	**1,572,807**	1,572,807
IT	**3,244,030**	3,244,030
Automobile	**40,113**	40,113
Accumulated Depreciation	**-8,586,824**	-8,586,824
Subtotal Non-Financial Assets	**20,913,869**	20,913,869
Accumulated Surplus	**13,707,626**	13,614,152

Peterborough Public Health

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

April 23, 2018

The Honourable Jody Wilson-Raybould
Minister of Justice
House of Commons
Ottawa, ON K1A 0A6
Jody.Wilson-Raybould@parl.gc.ca

Dear Ms. Jody Wilson-Raybould,

Re: Repeal of Section 43 of the Criminal Code of Canada

In December 2015, Senator Celine Hervieux-Payette introduced Bill S-206 to the Senate calling for the repeal of Section 43 of the Criminal Code of Canada. Today, Bill S-206 is still only at second reading. At its meeting on March 14th, 2018, the Board of Health for Peterborough Public Health (PPH) endorsed the motion by the Haliburton, Kawartha, Pine Ridge District Health Unit to repeal Section 43, which has been enclosed for your reference. PPH believes that physical punishment is neither appropriate nor effective. The goal of the Ontario Standards for Public Health Programs and Services (2017) Healthy Growth and Development Standard is to achieve optimal maternal, newborn, child and youth and family health. Section 43 of the Criminal Code of Canada justifies physical punishment of children thereby conflicting with the beliefs and mandate of PPH.

There is substantial research demonstrating that physical punishment can cause great harm and is an ineffective method of changing children's behavior. The research has demonstrated that in addition to increases in aggressive behaviour in children physical punishment has been associated with an increase in mental health problems into adulthood, impaired parent–child relationships, poorer cognitive development and academic achievement, delinquent behaviour and criminal behaviour in adulthood.

The repeal of Section 43 would acknowledge the many calls for action from government committees, individual Members of Parliament, children's services providers, professional organizations as well as the Truth and Reconciliation Commission of Canada. It will bring Canada into compliance with the United Nations Convention on the Rights of the Child, a Convention Canada ratified in 1991.

The repeal will also send a clear message that the use of physical punishment is not acceptable in a society that values its children. Children are one of our most vulnerable populations and need to be protected. Therefore, Peterborough Public Health urges you to support the repeal of Section 43 and to advocate for its immediate passage.

Yours in health,

Original signed by

Councillor Henry Clarke
Chair, Board of Health

/ag
Encl.

cc: The Right Hon. Justin Trudeau, Prime Minister of Canada
Local Members of Parliament
Local Members of Provincial Parliament
Local Government Councils
Local Boards of Education
Local Children's Planning Tables
Association of Local Public Health Agencies
Ontario Boards of Health

RESOLUTION #2017-03

Board of Health, Haliburton, Kawartha, Pine Ridge District Health Unit

December 7, 2017

Repeal of Section 43 of the Criminal Code Refresh 2017

WHEREAS, research indicates that physical punishment is harmful to children and youth and is ineffective as discipline; and

WHEREAS, the goal of the Ontario Public Health Standards (OPHS) Child Health Program (2008) is to enable all children to attain and sustain optimal health and developmental potential and of the draft Ontario Standards for Public Health Programs and Services (2017) Healthy Growth and Development Standard is to achieve optimal maternal, newborn, child, youth, and family health; and

WHEREAS, Section 43 of the Criminal Code of Canada justifies the use of physical punishment of children between the ages of 2 and 12; and

WHEREAS, the Ontario Public Health Association (OPHA) supports the repeal of Section 43 of the Criminal Code of Canada, as repeal would provide children the same protection from physical assault as that given to adults; and

WHEREAS, over 550 organizations in Canada, including the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit (in 2006) and the City of Kawartha Lakes, have endorsed the *Joint Statement on Physical Punishment of Children and Youth;* and

WHEREAS, calls for the repeal of Section 43 of the Criminal Code of Canada have been made repeatedly for almost 40 years; and

WHEREAS, Prime Minister Justin Trudeau stated the Calls to Action of the Truth and Reconciliation Commission, which includes the repeal of Section 43, would be fully implemented;

THEREFORE BE IT RESOLVED that the Board of Health for the Haliburton, Kawartha, Pine Ridge District Health Unit support the repeal of Section 43 of the Criminal Code of Canada and write to the Minister of Justice indicating the Board's position and urging swift action on this matter;

BE IT FURTHER RESOLVED that copies of this resolution be sent to the Prime Minister, all local Members of Parliament, all local Members of Provincial Parliament, all Member Municipalities, all local Boards of Education, all Ontario Boards of Health, and all local children's planning tables for support.

Peterborough Public Health

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

May 3, 2018

Hon. Jeff Leal, MPP Peterborough
jleal.mpp.co@liberal.ola.org

Re: Youth Exposure to Smoking in Movies

Dear MPP Leal:

Movies are wildly popular with youth, influence youth behaviours, and are largely unregulated when it comes to depicting tobacco products. Due to increased regulations prohibiting the marketing and advertising of commercial tobacco in Ontario, tobacco companies have been forced to seek novel ways to promote their deadly products. Results of monitoring tobacco imagery in films show that smoking in movies has become more prevalent in recent years.

In an effort to protect youth and limit the tobacco industry's influence on them, the Board of Health for Peterborough Public Health recently endorsed the following policy directions:

- require strong anti-smoking ads prior to movies depicting commercial tobacco use;
- ensure films with tobacco imagery are ineligible for government film subsidies;
- eliminate identifying tobacco brands;
- certify no payoffs for displaying tobacco placements in movies; and
- rate all new movies with smoking in them, 18A.

Luk and Schwartz (2017) conclude that "rating new movies with smoking in them '18A' in Ontario, with the sole exceptions being when the tobacco presentation clearly and unambiguously reflects the dangers and consequences of tobacco use or is necessary to represent smoking of real historical figures" will:

- protect 185,000 children and teens aged 0-17 living in Ontario today from being recruited to cigarette smoking by their exposure to onscreen smoking;
- save at least $1.1 billion in healthcare costs attributed to their exposure to onscreen smoking; and
- prevent the premature smoking-related deaths of 59,000 people recruited to smoking by tobacco imagery in movies.[1]

We were recently encouraged by the updated *Smoke-Free Ontario Act* and subsequent regulations which no doubt will further protect Ontarians where they live work and play from the dangers of commercial tobacco. Your support towards the aforementioned recommendations would be as equally welcome as we know your government is committed to achieving the lowest smoking rates in the country.

We thank you in advance for considering our request for support, and for your commitment to protecting youth from the tobacco industry.

Yours in health,

Original signed by

Councillor Henry Clarke
Chair, Board of Health

/ag

cc: Association of Local Public Health Agencies
Ontario Boards of Health

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[1] Luk, R., & Schwartz, R. (July 2017). Youth Exposure to Tobacco in Movies in Ontario, Canada: 2004-2016. *The Ontario Research Unit.*

Peterborough Public Health

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May 3, 2018

Laurie Scott, MPP Haliburton-Kawartha Lakes-Brock
laurie.scott@pc.ola.org

Re: Youth Exposure to Smoking in Movies

Dear MPP Scott:

Movies are wildly popular with youth, influence youth behaviours, and are largely unregulated when it comes to depicting tobacco products. Due to increased regulations prohibiting the marketing and advertising of commercial tobacco in Ontario, tobacco companies have been forced to seek novel ways to promote their deadly products. Results of monitoring tobacco imagery in films show that smoking in movies has become more prevalent in recent years.

In an effort to protect youth and limit the tobacco industry's influence on them, the Board of Health for Peterborough Public Health recently endorsed the following policy directions:

- require strong anti-smoking ads prior to movies depicting commercial tobacco use;
- ensure films with tobacco imagery are ineligible for government film subsidies;
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Luk and Schwartz (2017) conclude that "rating new movies with smoking in them '18A' in Ontario, with the sole exceptions being when the tobacco presentation clearly and unambiguously reflects the dangers and consequences of tobacco use or is necessary to represent smoking of real historical figures" will:

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- save at least $1.1 billion in healthcare costs attributed to their exposure to onscreen smoking; and
- prevent the premature smoking-related deaths of 59,000 people recruited to smoking by tobacco imagery in movies.[1]

We were recently encouraged by the updated *Smoke-Free Ontario Act* and subsequent regulations which no doubt will further protect Ontarians where they live work and play from the dangers of commercial tobacco. Your support towards the aforementioned recommendations would be equally welcome.

We thank you in advance for considering our request for support, and for your commitment to protecting youth from the tobacco industry.

Yours in health,

Original signed by

Councillor Henry Clarke
Chair, Board of Health

/ag

cc: Association of Local Public Health Agencies
Ontario Boards of Health

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[1] Luk, R., & Schwartz, R. (July 2017). Youth Exposure to Tobacco in Movies in Ontario, Canada: 2004-2016. *The Ontario Research Unit.*

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May 3, 2018

Ontario Film Review Board
c/o Ontario Film Authority
4950 Yonge Street, Suite 101B
Toronto, ON M2N 6K1
OFRBinfo@ontariofilmauthority.ca

Re: Youth Exposure to Smoking in Movies

Dear Ontario Film Review Board:

Movies are wildly popular with youth, influence youth behaviours, and are largely unregulated when it comes to depicting tobacco products. Due to increased regulations prohibiting the marketing and advertising of commercial tobacco in Ontario, tobacco companies have been forced to seek novel ways to promote their deadly products. Results of monitoring tobacco imagery in films show that smoking in movies has become more prevalent in recent years.

To raise awareness about this issue, Peterborough Public Health has been working with community partners who are concerned about the impact that movies have on the health and well-being of children and teens. As such, we recently collected 127 signatures from local residents who support increased regulations to protect kids and teens from smoking in movies.

The petition calls for the following policy directions:

- require strong anti-smoking ads prior to movies depicting commercial tobacco use;
- ensure films with tobacco imagery are ineligible for government film subsidies;
- eliminate identifying tobacco brands;
- certify no payoffs for displaying tobacco placements in movies; and
- rate all new movies with smoking in them, 18A.

Actors who smoke on screen make smoking tobacco products appear normal and give positive messages about smoking to young movie viewers. Typically movies fail to disclose the health effects related to smoking commercial tobacco. A number of studies have shown that smoking commercial tobacco in movies encourages adolescents to try smoking. The report *Youth Exposure to Tobacco in Movies in Ontario, Canada* concludes that adolescents' exposure to onscreen tobacco will result with an earlier onset of smoking initiation. Furthermore, of the 1,829 top movies released in Ontario from 2004-2016, 91% of these movies were youth rated, and 54% contained tobacco imagery.[1] Eighty-six percent of youth-rated top movies did not include an Ontario Film Review Board (OFRB) "tobacco use" content advisory.

Luk and Schwartz (2017) conclude that "rating new movies with smoking in them '18A' in Ontario, with the sole exceptions being when the tobacco presentation clearly and unambiguously reflects the dangers and consequences of tobacco use or is necessary to represent smoking of real historical figures" will:

- protect 185,000 children and teens aged 0-17 living in Ontario today from being recruited to cigarette smoking by their exposure to onscreen smoking;
- save at least $1.1 billion in healthcare costs attributed to their exposure to onscreen smoking; and
- prevent the premature smoking-related deaths of 59,000 people recruited to smoking by exposure to movies depicting tobacco imagery.[2]

Ontario has pledged to have the lowest smoking rates in the country. By simply changing the ratings for movies with smoking in them, you will be helping achieve this goal and protecting future generations from the leading cause of preventable death and disease in the province.

Yours in health,

Original signed by

Councillor Henry Clarke
Chair, Board of Health

/ag

cc: Association of Local Public Health Agencies
Ontario Boards of Health

[1] Luk, R., & Schwartz, R. (July 2017). Youth Exposure to Tobacco in Movies in Ontario, Canada: 2004-2016. *The Ontario Research Unit.*

[2] Ibid.

Ministry of Health and Long-Term Care

Office of the Minister

10th Floor, Hepburn Block
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Ministère de la Santé et des Soins de longue durée

Bureau du ministre

Édifice Hepburn, 10e étage
80, rue Grosvenor
Toronto ON M7A 2C4
Tél. 416 327-4300
Téléc. 416 326-1571
www.ontario.ca/sante

Ontario

May 3, 2018

Dear Colleagues,

Tobacco use remains Ontario's leading cause of preventable disease and premature death. It claims 16,000 lives each year — that is 44 lives every day — and costs the province $2.25 billion annually in direct health care costs.

Our government is committed to the people of Ontario to achieve the lowest smoking rate in Canada. We have supported more Ontarians in quitting tobacco use, protected people from exposure to second-hand smoke, encouraged youth and young adults to never start, and continued to address the changing landscape of new and emerging products.

Ontario has made great strides in reducing tobacco use and the associated health risks through investments in programs, policies and public education. Prior to the enactment of the Smoke-Free Ontario Act (SFOA) in 2006, Ontario had very few restrictions on where people could smoke tobacco. Since then, Ontario has created 100 per cent smoke-free enclosed public places and workplaces province-wide, including shopping malls, office buildings, factories, restaurants and bars. We are proud of the achievements made with our partners to reduce Ontario's smoking rate to 16 per cent in 2016.

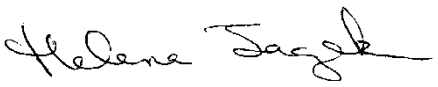
However, we have more work to do. We know that some communities experience the burden of tobacco disproportionately higher than other communities. We know that smoking rates are seven and three times higher, respectively, for on-reserve (30 per cent) and off-reserve (14 per cent) First Nation youth than in non-Indigenous youth (4 per cent) of the same age. We as a government are committed to working with Indigenous communities in a separate process to address the adverse effects of commercial tobacco.

I am pleased to launch the Smoke-Free Ontario (SFO) Strategy, the government's plan of action to further reduce the burden of tobacco addiction. Our vision is that within one generation, Ontario will be free of the epidemic of disease, death and other harms caused by tobacco, and the potential harms caused by smoking and vaping of other substances. We acknowledge that more needs to be done to reach our goal of reducing the smoking prevalence rate to 10 per cent by 2023. We know that new and emerging products may hinder the achievements Ontario has already made. That is why the government's SFO Strategy not only addresses tobacco, but also vapour products such as e-cigarettes and heat-not-burn products, and the smoking and vaping of medical cannabis. All of these products will be regulated under the Smoke-Free Ontario Act, 2017 (SFOA, 2017).

The Smoke-Free Ontario Strategy will create the right conditions for success and will include the development of a comprehensive evaluation plan to measure progress. We will continue to work with our health-care partners on our evolving strategy, including the members of the Executive Steering Committee, to implement recommendations from their report.

Working together, our new SFO Strategy will enable opportunities to reduce the harm of tobacco use and result in a healthier tomorrow for generations of Ontarians.

Sincerely,



Dr. Helena Jaczek,
Minister of Health and Long-Term Care

SMOKE-FREE ONTARIO

The Next Chapter - 2018

For a Healthier Ontario

TABLE OF CONTENTS

THE TOBACCO BURDEN

TOBACCO USE IS THE LEADING CAUSE OF PREVENTABLE DEATH AND DISEASE IN ONTARIO

Every day tobacco kills more Ontarians than alcohol, illicit substances, accidents, suicide and homicides combined. People who use tobacco are more likely to go to the hospital and stay longer. They are also likely to die younger. Tobacco products contain nicotine, which is a substance that makes them highly addictive.

Tobacco can be used in various ways, but smoking remains the most common method. Cigarette smoke contains more than 7,000 chemicals. It impacts almost every organ of the body, contributing to chronic diseases such as cancers, heart and lung diseases, and other diseases. Even people who do not smoke are affected by the health harms of tobacco through exposure to second-hand and/or third-hand smoke.

TOBACCO USE COSTS ONTARIO BILLIONS OF DOLLARS EACH YEAR

Over two billion dollars a year is spent by Ontario to treat and care for people with smoking-related health concerns. The provincial economy loses over five billion dollars a year in lost productivity or missed days of work because of smoking-related health issues. The overall costs of tobacco to society are even higher given how litter and smoke from tobacco affects the environment.

ONTARIO'S PROGRESS

The percentage of people who smoke in Ontario has decreased over the years. The provincial smoking rate is the third lowest in all of Canada with roughly one in five Ontarians who smoke. Over the past decade, Ontario has worked hard to reduce tobacco use in the province and has established itself as both a national and international leader in tobacco control. In 2005, the government created Smoke-Free Ontario encompassing Ontario's actions and investments in tobacco control, and combining evidence-based approaches to prevent children and young people from starting to smoke, helping Ontarians quit smoking and protecting Ontarians from exposure to second-hand smoke. Ontario's previous efforts, in partnership with Public Health Units, non-governmental organizations, health professionals and institutions, have provided people with the programs and services to live smoke-free.

Some key achievements of the programs and services that Ontario, together with its partners, has been able to deliver include helping people who smoke access:

- Counselling and supports in hospitals and community health care settings (e.g., family health teams, community health centres, etc.) to help quit smoking
- Phone counselling and online resources to help quit smoking
- No-cost nicotine replacement therapy in combination with counselling

THE SMOKE-FREE ONTARIO ACT

For over a decade, Ontario has been putting policies in place to reduce tobacco use in Ontario and these policies have provided the legislative force needed to further protect the health of Ontarians. The *Smoke-Free Ontario Act (SFOA)*, which came into force in 2006, is an example of ground-breaking legislation that helps to reduce access to tobacco products and to protect workers and the public from the hazards of second-hand smoke. The SFOA imposes strict controls on the sale of tobacco to young people, restricts the display and promotion of tobacco at point-of-sale, and prohibits smoking in enclosed workplaces and enclosed public places, as well as other designated places.

ONTARIO'S KEY TOBACCO CONTROL MILESTONES

2006

- Created *Smoke-Free Ontario Act (SFOA)* legislation to protect Ontarians from second-hand smoke
- Prohibited smoking in enclosed workplaces and enclosed public places

2009

- Protected children from exposure to second-hand smoke in motor vehicles

2010

- Prohibited the sale of most flavoured cigarillos and required that they be sold in packages of 20 or more

2015

- Prohibited smoking on patios, playgrounds and sports fields
- Created *Electronic Cigarettes Act (ECA)* legislation to regulate vapour products

2016

- Protected children from flavoured tobacco products
- Doubled the maximum fines for youth-related offences
- Prohibited indoor use of tobacco in waterpipe bars and restaurants
- Expanded outdoor smoke-free spaces (hospitals, psychiatric facilities, buildings owned by Province)

2017

- Prohibited the sale of menthol and clove-flavoured tobacco products

2018

- Implemented 100 per cent smoke-free hospitals
- Enacted *Smoke-Free Ontario Act (SFOA), 2017* to protect people from second-hand smoke and vapour
- Developed Smoke-Free Ontario Strategy

SMOKING RATES HAVE DECREASED IN ONTARIO FROM 24.5% IN 2000 TO 16% IN 2016

Note: Smoking data is from Statistics Canada's Canadian Community Health Survey (CCHS). In 2014, CCHS redesigned its data collection methodology; therefore, 2016 data is not directly comparable to previous years.

THE IMPERATIVE

Combatting tobacco use remains a significant challenge in Ontario. Despite widespread public knowledge about the harms of tobacco, and the significant investments in tobacco control by Ontario and its partners, the smoking rate has plateaued in recent years. Approximately two million Ontarians currently smoke and some groups — such as rural, LGBTQ and Indigenous communities, Northern Ontario residents and people of low socio-economic status — continue to have higher smoking rates than the provincial average. This speaks to complex underlying drivers making the issue challenging to solve.

Most people who smoke want to quit. Over a million Ontarians intend to quit each year, but only a small number of them are successful. Nicotine is highly addictive and it can take up to 30 quit attempts to be successful.

Ontario is committed to having the lowest smoking prevalence rate in Canada, but Ontarians face a number of barriers. Current challenges include gaps in service among a number of existing programs and services. In addition, there are gaps in existing e-cigarettes legislation and a lack of controls to protect Ontarians from the potentially harmful effects of second-hand smoke and vapour from medical cannabis.

A CHANGING LANDSCAPE IN ONTARIO: NEW AND EMERGING PRODUCTS

Electronic cigarettes (also called e-cigarettes) have become widely available and are growing in popularity, especially among youth and young adults. E-cigarettes are battery-operated devices that heat an internal fluid, generating a vapour that the user inhales. Evidence on the risks and benefits of e-cigarettes is still emerging. The risks of exposure to e-cigarettes' second-hand vapour are uncertain at this time. As a result, Ontario will continue to take a precautionary approach on the sale, supply, display, promotion and use of e-cigarettes.

MEDICAL CANNABIS

Unlike recreational cannabis, medical cannabis is used for its therapeutic benefits. Therefore, it will continue to be treated differently from recreational cannabis, which is addressed under the *Cannabis Act, 2017*. A primary concern of the government is to protect everyone from the potentially harmful effects of medical cannabis second-hand smoke and vapour.

SMOKE-FREE ONTARIO STRATEGY: ROADMAP TO SUCCESS

MOVING FORWARD

The Ontario government has developed a strategy to address the harms of tobacco smoke and vapour in a coordinated and comprehensive way. The Smoke-Free Ontario (SFO) Strategy will build on many of the existing programs, services and policies and add to this force through new strategic investments. The SFO Strategy will leverage efforts across the three strategic priorities of tobacco control (cessation, prevention, and protection) to address:

- gaps in current tobacco control infrastructure
- accessibility of tobacco products and vapour products
- demand for tobacco created by addiction, social acceptability and other factors
- potential health risks of new and emerging tobacco and vapour products, including e-cigarettes and heat-not-burn products
- minimizing exposure to second-hand smoke and vapour from tobacco, vapour products and medical cannabis

Across each strategic priority, the goal is to influence change at three different levels to ensure integration and comprehensiveness:

- individual and community-level (e.g., at-risk populations)
- program and service-level
- system-level (e.g., policy, legislation and regulations)

INDIVIDUALS

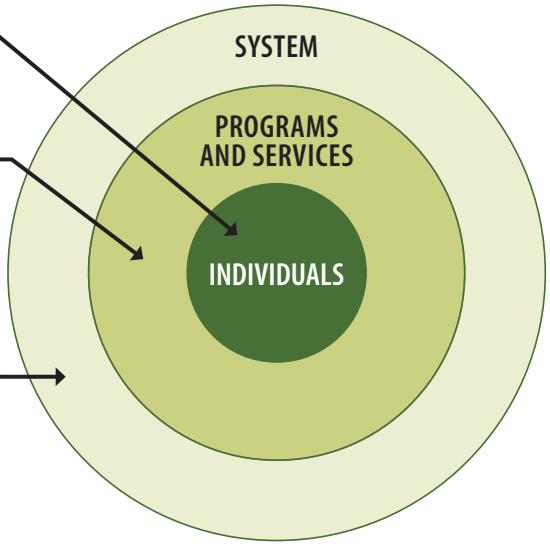
- TOBACCO USERS, FAMILY AND FRIENDS
- YOUTH AND YOUNG ADULTS
- INDIGENOUS AND OTHER PRIORITY POPULATIONS

PROGRAMS AND SERVICES

- INTEGRATED SMOKING CESSATION DELIVERY SYSTEM
- PREVENTION PROGRAMMING IN SCHOOLS, WORKPLACES AND COMMUNITY SETTINGS
- PUBLIC EDUCATION AND OUTREACH

SYSTEM

- LEGISLATIVE AND REGULATORY FRAMEWORK TO PROTECT AND PROMOTE THE HEALTH OF THE PEOPLE OF ONTARIO (*SMOKE-FREE ONTARIO ACT, 2017*)
- SURVEILLANCE AND MONITORING SYSTEM
- RESEARCH AND EVALUATION



Helping people who use tobacco to quit requires leadership across the country. Through the SFO Strategy, Ontario will continue to work collaboratively with provincial, federal and territorial partners to reach priority populations, and both develop and implement tobacco control solutions that meet the needs of Ontarians.

