June 27, 2018- Board of Health Meeting

Sault Ste. Marie Community Rooms A

www.algomapublichealth.com

June 27 2018 - Board of Health Meeting Book

Algoma Public Health Board of Health Meeting Table of Contents

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
JUNE 27, 2018 @ 5:00 PM - ROOM A, SSM
AGENDA

1.0 Meeting Called to Order

a. Declaration of Conflict of Interest

2.0 Adoption of Agenda Items

RESOLUTION	THAT the Agenda items dated June 27, 2018 be adopted as presented

3.0 Adoption of Minutes of Previous Meeting

a. April 25, 2018 Minutes

b. May 23, 2018 Minutes

RESOLUTION	THAT the Board of Health minutes for the month of April 2018 be adopted as amended and; THAT the Board of Health minutes for the month of May 2018 be adopted as presented

4.0 Delegations / Presentations

a. Accountability Indicators

5.0 Business Arising from Minutes

a. Land Acknowledgement

6.0 Reports to the Board

Medical Officer of Health and Chief Executive Officer Reports

i. MoH Report - June 2018

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

b. Finance and Audit Committee Report

i. Committee Chair Report for June 2018

RESOLUTION	THAT the Finance and Audit Committee Chair Report for June 2018 be approved as presented

ii. Financial Statements for the period ending April 30, 2018

RESOLUTION	THAT the Financial Statements for the period ending April 30, 2018 be approved as presented

iii. IT Service Outsourcing

RESOLUTION	THAT the Board of Health approve a one-year extension to the existing Service Level agreement with the current IT service provider under the same terms and conditions as the existing contract.

iv. Supply of Janitorial Services

RESOLUTION

Whereas: Algoma Public Health issued Request for Proposal (P2018-05-01) for the Supply of Janitorial Services for its main office at 294 Willow Avenue, Sault Ste. Marie, and
Whereas: Section 7 (c) Contract/Leases of Algoma Public Health's Procurement Policy (02-04-030) states the Board must approve contracts where the contract/lease is for multiple years and exceeds $55,000 per year
Therefore: Be it resolved that the Board of Health for the District of Algoma award the five-year contract (with an APH option to extend for a two year period) to " SQM Janitorial Services Inc." being the lowest price of the qualifying proposals

7.0 New Business/General Business

8.0 Correspondence

a.

i Letter to the Minister of Justice from Perth District Health Unit regarding Repeal of Section 43 of the Criminal Code dated June 14, 2018

9.0 Items for Information

a. Disposition of alPHa June 2018 Resolutions
b. GBHU BOH Motion 2018-39, Cannabis Sales Taxation Revenue
c. GBHU BOH Motion 2018-50, Oral Health Recommendations and Report
d. GBHU BOH Motion 2018-51, Food Literacy Curricula
e. GBHU BOH Motion 2018-52, Youth Exposure to Smoking in Movies

10.0 Addendum:

11.0 In-Camera

RESOLUTION THAT the Board of Health go In-Camera

12.0 Open Meeting

RESOLUTION THAT the Board of Health go into Open Meeting

13.0 Announcements/ Next Committee Meetings:

Governance Standing Committee
September 12, 2018 @ 4:30 pm
Prince Meeting Room, 3rd Floor

Next Board of Health Meeting:
September 26, 2018 @ 5:00 pm
Sault Ste. Marie, Room A

15.0 Adjournment

RESOLUTION THAT the Board of Health meeting adjourns

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 2018

ii. Draft Audited Financial Statements for the Period ending December 31, 2017

Upon presentation of the Draft Audited Financial Statements clarification was sought regarding the term loan interest calculation. Discussion took place and the Board was satisfied with the response in order to proceed with the resolution. Further assurance / clarification regarding the term loan Interest calculation to be provided at the May BoH meeting.