Ontario has a vision: that within one generation, Ontario will be free of the epidemic of disease, death and other harms caused by tobacco, and the potential harms caused by smoking and vaping of other substances.

To achieve this, Ontario's goals are to:

- Reduce the proportion of people who smoke in Ontario to 10 per cent by 2023
- Reduce exposure to the harmful effects of tobacco and the potentially harmful effects of other inhaled substances and emerging products (including medical cannabis)
- Reduce smoking-related health and social costs
- Reduce the number of smoking-related deaths by 5,000 each year

To meet these goals, the SFO Strategy focuses on the three strategic priorities of tobacco control: cessation, prevention and protection. The SFO Strategy sets out to:

- Increase the number of people who successfully quit using tobacco
- Prevent the initial and increased use of tobacco and vapour products
- Implement policies that reduce exposure to second-hand smoke and vapour; and explore opportunities to reduce the sale, supply and demand for tobacco and vapour products

STRATEGIC PRIORITIES

CESSATION

Goal

Increase the number of people who successfully quit using tobacco by 80,000 each year.

Approach

Individual: Motivate people who use tobacco to quit and increase their awareness of the cessation supports available.

Programs and Services: Create an integrated smoking cessation delivery system that increases the reach, access and availability of cessation aids and meets the needs of people who use tobacco in Ontario.

System: Create supportive environments through tax, pricing and smoke-free policies to motivate people who use tobacco to quit.

ACTIONS

1 ONTARIO WILL PROVIDE ACCESS TO QUALITY CESSATION SERVICES THROUGH ONE WINDOW

The government will implement an integrated smoking cessation delivery system, which will serve as a coordinated system of services to support people throughout their journey to quitting, eliminate duplication and effectively use resources.

The integrated delivery system will ensure coordination among health care, community and population-based services, and provide systematic referrals to ensure seamless services, supports and follow up for people who use tobacco and want to quit. The government will help people who are looking to quit access treatment efficiently and effectively. This includes:

- an easily recognized brand for all cessation services
- an online cessation hub
- 24/7 provincial quitline with wrap-around services (by telephone and online)

2 ONTARIO WILL ENSURE EVIDENCE-BASED SMOKING CESSATION SERVICES ARE IMPLEMENTED IN PUBLIC HOSPITALS AND IN COMMUNITY SETTINGS

Smoking cessation is a critical element of chronic disease management. Therefore, the government is leveraging its network of health system partners so that people who use tobacco are offered high-quality support with smoking cessation. A systematic approach to cessation services will be used across the continuum of care including prevention, primary care, acute care, rehabilitation, chronic care, home care and palliative care to ensure access is universal. Working with health care providers and community partners, the government will ensure evidence-based smoking cessation services in public hospitals and communities across the province to create an integrated smoking cessation delivery system.

SFO STRATEGY IN ACTION:

The Ottawa Model for Smoking Cessation (OMSC) is achieving organizational change in cessation within various clinical settings by changing practices within hospitals, primary care and mental health facilities, and embedding evidence-based cessation services into care pathways and other related patient care processes.

3 ONTARIO WILL ENSURE PEOPLE RECEIVE CONSISTENT, HIGH-QUALITY CESSATION SERVICES

People who smoke often need supports to successfully quit. To assist these people, the government will work with partners to develop and implement quality guidelines for health service providers to ensure that smoking cessation services are part of routine health care. A standardized approach to cessation in health care settings will ensure that all Ontarians receive consistent and effective care. The government, with its partners, will ensure that cessation service providers receive evidence-based training so that services that help achieve smoking quits are accessible to all Ontarians.

SFO STRATEGY IN ACTION:
The Centre for Addiction and Mental Health (CAMH)

Smoking Treatment for Ontario Patients (STOP) study, now a program, started in 2006. Since then, it has been building partnerships with other Smoke-Free Ontario-funded organizations, and engaging and helping over 100,000 people who smoke make a quit attempt. STOP has been implemented in Ontario's Family Health Teams, Community Health Centres, Aboriginal Health Access Centres, Public Health Units, Addiction Agencies and other health sectors, ensuring people who use tobacco have access to tobacco dependence treatment including no-cost nicotine replacement therapy.

4 ONTARIO WILL INCREASE ACCESS TO CESSATION AIDS

To help Ontarians quit smoking, the government is increasing access to no-cost nicotine replacement therapy (NRT). The government will work with delivery partners and health care providers across the province to reach more people who use tobacco by providing access to smoking cessation interventions including enhanced access to NRT in combination with counselling support. In a phased approach, the government will increase access to no-cost NRT in public hospitals and communities as part of a cessation system, and to Ontarians who are interested in quitting smoking.

5 ONTARIO WILL OFFER MORE INTENSIVE SUPPORTS FOR PRIORITY POPULATIONS

It is important that the right supports are provided to populations with high smoking rates. Populations at higher risk for tobacco use may require tailored and more intensive supports.

Indigenous communities, particularly First Nations living on-reserve, are an example of a priority population experiencing higher prevalence rates for commercial tobacco use. The government is committed to working with Indigenous communities to improve access to culturally appropriate cessation services. The government will also work with community service providers to reach other priority populations at the local level (e.g., new immigrants, rural communities). In addition, the government will maintain its focus on supporting equitable access to cessation programs by continuing to partner with organizations and agencies in the community to deliver cessation services in French.

EXAMPLE PRIORITY POPULATIONS

- Indigenous Peoples
- people with chronic diseases or a number of serious health problems
- people with mental health and addiction issues
- people who work in the industrial and service sectors
- young adults
- people who are at high risk of poor health outcomes from smoking (e.g., people in hospital) and people whose smoking will have a negative impact on their own or others' health (e.g., pre and postnatal women)
- cancer patients

> **"ONTARIO IS COMMITTED TO ITS GOAL OF HAVING THE LOWEST SMOKING RATE IN CANADA...TOBACCO TAXES ARE CRITICAL IN SUPPORTING PROVINCIAL HEALTH OBJECTIVES, SMOKING CESSATION AND PREVENTION."**
> 2018 ONTARIO BUDGET

6 ONTARIO WILL INSPIRE PEOPLE TO QUIT

Public education on the health harms and the benefits of quitting can help increase the attempts to quit by people who use tobacco. The government will run targeted public education campaigns to inform Ontarians about better access to smoking cessation support and services, and will also continue to run a cessation campaign indicating that setbacks are a natural part of the quitting journey. Reframing failure this way can have a positive impact on quit intentions and attitudes towards quitting, and help motivate smokers to quit.

7 ONTARIO WILL EXPLORE INCREASING THE TOBACCO TAX RATE

Through the Ontario 2018 Budget, the government increased tobacco taxes by $4 a carton of cigarettes and will again in 2019. This will bring Ontario's rate closer to the national average.

Research shows that a 10 per cent increase in total tobacco price would result in an approximate four (4) per cent reduction in cigarette demand. Tobacco tax increases will help support smoking cessation efforts under the SFO Strategy by motivating smokers to quit.

STRATEGIC PRIORITIES

PREVENTION

Goal

Prevent the initial and increased use of tobacco and vapour products such that no more than 10,000 people start smoking each year.

Approach

Individual: Develop actionable knowledge, skills and resiliency in youth and young adults so they can be smoke- and vapour-free.

Programs and Services: Partner on initiatives targeting youth and young adults in schools, workplaces and community settings to reduce social exposure to the use of tobacco and vapour products.

System: Implement a cohesive approach to reducing access and social exposure to tobacco and vapour products by building supportive environments through tax, pricing and other policies.

ACTIONS

1 ONTARIO WILL FOCUS ON THOSE MOST AT RISK WITH TAILORED SUPPORT

Ontario will align with the federal government's tobacco control strategy to place an emphasis on reaching specific high-risk populations. Those at greater risk for starting to use tobacco include Indigenous youth and young adults, and those transitioning into post-secondary education, or into the workforce. Peer pressure and elevated mental health stressors as well as risks at different life stages can also increase people's risk of using tobacco. The government will work with Public Health Units (PHUs) to reduce tobacco use at the local level. In addition, the government will provide guidance, resources and support to help PHUs implement effective prevention interventions with priority populations in their communities. The government will work with Indigenous communities to develop and implement culturally appropriate prevention interventions to reduce uptake of commercial tobacco, while respecting traditional practices.

SFO STRATEGY IN ACTION:

The ministry partners with Aboriginal Health Access Centres (AHAC) to provide culturally appropriate health promotion and chronic disease prevention initiatives in schools and in community organizations that focus on tobacco prevention, tobacco cessation and other chronic disease risk factors.

The Ontario Federation of Indigenous Friendship Centres delivers smoking prevention and cessation supports through the Urban Aboriginal Healthy Living Program.

The Aboriginal Tobacco Program (ATP) delivers tailored campaigns and workshops to Indigenous communities on commercial tobacco prevention, cessation and protection to reduce the high smoking rates. The ATP builds capacity towards Tobacco-Wise communities that are empowered to make the necessary changes to protect their well-being and that of their friends and community.

2 ONTARIO WILL RAISE AWARENESS OF PREVENTION

The government will run targeted public education campaigns to inform Ontarians about new vaping and smoking rules as part of efforts to prevent youth and young adults from taking up smoking and vaping. The government will also continue to work with community partners to educate youth and young adults in schools so they can remain smoke- and vapour-free. Ontario will support communication efforts that raise awareness on tobacco as a risk factor for serious diseases. In addition, Ontario will work with partners to educate Ontarians and significantly impact the burden of tobacco through prevention. This approach will align with the federal government's effort to promote healthy living and prevent chronic disease caused by risk factors such as tobacco.

3 ONTARIO WILL KEEP OUR YOUTH AND YOUNG ADULTS SAFE FROM TOBACCO AND VAPOUR PRODUCTS

The accessibility of tobacco products and vapour products influences youth and young adults' attitudes towards the use of these products and their susceptibility to smoking.

Ontario is strengthening the laws with respect to how tobacco and vapour products can be displayed and promoted in stores. The new law prohibits branded accessories (e.g., lighters) from being displayed in all stores. The new law also restricts specialty tobacco and vapour product stores from displaying products that are visible to the public from outside the store and prohibits anyone less than 19 years of age from entering these stores. By prohibiting the sale of tobacco products and e-cigarettes to anyone less than 19 years of age and by limiting exposure to these products, the government is helping to discourage youth and young adults from starting to use tobacco and vapour products.

DID YOU KNOW?

Evidence shows that almost 90 per cent of adults who ever smoked daily (aged 30–39) reported trying their first cigarette by the time they were 18 years old — and nearly two-thirds of them began smoking daily by this age.

STRATEGIC PRIORITIES

PROTECTION

Goal

Implement policies that reduce exposure to second-hand smoke and vapour.

Approach

Individual: Protect people from exposure to second-hand smoke and vapour.

Programs and Services: Build training capacity for tobacco inspectors and enforcement managers, as well as enforcement of an expanded legislative and regulatory framework.

System: Create and support adoption of smoke- and vapour-free environments to protect people from the harmful effects of tobacco smoke and the potentially harmful effects of vapour.

ACTIONS

1 ONTARIO WILL CLOSE THE GAPS ON TOBACCO AND VAPOUR PRODUCT LAWS

The market landscape of new and emerging tobacco and vapour products continues to evolve rapidly. Ontario is responding by strengthening existing smoking and vaping laws to protect people from exposure to tobacco smoke and vapour products. The new *Smoke-Free Ontario Act, 2017* (SFOA, 2017), which will come into force July 1, 2018, will replace both the previous *Smoke-Free Ontario Act* (SFOA) and the *Electronic Cigarettes Act, 2015* (ECA) with a single legislative framework. A single law will make it clearer for both the public and retailers to understand and comply with Ontario's rules related to the sale, supply, display, promotion and use of tobacco and vapour products. The new Act also regulates the smoking and vaping of medical cannabis and will provide clarity to medical cannabis users on where they can smoke and vape their medical cannabis.

The SFOA, 2017 also provides additional flexibility to add other products or substances in the future that will be subject to the Act's restrictions on the sale, supply, display, promotion and use.

2 ONTARIO WILL CREATE MORE SMOKE- AND VAPOUR-FREE SPACES

Prohibiting the smoking of tobacco in more outdoor areas can help people who smoke to smoke less. It can also prompt people to consider quitting, and if they have quit, or are trying to quit, this can help them stay on track by reducing visual cues for smoking. It also protects other Ontarians from exposure to second-hand smoke.

Under the new law, the use of an e-cigarette and the smoking and vaping of medical cannabis would be prohibited in the same places where the smoking of tobacco is currently prohibited. The law also expands smoke- and vapour-free areas around outdoor restaurants and bar patios, and areas around schools and children and youth recreational facilities.

3 ONTARIO WILL GIVE OUR FRONT-LINE PARTNERS THE TOOLS THEY NEED

Ontario will continue to align with the federal government's efforts to combat the unregulated tobacco market. Ontario will also leverage partnerships with tobacco authorities at all levels to implement activities, including policy and surveillance interventions, to monitor and reduce the availability of unregulated tobacco.

To optimize oversight of unregulated tobacco in retail locations, Ontario will collaborate across all levels of government on joint inspections and enforcement. This cooperative approach will leverage existing resources and enhance coordination and effectiveness of inspection activities to address non-compliance under both the *Tobacco Tax Act* and the *Smoke-Free Ontario Act, 2017* (SFOA, 2017).

In addition, the government will continue to support provincial and federal policies to regulate the manufacturing, sale, labelling and promotion of tobacco products to reduce the health consequences of tobacco use. The government will enhance Public Health Unit front-line compliance and enforcement knowledge and expertise by aligning training for inspectors and enforcement managers with common foundational training delivered across Ontario's regulatory and compliance ministries, agencies and other authorities. This model supports a modern compliance approach by providing the Public Health Units' tobacco inspectorate with greater access to resources, knowledge and expertise, training and best practices from across organizations.

POTENTIAL FUTURE CONSIDERATIONS

Even as this report is being written, new evidence on tobacco and vapour products is emerging. As the SFO Strategy is being implemented, the government will continue to work with scientific experts, as well as tobacco control and health service partners, to monitor the evidence, and to identify opportunities to implement effective initiatives to impact the burden of tobacco.

1 ONTARIO WILL EXPLORE WAYS TO REDUCE THE AVAILABILITY OF TOBACCO PRODUCTS

Evidence shows that when tobacco is harder to obtain, fewer people start smoking. Distancing points of sale of tobacco from where children and youth congregate, and other priority locations, make these products less available to priority populations.

The government will explore options to reduce the availability of tobacco products sold at retail locations in the province (e.g., retail density and zoning restrictions).

2 ONTARIO WILL EXPLORE OPPORTUNITIES TO FURTHER EXPAND SMOKE- AND VAPOUR-FREE POLICIES

When people are exposed to others using tobacco or vapour products it not only has health impacts from second-hand smoke or vapour, but it creates the impression that the use of tobacco and vapour products is common and socially acceptable. Limiting exposure to second-hand smoke and vapour and changing perceived norms on smoking can reduce the demand for these products.

The government will work with community partners to explore additional policies to create more smoke- and vapour-free public spaces and reduce social cues to smoking and vaping (e.g., smoke and vapour-free post-secondary campuses, outdoor workplace smoking policies).

3 ONTARIO WILL EXPLORE MEASURES TO INCREASE TRANSPARENCY

The government will explore approaches to increase transparency and disclosure of industry practices to ensure health tobacco policies are created in the best interest of Ontarians.

ENABLING SUCCESS

The government believes that activities that extend across all areas of focus are critical to helping the SFO Strategy achieve its goals.

ONTARIO WILL PRIORITIZE A RESEARCH AND EVIDENCE-BASED APPROACH

Ontario will align itself with the federal government's evidence-based approach, by utilizing data from a variety of sources including surveillance, research and evaluation. Ontario is committed to supporting evidence that contributes to effective tobacco control by developing a coordinated research agenda that is responsive to emerging issues and relevant to the government, its partners and communities.

The province wants to get the most out of investments that make a difference in people's lives. The government is committed to funding programs based on evidence, and will encourage partners to work together towards implementing interventions that work and have a positive impact.

SFO STRATEGY IN ACTION:

The government invests in tobacco control research as part of the **Health System Research Fund (HSRF)**. A number of tobacco research projects on various topics to inform tobacco policy, program development and strategic planning going forward are currently being funded.

ONTARIO WILL BUILD CAPACITY IN THE COMMUNITY

The government will help strengthen the ability of the public health system by providing leadership to build competency in the field. Community development through training and public education and awareness will be supported.

TRACKING OUR PROGRESS

ONTARIO WILL TRACK PROGRESS AND REPORT BACK ON SUCCESS

To ensure that the SFO Strategy is meeting its goals, the government will look at the current state and assess the gaps to achieving its target (reducing the proportion of people who smoke to 10 per cent). Ontario will work with partners to build a comprehensive data backbone to provide a clearer picture of the impacts being made. It will work with partners to organize all the important indicators from different sources into a coordinated system and plan how best to measure progress.

The government will work with internal and external partners to find new measures to strengthen the database, and enhance existing internal data collection systems to monitor trends and address gaps and needs.

SFO STRATEGY IN ACTION:

The Tobacco Inspection System (TIS) is a data collection system that is currently used to collect inspection data for compliance with the SFOA and ECA. Building off TIS and developing system enhancements will provide a platform for standardized reporting and monitoring of key performance indicators.

Ontario will track population health measures related to smoking and vaping that are available, including:

- exposure to second-hand smoke and vapour
- locations of second-hand smoke exposure
- smoking-related deaths in non-smokers
- smoking and vaping use
- smoking-related mortality

- Quitting rates across the province and by different groups of people (e.g., different age groups, priority populations)
- Quit attempts across the province and by different groups of people (e.g., different age groups, priority populations)

To ensure transparency and accountability, the government will report on progress annually and provide context for the data to support evidence-based public health decisions.

ONTARIO WILL EVALUATE THE SFO STRATEGY'S PERFORMANCE AND LOOK FOR WAYS TO IMPROVE OUTCOMES

The government is committed to evaluating the SFO Strategy's programs and policies to allow for continual improvements, insight and information sharing, and to identify what is working and making a positive difference.

In an ever-changing environment, new opportunities will arise and Ontario may also face unexpected challenges. Regular and meaningful evaluations of the SFO Strategy's activities will be key to uncovering opportunities and identifying successful investments.

The government will develop an evaluation plan that focuses on actionable measures of the SFO Strategy's programs and services such as:

- Who is being reached?
- Are the programs, services and policies doing what they are intended to do?
- Are we meeting the needs of both people who use tobacco and stakeholders?

CONCLUSION

The Smoke-Free Ontario Strategy reflects the government's commitment to reducing the burden of tobacco and vapour products in Ontario and moves the province one step closer to ending the epidemic of tobacco-related disease. The strategy continues to build on Ontario's momentum and enables Ontarians to live smoke- and vapour-free. The Smoke-Free Ontario Strategy is poised for success because of its ability to address both tobacco and vapour products in a coordinated way as well as its flexibility in addressing new products. Ontario will continue to leverage local and national partnerships to take on a complex and ever-changing issue with determination and confidence.

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Providing leadership in public health management

MEMO

To: Chairs and Members of Boards of Health
Medical Officers of Health
alPHa Board of Directors
Presidents of Affiliate Organizations

From: Loretta Ryan, Executive Director

Subject: ***alPHa Resolutions for Consideration at June 2018 Annual General Meeting***

Date: May 10, 2018

Please find enclosed a package of the resolutions to be considered at the Resolutions Session which takes place at the Novotel Toronto Centre Hotel, 45 The Esplanade, Toronto, Ontario, on June 11, 2018 from 8:00 to 10:00 AM as part of alPHa's 2018 Annual General Meeting (AGM).

These resolutions were received prior to the deadline for advance circulation. They have been reviewed and recommended by the alPHa Executive Committee to go forward for discussion at the AGM. (As of this writing, late resolutions were not received and are not included in this package. Late resolutions are indicated as such and not typically reviewed by the Executive Committee.)

Sponsors of resolutions should be prepared to have a delegate present to speak to their resolution(s) during the session.

IMPORTANT NOTE FOR LATE RESOLUTIONS:

Late resolutions (i.e. those brought to the floor) will be accepted, but please note that any late resolution must come from a Health Unit, the Board of Health Section, the Council of Medical Officers of Health, the Board of Directors or an Affiliate Member Organization of alPHa. They may not come from an individual acting alone.

To have a late resolution considered it must be first submitted in writing to an alPHa staff member **by 7:00 AM, Monday, June 11, 2018 (i.e. one hour before the start of the Resolutions Session)** so that it may be prepared for review by the membership. This includes a review by the Resolutions Chair appointed by the Executive Committee. The Chair will quickly review the resolution to determine whether it meets the criteria of a proposed resolution as per the "Procedural Guidelines for alPHa Resolutions" found at www.alphaweb.org/resolutions.asp. If the resolution meets these guidelines, it proceeds to the membership to vote on whether there is time to consider it. A successful vote will garner a 2/3 majority support. If this is attained, it will be displayed on the screen and read aloud by its sponsor followed by a discussion and vote.

Each late resolution will go through this process. We value timely and important resolutions and want to ensure that there is a process to consider them.

Cont'd

IMPORTANT NOTE FOR VOTING DELEGATES:

Members must register to vote at the Resolutions Session. A registration form is attached. Health Units must indicate who they are sending as voting delegates and which delegates will require a proxy vote. Only one proxy vote is allowed per person.

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/board of health.*

Delegates are asked to obtain their voting card and proxy (if applicable) from the registration desk during the conference. They will be asked to sign off verifying that they did indeed receive their card(s). This is done so that we have an accurate record of who was present and voted during the meeting.

To help us keep printing costs down, **please bring your enclosed copy of the resolutions with you** to the Resolutions Session.

Attached is a list describing the number of votes for which each Health Unit qualifies. Please note that we have updated this list based on population statistics taken from the 2011 Statistics Canada Census data "Census Profile".

If you have any questions on the above, please feel free to contact Susan Lee, Manager, Administrative and Association Services, at 416-595-0006 ext. 25 or via e-mail at susan@alphaweb.org

Enclosures:

- Resolutions Voting Registration Form
- Number of Resolutions Votes Eligible Per Health Unit
- June 2018 Resolutions for Consideration

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Providing leadership in public health management

2018 alPHa Resolutions Session
June 11, 2018 – 8:00 to 10:00 AM
Novotel Toronto Centre, 45 The Esplanade, Toronto, Ontario

REGISTRATION FORM FOR VOTING

Health Unit _____

Contact Person & Title _____

Phone Number & E-mail _____

Name(s) of Voting Delegate(s):

Name	**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.		

Email this form to *susan@alphaweb.org* on or before June 2, 2018

* 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.

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Number of Resolutions Votes Eligible Per Health Unit

HEATLH UNITS	*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	
Southwestern	
Wellington-Dufferin-Guelph	
POPULATION UNDER 200,000	**4**
Algoma	
Brant	
Chatham-Kent	
Grey Bruce	
Haldimand-Norfolk	
Haliburton, Kawartha, Pine-Ridge	
Hastings-Prince Edward	
Huron	
Lambton	
Leeds, Grenville and Lanark	
North Bay Parry Sound	
Northwestern	
Perth	
Peterborough	
Porcupine	
Renfrew	
Sudbury	
Thunder Bay	
Timiskaming	

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

Health Unit population statistics taken from: Statistics Canada. 2011 Census. *Census Profile.*

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Agencies

June 2018

RESOLUTIONS FOR CONSIDERATION

Resolutions Session, 2018 alPHa Annual General Meeting
Monday, June 11, 2018
Champagne Ballroom, 2nd Floor
Novotel Toronto Centre
45 The Esplanade
Toronto, Ontario

DRAFT RESOLUTIONS FOR CONSIDERATION
at June 2018 alPHa Annual General Meeting

DRAFT alPHa RESOLUTION A18-1

TITLE: **Sustainable Funding for Local Public Health in Ontario**

SPONSOR: **Peterborough Public Health**

WHEREAS it is widely recognized that public health interventions save lives and represent a significant return on investment and the goal of the Ministry of Health and Long-Term Care is a sustainable publicly funded health system that is based on helping people stay healthy, delivering good care when people need it, and protecting the health system for future generations; and further

WHEREAS the operation of boards of health (or local public health agencies) is governed by the Health Protection and Promotion Act (HPPA) which requires the obligated[1] municipalities to pay all related expenses and the Minister of Health to, under Section 76, "make grants for the purposes of this Act on such conditions as he or she considers appropriate", which since 2007, has been by policy defined at a ratio of 75:25 (provincial/municipal); and further

WHEREAS provincial funding for local public health in Ontario is achieved through a combination of cost-shared (Ministry of Health and Long-Term Care (MOHLTC) Grants and Municipal/First Nations contributions) and 100% Ministry (MOHLTC, Ministry of Child and Youth Services, Ministry of Community and Social Services) programs so that the cost-shared annual operating budget comprises a significant amount of the overall local public health budgets; and further

WHEREAS the funding challenges faced by local public health in recent years has included:

- a lack of annual increases (which has led to increased proportional funding from local partners and decreased provincial shares – Appendix A);
- insufficient ongoing provincial funding to fully implement both cost-shared and 100% provincially funded programs;
- application of a funding formula that has not been validated and lacks support from the field;
- funding approvals provided late in the fiscal year; and further

WHERAS that as funding shortfalls have grown, boards of health have been forced to reduce staffing levels and been unable to fulfill program requirements, despite the recent revision of program standards to provide a greater level of flexibility at the local level, putting communities at an increased risk of losing services and not achieving desired public health outcomes;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies' (alPHa) board and staff will make the long-term sustainable provincial funding for local boards of health a priority for advocacy and strategy development for its members, specifically that the following elements be addressed:

- alPHa continue to advocate for adequate levels of funding for all public health programs and a minimum commitment for a 75% provincial proportion for cost-shared programs to ensure the needs for the effective and optimal delivery of evidence informed and legislated interventions and services to promote or protect local public health are sustained;

- alPHa engage with other strategic and provincial partners, such as the Association of Municipalities of Ontario (AMO), the City of Toronto, the Ontario Public Health Association (OPHA), the Canadian Public Health Association (CPHA), the Association of Ontario Health Centres (AOHC) etc. to develop, implement, sustain and update as required an ongoing provincial campaign to identify and secure the real resource needs for an optimal local public health system in Ontario; and

- alPHa commission and share a position paper that explores, researches and reports on the evidence to support the local governance and delivery of public health services and the true funding requirements to ensure all communities, including First Nations whether in partnership with existing boards of health or in alternate models, are able to benefit fully from what public health has to offer.

[1] Obligated municipalities are defined by the HPPA to include any upper-tier or single-tier municipality that is situated, in whole or part, in the area that comprises the health unit, which is the geographic area on the jurisdiction of the local board of health. First Nations who enter into Section 50 agreements with boards of health attain the status of an obligated municipality.

Supplementary information attached (1 page)

APPENDIX A – MUNICIPAL/REGIONAL FUNDING FOR PUBLIC HEALTH

In 2016, an alPHa survey indicated the following distribution for municipal contributions for cost-shared programs:

Municipal/Regional Funding %	Public Health Units	
	Number	%
25% to 26%	8	27%
26% to 30%	9	30%
31% to 35%	7	23%
36% to 40%	4	13%
41% to 45%	2	7%
Totals	30	100%

DRAFT alPHa RESOLUTION A18-2

TITLE: **Public Health Support for a Minimum Wage that is a Living Wage**

SPONSOR: **Peterborough Public Health**

WHEREAS low income Ontarians are at higher risk of premature death and more likely to suffer more illnesses, even after controlling for factors including age, sex, race, smoking status, and place of residence; and

WHEREAS high income inequality leads to increased social problems, and poorer health of the population as a whole; and

WHEREAS based on the Canadian census Low-Income Measure, after tax (LIM-AT), the low-income rate in Ontario grew from 12.9% to 14.4% from 2005 to 2015, totalling 1,898,975 Ontarians living on low income; and

WHEREAS in contrast with other provinces where recent economic growth and average income increases grossly translated to gains for most families, income inequality in Ontario continues to grow; and

WHEREAS approximately one-third of Ontario workers earned less than $15 an hour in 2016, a rate lower than the calculated living wage in 2016 for the majority of communities throughout the province; and

WHEREAS nearly two-thirds of minimum wage workers in Ontario are adults supporting themselves and their families; and

WHEREAS there is an increasing trend for workers to be employed in precarious jobs with low wages, no benefits, and uncertainty in hours (scheduling) and tenure (longevity in position); and

WHEREAS recent legislative changes to minimum wage in Ontario (Bill 148) present a step in the right direction, current wage adjustments will not reach a level required to meet basic living needs in most Ontario communities; and

WHEREAS a living wage outlines the hourly rate at which a household, based on a family of four, can meet its basic needs based on the actual costs of living in a community, after factoring in both government transfers to families and deductions; and

WHEREAS a living wage affords individuals and families the opportunity to lift themselves out of poverty and provides a basic level of economic security; and

WHEREAS a living wage not only promotes a reduction in poverty, decreased income insecurity and improved health at individual and family levels, evidence also supports fiscal benefits to government and the economy; and

WHEREAS the Universal Declaration of Human Rights, Article 23, Section 3 states: "Everyone who works has the right to just and favourable remuneration ensuring for himself and his family an existence worthy of human dignity…", a living wage transcends simple public policy and addresses principles of justice and basic human rights;

NOW THEREFORE BE IT RESOLVED THAT the Association of Local Public Health Agencies (alPHa) endorse the principles encompassed in a living wage;

AND FURTHER that alPHa request that the provincial Government consider adopting a living wage perspective when setting future minimum wage rates to ensure that it covers the actual costs of living in most Ontario communities, as a way to reduce poverty and income insecurity and promote the health of Ontarians;

AND FURTHER that the Premier of Ontario, the Chief Medical Officer of Health for Ontario, the Ontario Public Health Association, the Association of Municipalities of Ontario, the Ontario Living Wage Network and Living Wage Canada be so advised.

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DRAFT alPHa RESOLUTION A18-3

TITLE: **Public Health's Role in Food Affordability Surveillance**

SPONSOR: **Ontario Dietitians in Public Health**
(Formerly Ontario Society of Nutrition Professionals in Public Health)

WHEREAS food insecurity is well documented as a determinant of health and impacts health equity[i]; and,

WHEREAS both the 2018 Provincial Budget (2018)and the Income Security: A Roadmap for Change report (October 2017) refer to the need for a "made-in-Ontario Market Basket Measure that could serve to inform future decisions about rate increases and reports to the income security system"[ii] ; and,

WHEREAS the cost of food is suggested as a component of a Market Basket Measure[iii] (pg. 71); and,

WHEREAS the Ministry of Health and Long-term Care's Population Health Assessment and Surveillance Protocol (2018)[iv] includes food affordability (as part of food environments) (pg. 9) as a category "of population health data that shall be used for population health assessment and surveillance to inform public health practice, programs and services" (pg. 8); and,

WHEREAS Registered Dietitians in local public health agencies across Ontario have led the collection of Nutritious Food Basket data, based on the National Nutritious Food Basket and the previous Nutritious Food Basket Protocol (2014), and dissemination of results which have repeatedly and consistently shown when combined with housing costs that many types of income sources are inadequate; and,

WHEREAS the 2016 Annual Report of the Chief Medical Officer of Health, Improving the Odds: Championing Health Equity in Ontario, makes the case that public health units have the expertise and interconnectivity to champion health equity at the local level and outlines the importance of data and evidence;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) call upon the Chief Medical Officer of Health of Ontario and the Ministers of Health and Long-Term Care and Community and Social Services, to confirm Public Health's role in the collection of food affordability data, and in formalizing the process to develop an Ontario Market Basket Measure.

[i] Tarasuk, V, Mitchell, A, Dachner, N. (2016). *Household food insecurity in Canada, 2014*.Toronto: Research to identify policy options to reduce food insecurity (PROOF).Retrieved from http://proof.utoronto.ca/
[ii] Sousa, C. Government of Ontario (2018) *A Plan for care and opportunity: 2018 Ontario Budget, Budget papers*. Retrieved from: http://budget.ontario.ca/2018/budget2018-en.pdf

[iii] Income Security: A Roadmap for Change (2017) Retrieved from: https://files.ontario.ca/income_security_-_a_roadmap_for_change-english-accessible_updated.pdf

[iv] Ministry of Health and Long-Term Care. Population and Public Health Division (2018) *Population Health Assessment and Surveillance Protocol, 2018.* Retrieved from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Population_Health_Assessment_Surveillance_2018_en.pdf

DRAFT alPHa RESOLUTION A18-4

TITLE: **Extending the Ontario Pregnancy and Breastfeeding Nutritional Allowance to 24 Months**

SPONSOR: **Elgin St. Thomas Public Health**

WHEREAS The global public health recommendation is for babies to be exclusively breastfed for the first six months of life and thereafter begin iron-rich foods while breastfeeding continues for two years and beyond; and

WHEREAS A key recommendation from the Ontario Healthy Kids Strategy is for children to be breastfed until age two to help protect against obesity; and

WHEREAS While most Ontario mothers plan to breastfeed and initiate breastfeeding, only about 33 percent exclusively breastfed their baby to six months in 2013/14 (Best Start, 2015); and

WHEREAS Ontario women living in neighbourhoods with lower median household incomes, lower levels of educational attainment, and higher levels of unemployment [including mothers receiving social assistance] are more likely to have lower rates of breastfeeding initiation and duration (Best Start, 2015); and

WHEREAS The Pregnancy and Breastfeeding Nutritional Allowance may only be paid to breastfeeding mothers receiving social assistance until the baby reaches 12 months of age; and

WHEREAS Mothers require healthy foods, extra fluids and calories while breastfeeding (American Academy of Pediatrics, 2012); and

WHEREAS There are numerous documented nutritional and child health benefits associated with breastfeeding beyond 12 months; and

WHEREAS There are multiple studies showing evidence that a mother's risk of breast cancer, ovarian cancer, osteoporosis and cardiac disease decrease the longer that they breastfeed; and

WHEREAS Increasing the number of women on social assistance that breastfeed beyond 12 months has the potential to reduce health disparities; and

WHEREAS The Southwestern Ontario Lactation Consultants Group believes that the Breastfeeding Nutritional Allowance should normalize breastfeeding to two years and beyond and align with global infant feeding guidelines;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) support the advocacy letter written by the Southwestern Ontario Lactation Consultants Group and call upon the Ministry of Community and Social Services to extend the Ontario Pregnancy and Breastfeeding Nutritional Allowance from 12 months to at least 24 months while breastfeeding.

Supplementary information attached (3 pages)

Ontario Ministry of Community and Social Services
80 Grosvenor St., Hepburn Block, 6th Floor
Toronto ON M7A 1E9

July 31, 2017

To Whom It May Concern,

We are writing this letter on behalf of the Southwestern Ontario Lactation Consultants Group with representation from Hospitals, Public Health Units, Private Practice Lactation Consultants and Breastfeeding Peer Support Leaders from the Southwest Region. It was recently brought to our attention that breastfeeding mothers can only receive the Pregnancy and Breastfeeding Nutritional Allowance until their baby is 12 months of age. We are formally requesting the Ministry of Community and Social Services extend the Pregnancy and Breastfeeding Nutritional Allowance until children are at least 2 years of age.

As a global public health recommendation, babies should be exclusively breastfed until 6 months of age. Thereafter it is recommended that they continue to breastfeed for up to two years and beyond with the addition of iron-rich complementary foods. (Health Canada, 2012; Pound, Unger, Canadian Paediatric Society & Nutrition and Gastroenterology Committee, 2012; World Health Organization [WHO] & United Nation Children's Fund [UNICEF], 2003). Despite this recommendation, the majority of Canadian mothers discontinue breastfeeding well before 2 years. In fact, Ontario women living in neighborhoods with lower median household incomes, lower levels of educational attainment, and higher levels of unemployment, are less likely to breastfeed exclusively at discharge from hospital (BORN, 2015) and are more likely to have lower rates of breastfeeding initiation and duration (Best Start Resource Centre, 2015).

Breastfeeding should be supported and promoted in these vulnerable populations, which include women who receive social assistance from Ontario Works or the Ontario Disability Support Program. A continued Breastfeeding Nutritional Allowance until children are at least 2 years of age would establish that the Ministry of Community and Social Services supports global infant feeding guidelines and would help to normalize breastfeeding to 2 years and beyond, regardless of income level. Furthermore, supporting women that receive social assistance to continue to breastfeed could potentially reduce health disparities because their families may experience some of the documented benefits of breastfeeding after 12 months of age.

Research conducted on toddlers who are breastfed indicates that there are many nutritional benefits associated with continued breastfeeding. Human milk expressed after one year of age has been found to have significantly more fat and energy content than earlier milk (Mandel, Lubetzky, Dollberg, Barak, & Mimouni, 2005). Human milk in the second year postpartum has also been shown to have substantial amounts of protein and most vitamins (Dewey, 2001).

Breastfeeding beyond 12 months has demonstrated many positive health effects for children and their mothers. Breastfeeding toddlers between the ages of 1 and 3 years have been found to have fewer illnesses, illnesses of shorter duration, and lower mortality rates (Molbak et al., 1994; van den Bogaard

et al., 1991; Gulick 1986). Children who are weaned from breastfeeding before 2 years of age are at a higher risk of illness (American Academy of Family Medicine, 2016). Recent research has also shown that human milk in the second year postpartum contains significantly higher concentrations of immune factors such as lactoferrin, lysozyme and Immunoglobulin A (Perrin, Fogleman, Newburg, & Allen, 2016). Additionally, there are multiple studies showing evidence that a mother's risk of breast cancer, ovarian cancer, osteoporosis and cardiac disease decrease the longer that they breastfeed their children.

In conclusion, support for women to continue breastfeeding for at least 2 years, particularly vulnerable populations receiving social assistance, is imperative. The numerous nutritional and health benefits of breastfeeding to 2 years and beyond cannot be denied. A small amount of continued financial support for breastfeeding women would not only help them to meet their caloric needs while breastfeeding, but would also support breastfeeding into toddlerhood as the normal way of feeding. The Southwestern Ontario Lactation Consultants group urges the Ministry of Community and Social Services to extend the Nutritional Allowance while mothers are breastfeeding until children are at least 2 years of age.

Sincerely,

Members of the Southwestern Ontario Lactation Consultants Group
c/o Jennifer Wyscaver, Public Health Nurse
Elgin St. Thomas Public Health

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DRAFT alPHa Resolution A18-5

TITLE: **A Comprehensive Approach to Infection Prevention and Control (IPAC) in Regulated Health Professional Settings**

SPONSOR: **Simcoe Muskoka District Health Unit**

WHEREAS comprehensive IPAC practices in regulated health professional workplaces are essential to prevent blood borne disease transmission; and

WHEREAS most regulated health professionals do not receive comprehensive training in IPAC during their professional training; and

WHEREAS the regulatory colleges of health professionals lack a provincially supported mandate to proactively audit IPAC practices or to investigate complaints of infection control lapses in the settings of their members; and

WHEREAS in 2015, the Ministry of Health and Long-Term Care amended the *Infection Prevention and Control (IPAC) Practices Complaints Protocol* and released the new *Infection Prevention and Control (IPAC) Lapse Disclosure* guidance document with a new requirement for Boards of Health to actively investigate public complaints related to IPAC in regulated health professional settings and to publically disclose on the findings; and

WHEREAS the number of IPAC complaints in regulated health professional settings has been increasing substantially since 2015;

WHEREAS boards of health have limited resources to investigate IPAC complaints in regulated health professional settings; and

WHEREAS regulated health professionals often question the expertise of Boards of Health when investigating IPAC complaints;

NOW THEREFORE BE IT RESOLVED THAT the Association of Local Public Health Agencies recommend to the Ontario Minister of Health and Long-Term Care and the Ontario Minister of Advanced Education and Skills Development that a legislative and policy framework be developed to achieve the following:

1) That regulated health professional training programs offered by Ontario colleges and universities contain comprehensive IPAC content within their curriculum; and
2) That the Ontario regulatory colleges of health professions implement continuous quality improvement with the routine inspection of their members' practice settings for adherence to IPAC best practices, and that they also provide a robust response in collaboration with local Boards of Health to IPAC complaints; and
3) That provincially recognized core competencies and qualification requirements be identified for local public health practitioners regarding the prevention, investigation and mitigation of IPAC lapses; and

4) And that base funding be sufficiently enhanced for Boards of Health to respond to the increasing demands of IPAC complaints and lapses;

AND FURTHER that the Chief Medical Officer of Health for Ontario, the Ontario Assistant Deputy Minister of the Population and Public Health Division, all Ontario regulated health professional colleges, and the Ontario Public Health Association be so advised.

Supplementary information attached (9 pages)

A Comprehensive Approach to Infection Prevention and Control (IPAC) in Regulated Health Professional Settings:

Backgrounder for alPHa Resolution, April 2018,
From the Board of Health for the Simcoe Muskoka District Health Unit

What is the evolution of IPAC complaints and lapses being included in the Ontario Public Health Standards?

In the wake of the 2003 outbreak of Severe Acute Respiratory Syndrome (SARS) in Ontario, it was clear that provincial infection prevention and control (IPAC) programs were under-resourced, practices were not standardized across the continuum of care and basic knowledge and training in the fundamentals of IPAC were insufficient (PIDAC, 2012). In Chapter 2 of *A Plan of Action: Final Report of the Ontario Expert Panel on SARS and Infectious Disease Control* ("Walker Report"), there is a clear mandate to "articulate the core foundational elements for a formal program of infection control in all acute and non-acute facilities, including necessary resources". This outlined the need to develop comprehensive provincial infection control standards of practice for all health care settings in Ontario, including acute and non-acute care hospitals, long-term care facilities and primary care/community settings (MOHLTC, 2004).

In 2004, the MOHLTC responded to the Walker Report by introducing *Operation Health Protection: an Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario*. Key outcomes included the development of a provincial advisory committee on infectious diseases and creation of the Ontario Agency for Health Protection and Promotion. The Provincial Infectious Diseases Advisory Committee's (PIDAC) has established several best practice documents in infectious disease management and infection prevention and control largely targeted for health care institutional settings (e.g. acute care, long-term care).

Seven years later, in May 2011, an "out of hospital" endoscopy clinic in Ottawa, was inspected by the College of Physician and Surgeons of Ontario (CPSO) and significant deficiencies in the cleaning and disinfection of the endoscopes were identified. CPSO ordered the clinic physician to cease performing endoscopies at the clinic and notified the Ontario Ministry of Health and Long-Term Care (MOHLTC) about the issue who in turn, notified Ottawa Public Health (OPH), the local public health department. OPH was required to assess the risk of transmission of hepatitis B virus, hepatitis C virus and human immunodeficiency virus to patients and to determine whether a public health response (including patient notification) was needed. A decision to notify patients was made by OPH in consultation with infection control and public health experts and based on assessments of infection risk and ethical considerations. Due to

the large number of affected patients (~6800 individuals), the clinic could not independently undertake notification and follow-up. Therefore, the responsibility of patient notification fell to OPH who had to manage the investigation despite having no clear roles or responsibilities to provide guidance and/or a legal framework in such event. While not the first large-scale public health disease investigation in Ontario related to infection prevention and control practices, the Ottawa response brought to light a series of public health policy issues and resource challenges.

In 2012, alPHa advocated, citing the Ottawa Public Health investigation, to the MOHLTC that a process needed to be initiated to discuss the oversight of IPAC practices in clinical settings including clarification of the roles and responsibilities of public health units. While an Ontario Public Health Standards' protocol regarding IPAC complaints was already in existence, in 2015 this protocol was amended to direct public health units to respond to complaints in regulated health settings. This response is to be in collaboration with the appropriate regulatory colleges and in any facility where regulated health professionals operate. To date, no resources have been provided by the MOHLTC to local public health units to support this mandated response.

What is an IPAC complaint versus an IPAC lapse?

An IPAC complaint is an infection prevention and control (IPAC) complaint made by any member of the public against any public setting including, but not limited to, schools, child care settings, sports clubs, personal services settings, or any facility in which regulated health professionals operate.

An infection prevention and control (IPAC) lapse is when, following an assessment by public health, there is a failure to follow IPAC practice standards resulting in a risk of transmission of infectious diseases to clients, attendees or staff through exposure to blood, body fluids, secretions, excretions, mucous membranes, non-intact skin, or contaminated equipment and soiled items. IPAC practice standards include the most current guidance available from the Provincial Infectious Diseases Advisory Committee (PIDAC), Public Health Ontario, the ministry, and any relevant Ontario regulatory college IPAC protocols and guidelines.

What is the evidence to suggest disease transmission in community Regulated Health Professional Settings?

Experiences with Severe Acute Respiratory Syndrome (SARS) in 2003 and pandemic H1N1 virus in 2009, have underscored the notion that every person is vulnerable if proper safeguards are not in place to prevent the transmission and acquisition of infection (Public Health Ontario, 2015). The risk of infection in regulated health professional settings varies based on the innate qualities of the infectious disease pathogen, the type of procedure, the adherence to infection prevention and control best practices, and the prevalence of infection in the population. The

true incidence of infections when reprocessing best practices are not followed is unknown because of inadequate surveillance or no surveillance at all (Kovaleva, Peters, van der Mei & Degener, 2013). However, studies suggest that bacterial infections exceed viral, parasitic or fungal infections. The risks of transmission of bloodborne pathogens (such as hepatitis b, hepatitis c and HIV) in regulated health settings is lower than for bacterial pathogens, but such transmission has occurred. For example, in 1996 a Toronto physician was investigated following multiple cases of hepatitis B being linked to the physician's numerous clinics. In total, approximately 15 000 patients were put at risk and 75 patients were confirmed to have contracted hepatitis B from the clinics when the electrode needles used for electroencephalograms were improperly sterilized between clients (Mackay, 2002). Three published reports of hepatitis B and hepatitis C transmission in American dental settings identified 7 cases of transmission related to lapses in infection prevention and control practices (Cleveland, Gray, Harte, Robison, Moorman & Gooch, 2016).

What IPAC concepts are not included in curriculums for regulated health professionals?
Infection Prevention and Control education varies by educational institution, academic program, professional discipline and location of practicums. Some regulated health professions, such as dental hygiene, receive comprehensive training in select IPAC portfolios. While courses such as microbiology, immunology, and communicable diseases are common in most regulated health programs, there are significant deficiencies in many curriculums. Key infection prevention competencies such as surveillance and epidemiology, occupational health, routine practices and additional precautions, program evaluation, environmental cleaning and medical device reprocessing are often lacking. SMDHU conducts orientation for family medicine residents monthly and all residents (from various educational institutions) have noted they do not receive appropriate IPAC education. This is evidenced by the regulated health professionals SMDHU investigators have encountered during IPAC complaint follow-ups as well as local educational institutions seeking ad hoc education sessions on IPAC.

What is the role of the regulated colleges in IPAC complaints?
Public health units are required to report IPAC complaints associated with a regulated health professional to the appropriate regulatory college, however, many of these colleges (there are 28 in Ontario) do not have the IPAC resources in place to respond in a manner that provides any relief for the work done by public health. Most regulatory colleges do not proactively conduct IPAC audits of their members, have the legislative framework to inspect settings and/or require immediate changes, or have the IPAC expertise readily available to consult on the complaint.

For example, the College of Nurses of Ontario (CNO) has identified they cannot conduct a joint investigation within prescribed timelines due to capacity issues. The Royal College of Dental

Surgeons of Ontario (RCDSO) has a small team of investigators that are tasked in responding to all complaints including, but not limited to: billing, malpractice, harassment and IPAC. Currently if an RCDSO investigator wanted to conduct a joint onsite assessment with a public health unit, they would require their members' consent prior to entering the setting. If a member of the public made an IPAC complaint directly to the RCDSO, the general process for the response is to ask for written submissions from the complainant and the dentist. This is then brought forward to the College's Inquiries, Complaints and Reports Committee who makes a decision based on the documentation placed before it.