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 HR software

Questions were asked and answered regarding the functionality, time efficiency and cost savings of implementation to the satisfaction of the Board

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**

ALGOMA PUBLIC HEALTH
BOARD OF HEALTH MEETING
MINUTES
MAY 23, 2018 @ 5:00 PM - SSM ROOM B

PRESENT :	**BOARD MEMBERS**	**APH EXECUTIVES/ MEMBERS**	
	Ian Frazier	**Dr. Marlene Spruyt**	**MOH / CEO**
	Sergio Saccucci	**Dr. Jennifer Loo**	**AMOH**
	Lee Mason	**Justin Pino**	**CFO / Director of Operations**
	Dr. Heather O'Brien	**Antoniette Tomie**	**Director of HR / Corporate Services**
	Deborah Greystone	**Laurie Zeppa**	**Director of Health Promotion & Prevention**
	Sue Jensen	**Tania Caputo**	**EA To MOH and Secretary to the BoH**
	Adrienne Kappes		
	Dr. Patricia Avery		
	Dennis Thompson		
	Karen Raybould		
T/C :	**Sue Jensen**		
REGRETS :	**Dr. Lucas Castellani**		

1.0 Meeting Called to Order

Mr. Frazier called the meeting to order at 5:03 pm

a. Land Acknowledgement

Deferred to June Agenda

b. Declaration of Conflict of Interest

Mr. Frazier called for conflicts of interest; none were declared

2.0 Adoption of Agenda Items

2018-49

Moved: L. Mason

Seconded: H. O'Brien

THAT the Agenda items dated May 23, 2018 be adopted as amended

CARRIED

3.0 Adoption of Minutes of Previous Meeting

a. April 25, 2018 Minutes

Deferred to June agenda - additional details required

4.0 Delegations / Presentations

a. Inspection Programs – Food Safety

Mr. Chris Spooney, Manager of Environmental Health, presented information on the importance and goals of the APH Food Safety Program. Discussion ensued regarding compliance rates and inspections. Questions were asked and answered on the risk levels of various food prep circumstances, food handler courses and guidelines. Information on the APH website is available for the public along with Restaurant Inspection Reports.

5.0 Business Arising from Minutes

a. APH BoH Annual Schedule - Updated

The calendar outlines the main planned activities by month in each of the Board of Health, Finance & Audit Committee and Governance Committee Meetings. The schedule will continue to evolve as needed.

6.0 Reports to the Board

Medical Officer of Health and Chief Executive Officer Reports

i. MoH Report - May 2018

Dr. Spruyt's report highighted the 3 day Bridges out of Poverty training event in partership with SSM District Social Services. The Program Highlights included this month were "The District" Board Report and Baby Friendly Initiative Annual Report

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

2018-50

Moved: P. Avery

Seconded: K. Raybould

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

CARRIED

b. Finance and Audit Committee Report

i. Draft Financial Statements for the period ending March 31, 2018

Discussion on the funding announcement that was received early this year with the first increase to base funding since 2014. The senior team is currently planning on the allocations of those funds and the board will continue to see updates as those develop. Questions and answers on the programs, positions and expenses driving the outcomes. Salary and wages are important factors and therefore vital to understand needs based on new work and then post for positions once all factors are considered.

2018-51

Moved: A. Kappes

Seconded: D. Thompson

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

CARRIED

7.0 New Business/General Business

8.0 Correspondence

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

Dr. Spruyt pointed out this item as specific information relevant to APH as our district has one of the highest percentages of tobbacco use in Ontario. Strategies outlined within could potentially be implemented. Questions and discussion regarding if additional funding dollars could be utilized for such initiatives. Following discussion cited the Northern Ontario Equity Strategy council that look to find solutions that are tailored to our specific needs .

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 That The Board of Health go In-Camera

2018-52

Moved: D. Greystone

Seconded: L. Mason

THAT the Board of Health go In-Camera at 6:03 pm

CARRIED

Mr. Justin Pino and Mr. Leo Vecchio excused themselves from the meeting prior to the in-camera session.

11.0 That The Board of Health go into Open Meeting

2018-53

Moved: L. Mason

Seconded: H. O'Brien

THAT the Board of Health go into open meeting at 6:34 pm

CARRIED

12.0 Addendum: By-law 06-02 Ontario Building Code Appointments be approved as presented

A change in organizational structure led to the revision of the bylaw and discussion took place regarding the training requirement for the Chief Building Officer.