There is a need for regulatory colleges to do preventative routine inspections of their membership's practice settings to prevent IPAC lapses?

Boards of health are required to conduct preventative routine inspections of a range of service settings (such as food premises, small drinking water systems and personal service settings) in order to support, education, encourage and require sufficient infection control practices in these settings (to prevent food borne, waterborne and blood borne infections respectively). Such an approach is also needed in the practices of the regulated health professionals. It would be suitable for their regulatory colleges to be required by the province to systematically fulfill this role, employing a continuous quality improvement approach. This would help to reduce the number of IPAC lapses, thus better protecting the health of the public, while also stemming the number of investigations needed.

What is the role of the Ministry of Health and Long-Term Care and Public Health Ontario?

The roles and responsibilities of the three primary stakeholders involved with infection prevention and control (IPAC) complaints are defined under the *MOHLTC's Roles and Responsibilities in Community Health Care Settings during Potential Infection Prevention and Control Lapse Investigations, 2017*. The local public health unit is responsible for investigating IPAC complaints, notifying applicable regulatory colleges, managing and providing guidance for IPAC improvement, enforcement activities as necessary and public reporting or patient notification, as needed. The MOHLTC has no direct role in the lapse investigation, however, they are responsible for creating the regulatory documents that support IPAC complaints and may be involved with policy interpretation. Public Health Ontario provides scientific and technical advice to support complaint investigations, coordinates laboratory samples, organizes multi-jurisdictional investigations, and develops tools and resources to support local investigations.

What is an IPAC professional?

As per the Certification Board of Infection Control and Epidemiology (CBIC), infection prevention and control professionals are nurses, physicians, public health professionals, epidemiologists, microbiologists, or medical technologists who work to prevent infectious

diseases from spreading. They look for patterns of infection within the facility; observe practices; educate; advise operators and other professionals; compile infection data; develop policies and procedures; and coordinate with local and national public health agencies.

In Canada, there is no national designation or certification process for IPAC professionals. Infection Prevention and Control Canada (IPAC Canada) is a national, multidisciplinary organization that recognizes as a core requirement for the position of Infection Prevention and Control Professional the achievement of either:

- Certification in infection prevention and control (CIC®) from CBIC; or
- In Quebec, the designation of Clinical Nurse Specialist in Infection Prevention and Control.

Certification signifies that the specialized body of knowledge required for competent performance of current infection prevention and control practices has been attained and maintained. The CIC© is the most widely recognized certification for infection control professionals in North America.

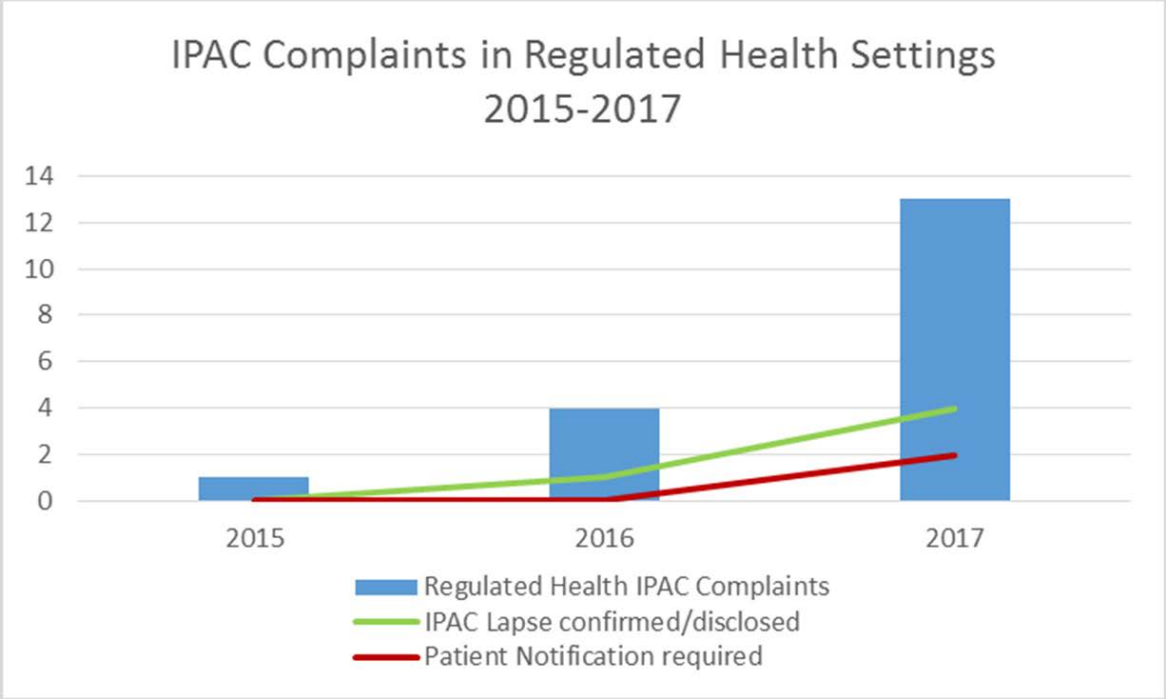
What challenges are public health units facing?

There are two key issues arising from a program perspective. First, potentially intrusive and damaging investigations, as perceived by the respondents, are occurring with regulated health professionals with whom public health had no prior relationship. Unlike operators of Personal Service Settings or Long-Term Care Homes, for example, these community healthcare locations rarely interact with local public health units and often have very little understanding as to the public health role and authority. Because these investigations are conducted on a complaint basis, there is no opportunity to develop a relationship that establishes public health in our preferred role of being a supportive resource for IPAC practices. Public Health is being seen in a more limited role of enforcement or policing of the protocol, which is not our primary function. In addition, these new relationships become easily strained once an investigation is required to move forward to public disclosure and/or patient notification. This is a part of the process generally viewed by the operator as contentious and threatening to their business.

Second, the resources required to respond to IPAC complaints are significant and increasing. Traditionally, public health professionals trained in IPAC have experience within specific settings such as hospitals, child care centres and tattoo shops, for example. Since taking on this new role, public health has had to expend considerable time and resources enhancing our expertise. While the principles of IPAC apply to all settings, an investigator is required to be familiar with the unique processes, instruments and equipment associated with each diverse setting. As we investigate each complaint, our knowledge is growing; however, learning the processes and practices of each setting remains a significant challenge to our program.

The overall rates of IPAC complaints, including those considered to be lapses and of those, requirements to do patient notification are increasing as in Figure 2 below.

Figure 2. Number of SMDHU IPAC complaints in Regulated Health Settings, 2015-2017.



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Via Electronic Mail

April 18, 2018

The Honourable Helena Jaczek
Minister of Health and Long-Term Care
Ministry of Health and Long-Term Care
Hepburn Block
10th Floor
80 Grosvenor St
Toronto, Ontario
M7A 2C4

The Honourable Mitzie Hunter
Minister of Advanced Education and Skills Development
Mowat Block
3rd Floor
900 Bay Street
Toronto, Ontario
M7A 1N3

Dear Minister Jaczek and Minister Hunter:

On behalf of the Simcoe Muskoka District Board of Health members I would like to preface this letter with an acknowledgment of the funding increase announcement to all public health units in Ontario last week. This funding will be essential to the continuation of our very important public health programs and for that, we are grateful.

Re: A Comprehensive Provincially Mandated Approach to IPAC in Regulated Health Professional (RHP) settings.

In October of 2015, the Ministry of Health and Long-Term Care (MOHLTC) released updates to the provincial guidelines entitled “Ontario Public Health Standards (OPHS), 2015”. These updates included the revised Infection Prevention and Control Practices Complaint Protocol, 2018 (the “Protocol”): a protocol revised to increase transparency and accountability through improved reporting capabilities. Since the introduction of this new Protocol, public health units have been responding to Infection Prevention and Control (IPAC) lapses that have greatly exceeded our expectations with respect to the complexity, workload and risk associated with our investigations. While investigations in community settings such as schools and personal services settings can be challenging, it is the investigations occurring in facilities with regulated health professionals (RHPs) that have been the most arduous and which raise the greatest financial and legal risks to Ontario Boards of Health.

As per the Protocol, IPAC lapses associated with a RHP must be reported to the appropriate regulatory college, however, many of these 28 colleges do not have the IPAC resources in place to respond to their members in a manner that provides relief for the work done by public health. Most regulatory colleges do not conduct routine IPAC audits of their members nor do they have the capacity to respond to IPAC complaints jointly with local public health units or the IPAC expertise readily available to consult on a lapse.

The revised Protocol also requires health units to publicly disclose all IPAC lapses that have been identified in any public setting. Since taking on this new role, public health has had to expend considerable time and resources enhancing our competency. While the principles of IPAC apply to all settings, an investigator is required to be familiar with the unique processes, instruments and equipment associated with each diverse regulated health setting.

A comprehensive, provincially mandated strategy to enhance IPAC in regulated health professional settings is essential for patient safety and public health . This strategy needs to include, the requirement that regulated health professional regulatory colleges implement continuous quality improvement with routine inspections of their members' practices and that the colleges be required to provide a robust response in collaboration with local public health units with respect to IPAC complaints.

In addition, we urge you to consider the development of province wide, core competencies and qualifications required by health unit staff conducting IPAC investigations and that Boards of Health be provided with sufficient resources to address the demands on public health units that are experiencing a notable increase in numbers of IPAC investigations since the provincial requirements began in 2015.

There is a need for a much more comprehensive, provincially mandated approach to IPAC in regulated health professional settings and to this end on April 18, 2018 the Simcoe Muskoka District Health Units Board of Health approved a motion to recommend to the Ontario Minister of Health and Long-Term Care and the Ontario Minister of Advanced Education and Skills Development that a legislative and policy framework be developed to achieve the following:

1) That regulated health professional training programs offered by Ontario colleges and universities contain comprehensive IPAC content within their curriculum; and
2) That the Ontario regulatory colleges of health professions implement continuous quality improvement with the routine inspection of their members' practice settings for adherence to IPAC best practices, and that they also provide a robust response in collaboration with local Boards of Health to IPAC complaints; and
3) That provincially recognized core competencies and qualification requirements be identified for local public health practitioners regarding the prevention, investigation and mitigation of IPAC lapses; and
4) And that base funding be sufficiently enhanced for Boards of Health to respond to the increasing demands of IPAC complaints and lapses.

Thank you for your consideration of this matter.

Sincerely,

ORIGINAL SIGNED BY

Scott Warnock
Chair, Board of Health

Cc: Chief Medical Officer of Health of Ontario
Assistant Deputy Minister
Association of Local Public Health Agencies
Ontario Public Health Association
Local Members of Parliament in Simcoe Muskoka
Central Local Health Integration Network
North Simcoe Muskoka Local Health Integration Network
Ontario Regulatory Colleges for Health Professionals

Oral Health Report 2018 Update

WINDSOR-ESSEX COUNTY
HEALTH UNIT

WINDSOR-ESSEX COUNTY HEALTH unit
Bureau de santé de Windsor-comté d'Essex

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Acknowledgements: This report was adapted from the Windsor-Essex County Health Unit "Oral Health 2016 Report" (2016).

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Windsor-Essex County
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Oral Health Report 2018 Update

Windsor-Essex County Health Unit

April 2018

Contents

Abbreviations & Glossary

APHEO – Association of Public Health Epidemiologists in Ontario

BOHP – Baby Oral Health Program

CI – Refers to the 95% confidence interval - the range within which we can be 95% certain that the true population estimate falls

CINOT – Children in Need of Treatment Program

deft – Decayed/extracted/filled primary teeth

DMFT – Decayed/missing/filled permanent teeth

ECC – Early childhood caries

ED – Emergency department

EESS – Emergency and Essential Services Stream of the Healthy Smiles Ontario Program

Epidemiology – the study of the causes and patterns of health related events in populations

HSO – Healthy Smiles Ontario Program

JK/SK – Junior/Senior Kindergarten

LHIN – Local Health Integration Network

MOHLTC – Ontario Ministry of Health and Long-term Care

NACRS – National Ambulatory Care Reporting System

ODSP - Ontario Disability Support Program

OHISS – Oral Health Information Support System

OPHS - Ontario Public Health Standards

PATF - Professionally applied topical fluoride

Periodontal disease – Disease of the gums with symptoms that range from inflammation to tissue damage

PFS – Pit and fissure sealant

PHO – Public Health Ontario

RRFSS – Rapid Risk Factor Surveillance System

SES – Socioeconomic status

WEC – Windsor-Essex County; includes the municipalities of Amherstburg, Essex, Kingsville, Lakeshore, LaSalle, Leamington, Pelee, Tecumseh, and Windsor

WECHU – Windsor-Essex County Health Unit

Executive Summary

Oral health is vital to general health and overall well-being at every stage of life. Most oral health conditions are largely preventable and share common risk factors with other chronic disease, as well as their underlying social determinants of health, such as income, employment, education, or other social factors that can impact health.

Public health units are well-situated to take a leading role in improving oral health in the communities they serve. The ***Oral Health Report 2018 Update*** was prepared by the Windsor Essex County Health Unit to provide current information about the oral health status of residents in the City of Windsor and the county of Essex. The key findings are summarized below.

Oral health profile of Windsor-Essex County:

- Nearly 1 in 4 residents report having no dental insurance coverage
- Just over 1 in 10 households saw a dental professional for their child for the first time before their child's first birthday
- There is an average of 921 emergency department visits each year for problems related to oral health.
- The estimated average total cost for emergency dental visits is $508,259 per year in Windsor-Essex County
- Over 9 in 10 visits to the emergency departments were by adults (18+) with the highest rates observed by young adults between 20 to 29 years of age.
- Each year, there is an average of 1,323 day surgeries for oral health (caries-related) reasons with the rates of day surgeries consistently higher in children (1 to 17 years) between 2010 and 2016.
- Approximately 4 in 5 residents in Windsor-Essex County support community water fluoridation
- None of the nine municipalities in Windsor-Essex County fluoridate their water supplies.

Oral health assessment in schools and preventative services in Windsor-Essex County:

- In the 2016/2017 school year, 18,179 children from 119 schools were screened for oral health issues. Between 2011/2012 to 2016/2017, the percentage of children with decay or requiring urgent care has increased by 51%.
- A three-fold increase in the proportion of children eligible for topical fluoride was observed between 2011/2012 and 2016/2017 school year.

- When compared to Ontario, the percentage of children with urgent dental needs in 2016/2017 was two-times greater in Windsor-Essex County. A similar trend was observed for all other school years.
- There is a decreasing trend in the proportion of caries-free children observed in JK, SK and Grade 2, from 7 in 10 (70%) children being caries-free in JK to 5 in 10 (50%) in Grade 2.
- The measure of decayed, missing, extracted, and filled teeth (deft/DMFT index) was highest in 2016/2017 and lowest in 2011/2012 school year indicating a trend in more oral health concerns among children at the time of school entry over time. Similar observations were found across the different grades.
- From 2011/2012 to 2016/2017, communities that recently ceased fluoridation observed a greater decrease in the percentage (13%) of students without caries compared to an 8% decrease in the communities that were never fluoridated.
- Between 2011/2012 and the 2016/2017 school year, there were no instances of moderate or severe fluorosis in children screened.
- With the new Healthy Smiles Ontario program, a total of 7,973 preventative oral health services were offered by the Windsor-Essex County Health Unit in the 2016/2017 school year.

Introduction

What is oral health?

Oral health is a key part of overall well-being and can directly impact a person's quality of life. The Canadian Dental Association outlines oral health as a state that is linked to a person's physical and emotional well-being (Canadian Dental Association, 2010). Good oral health means being free of mouth and facial pain, cavities, periodontal disease, and any other negative issues that impact the oral cavity (Petersen, 2003).

Two of the most common oral health concerns are tooth decay (cavities) and periodontal disease (gum disease) (Ministry of Health and Long-Term Care, 2012). In fact, cavities are one of the most prevalent chronic infectious diseases among Ontarians; yet these same oral health issues are largely preventable (Ministry of Health and Long-Term Care, 2012).

To prevent oral health issues, it is recommended to brush twice a day, floss once a day, visit the dentist regularly, and eat a healthy diet (Canadian Dental Association, 2010). Regular professional oral health care is an important part in maintaining good oral health, as it involves prevention, diagnosis, and treatment of issues such as cavities and gum disease, in a timely manner (College of Dental Hygienists of Ontario, 2014).

Why does oral health matter?

Oral health issues can also impact a person's quality of life. Missing teeth and oral pain can impact a person's speech, what they eat, and how they socialize (College of Dental Hygienists of Ontario, 2014). In fact, some studies have shown that people who report chronic mouth pain are more likely to take a sick day (Quinonez, Figueiroedo, & Locker, 2011).

In recent years an increasing amount of research has shown the important link between oral health and overall health. Oral health issues have been linked to respiratory infections, cardiovascular disease, diabetes, and poor nutrition. More recently, evidence has emerged that shows a link between maternal periodontal disease and babies with low birth weights (Ministry of Health and Long-Term Care, 2012).

Why is oral health important to children?

Oral health is a key part of a child's overall health and well-being. It is important to many aspects of a child's development, as poor oral health can lead to issues with eating, speech development, and self-esteem (Rowan-Legg, 2013). Dental issues and oral pain can also result in missed school days and negatively impact learning and behaviour. In Canada, it is

estimated that 2.3 million school days are lost each year due to dental visits or dental sick days (Health Canada, 2010).

In Canada, cavities are the most common chronic childhood disease, with more than 50% of children between the ages of 6 to 11 having had a cavity, while toddlers 2 to 4 years of age are also demonstrating increasing rates of cavities, as well (Rowan-Legg, 2013). Another oral health concern that children may experience is early childhood caries (ECC); a condition where one or more missing, decayed or filled teeth are present in a child. When serious cases of ECC occur, surgery may be required. This type of surgery is the most common surgery among children in Canada, with the highest prevalence among Aboriginal children (Canadian Institute for Health Information, 2013) (Seto, Ha Thanh, & Quinonez, 2014). In Ontario, the Erie St Clair Local Health Integration Network (LHIN) – which includes Windsor-Essex, Chatham-Kent, and Sarnia-Lambton – has the third highest rate of this type of surgery (21 per 1,000 children between 1-5 years of age), following the highest rates in the North East and North West LHINs (Canadian Institute for Health Information, 2013).

Preventative dental care for children can benefit oral health and reduce costs later on (Rowan-Legg, 2013). Health promotion and prevention at an early age can help develop a solid foundation for life-long oral health. The Canadian Dental Association recommends a dental assessment for babies within six months of their first tooth or by the child's first birthday. This allows for identifying any concerns at an early stage, and allows for the opportunity to provide caregivers with information on proper oral hygiene and nutrition.

What are the barriers to good oral health?

There are direct links between poor oral health and poor overall health, so it is not surprising that oral diseases have many of the same social and economic determinants (e.g., income, employment, education, access to health services, social support and other factors that impact the health of people and communities) as other chronic diseases (College of Dental Hygienists of Ontario, 2014). Oral health and general health should not be thought of separately; oral health is one important component of overall health (Seto, Ha Thanh, & Quinonez, 2014). This becomes clear when oral health is looked at in relation to chronic disease risk factors. Diabetes, heart disease, and cancer all share common risk factors such as poor diet, alcohol use, and smoking and these are also possible risk factors for poor oral health, along with several others (Federal, Provincial and Territorial Dental Working Group, 2012).

In Ontario, the majority of oral health care services are not publicly funded, which means that Ontarians are responsible for the costs of their own dental care. In Ontario, public dental coverage is the lowest of all the provinces, as only 1% of the dental services are publically funded (Canadian Centre for Policy Alternatives, 2011). Ontario provides public dental

coverage to children of low income families, but there are very few options for adults with low income, including seniors (Wellesley Institute, 2015).

There are four ways people pay for their dental care: out of their own pocket, through government subsided programs (e.g., Ontario Works, and Healthy Smiles Ontario), third-party insurance (often through employer insurance benefits), or private dental insurance.

The lack of coverage and access to oral health care is a key barrier for good oral health. There are several other indicators that can act as barriers to good oral health, including, education level, income, age, where you live (urban or rural), and immigrant status. Compared to the rest of the population, immigrants receive less preventative services and more treatment, and experience more negative oral health outcomes (Canadian Academy of Health Sciences, 2014). This is important for Windsor-Essex County given the large immigrant population in the region. Furthermore, a recent systematic review found that newcomer families (refugees and immigrants) have poor oral health and face several barriers to using dental care services (Reza, et al., 2016), including language, navigating a new health care system, and lack of financial resources.

One outcome of poor access to oral health care can be seen through the burden it has created on other parts of the health care system. People are going to hospital emergency departments for dental problems because they are in pain and cannot afford dental treatment in the regular oral health care setting (Quiñonez, Gibson, Jokovic, & Locker, 2009). This access problem can also impact how frequently people use physician offices for dental pain.

What is public health's role in oral health care?

The Windsor-Essex County Health Unit, along with all other Public Health Units in Ontario, offers oral health programs in accordance with the Ontario Public Health Standards (OPHS, 2018). The Ontario Public Health Standards revised effective January 2018 outline the minimum requirements and expectations for programs and services offered by local boards of health and identify the role of public health within oral health. Under the Ontario Public Health Standards (2018) oral health is identified under the School Health standard, the Chronic Disease Prevention and Wellbeing standard, and the Healthy Growth and Development standard. Requirements under the Healthy Growth and Development standard and the Chronic Disease Prevention and Wellbeing standard include the collection, analysis of oral health data to monitor trends over time, identify emerging trends and identify priority populations and health inequities. Boards of health are further required to share this information with local partners including municipalities. The aim of these two standards are to decrease the burden of chronic diseases of public health importance and improve wellbeing as well as ensuring children and families achieve optimal health.

The School Health Standard includes requirements for the delivery of the Healthy Smiles Ontario (HSO) program as well as the assessment and surveillance of oral health within the school setting as outlined in the Oral Health Protocol (2018; OPHS, 2018, page 53). Expected outcomes identified by the Ministry of Health and Long Term Care (MOHLTC) via the school health standard include (OPHS, 2018, page 52):

- The board of health achieves timely and effective detection and identification of children and youth at risk of poor oral health outcomes, their associated risk factors, and emerging trends
- Children and youth from low-income families have improved access to oral health care
- The oral health of children and youth is improved

Objectives

The purpose of the 2018 update of the Oral Health Report is to provide an overview of the oral health status in Windsor-Essex County. This report is a refresh of the 2016 Oral Health Report, in which the population health data and information relevant to the new Ontario Public Health Standards have both been updated. Specifically, this report is intended to:

1. Address a request for information on oral health status in correlation with a 5-year moratorium on community water fluoridation in the City of Windsor.
2. Provide an oral health profile of the Windsor-Essex County population using available assessment and surveillance data for the period of 2011 to 2017.
3. Provide recommendations based on local data for the improvement of oral health within Windsor-Essex.

Methods

To fulfill the objectives of this report, data were collected from various sources. The specific data sources for each section of the report are listed below:

- The oral health profile was constructed by using data from the Rapid Risk Factor Surveillance System, Community Needs Assessment and the National Ambulatory Care Reporting System.
- Data for oral health programs were sourced from the Oral Health Information Support System, and the Windsor-Essex County Health Unit records.

The data were analyzed by the Epidemiology & Evaluation Department at the Windsor-Essex County Health Unit. The specific analytical methodology for each data source is described in the next section. Data presented represent a snapshot of the information at the time of extraction and may differ from previous or subsequent reports.

Data Sources

Rapid Risk Factor Surveillance System (RRFSS): RRFSS is a telephone survey conducted across various public health units across Ontario. The survey selects a random sample of adults 18 years and older from the health unit area. Individuals who don't have landline telephones and those not living in households (e.g. in correctional institutions) are excluded from the RRFSS sampling frame. A module in RRFSS is generally a group of questions related to a specific topic. RRFSS modules regarding dental insurance coverage, early childhood dental visits, early childhood tooth decay, and support for community water fluoridation were analyzed. RRFSS data reporting requirements allow estimates with a coefficient of variation (a measure of an estimate's variability) between 0 and 16.5 to be released without qualification. However, estimates with a coefficient of variation between 16.6 and 33.3 can only be released with caution (denoted with a superscript 'E'), while those estimates with a coefficient of variation greater than 33.3 cannot be released (denoted with a superscript 'F').