2018-54

Moved: H. O'Brien

Seconded: S. Saccucci

THAT the By-law 06-02 Ontario Building Code Appointments be approved as presented

CARRIED

13.0 Announcements:

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

Next Board Meeting:

June 27, 2018 @ 5:00pm

Sault Ste. Marie, Room A

15.0 That the meeting adjourn

2018-55

Moved: H. O'Brien

Seconded: A. Kappes

THAT the Board of Health meeting adjourns

CARRIED

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

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Accountability Agreement Indicators

Overview and review of 2017

Dr. Marlene Spruyt
Medical Officer of Health/CEO

Performance Measurement

- Performance management involves establishing goals, monitoring progress, and making adjustments to achieve desired outcomes.
- Intended to capture, report on, and respond to the performance of boards of health and health units and the public health system.

Accountability Agreements

- Accountability Agreements between BOH and the MOHLTC were introduced in 2011
- Initially set for a 3 year term from 2011-2013, then renewed for 2014-2016
- Set of indicators are common across all BOH in the province
- Pause in 2018 with introduction of new standards

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Structure

- In the 1st year of an indicator, baselines are established for each indicator with each board of health.

- In subsequent years, targets for performance improvement will be established in consultation with each board of health, relative to its baseline level of achievement.

Indicator Types

- Performance indicators: annual targets for achievement
- Monitoring indicators: do not have targets and performance is reviewed internally by the ministry to ensure expectations are met
- Long-term indicators: measure population level outcomes when data becomes available

2017 Indicator Performance

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Common challenges for meeting targets

- Business owner availability
- Establishment going in and out of business
- Weather for travel to some inspection sites
- Staffing shortages – short and long term
- Data entry issues
- Cooperation of external agencies/partners
- Unrealistic targets given nature of APH's region

Indicator 1.1

% of population (19+) that exceeds the Low-Risk Alcohol Drinking Guidelines

- Not currently monitored; considered as long term indicators
- Baseline in 2013/14 was 36.8%

Indicator 1.2

Fall-related emergency visits in older adults aged 65+

- Not currently monitored; considered as a long-term indicator
- Baseline in 2009 was 6,235 visits
- Stay on Your Feet funding implemented to attempt to address this

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Indicator 1.3

% of youth (ages 12-18) who have never smoked a whole cigarette

- Not currently monitored; considered as a long term indicator
- Baseline in 2009/10 was 77.2%
- Tobacco Youth Engagement funding directed at this issue

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Indicator 1.4

% of tobacco vendors in compliance with youth access legislation at the time of last inspection

Target >= 90%

- Jan - Dec 2017 ▶ 98 / 98 = 100%
- 2016 ▶ 97 / 103 = 94.2%

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Indicator 1.5

% of secondary schools inspected once per year for compliance with section 10 of the Smoke-Free Ontario Act (SFOA)

Target 100%

Has been removed from reporting requirement

- 2016 Year End ➧ 12 / 12 = 100%

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Indicator 1.6

% tobacco retailers inspected for compliance with section 3 of the Smoke-Free Ontario Act (SFOA)

Target 100%

Has been removed from reporting requirement

- 2016 Year End
  - Seasonal → 100% 
  - Non-seasonal → 97.8%

Indicator 1.7

% tobacco retailers inspected for compliance with display, handling and promotion sections of the Smoke-Free Ontario Act (SFOA)

Target 100%

- Jan - Dec 2017 ▶ 94 / 94 = 100% 
- 2016 Year End ▶ 99%
- 2015 Year End ▶ 92.1%

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Indicator 1.8

Oral health Assessment and Surveillance

Target 100%

% of schools screened

- Jul 1, 2016 - Jun 30, 2017 ➧ 100%
- 2016 ➧ 100%
- 2015 ➧ 98%

% of all JK, SK and Grade 2 students screened in all publically funded schools

- Jul 1, 2016 – Jun 30, 2017 ➧ 100%
- 2016 ➧ 100%
- 2015 ➧ 95.2%

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Indicator 1.9

Implementation status of NutriSTEP Preschool Screen

- 2015 Year End Target – Intermediate Stage
- 2016 achieved Advanced Status Target reached
- Maintaining in 2017