National Ambulatory Care Reporting System (NACRS): This database captures client visits for ambulatory care in facilities and the community. It is administered by the Canadian Institute for Health Information and contains ambulatory care data for outpatient and community-based clinics, emergency department (ED) visits, and day surgeries. In addition to service-specific information, it also collects demographic information. Data for oral health-related ED visits and day surgeries in Windsor-Essex County (2010-2016) were extracted from intelliHEALTH Ontario and presented in this report. The NACRS data was extracted in March, 2018. Counts and rates of ED visits and day surgeries may be higher from previous reports, due to the availability of more up-to-data at the time of data extraction.

For ED visits, only unscheduled ED visits for one of the following 'all problem' diagnosis codes (International Classification of Disease – 10th revision - CA) were included: K029, K047, K050-K052, K0769, K0887 or K122. For day surgeries, only surgeries for 'main problem' diagnosis codes of K020-K024, K028-K029, or K047; and a treatment code (Canadian

Classification of Health Interventions) of 1FD52, 1FE29, 1FE53JARV, 1FE57, 1FE87JAH1, 1FE89, 1FF53, 1FF56, 1FF59JA, 1FF80, 1FF87, or 1FF89 were included. The diagnosis codes selected do not include oral health diagnoses related to injuries. When oral health related issues are mentioned, they refer only to the mentioned conditions, not all oral health related conditions.

Population Data: Public health unit and Ontario population estimates (2010-2016) were extracted from intelliHEALTH Ontario. The 2011 Canadian population estimates (standard population) were extracted from Statistics Canada. Rates presented by year were standardized by age and sex according to the standard population.

Oral Health Information Support System (OHISS): The Oral Health Information Support System (OHISS) is a database used for oral health screening and surveillance activities by public health units as mandated by Ontario Public Health Standards (2008). OHISS captures data on all children and youth under 18 who partake in publicly funded dental services (e.g., screening). Data extracted from OHISS for the 2011/2012 to 2016/2017 school years was used to generate the core indicators described in **Supplementary Table 1 (Appendix A)**.

Core Indicators

The Association of Public Health Epidemiologists in Ontario (APHEO) has developed a suite of standardized indicators that align with the Ontario Public Health Standards and allow for consistent reporting of population health data by public health agencies in Ontario (APHEO and Public Health Ontario, 2012). Included in these are oral health indicators which primarily focus on the oral health status of school-age children and youth (see **Supplementary Table 1, Appendix A**). This report provides these prescribed oral health indicators for the previous six school years (2011-2017) as well as additional indicators that were deemed relevant to oral health.

Oral Health Profile of Windsor-Essex County

This oral health profile of the Windsor-Essex County population presents the most recent and complete information collected through the Rapid Risk Factor Surveillance System (2015-2017), Windsor-Essex County Health Unit Community Needs Assessment (2016), and the National Ambulatory Care Reporting System (2010-2016). The specific oral health information presented in this section includes:

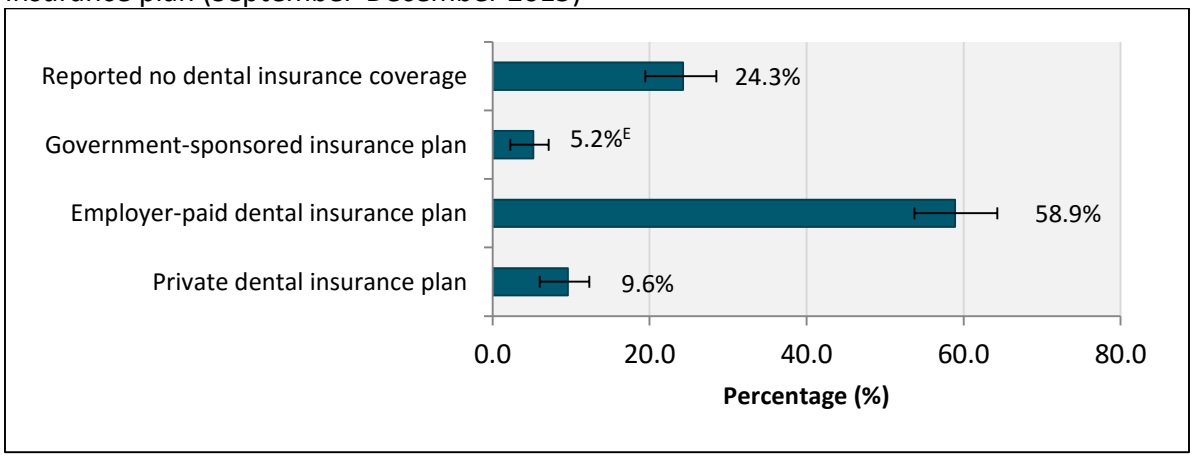
- Dental insurance coverage
- Early childhood dental habits
- Support for community water fluoridation
- Emergency department visits for oral health issues
- Day surgeries for oral health (caries-related) issues

Dental Insurance

The type of dental insurance coverage for Windsor-Essex County residents (≥ 18 years old) is reported in **Figure 1**. Almost one-quarter of adults in Windsor-Essex County do not have dental insurance coverage. For those with some form of coverage, an employer-paid dental insurance plan was the most commonly reported form of coverage - nearly 60% of adults. Almost ten percent of adults have some private dental insurance plan and only five-percent of adults have some government-sponsored dental insurance plan.

Additionally, approximately four percent of adult residents refused or turned down treatment, because they did not have any insurance coverage (4.4%[E] of adults, 95% CI: 2.6 to 7.4%).

Figure 1. The percentage of Windsor-Essex County residents (18 years old) with a dental insurance plan (September-December 2015)



Source: Rapid Risk Factor Surveillance System (RRFSS), Sep-Dec 2015, Windsor-Essex County Health Unit

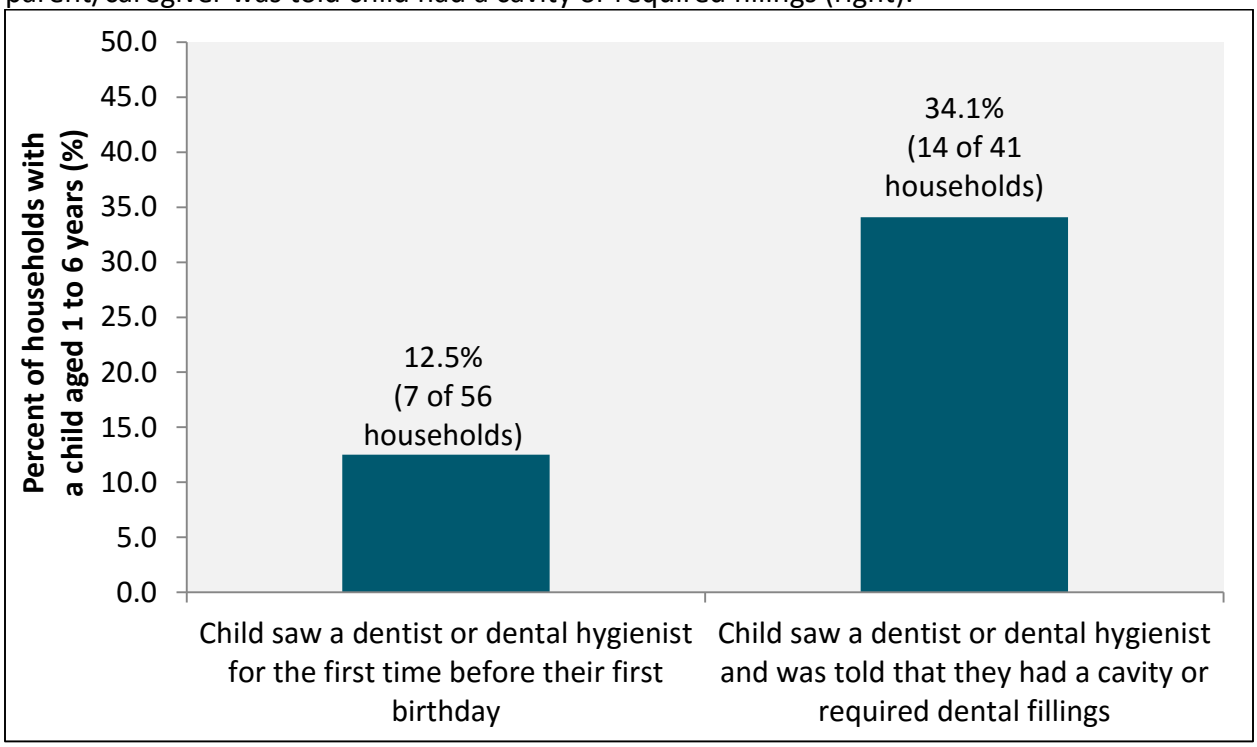
Note: Sample size of 401 respondents. Respondents who did not know the type of insurance plan they had are not depicted in this figure (< 10 respondents).

[E]Interpret estimate with caution due to high variability of the estimates.

Early Childhood Dental Habits

Only 13% of households with a child between the age of one and six years reported that the child saw a dentist or dental hygienist for the first time before their first birthday (**Figure 2**). Moreover, in 34% of households where the child saw a dental professional, the parent was told that the child had a cavity or required dental fillings.

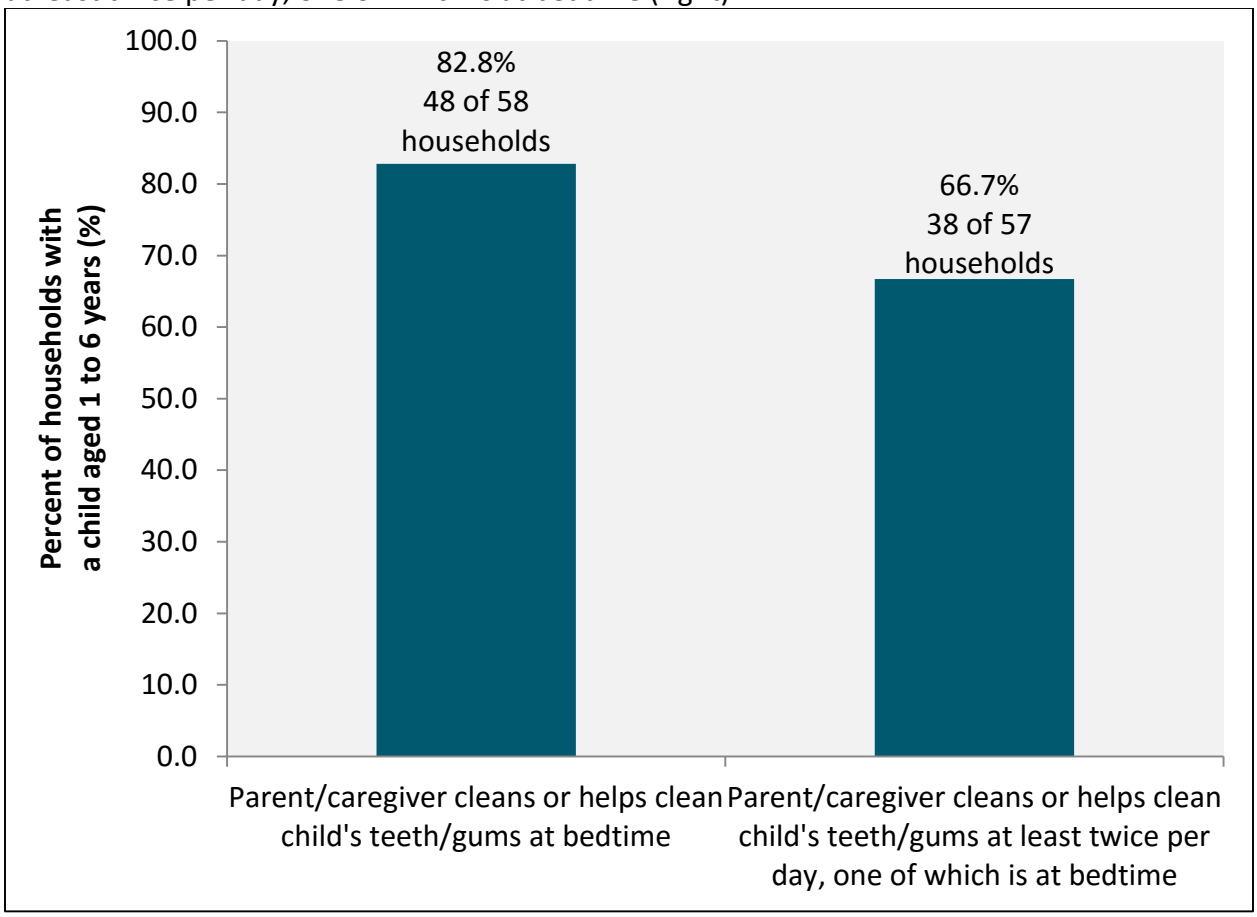
Figure 2. The percentage of households in Windsor-Essex County with a child between 1 and 6 years that saw a dental professional: for the first time before their first birthday (left); parent/caregiver was told child had a cavity or required fillings (right).



Source: Rapid Risk Factor Surveillance System (RRFSS), Jan-Apr 2016 and Jan-Apr 2017, Windsor-Essex County Health Unit

Protective behavioural factors like teeth are gum cleaning are associated with the prevention of early childhood tooth decay in children aged <1 to 6 years. **Figure 3** shows the teeth and gum cleaning habits as reported by the parent/caregiver. When parents/caregivers with a child 1-6 years old were asked whether they clean or help to clean the child's teeth or gums, almost 83% said they do so. Almost 67% of households stated that they clean or help to clean the teeth or gums twice daily, one of which is at bedtime.

Figure 3. The percentage of households in Windsor-Essex County with a child between 1 and 6 years where the parent/caregiver cleans or helps to clean child's teeth/gums: at bedtime (left); at least twice per day, one of which is at bedtime (right).



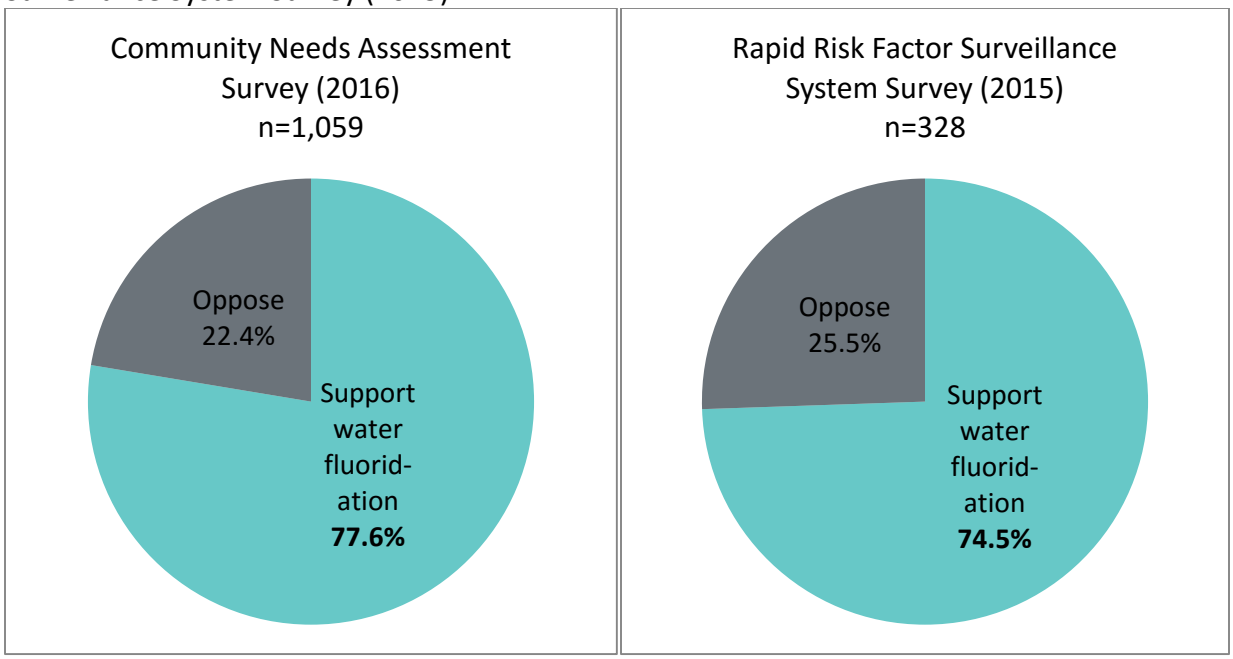
Source: Rapid Risk Factor Surveillance System (RRFSS), Jan-Apr 2016 and Jan-Apr 2017, Windsor-Essex County Health Unit

Community Support for Community Water Fluoridation

Support for community water fluoridation was assessed as part of the RRFSS survey in 2015, and Windsor-Essex County Health Unit's Community Needs Assessment survey in 2016 (see **Figure 4**). Both surveys showed similar results regarding support for community water fluoridation.

According to the survey results, the vast majority of adult residents in Windsor-Essex County support community water fluoridation (75% according to RRRFS, and 78% according to the Community Needs Assessment Survey).

Figure 4. Support for community water fluoridation by adults (≥ 18 years old) in Windsor-Essex County according to the Community Needs Assessment Survey (2016) and Rapid Risk Factor Surveillance System Survey (2015)



Sources: Community Needs Assessment, 2016, Windsor-Essex County Health Unit; Rapid Risk Factor Surveillance System (RRFSS), Sep-Dec 2015, Windsor-Essex County Health Unit.
Note: Don't Know/Unsure responses were excluded.

Emergency Department Visits for Oral Health issues

An outcome of poor access to oral health care can be seen through the impact it has on the health care system. People are using hospital emergency departments for dental problems because they are in pain and cannot afford dental treatment in the regular oral health care setting (Quiñonez, Gibson, Jokovic, & Locker, 2009).

This is an expensive and ineffective alternative to preventative oral health care. Individuals who access emergency departments (ED) for oral health issues tend to receive pain medication (e.g., opioids), and not treatment to resolve the oral health problem, which means that many will return to the ED. In an Ontario study, it was found that the majority (78%) of these types of visits were triaged as non-urgent, and most (93%) were simply discharged (Quiñonez, Gibson, Jokovic, & Locker, 2009).

In 2013, there were almost 59,000 visits to the ED for oral health problems. At a minimum cost of $513 per visit (2012 Canadian Dollars), the total estimated cost for dental visits to EDs in Ontario was at least $30 million in 2013 (Maund, 2014a). Visits to Ontario physicians' offices for oral health problems in 2012 totalled 217,728 visits at a cost of $7.3 million for that year (Maund, 2014b).

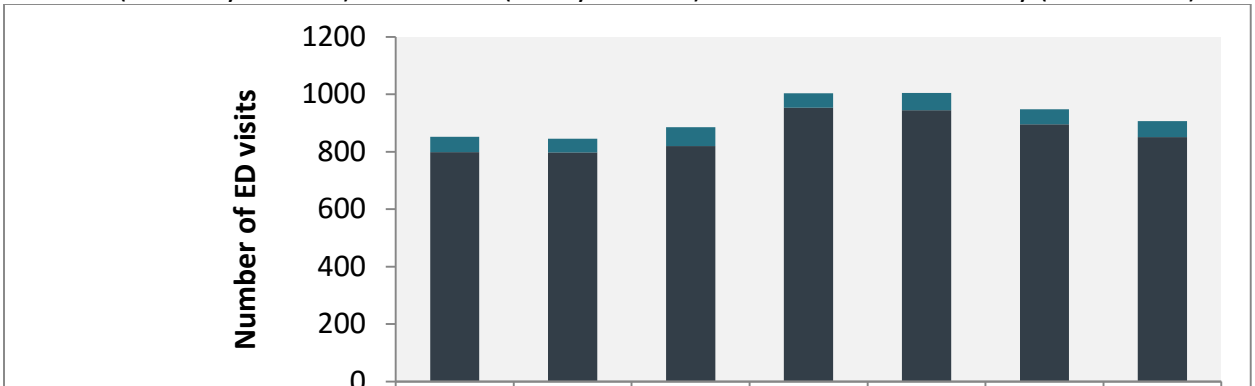
The number of EDs visits in Windsor-Essex County for oral health issues is reported by year in **Figure 5**. On average there were 921 ED visits annually for problems related to oral health (between 2010 and 2016), corresponding to an average annual rate of 240 oral health-related ED visits per 100,000 population. Based on a minimum of $513 per visit (Maund, 2014a), it is estimated that the average total cost for ED dental visits is $472,400 per year in Windsor-Essex County (2012 Canadian Dollars). Adjusted for inflation, this amount rises to $508, 259 (2017 Canadian Dollars).

Children (1-17 years old) represented only six percent of oral health-related ED visits in Windsor-Essex County (see **Figure 5**); this makes sense given that there are a number of publicly funded programs for children in Ontario (e.g., Healthy Smiles Ontario).

The age distribution of ED visits by five-year age groups is shown in **Figure 6**. Annually, adults 20-49 account for the majority of ED visits (66%) for oral health related problems. Those in their mid-to-late twenties had the highest rate of ED visits for oral health related issues (25-29 year olds: 537 ED visits per 100,000 population). After this age period, the rates subsequently decreased.

The oral health conditions of children and adults who visited the ED in Windsor-Essex County (2010-2016) are reported in **Table 1** and **Table 2**, respectively. The bulk of these oral health problems are diseases of the pulp and other disorders of teeth and supporting structures (e.g. 23% and 30% of ED visits for oral-health related conditions in children and adults, respectively, were for toothache not otherwise specified). In some cases the oral health problem was unspecified; this diagnosis may reflect emergency physicians' inability to assuredly diagnose many oral health conditions (Sun & Chi, 2014).

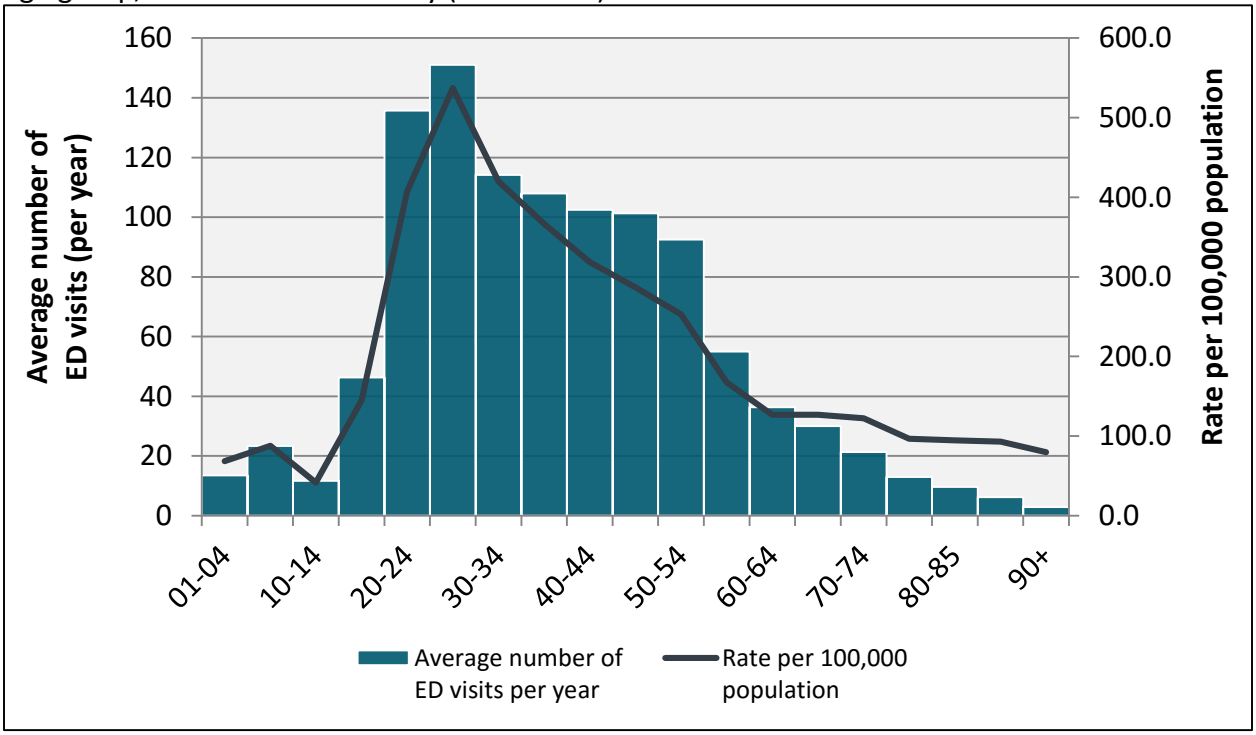
Figure 5. The annual number of oral health-related emergency department (ED) visits by children (1 to 17 years old) and adults (≥ 18 years old) in Windsor-Essex County (2010-2016)



	2010	2011	2012	2013	2014	2015	2016
Total	852	845	885	1004	1005	948	907
Children (1 to 17 years)	53	48	65	50	60	52	56
Adults (18+)	799	797	820	954	945	896	851

Source: Ambulatory Emergency External Cause [2010-2016], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [March 19, 2018].