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Indicator 1.10

Baby-Friendly Initiative (BFI) Status

- 2015 Year End – Designated
- Re-designation achieved Apr 2016

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Indicator 2.1

% of high-risk food premises inspected once every 4 months while in operation

Target 100%

- 2017 Year End ▶ 106 / 111 = 95.5%
- 2016 Year End ▶ 331 / 359 = 92.2%

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Indicator 2.2

% of moderate-risk food premises inspected once every 6 months while in operation

Target 98.4%

- 2017 reporting not required
- 2016 Year End ➧ 337 / 388 = 96.1%

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Indicator 2.3

% of Class A pools inspected while in operation

Target 100%

- 2017 Year End ▶ 8 / 8 = 100%
- 2016 Year End ▶ 7 / 7 = 100%

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Indicator 2.4

% of high-risk Small Drinking Water Systems (SDWS) inspections completed for those that are due for re-inspection

Target 90%

- 2017 reporting under review
- 2016 Year End ➧ 10 / 11 = 90.9%

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Indicator 2.5

% public spas inspected while in operation

Target 100%

- 2016 Year End ▶ 15 / 15 = 100%

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Indicator 2.6

% of restaurants with a Certified Food Handler(CFH) on site at time of inspection

- New monitoring indicator for 2017
- Data not yet available
- No data for 2016

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Indicator 3.1

% of personal services settings inspected annually

Target 100%

- Jan - Dec 2017 — 177 / 179 = 98.9%
- 2016 Year End — 165 / 170 = 97.1%
- 2015 — 100%

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Indicator 3.2

% of suspected rabies exposures reported with investigation initiated within one day of public health unit notification

Target 100%

- 2016 Year End
  - 239 / 239 = 100%
- 2015
  - 193 / 193 = 100%

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Indicator 3.3

% of confirmed gonorrhea cases where initiation of follow-up occurred within two business days

Target 100%

- 2017 reporting not required
- 2016 Year End
  - 92 / 94 = 97.9%
- 2015
  - 68 / 68 = 100%

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Indicator 3.4

% of confirmed iGAS cases where initiation of follow-up occurred on the same day as receipt of lab confirmation of a positive case

Target 100%

- 2016 Year End ➧ 6 / 6 = 100%
- 2015 ➧ 100%)

Indicator 3.5

% of salmonellosis cases where one or more risk factor(s) other than “Unknown” was entered into iPHIS

Target 90%

- 2016 Year End ▶ 17 / 17 = 100%
- 2015 ▶ 85.7%
- 2014 ▶ 66.7%

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Indicator 3.6

% of confirmed gonorrhea cases treated according to the recommended Ontario treatment guidelines

No target - Monitoring

- 2017 Year End ▶ 25 / 39 = 64%
- 2016 Year End ▶ 67 / 94 = 71.3%
- 2015 Year End ▶ 73.2%

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Indicator 4.1

% of HPV vaccine wasted that is stored / administered by the public health unit

Target changes based on previous years performance but generally less than 5 % initially

- Sep 2016 - Aug 2017 — 4.1%
- Sep 1, 2015 – Aug 31, 2016 — 3.6%
- Previous year — 0.6%

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Indicator 4.2 (4.10)

% of influenza vaccine wasted that is stored/administered by the public health unit

Target 2.3% was based on previous years performance of 2% - now monitoring

- Sep 2016 - Aug 2017 ➧ 6%
- Sep 1, 2015 - Aug 31, 2016 ➧ 8.0%

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Indicator 4.3

% of refrigerators storing publically funded vaccines that have received a completed routine annual cold chain inspection

Target 100%

- 2017 Year End ▶ 113 / 113 = 100% 
- 2016 Year End ▶ 115 / 115 = 100%
- 2015 Year End ▶ 97.7%

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Indicator4.4

% of school-aged children who have completed immunizations for hepatitis B

Monitoring

- As of Jun 30, 2017
  - 709 / 1002 = 70.8%
- 2016
  - 683 / 1009 = 67.7%
- 2015
  - 724 / 980 = 71.5%
- 2014
  - 76.1 %

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Indicator 4.5

% of school-aged children who have completed immunizations for HPV

Monitoring

• As of Jun 30, 2017	602 / 1002 = 60.1%
• 2016	302 / 502 = 60.2%
• 2015	285 / 493 = 57.8%
• 2014	283 / 498 = 56.8%

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Indicator 4.6

% of school-aged children who have completed immunizations for meningococcus

Monitoring

• Jun 30, 2017	850 / 1002	= 84.8%
• Jun 2016	868 / 1009	= 86.0%
• Jun 2015	820 / 980	= 83.7%
• Jun 2014	868 / 1041	= 83.4%

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Indicator 4.7

% of MMR vaccine wastage

New in 2016 - Baseline not yet developed

- Jan to Dec 2017 = 1.4%
- 2016 = 20.4%

Indicator 4.8

% of 7 or 8 year old students in compliance with ISPA

New in 2016

- As of Jun 30, 2017 ▶ 987 / 1024 = 96.4%
- 2016 ▶ 946 / 1037 = 91.2%

Indicator 4.9

% of 16 or 17 year old students in compliance with ISPA

New in 2016 - Monitoring

- As of Jun 30, 2017 ▶ 936 / 975 = 96.0%
- 2016 ▶ 945 / 1021 = 92.6%

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 Anishinaabeg, 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.

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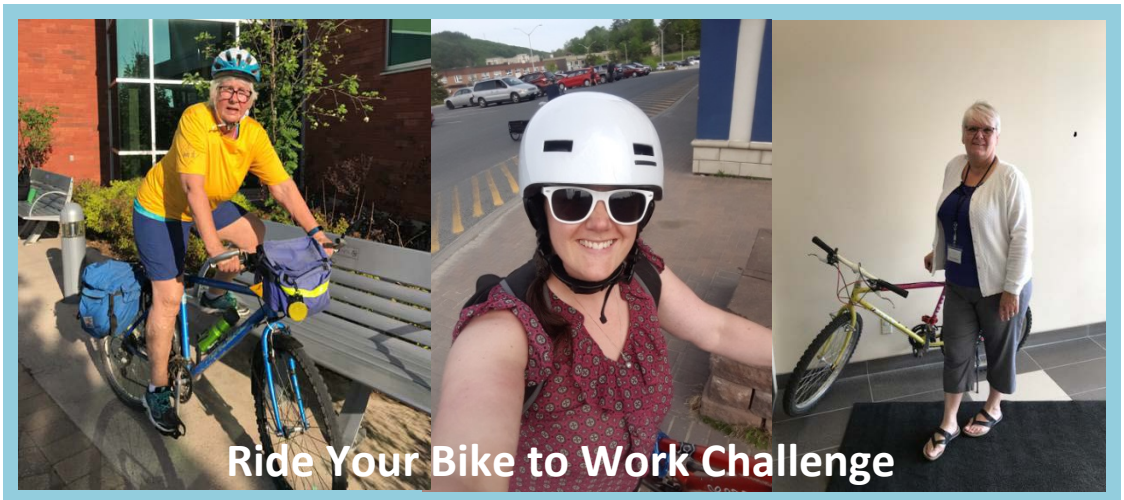
MEDICAL OFFICER OF HEALTH / CHIEF EXECUTIVE OFFICER
BOARD REPORT - JUNE 27, 2018

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



Ride Your Bike to Work Challenge

Staff Education Day 2018 – Service Award Presentation

TABLE OF CONTENTS

APH AT-A-GLANCE

Summer has arrived and many are enjoying the warm weather. The Ministry of Health and Long Term Care (MOHLTC) has been in caretaker mode during the approach to the provincial election and very little in the way of communication or policy direction has occurred. We continue to implement the new standards and prepare for the many impending regulatory changes. Limited activity at the Ministry level makes it more difficult to get feedback on the interpretation of previous directives.

Jennifer and I attended the Algoma West Academy of Medicine "Meet the Candidates Night" on May 29th. All candidates communicated that they feel health services area priority. As you are all aware there will be a new government sworn in on June 29th and we await further communications on how this may alter current health policy.

An All Staff Education day was held June 5. We explored how individual temperament/personality style affects the way we deal with change in our work environment. Awareness of different perspectives allows us to understand and improve how we communicate and implement activities in the workplace.

Jennifer and I as well as Ian were able to attend the annual Association of Local Public health Agencies (alPHa) meeting in Toronto on June 11 & 12 and the resolutions from that meeting have been shared with you.