Figure 6. Average number of oral health-related emergency department (ED) visits and rate by age group, Windsor-Essex County (2010-2016).



Source: Ambulatory Emergency External Cause [2010-2016], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [March 19, 2018].

Table 1. Oral health conditions of children (1-17 years old) visiting the emergency department in Windsor-Essex County (2010-2016).

Diagnosis (ICD-10 Code)	Number of ED visits (2010-2016)	Percent of all ED Visits for OH Conditions (%)
Periapical abscess without sinus (K047)	194	50.5%
Toothache, not otherwise specified (K0887)	90	23.4%
Chronic gingivitis (K051)	39	10.2%
Dental caries, unspecified (K029)	19	4.9%
Cellulitis and abscess of mouth (K122)	14	3.6%
Temporomandibular joint disorder, unspecified (K0769)	10	2.6%
Acute gingivitis (K050)	8	2.1%
Acute periodontitis (K052)	6	1.6%
Impacted teeth (K011)	< 5	1.0%

Source: Ambulatory Emergency External Cause [2010-2016], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [March 19, 2018].

Table 2. Oral health conditions of adults (≥18 years old) visiting the emergency department in Windsor-Essex County (2010-2016).

Diagnosis (ICD-10 Code)	Number of ED visits (2010-2016)	Percent of all ED Visits for OH Conditions (%)
Periapical abscess without sinus (K047)	3016	49.8%
Toothache, not otherwise specified (K0887)	1801	29.7%
Dental caries, unspecified (K029)	464	7.7%
Cellulitis and abscess of mouth (K122)	255	4.2%
Chronic gingivitis (K051)	194	3.2%
Temporomandibular joint disorder, unspecified (K0769)	203	3.3%
Acute periodontitis (K052)	50	0.8%
Impacted teeth (K011)	48	0.8%
Diseases of salivary gland, unspecified (K119)	10	0.2%
Acute gingivitis (K050)	9	0.1%
Other dental caries (K028)	8	0.1%
Periapical abscess with sinus (K046)	6	0.1%

Source: Ambulatory Emergency External Cause [2010-2016], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [March 19, 2018].

Day Surgeries for Oral Health (Caries-Related) Issues

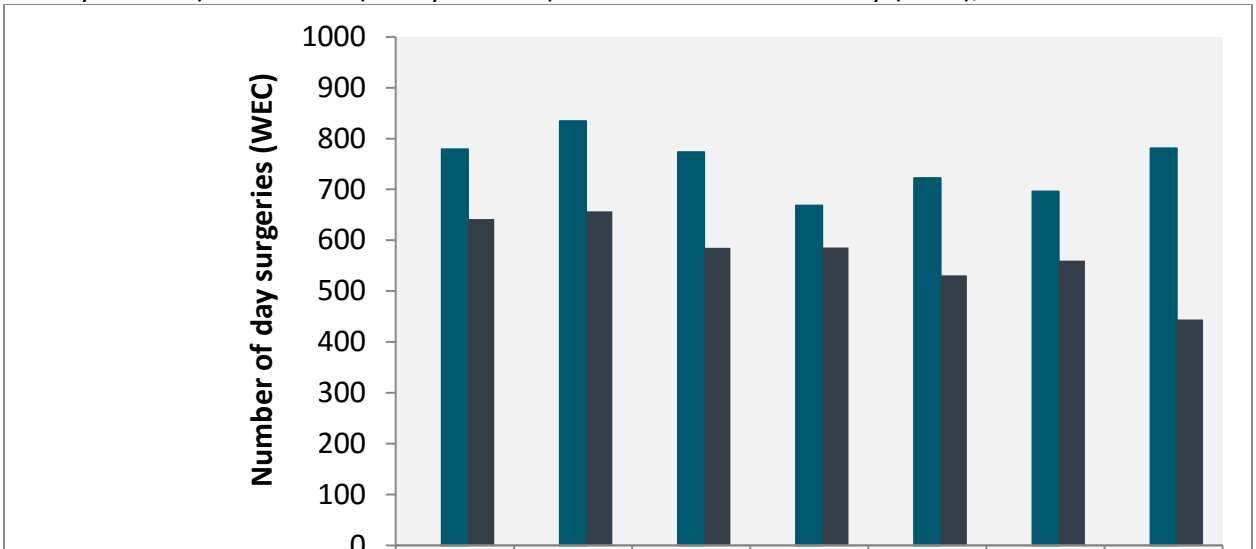
The most common type of day surgery for children in Canada is for oral health issues primarily caused by early childhood cavities. In fact, nearly 1 in 3 day surgeries among children are for oral health issues (Canadian Institute for Health Information, 2013). Despite the commonness of this problem, the majority of these cases are preventable. Children with the highest risk of developing oral health issues that require day surgery include Indigenous, those from low-income households, and those from rural communities (Canadian Institute for Health Information, 2013).

The number of day surgeries in Windsor-Essex County (2010-2016) is reported in **Figure 7**, and the rates locally and in Ontario are reported in **Figure 8**. In Windsor-Essex County, annually, there are 1,323 day surgeries on average for caries-related related issues, corresponding to an average annual rate of 326 day surgeries per 100,000 population. In 2016, the rate of oral day surgeries for caries-related issues was almost 3-times greater in Windsor-Essex County compared to Ontario.

The annual average number of day surgeries and rate were higher in children than adults. There were 750 surgeries per year on average in children (annual average rate of 186 day surgeries per 100,000 population) compared to 572 surgeries per year on average in adults (annual average rate of 140 day surgeries per 100,000 population); see **Figure 7** and **Figure 9**. The age distribution of day surgeries by five-year age groups is shown in **Figure 10**. Children 1 to 10 years had the highest rate of day surgeries among any age group. Although children had higher rates overall than adults, an increase in the rate of day surgeries was once again observed from 65 years and onwards.

Table 3 and **Table 4** show the oral-health (caries-related) conditions for which children and adults had day surgeries, respectively. Over 95% of day surgeries in children and adults were for caries related concerns. In Ontario, the healthcare costs for these procedures are, on average, $1,408 per surgery (2012 Canadian Dollars) (Canadian Institute for Health Information, 2013). Based on this average cost and using a local average of 1,323 oral day surgeries per year, it is estimated that oral day surgeries among children and youth in Windsor-Essex County costs $1.86 million each year (2012 Canadian Dollars). Adjusted for inflation, this amount rises to $2.00 million (2017 Canadian Dollars). The cost and burden of oral surgeries that is placed on the healthcare system could be reduced through health promotion and prevention strategies.

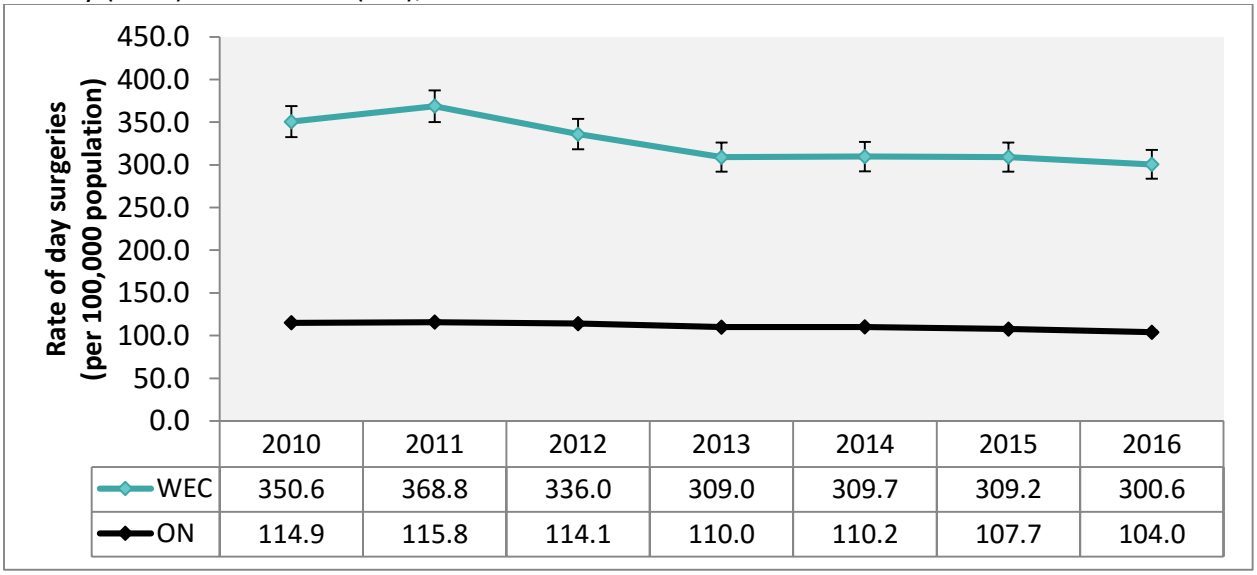
Figure 7. The number of day surgeries for oral health (caries-related) issues among children (1 to 17 years old) and adults (≥ 18 years old) in Windsor-Essex County (WEC), 2010-2016.



	2010	2011	2012	2013	2014	2015	2016
Total	1421	1491	1358	1254	1253	1256	1225
Children (1 to 17 years)	779	834	773	668	722	696	781
Adults (18+)	642	657	585	586	531	560	444

Source: Ambulatory Emergency External Cause [2010-2016], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [March 19, 2018].

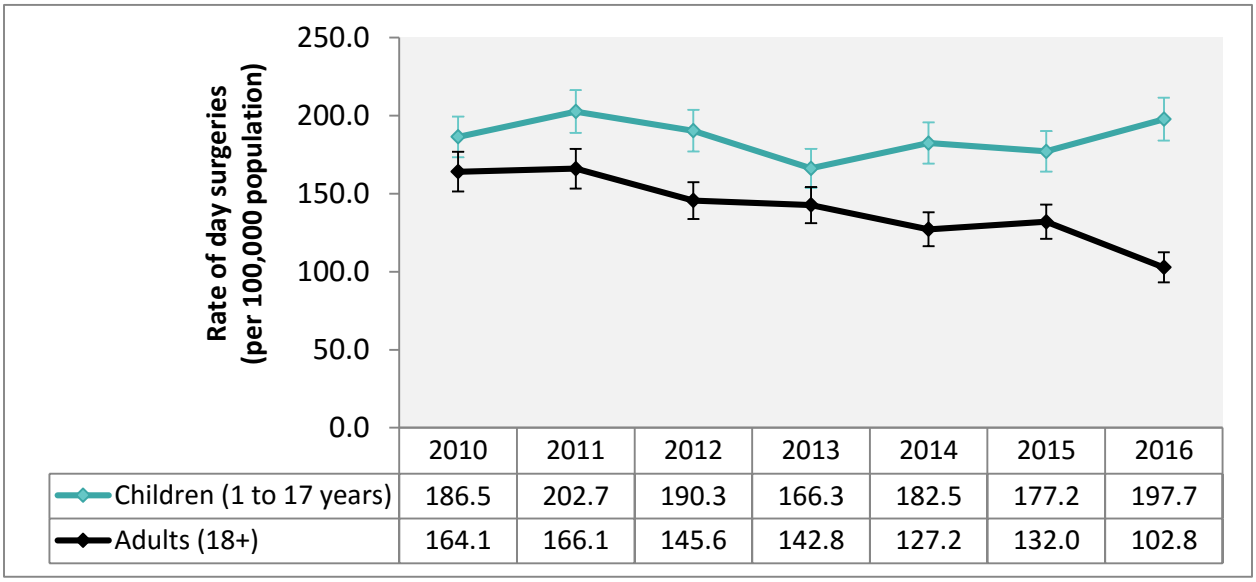
Figure 8. The rate of day surgeries for oral health (caries-related) issues in Windsor-Essex County (WEC) and Ontario (ON), 2010-2016.



	2010	2011	2012	2013	2014	2015	2016
WEC	350.6	368.8	336.0	309.0	309.7	309.2	300.6
ON	114.9	115.8	114.1	110.0	110.2	107.7	104.0

Source: Ambulatory Emergency External Cause [2010-2016], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [March 19, 2018].

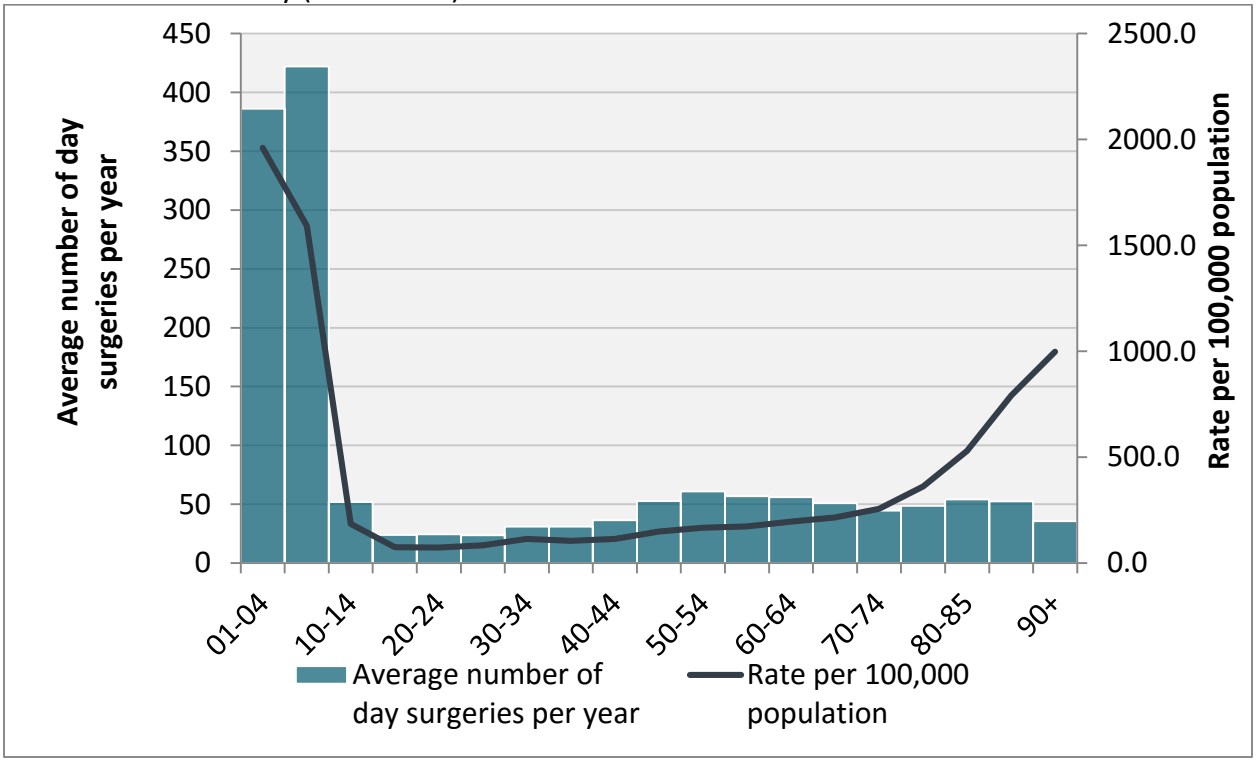
Figure 9. The rate of day surgeries for oral health (caries-related) issues among children (1 to 17 years) and adults (≥ 18 years old) in Windsor-Essex County (WEC), 2010-2016.



	2010	2011	2012	2013	2014	2015	2016
Children (1 to 17 years)	186.5	202.7	190.3	166.3	182.5	177.2	197.7
Adults (18+)	164.1	166.1	145.6	142.8	127.2	132.0	102.8

Source: Ambulatory Emergency External Cause [2010-2016], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [March 19, 2018].

Figure 10. Average number of oral health (caries-related) day surgeries and rate by age group, Windsor-Essex County (2010-2016).



Source: Ambulatory Emergency External Cause [2010-2016], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [March 19, 2018].

Table 3. Oral health (caries-related) conditions of children (1-17 years old) in Windsor-Essex County who had day surgeries (2010-2016).

Diagnosis (ICD-10 Code)	Number of ED visits (2010-2016)	Percent of all day surgeries for OH Conditions (%)
Dental caries, unspecified (K029)	5065	96.4%
Periapical abscess without sinus (K047)	115	2.2%
Other dental caries (K028)	72	1.4%
Caries of dentine (K021)	< 5	< 0.1%

Source: Ambulatory Emergency External Cause [2010-2016], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [March 19, 2018].

Table 4. Oral health (caries-related) conditions of adults (≥18 years old) in Windsor-Essex County who had day surgeries (2010-2016).

Diagnosis (ICD-10 Code)	Number of ED visits (2010-2016)	Percent of all ED Visits for OH Conditions (%)
Dental caries, unspecified (K029)	3712	92.7%
Periapical abscess without sinus (K047)	252	6.3%
Other dental caries (K028)	36	0.9%
Caries of dentine (K021)	4	0.1%
Caries limited to enamel (K020)	< 5	< 0.1%

Source: Ambulatory Emergency External Cause [2010-2016], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [March 19, 2018].

Oral Health Programs in Windsor-Essex County

There are several oral health programs that operate in Windsor-Essex County with the aim of improving oral health, primarily among children. Some programs are a collaboration of public health, community partners, school boards, and government agencies. The oral health programs in Windsor-Essex County are described in the following sections: (i) School Screenings and (ii) Preventive Services

School Screenings

School dental screenings are conducted each year in all publicly funded elementary schools and some privately funded elementary schools. The Ontario Public Health Standards (OPHS) outline the requirement of providing annual oral health screenings to students in JK, SK, and Grade 2 at all publicly funded schools as per the Oral Health Assessment and Surveillance Protocol (Ontario Ministry of Health and Long-Term Care, 2018). Based on the Grade 2 screening results, a calculation is done to determine the school's screening intensity level. Schools that are calculated to have a higher intensity level are required to have additional grades screened.

The "no touch" screening is done by a Registered Dental Hygienist. A ten to thirty second visual inspection of the child's mouth is conducted with the aid of a sterilized mouth mirror and a light source. Data is collected and recorded in the Oral Health Information Support System (OHISS) for interpretation, analysis and statistical purposes.

Caregivers are notified prior to the screening date and may exclude their child from screening by notifying the school administration in writing prior to the date of the screening. A letter of no consent will be honoured for that school year only.

Through these screenings and other screening that are conducted in the community, children are identified that are in need of preventive services or urgent dental care. If the child does not have a dental provider and is in need of further care they may be referred to one of the health unit's two clinics or to a local oral health provider.

The following school screening results for Windsor-Essex County uses information extracted from OHISS (2011/2012 to 2016/2017 school years) to describe the oral health status of children in JK to Grade 8 who participated in the school screening program. This program is not able to screen all children but, of the children (in JK to Grade 8) living in Windsor-Essex County, an average of 35% of all children in this age group are screened each year through the school screening program. Of the JK, SK, and Grade 2 children in publicly funded schools in Windsor-Essex County, approximately 92% are screened each year through school screening program. The other eight percent were either absent or were excluded during the day of the screening.

The total number of students screened in all grades across all schools in Windsor-Essex County is reported in **Table 5**.

Table 5. Oral health screening of children at schools in Windsor-Essex County (2011-2017).

School Year	Students Screened	Students Absent	Students Excluded/Refused
2011-2012	14,764	1,200 (8.1%)	333 (2.3%)
2012-2013	20,373	1,494 (7.3%)	572 (2.8%)
2013-2014	21,104	1,319 (6.3%)	696 (3.3%)
2014-2015	14,649	873 (6.0%)	458 (3.1%)
2015-2016	17,005	1,052 (6.2%)	692 (4.1%)
2016-2017	18,179	1,195 (6.6%)	606 (3.3%)

Source: Oral Health Information Support System [2011-2017], Ministry of Health and Long-Term Care (Accessed April 12, 2018).

For the 2016-2017 school year, this program conducted screenings at 119 school facilities. Nineteen (16%) of these schools had high intensities of tooth decay among grade 2 students. Compared to Ontario data (from 28 Public Health Units) for 2015-2016 (the latest school-year for which provincial data was available), 3477 school facilities were screened and 518 (15%) were considered to have high screening intensities (Ontario Ministry of Health and Long-Term Care, 2016). The number of school facilities where dental screening was conducted and the intensity of tooth decay among Grade 2 students are reported in **Table 6** for the Windsor-Essex County population.

Table 6. The number of school facilities screened in Windsor-Essex County (2011-2015) and the intensity of tooth decay among Grade 2 students at those facilities.

School Year	Facilities Screened	High Intensity Facilities	Medium Intensity Facilities	Low Intensity Facilities
2011-2012	120	13 (10.8%)	12 (10.0%)	95 (79.2%)
2012-2013	116	10 (8.6%)	13 (11.2%)	93 (80.2%)
2013-2014	114	16 (14.0%)	13 (11.4%)	85 (74.6%)
2014-2015	116	11 (9.5%)	18 (15.5%)	87 (75.0%)
2015-2016	115	24 (20.9%)	14 (12.2%)	77 (67.0%)
2016-2017	119	19 (16.0%)	11 (9.2%)	89 (74.8%)

Source: Oral Health Information Support System [2011-2017], Ministry of Health and Long-Term Care (Accessed April 12, 2018).