The Cannabis Act has finally been passed at the federal level and more information about what that means can be found in this press release.

https://www.canada.ca/en/health-canada/news/2018/06/bill-c-45-the-cannabis-act-passed-in-senate.html

PROGRAM HIGHLIGHTS

Topic: Reducing exposure to health hazards to create healthier communities

From: Chris Spooney, Environmental Health Manager

Public Health Goal: To reduce exposure to health hazards and promote the development of healthy built and natural environments that support health and mitigate existing and emerging risks, including the impacts of a changing climate.

Program Standard Requirements addressed in this report:

Healthy Environments

- **Conduct surveillance** of environmental factors in the community
- **Collaborate with community partners** to develop effective strategies to reduce exposure to health hazards and promote healthy built and natural environments
- **Implement a program of public health interventions** to reduce exposure to health hazards and promote healthy built and natural environments
- **Communicate** effectively with the public
- The board of health shall **investigate potential health hazards** and **respond by preventing or reducing exposure** to health hazards

2015-2020 Strategic Priorities addressed in this report:
Effective Collaboration and Improving Health Equity

Key Messages

- Hazard Identification and Risk Assessment (HIRA) is a process that Algoma Public Health (APH) uses to identify, assess, and respond to health hazards in the community.
- APH investigates complaints, collaborates with partners, and engages in health promotion initiatives in an effort to reduce exposure to health hazards and promote healthy environments.
- APH will work to strengthen public communication regarding common health hazards, and continue to monitor local and regional opportunities to advance policies that protect and promote health.

Introduction

APH has a broad health protection mandate to reduce exposures to environmental health hazards and to prevent and reduce the burden of illness from potential, suspected, and/or identified health hazards. This work is conducted under the Healthy Environments Program Standard of the Ontario Public Health Standards, 2018, and adheres to the Health Hazard Response Protocol, 2018. Foundational to this work is the Hazard Identification and Risk Assessment (HIRA) process, which is used to identify and assess hazards in terms of their potential health harms, and the magnitude and probability of exposure to the population[1]

Definitions
Health Hazard: A health hazard can be (a) a condition of a premise, (b) a substance, thing, plant or animal other than man, or (c) a solid, liquid, gas or combination of any of them, that has or that is likely to have an adverse effect on the health of any person.[1]

Risk Assessment: The scientific process that characterizes the potential risk of hazards to human health, consisting of four main steps: hazard identification, dose-response assessment, exposure assessment, and risk characterization.[2]

Health Hazards and Health Hazard Complaints in Algoma
In 2017 APH received 1,078 complaints from the public regarding perceived health hazards. The 3 most common types of complaints were:

1. Bedbugs (19.3%)
2. Mould (16.8%)
3. Pests (13.8%)

Other types of complaints include: garbage, hoarding, and indoor and outdoor air quality. It's important to note that while pests are a nuisance, they often do not represent a threat to the public's health. During these instances, APH provides education and refers the matter to others in the community who are better positioned to resolve the (e.g., pest control companies).

Many other environmental health hazards are a potential source of health harm to the Algoma population, but may not always be perceived as such. Common environmental health hazards include episodes of extreme outdoor temperature, indoor radon gas, and unsafe water quality at beaches.

APH Intervention
As part of the health protection mandate, APH investigates complaints and conducts follow-ups, provides guidance for partners during instances when the HIRA process is required, and engages in health promotion initiatives regarding health hazards and strategies for mitigation.

Complaint investigation and follow-up
Public Health Inspectors (PHI) receive complaints and determine if they are within public health's jurisdiction (if not, a referral to the appropriate organization is made). PHIs gather relevant information about the complaint, and conduct a HIRA to characterize the potential risk of the hazard. Should the complaint represent a health hazard to the public (e.g., unsafe food handling at a restaurant), the PHI will gather evidence for the hazard and issue an appropriate response. Depending on the nature of the incident, a response may be in the form of education, equipment seizure, ticketing, remediation, or issuing a closure. Complaints are deemed closed once the issue has been addressed, and the complainant is notified that it has been dealt with.