The screening outcomes for Windsor-Essex County children are reported in **Table 7**. From 2011/2012 to 2016/2017, the percentage of children that did not require any care decreased substantially by 43% and the percentage of children with decay or requiring urgent care has increased by 51% over this period of time. The most alarming trend was the 3-fold increase in the proportion of children eligible for topical fluorides (a change of 236%) over this time period. Eligibility for topical fluoride occurs when children meet at least two of the following criteria: (i) community water fluoride concentration is less than 0.3 ppm, (ii) a past history of smooth surface decay, (iii) a presence of smooth surface decay (OMHLTC, 2008b). Hence, the cessation of community water fluoridation in 2013 in Windsor may explain the

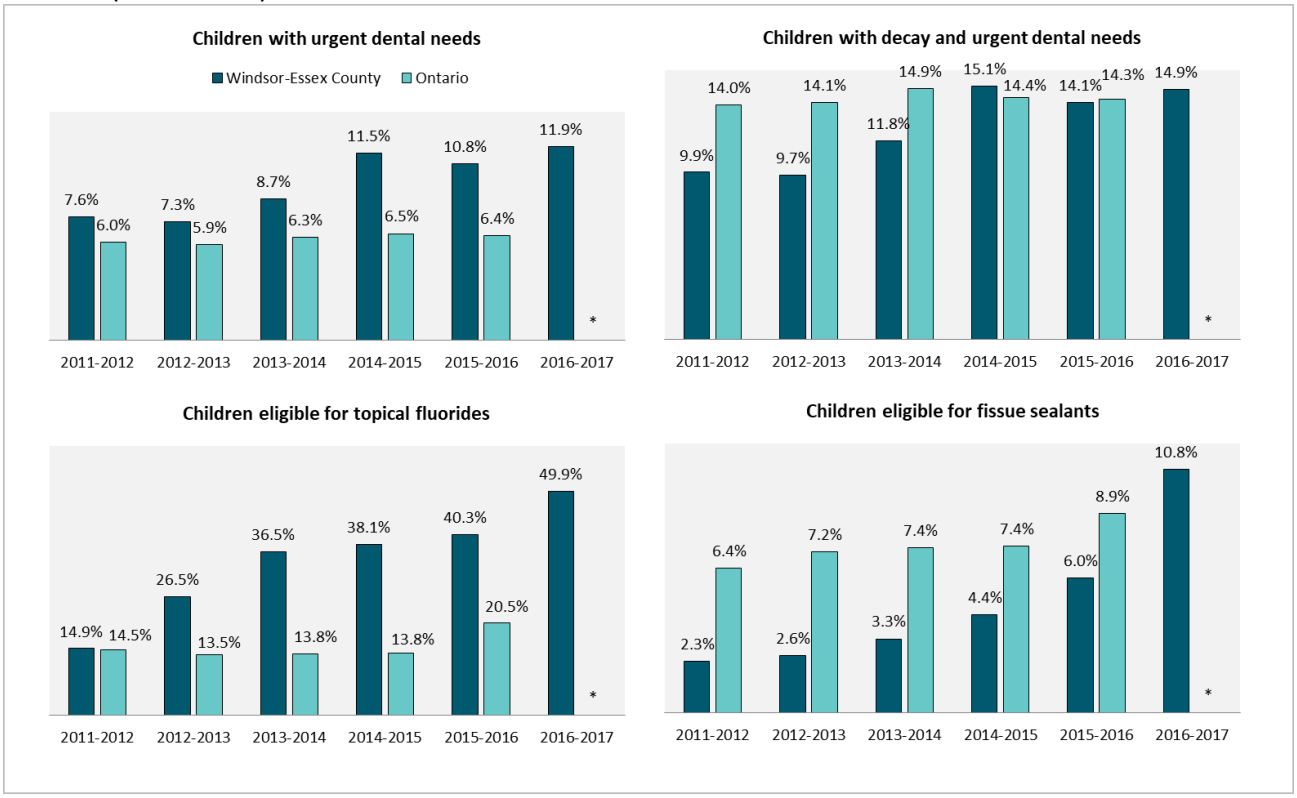
increase in children eligible for topical fluoride. There were also an increasing proportion of children eligible for fissure sealant and scaling, but incidences of fluorosis remain relatively rare.

Table 7. Screening outcomes for children at schools in Windsor-Essex County (2011-2017).

Indicator	Measure	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017
Children screened	n	14,764	20,373	21,104	14,649	17,005	18,179
No care required	n	11,798	13,804	12,152	8,478	9,189	8,239
	%	79.9	67.8	57.6	57.9	54.0	45.3
Non-urgent care required	n	348	507	663	525	558	544
	%	2.4	2.5	3.1	3.6	3.3	3.0
Urgent care required	n	1,119	1,479	1,829	1,682	1,838	2,158
	%	7.6	7.3	8.7	11.5	10.8	11.9
Decay or urgent care required	n	1,467	1,986	2,492	2,207	2,396	2,702
	%	9.9	9.7	11.8	15.1	14.1	14.9
Children eligible for topical fluorides	n	2,193	5,393	7,694	5,576	6,847	9,068
	%	14.9	26.5	36.5	38.1	40.3	49.9
Children eligible for fissure sealants	n	338	521	695	641	1,023	1,972
	%	2.3	2.6	3.3	4.4	6.0	10.8
Children eligible for scaling	n	603	1,327	2,009	1,146	1,635	1,977
	%	4.1	6.5	9.5	7.8	9.6	10.9
Children eligible for preventative services but did not require urgent care	n	1,750	4,589	6,499	3,985	5,498	7,319
	%	11.9	22.5	30.8	27.2	32.3	40.3
Moderate or severe fluorosis at time of school entry	n	0	0	0	0	0	0
	%	0	0	0	0	0	0

Source: Oral Health Information Support System [2011-2017], Ministry of Health and Long-Term Care (Accessed April 12, 2018).
n – Number of children
% – Percentage of children screened

Figure 11. Comparison of school screening outcomes between Windsor-Essex County and Ontario (2011-2017).

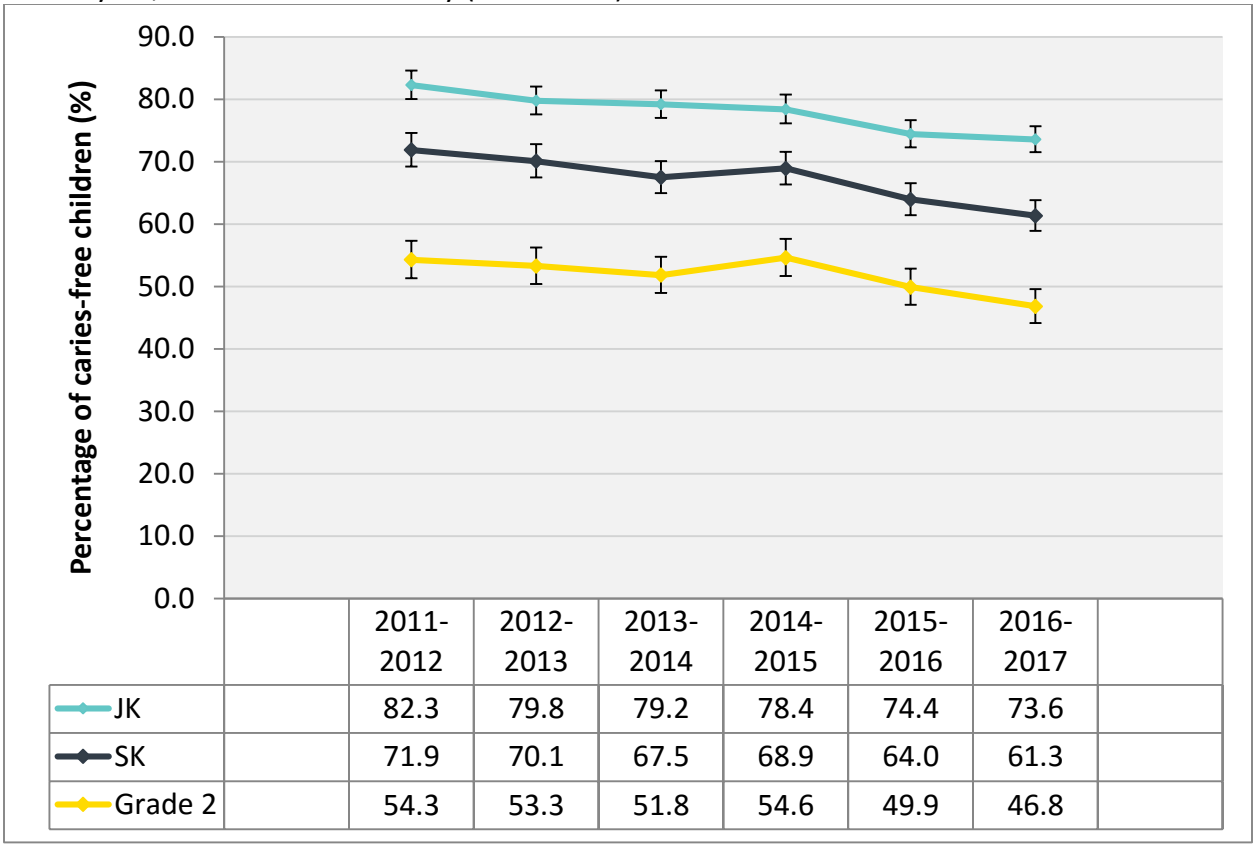


Source: Oral Health Information Support System [2011-2017], Ministry of Health and Long-Term Care (Accessed April 12, 2018).
*Comparison data for Ontario (2016/2017) was not available at the time of data extraction. Denoted by an asterisk in the figure.

School screening outcomes were compared between Windsor-Essex County and Ontario, and these findings are reported in **Figure 11**. The percentage of children with urgent dental needs in 2016-2017 was 2-times greater in Windsor-Essex County compared to Ontario (2015-2016 Ontario data used for comparison). A similar trend was observed for all other school years. In Windsor-Essex County children with decay and urgent dental needs was either similar to or greater than the Ontario equivalent measure for all school years. The percentage of children eligible for topical fluorides has increased dramatically in Windsor-Essex County since 2011-2012 but has remained relatively stable in Ontario. In 2016-2017, 2-times more children in Windsor-Essex County were eligible for topical fluorides compared than Ontario (2015-2016 Ontario data used for comparison). The percentage of children eligible for fissure sealants is greater in Ontario than Windsor-Essex County for all previous school years (2016-2017 WEC data compared to 2015-2016 Ontario data). In general, children in Windsor-Essex County appear to have greater oral health needs when compared to children in Ontario.

The percentage of children who did not have any dental caries at the time of screening is reported in **Figure 12** by grade and school year. There is a common trend observed for all school years: at school entry (JK), 7 out of 10 children are caries-free but by second grade only 5 out of 10 children (50%) are caries-free. There was a decreasing trend in the proportion of caries-free children in JK and SK for the reported time period. For example, in 2011-2012, 82% of children were caries free, but by 2016-2017 this number decreased to 74%. This data indicates that more tooth decay is being observed among children at the time of school entry.

Figure 12. The percentage of caries-free children in the screening program by school grade and school year, Windsor-Essex County (2011-2017).

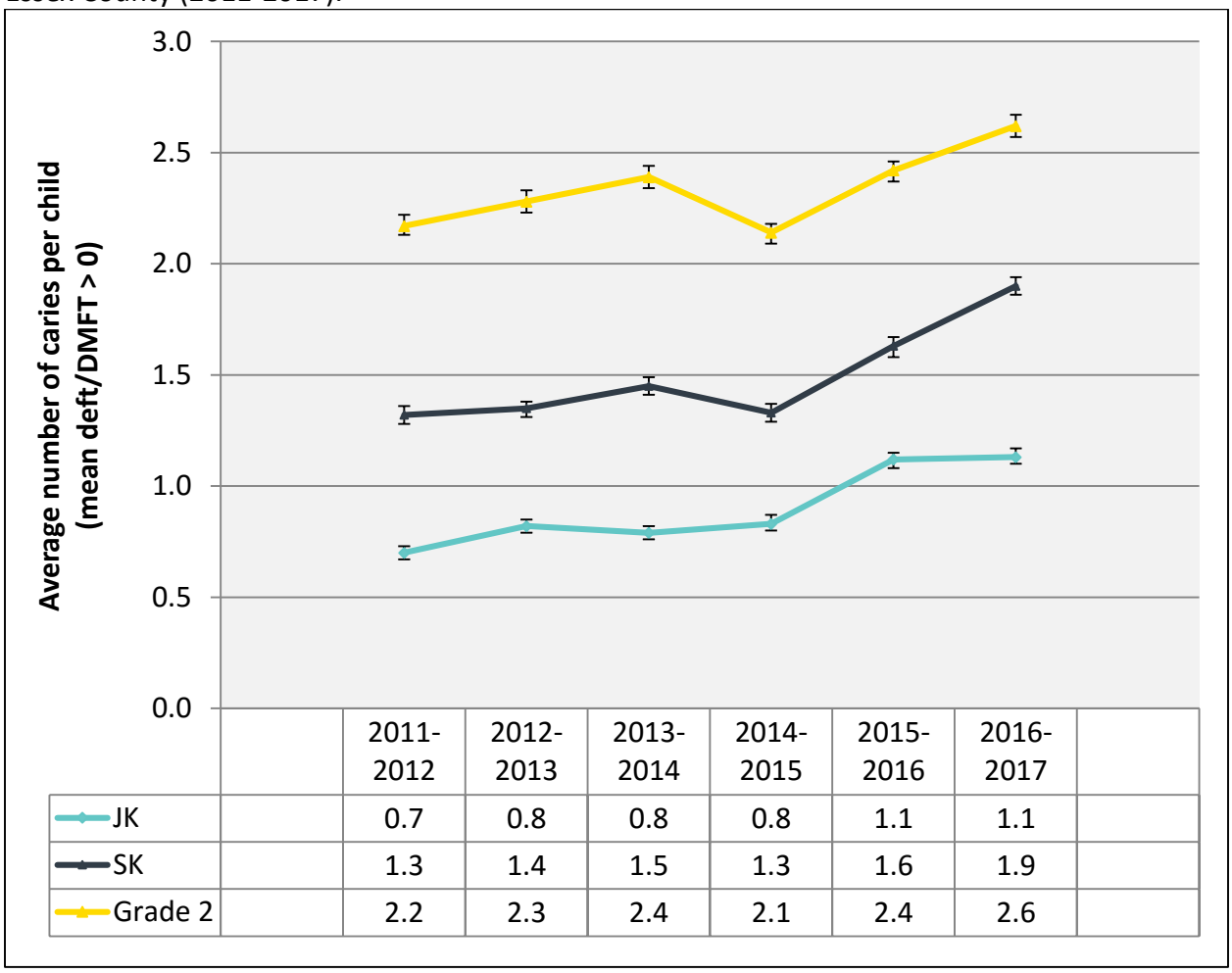


	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017
JK	82.3	79.8	79.2	78.4	74.4	73.6
SK	71.9	70.1	67.5	68.9	64.0	61.3
Grade 2	54.3	53.3	51.8	54.6	49.9	46.8

Source: Oral Health Information Support System [2011-2017], Ministry of Health and Long-Term Care (Accessed April 12, 2018).

The mean deft/DMFT index is a measure of decayed, missing, extracted, and filled teeth (a greater value indicates more decayed/missing/extracted/filled teeth). The deft/DMFT index for children (JK to Grade 2) in Windsor-Essex County is reported in **Figure 13**. For JK students, the deft/DMFT index was greatest in 2016-2017 and lowest in 2011-2012. This indicates a trend in more decayed, extracted/missing, or filled primary and permanent teeth among children at the time of school entry. There was also an overall trend by grade level - the deft/DMFT index increased for students in higher grade levels.

Figure 13. The deft/DMFT index of screened children by school grade and school year, Windsor-Essex County (2011-2017).



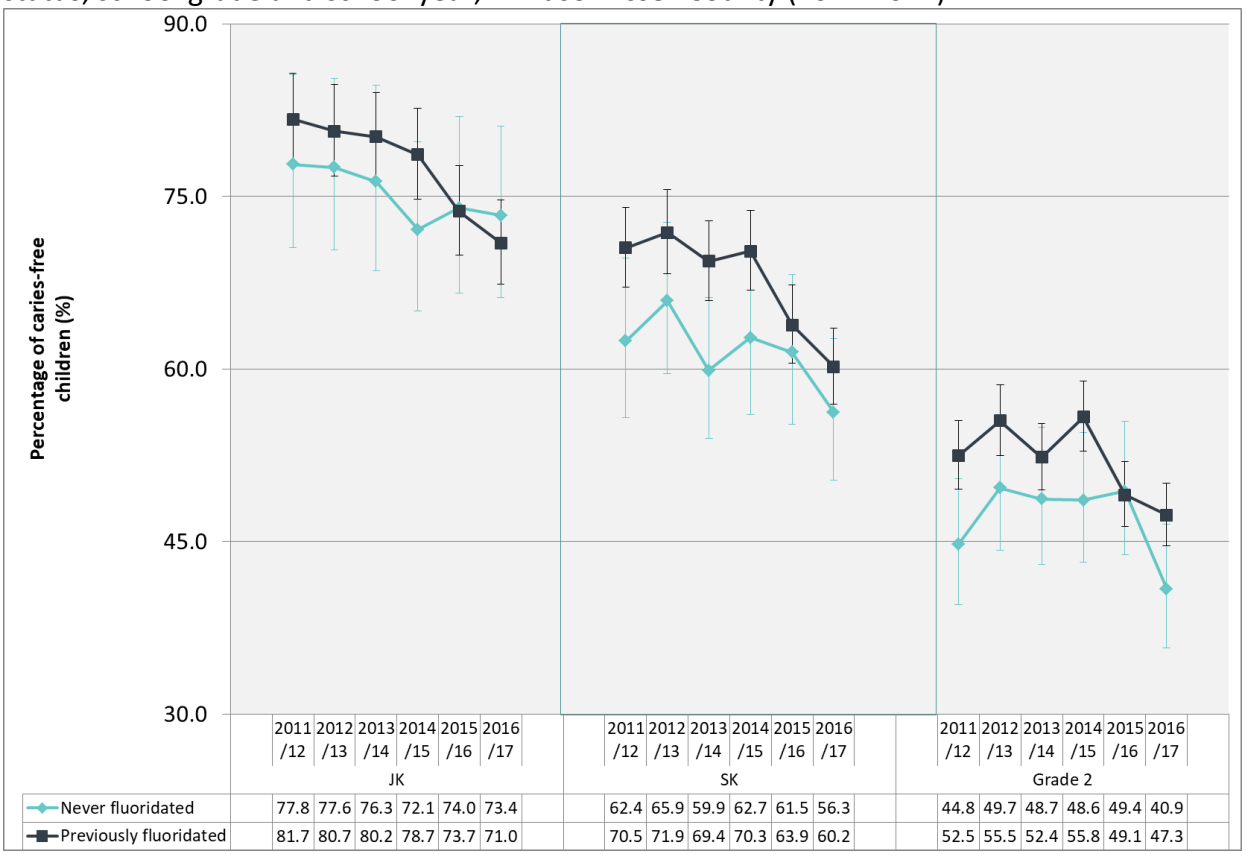
	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017
JK	0.7	0.8	0.8	0.8	1.1	1.1
SK	1.3	1.4	1.5	1.3	1.6	1.9
Grade 2	2.2	2.3	2.4	2.1	2.4	2.6

Source: Oral Health Information Support System [2011-2017], Ministry of Health and Long-Term Care (Accessed April 12, 2018).

The percentage of children in publicly funded schools across three grades and two groups of communities (Kingsville, Essex, and Leamington – never fluoridated; Windsor, LaSalle, and Tecumseh – previously fluoridated) are shown in **Figure 14** and **Figure 15**. As described previously, oral health outcomes worsen with increasing age. There is also a gradual decrease in the percentage of children without any caries across time. From 2011-2012 to 2016-2017, overall, there was an 8% decrease in the percentage of JK, SK, and Grade 2 students who are

caries-free in the never fluoridated communities (Kingsville, Essex, and Leamington – 61% to 57%). For the same time period, in previously fluoridated communities (Windsor, LaSalle, and Tecumseh), there was a 13% decrease in the percentage of students without caries (68% to 59%).

Figure 14. The percentage of caries-free children in public schools by community fluoridation status, school grade and school year, Windsor-Essex County (2011-2017).

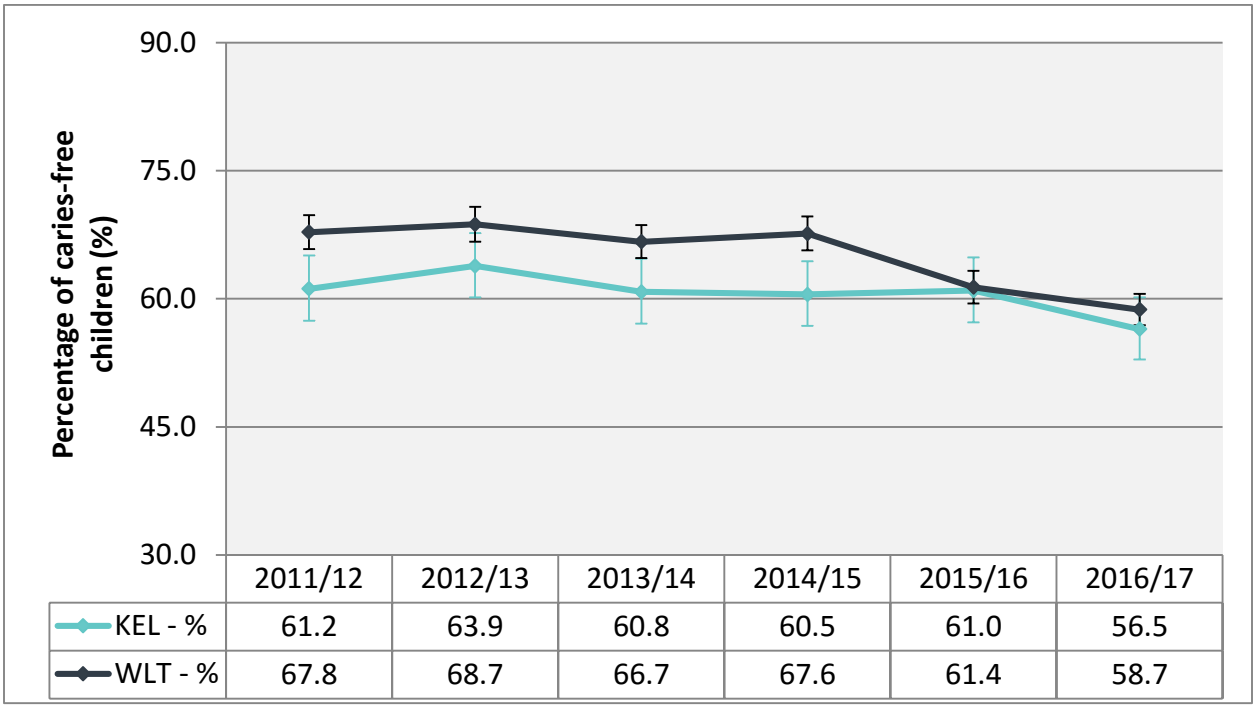


	JK						SK						Grade 2					
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Never fluoridated	77.8	77.6	76.3	72.1	74.0	73.4	62.4	65.9	59.9	62.7	61.5	56.3	44.8	49.7	48.7	48.6	49.4	40.9
Previously fluoridated	81.7	80.7	80.2	78.7	73.7	71.0	70.5	71.9	69.4	70.3	63.9	60.2	52.5	55.5	52.4	55.8	49.1	47.3

Source: Oral Health Information Support System [2011-2017], Ministry of Health and Long-Term Care (Accessed April 12, 2018).

Note: KEL refers to Kingsville, Essex, and Leamington; WLT refers to Windsor, LaSalle, and Tecumseh. Pelee was excluded to low sample size.

Figure 15. The percentage of caries-free children in public schools by community fluoridation status and school year, Windsor-Essex County (JK, SK and Grade 2 - 2011-2017).



	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
KEL - %	61.2	63.9	60.8	60.5	61.0	56.5
WLT - %	67.8	68.7	66.7	67.6	61.4	58.7

Source: Oral Health Information Support System [2011-2017], Ministry of Health and Long-Term Care (Accessed April 12, 2018).

A summary of the core indicators for oral health prescribed by APHEO are reported in **Table 8** along with the observed trend of these measures from 2011/2012 to 2016/2017. Every trend indicated a worsening in oral health status for children in Windsor-Essex County with the exception of moderate or severe fluorosis which remained unchanged.

Table 8. Trends of the core indicators for oral health as identified by the Association of Public Health Epidemiologists in Ontario, Windsor-Essex County (2011-2017).

Indicator	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	Overall Trend
deft/DMFT index*	1.02	1.09	1.13	1.10	1.38	1.52	49% ↑
Caries-free children* (%)	77%	75%	73%	73%	69%	67%	13% ↓
Children with urgent dental needs (%)	7.6%	7.3%	8.7%	11.5%	10.8%	11.9%	57% ↑
Children with decay and urgent dental needs (%)	9.9%	9.7%	11.8%	15.1%	14.1%	14.9%	51% ↑
Children eligible for topical fluorides (%)	14.9%	26.5%	36.5%	38.1%	40.3%	49.9%	235% ↑
Children eligible for fissure sealants (%)	2.3%	2.6%	3.3%	4.4%	6.0%	10.8%	370% ↑
Fluorosis Index – moderate or severe fluorosis *+ (%)	0	0	0	0	0	0	0% -

Source: Oral Health Information Support System [2011-2015], Ministry of Health and Long-Term Care (Accessed April 17, 2018).
*At school entry (kindergarten).
+This indicator refers to children with a score of 3 (moderate) or 4 (severe) on the 0-4 score (Dean's) fluorosis index. It's a modified version of the APHEO indicator.

Overall, the school screening results demonstrate that children in Windsor-Essex County have greater oral health needs compared to the province and that the oral health of children in Windsor-Essex County has worsened over the time period examined by this report. These trends warrant concern and increased efforts to prevent poor oral health among children and youth in our region.

Preventive Services

The Oral Health Department at the Windsor-Essex County Health Unit also offers preventive services. The health unit has dental clinics located in Windsor, Essex, and Leamington. These services are available to children 17 years and under, and include scaling, professionally applied topical fluoride (PATF), pit and fissure sealants (PFS), and oral health education. The number of preventative oral health services offered by the health unit is summarized in **Table 9**.

Table 9. The number of preventative oral health services offered by the Windsor-Essex County Health Unit at its various locations throughout the region (2011-2017).

Year	Windsor	Essex	Leamington	Total
2011	767	266	898	1,931
2012	846	336	1,601	2,783
2013	1,118	233	1,165	2,516
2014	1,001	213	928	2,142
2015	779	194	1,259	2,232
2016	2,880	13	1,879	4,772
2017	4,530	-	3,443	7,973

Source: Internal records, Windsor-Essex County Health Unit.

Baby Oral Health Program (BOHP)

The Oral Health Team at the WECHU provides free dental screening for all children, 4 years and younger in Windsor-Essex County through the Baby Oral Health Program. This program began in 2014. Early dental screening helps make sure that a child's teeth are growing well and are not at risk for cavities or tooth decay. If left untreated, tooth decay in a child can cause pain, affect how adult teeth come in, or even affect speech.

A screening by a public health dental hygienist includes a check for cavities, a discussion about a healthy mouth and teeth, including information on healthy eating, and fluoride treatment at no cost, if needed. Need is determined by a caries "risk assessment" that is performed to see whether a child would benefit from a fluoride varnish application. Each child is provided a BOHP kit (see **Figure 16**), which consists of a bag that looks like a bunny rabbit and contains:

- Oral Health education resource
- Pamphlets on brushing and flossing
- Tooth eruption magnet that tells parent when to expect baby teeth and when they fall out
- Toothbrush
- Infant finger brush

Information about the program has been shared with parents and a variety of other service providers and primary care professionals, including all dentists, most doctors/walk-in-clinics, nurse practitioners, recreation centres, Ontario EarlyON Child and Family Centres, child care centres, children's consignment stores, and the midwives of Windsor. This information has been disseminated through flyers, posters, news releases, and social media. In fact, during Oral Health Month in April 2015 and 2016, social media was used as part of a larger promotional strategy for the Baby Oral Health Program.

When the BOHP launched in 2014 there were 12 children (0-4 years old) screened through this program. In 2017, there were 336 children (0-4 years old) screened through the BOHP in Windsor-Essex County.

Additionally, starting in late 2016, the BOHP program expanded to include new mothers to promote the importance of infant oral health and the one-year dental visit. This expansion of the BOHP was in collaboration with the oral health advisory committee with includes the Essex Dental Society and the City of Windsor.

Figure 16. The kit distributed to children in the Baby Oral Health Program.

Financial Assistance Programs

In Ontario, there are relatively few oral health programs that are available to those who cannot afford them. The majority of these programs are for children 17 years old and under. In Windsor-Essex County, like most communities across the province, there are an exceptionally limited number of programs for adults. The available programs and their eligibility requirements are listed below.

Children in Need of Treatment Program (CINOT)

CINOT was a provincially and municipally funded program for children in need of treatment. It has since been amalgamated into the new Healthy Smiles Ontario program.

Healthy Smiles Ontario Program (HSO)

On January 1st, 2016 six publically funded dental programs for children were combined into the new Healthy Smiles Ontario (HSO) program. The programs amalgamated included Ontario Works (OW), Ontario Disability Support Program (ODSP), and Children in Need of Treatment Program (CINOT). HSO is a government-funded dental program that provides free preventative, routine emergency, and essential dental services for children and youth 17 years old and under from low income households. There are three program streams within the HSO program.

1. **HSO-Core** – children are automatically enrolled in this stream if they receive assistance under: i) Temporary Care Assistance ii) Assistance for Children with Severe Disabilities or iii) their family receives OW or ODSP. Families may also apply if they have children 17 years of age and under, live in Ontario, AND come from a household that meets the income eligibility requirements.
2. **HSO-EESS** (formerly CINOT) – to qualify for the Emergency and Essential Services Stream (EESS) a child must have a clinical need and be able to show financial hardship. They are covered for 12 months from the date of their enrolment. If their family has private dental insurance coverage they are still eligible for this program.
3. **HSO-PSO** – a child can qualify for the Preventative Services Only (PSO) stream from the results of an oral health assessment or dental screening. Once enrolled, a child will be covered up to 12 months for professionally applied topical fluoride, pit and fissure sealant, scaling, and interim stabilization therapy services.

The number of HSO-EESS (formally CINOT) eligible children in Windsor-Essex County is reported in **Table 10** by calendar year. The average annual number of HSO-EESS eligible children presenting to the oral health clinics in the City of Windsor and the County of Essex were 966 and 403, respectively. Although fewer children are being screened and there are less HSO-EESS eligible children, the total proportion of HSO-EESS eligible children has increased from 41% in 2012 to 55% in 2017.

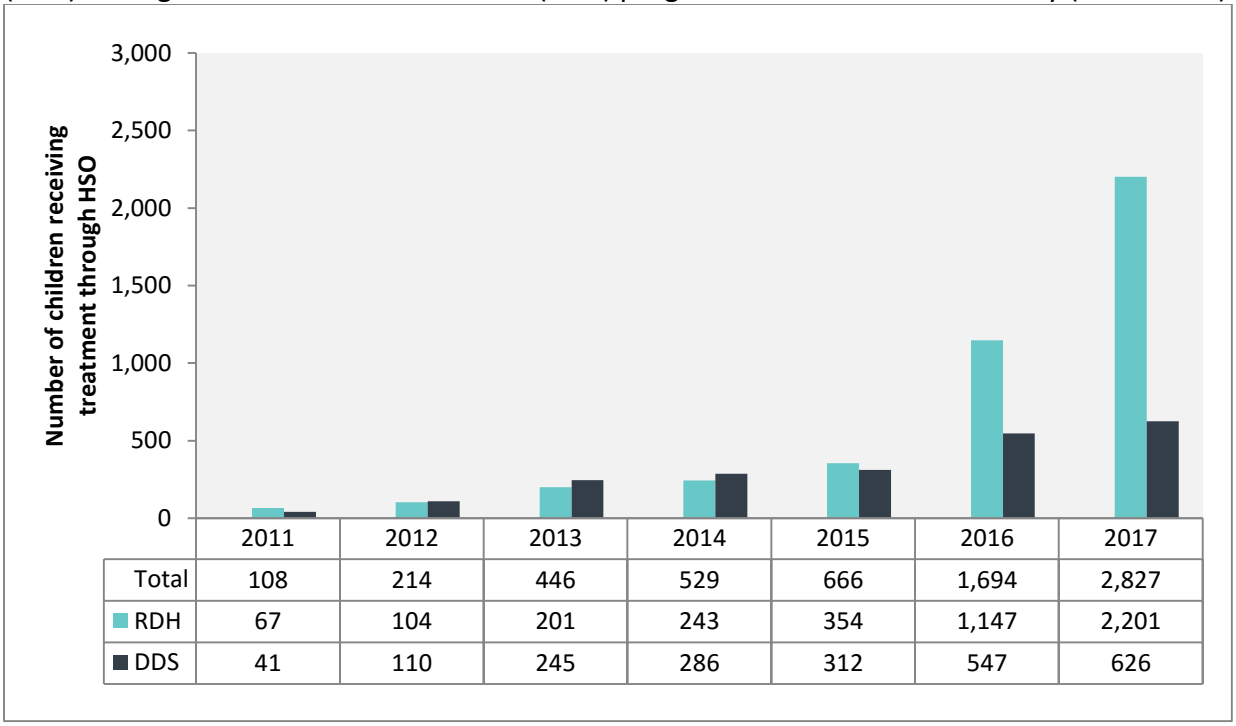
From 2011 to 2015, there was six-fold increase in the number of children receiving HSO treatments (see **Figure 17**). The large increases in treatment in 2016 and 2017 are due to the changes to HSO program in January 2016. Since the changes in 2016, there was a 67% increase in the number of children receiving HSO treatments.

Table 10. The number of children eligible for the Healthy Smiles Ontario-Emergency and Essential Services Stream (HSO-EESS) program presenting to the Windsor, Essex, and Leamington oral health clinics (2011-2017).

Year	Number of Children Screened			Number of HSO-EESS Eligible Children (%)			Total HSO-EESS Eligible Children
	Windsor	Essex	Leamington	Windsor	Essex	Leamington	
2011	2122	297	1106	935 (44%)	91 (31%)	435 (39%)	1461 (41%)
2012	1338	140	671	685 (51%)	55 (39%)	359 (54%)	1099 (51%)
2013	1348	65	593	706 (52%)	32 (49%)	265 (45%)	1003 (50%)
2014	1205	55	564	608 (50%)	20 (36%)	269 (48%)	897 (49%)
2015	1082	117	543	547 (51%)	38 (32%)	280 (52%)	865 (50%)
2016	1319	12	753	731 (55%)	2* (17%)	427 (57%)	1160 (56%)
2017	1082	0	1024	617 (57%)	-	545 (53%)	1162 (55%)

Source: Internal records, Windsor-Essex County Health Unit.
*Essex clinic closed in February 2017

Figure 17. Number of children receiving treatment by either a dental hygienist (RDH) or dentist (DDS) through the Health Smiles Ontario (HSO) program in Windsor-Essex County (2011-2017).



	2011	2012	2013	2014	2015	2016	2017
Total	108	214	446	529	666	1,694	2,827
RDH	67	104	201	243	354	1,147	2,201
DDS	41	110	245	286	312	547	626

Source: Internal records, Windsor-Essex County Health Unit.

Recommendations and Conclusions

Majority of oral health issues are preventable. Good oral health and prevention of oral health concerns can be achieved through a comprehensive approach to prevention addressing risk factors for poor oral health. Prevention approaches are multi-faceted and should address individual (brushing, healthy eating), environmental (community water fluoridation, access) and social factors (access to oral health services, social determinants of health) as well as policy (publically funded and accessible services).

Based on the data and analysis, the Windsor-Essex County Health Unit proposes the following recommendations to improve the oral health status in Windsor-Essex:

1. Windsor-Essex municipalities should consider continue to or introduce community water fluoridation as a key prevention strategy for dental caries.
2. Continue and increase support for oral health education and awareness in the community.
3. Improve access to oral health services within Windsor-Essex.
4. Advocate for improved funding for oral health services and expansion of public dental programs such as Healthy Smiles Ontario to priority populations including.

The results of this report allow us to draw several conclusions about the oral health status of residents in Windsor-Essex County. In general, children in Windsor and Essex County appear to have greater oral health needs when compared to children in Ontario, and the oral health status of this population is worsening over time, as examined in this report. Additionally, many residents lack access to any form of dental services.

These critical findings demonstrate the significant need to expand programming and advocacy efforts to prevent poor oral health in our region. The results and recommendation provide a direction on addressing the needs of our community. The WECHU, its community partners, and the community can play a key role to move these recommendations forward.

Appendix A: Oral Health Core Indicators

Supplementary Table 1. Core indicators for the oral health of children and youth as identified by the Association of Public Health Epidemiologists in Ontario.

Name	Definition	Method	OHISS[1]
deft/DMFT index	The proportion of the number of teeth decayed, missing/extracted or filled to the total number of teeth examined in kindergarten children.	**Numerator**: number of decayed, missing, extracted, or filled teeth in kindergarten children.	DMF Total (DMF Details Report, JK)
		Denominator: total number of teeth examined in kindergarten children.	Total screened (DMF Report, JK)
Caries-free children	The proportion of the children at school entry who have never had any cavities.	**Numerator**: total number of children at school entry who have never had a cavity.	DMF=0 (DMF Report, JK)
		Denominator: total number of kindergarten children surveyed.	Total screened (DMF Report, JK)
Children with urgent dental needs	The proportion of children with urgent dental needs.	**Numerator**: number of children with urgent dental treatment needs.	CUC (SSR, all grades)
		Denominator: total number of children examined.	Screened (SSR, all grades)
Children with decay and urgent dental needs	The proportion of children with decay and urgent dental needs.	**Numerator**: number of children with decay and/or urgent dental treatment needs.	CUC+N-Urg[2] (SSR, all grades)
		Denominator: total number of children examined.	Screened (SSR, all grades)
Children eligible for CINOT[3]	The proportion of children eligible for children in need of treatment (CINOT) program.	**Numerator**: number of children eligible for CINOT.	N/A
		Denominator: total number of children examined (from birth to grade 8).	N/A
Children eligible for topical fluorides	The proportion of children eligible for topical fluorides.	**Numerator**: number of children eligible for topical fluorides.	PATF (SSR, all grades)
		Denominator: total number of children examined.	Screened (SSR, all grades)
Children eligible for fissure sealants	The proportion of children eligible for fissure sealants.	**Numerator**: number of children eligible for fissure sealants.	PFS (SSR, all grades)
		Denominator: total number of children examined.	Screened (SSR, all grades)

Fluorosis Index – Moderate or severe[4]	The proportion of the children at school entry who have moderate or severe dental fluorosis.	**Numerator**: number of children at school entry who have moderate or severe fluorosis (score of 3 or 4 on the 0-4 score Dean's index).	FL_3, FL_4 (SSR, JK)
		Denominator: total number of kindergarten children surveyed.	Screened (SSR, JK)

Source: Core Indicators, Association of Public Health Epidemiologists in Ontario (Updated August 2014), Accessed April 2018 (http://core.apheo.ca/index.php?pid=55).
SSR – Screening Summary Report
[1]Field name on report (name of report).
[2]Assumption: non-urgent decay.
[3]Available through internal records only.
[4]This indicator is a modified version of the APHEO core indicator, which reports on the proportion of children with fluorosis of any level of severity (score ≥ 1 on a 0-4 score Dean's index).

Appendix B: Community Water Fluoridation Statement

The Windsor-Essex County Health Unit's Board of Directors recommends that the Province of Ontario amend the regulations of the Safe Drinking Water Act to require community water fluoridation for all municipal water systems (when source-water levels are below the Health Canada recommended level of 0.7 mg/L) to prevent dental caries (tooth decay) and provide the funding and support to municipalities required.

- Community water fluoridation promotes good (oral) health and the relationship between poor oral health and poor physical and mental health is clear.
- Community water fluoridation is essential to minimize tooth decay, and help to restore and strengthen tooth enamel.
- Community water fluoridation is recognized as the single most effective public health measure to prevent tooth decay.
- Those in lower socio-economic status (SES) are at higher risk for poor health and oral health.
- Community water fluoridation is about equity. It is the most economical way to benefits all residents in the community irrespective of their SES, education or employment status.
- Most oral health services in Ontario are at a cost to our residents and favour those who can afford to pay.
- Global Health experts (World Health Organization, Centers for Disease Control, Health Canada) and scientific evidences support community water fluoridation to prevent tooth decay.
- When fluoride is added to the water at the recommended levels, studies have shown there is no link to negative health outcomes.
- For every $1 of spending on community water fluoridation, $38 is saved in future dental treatment.
- Fluorosis (a cosmetic alteration of the appearance of the tooth enamel) is associated only with areas that have exceeded the recommended concentration of fluoride in the drinking water.
- Research has shown declines in tooth decay where community water fluoridation has been introduced.

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Windsor-Essex County Board of Health

RECOMMENDATION/RESOLUTION REPORT – Oral Health Report Update (2018)

April 19th, 2018

ISSUE

Oral health is a key part of overall well-being and can directly impact a person's quality of life. The Canadian Dental Association outlines oral health as a state that is linked to a person's physical and emotional well-being (Canadian Dental Association, 2010). Good oral health means being free of mouth and facial pain, cavities, periodontal disease, and any other negative issues that impact our mouths (World Health Organization). Two of the most common oral health diseases are tooth decay (cavities) and periodontal disease (gum disease). In Canada, 57% of children, 59% of adolescents and 96% of adults have been affected by tooth decay.

Oral health has a direct as well as an indirect impact on a person's overall health and quality of life. At a community level, complications from poor dental health may also have serious consequences for our healthcare system including unnecessary oral health related trips to our hospital emergency departments further adding to the existing long waits in the emergency rooms. In Ontario, over 60,000 emergency department visits were related to tooth pain. The Ontario medical system spends at least 38 million dollars per year treating oral health problems in emergency departments and physician's offices. Prevention is critical to good health. Tooth decay and gum diseases are almost always preventable, with preventive oral health services/strategies that should be available to all individuals in our community. In Ontario, the majority of oral health care services are not publicly funded, which means that Ontarians are responsible for the costs of their own dental care. Ontario provides public dental coverage to children of low income families, but there are very few options for adults with low income, including seniors (Wellesley Institute, 2015).

Windsor-Essex County's Oral Health 2016 report highlighted the oral health profile of our community and also made recommendations to improve the oral health status and access to oral health care in our community. Despite all these efforts, the oral health status of our community continues to remain a public health concern.

BACKGROUND

Oral health and general health should not be thought of separately; oral health is one important component of overall health (Seto et al.2014). In recent years an increasing amount of research has shown an important link between oral health and overall health. Oral health issues have been linked to respiratory infections, cardiovascular disease, diabetes, as well as a potential link between maternal periodontal disease and babies with low birth weights.

Many of the same social and economic determinants of health (e.g., income, employment, education, access to health services, social support networks) also impact the oral health of people and communities. The World Health Organization states that oral health is an important determinant of the quality of life.

ORAL HEALTH SERVICES IN WINDSOR AND ESSEX COUNTY:

There a many programs that operate in Windsor-Essex County with the aim of improving oral health, primarily among children. These include programs and services offered in collaboration between public health, school boards, primary care and others. The Windsor-Essex County Health Unit (WECHU) provides clinics in both Leamington and Windsor serving children and youth from 0-17 under the Healthy Smiles Ontario program (HSO). HSO is a government-funded dental program that provides free preventive, routine, and emergency dental services for children and youth 17 years old and under from low-income households. Over the past several years WECHU has seen an increase in the number of individuals requiring treatment as well as an increase in the wait times associated with services. As a result, the WECHU has increased their staffing and clinics with additional funding from the Ministry of Health and Long Term Care in order to address some of the increasing need. The WECHU has also worked closely over the past few years with the dental community and its community partners to increase oral health education including the introduction and implementation of the baby oral health program and fluoride varnish pilot.

Unlike those for children, there are very few publically funded programs available to adults, including seniors, in Ontario. Ontario Works and the Ontario Disability Support Program offer services to some adults, but are limited to very basic dental services (which are at the discretion of the municipality that funds these programs). In Windsor-Essex County there are two options available for adults and seniors who do not have insurance or the resources to pay for dental services (cleanings only). St. Clair College offers full mouth scaling by dental hygiene students. A second program offering dental services (cleanings only) is Street Health, a program of the Windsor Essex Community Health Centre. Operation Smile is an event that is hosted by the Essex County Dental Society, in partnership with the St. Clair College dental clinic. The yearly one-day event is designed to promote oral health in the community and offers basic restorative and surgical services to people that might not otherwise have access to such services.

ORAL HEALTH ASSESSMENT AND SURVEILLANCE REPORTING IN WINDSOR-ESSEX:

The Windsor-Essex County Health Unit (WECHU) provides programs and services under the guidance and direction of the Health Promotion and Protection Act (HPPA) and the Ontario Public Health Standards (OPHS). The OPHS include a requirement for the assessment, surveillance and reporting of oral health data including information collected through school based screening conducted in accordance with the Oral Health Protocol. The information collected through school screening includes the number of decayed, missing and filled teeth (DMFT) for each child in JK, SK and grade 2 and is recorded in the Oral Health Information Support System (OHISS). The WECHU began reporting DMFT in OHISS in the school year 2011/2012 and has continued to screen and report since that time.

In keeping with population assessment and surveillance requirements identified in the OPHS and associated protocols, in 2015 the WECHU devised a plan to report oral health data to community stakeholders, the general public, and target populations for the purpose of knowledge exchange, informing healthy public policy and health service planning. This plan included the development of the first Oral Health Report released in 2016 with the intent to update every five years. The 2016 Oral Health Report provided a comprehensive view of the oral health status of residents in Windsor-Essex using the

most current data available and accessible by the health unit for the past five years. In the beginning of 2016, Ontario made changes to all provincially funded oral health programs combining them into a newly launched Healthy Smiles Ontario (HSO). Due to the changes in how eligibility is assessed and services are provided under HSO it was determined that reporting data up to 2016 was a natural starting point for the Oral Health survey ensuring the five-year cycle from 2016 to 2021 would represent five years under the new HSO system.

REQUESTS FOR ORAL HEALTH ASSESSMENT AND SURVEILLANCE DATA AND RESPONSE:

In 2013 the City of Windsor council made a decision to discontinue the fluoridation of the water supply. This decision affected the communities of LaSalle, Tecumseh and the City of Windsor. Specifically, the council decision was as follows:

*That City Council **PASS** a by-law **DIRECTING** the Windsor Utilities Commission to **CEASE** the fluoridation of the City of Windsor water supply while ensuring continued regulatory compliance, and that the savings from this action **BE DIRECTED** to oral and health nutrition education in Windsor and Essex County, for a period of 5 years, to be spent at the discretion of the Community Development and Health Commissioner.*

At that time the WECHU had agreed to look at its oral health data and that of the community for a period of five years beginning in 2013 and bring back a report on the oral health of the community in 2018. Since this time, the WECHU has continued to collect and analyze its oral health data and has consulted with experts in oral health research to best determine what is able to be reported given the data available and the time frame of collection. The Oral Health Report (2018, update) provides 6 years of school screening data and allows the WECHU to look at overall oral status of the community, compare with Ontario averages and determine the trends for oral health outcomes across Windsor-Essex.

Based on the findings detailed in the Oral Health report (2018 update) the WECHU recommends:

- Windsor-Essex municipalities continue to or introduce community water fluoridation as a key prevention strategy for dental caries
- Continued support for oral health education and awareness in the community
- Improve access to oral health services within Windsor-Essex
- Advocate for improved funding and expansion for public dental programs such as Healthy Smiles Ontario

AMENDED MOTION

Whereas Oral health is an essential part of overall health, and

Whereas the Ontario Public Health Standards require the assessment, surveillance and reporting of Oral Health data to community partners including municipalities, and

Whereas municipalities are in the position to create healthy public policies and bylaws that impact resident's health and overall wellbeing, and

Whereas the Oral health of residents in Windsor-Essex is much worse than Ontario and comparable communities and continues to worsen, and

Now therefore be it resolved that the Windsor-Essex County Board of Health receive the Oral Health Report (2018) and supports the accompanying recommendations for:

- The City of Windsor to reintroduce fluoridation in the water system.
- The County municipalities to reintroduce fluoridation in the water system.
- Ongoing support for oral health education and awareness in the community.
- Improved access to oral health services within Windsor-Essex.
- Advocacy efforts for improved funding and expansion for public dental programs such as Healthy Smiles Ontario.

FURTHER THAT the Windsor-Essex County Board of Health share the Oral Health Report (2018) and this resolution with municipal and community partners, stakeholders, the general public and identified target groups, and

FURTHER THAT the Windsor-Essex County Board of Health request through delegation to present the Oral Health report, its findings and recommendations at the whole of City of Windsor Council and the County of Essex Council in May/June of 2018, and

FURTHER THAT the Oral Health Report (2018) and this resolution be shared with all other health units in the province of Ontario, the Minister of Health and Long Term Care, the Ontario Dental Association and local members of parliament.