Consultation and anticipatory guidance
APH partners with provincial organizations such as the Ministry of Environment and Climate Change and Public Health Ontario, as well as local organizations such as the Sault Ste. Marie Emergency Control Group and the Public Utilities Commission (PUC), in order to effectively identify and respond to health hazards in the community. Collaborations in the past have helped to ensure a safe water supply for Algoma communities, and raise awareness regarding air quality and extreme heat events.

Recently APH has engaged with the City of Sault Ste. Marie (the City) specifically regarding extreme heat

surveillance and reporting. Through a partnership with Environment Canada, APH receives notification of extreme heat advisories for the Algoma District, shares this information with the City (who then activates their community-wide 'cooling stations'), and then reports on the health hazard to members of the public through a media release, which also includes health promotion messaging (e.g., strategies for mitigating risk of heat-related illness). We expect as other communities in the district expand their Climate Change and Emergency Preparedness activities we will be more involved with the health hazards of extreme heat and cold.

Health promotion

APH utilizes a health promotion approach when identifying and assessing risk for health hazards. Each year the Environmental Health program encourages residents of Algoma to test for radon in their homes. Radon is classified as a carcinogen and is one of the leading causes of lung cancer.[2]

In the November 2017 Radon report to the Board of Health, APH committed to monitoring proposed changes to the Ontario Building Code, with the intention of acting upon any advocacy and/or policy windows that amended legislation may create. The City of Elliot Lake is a unique example in the Algoma District, as new structures are required to have radon levels below 200 Bq/m^3.[3] Currently, a proposed amendment to the Ontario Building Code would extend this requirement to all new buildings in the province[3]. Amendments to the Building Code would offer a more long-term, equitable solution for Ontario residents, as many cannot afford to test their homes for radon gas.

APH also uses the agency website to communicate key health messages to the public for a range of health hazards, including air quality, lead, radon, and food safety.

Next Steps

With recent increased capacity in APH Communications, and new Ontario Public Health Standard (OPHS) requirements related to Healthy Environments and Climate Change, APH will work to strengthen existing communication strategies for disseminating health messages and alerts related to common environmental health hazards (e.g., heat alerts, cold alerts, summer water/beach safety messages, etc.).

References

1. Ministry of Health and Long-Term Care. (2018). Health Hazard Response Protocol, 2018. Available from: http://health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/protocols_guidelines/Health_Hazard_Response_Protocol_2018_en.pdf
2. Committee on Health Risks of Exposure to Radon (BEIR VI), National Research Council. Health effects of exposure to radon: BEIR VI. Washington, DC: National Academies Press; 1999. Available from: http://www.nap.edu/catalog.php?record_id=5499
3. Ministry of Municipal Affairs. (2016). Proposed Change To The 2012 Building Code O. Reg. 332/12 As Amended. Available from: http://www.mah.gov.on.ca/AssetFactory.aspx?did=15319

Topic: Indigenous/First Nations Relationship Building

From: Laurie Zeppa, Director of Health Promotion and Protection , Health Equity PHNs

Public Health Goal: To improve and protect the health and well-being of the population of Algoma and to reduce health inequities.

Public Health Standards- Requirements addressed in this report:
Health Equity Foundational Standard

- The Board of Health shall engage in multi-sectoral collaboration including engagement with the communities and organizations, as well as with First Nations communities. The *Relationship with Indigenous Communities Guideline, 2018* emphasizes the importance of engaging with Indigenous communities to create meaningful relationships and collaborative partnerships and to work towards decreasing health inequities.

2015-2020 Strategic Priorities addressed in this report:
Improve Health Equity, Collaborate Effectively, Be Accountable and Enhance Employee Engagement

Key Messages

- Approximately 13.8% of the population in the Algoma District report Aboriginal Identity, compared to 2.8% in Ontario.
- The Canadian and Ontario governments have released key documents that help guide public health practice to support meaningful engagement with Indigenous/First Nations partners.
- Algoma Public Health's (APH) participation in a regional engagement research project will help guide next steps for the agency.

Introduction
Public health has a mandate to protect and promote the health of all Ontarians. Of the 35 public health units in Ontario, 21 intersect with the boundaries of 133 First Nations communities;[1] APH being one of these health units.

The Canadian and Ontario governments have provided a foundation from which public health can approach relationship building with Indigenous/First Nations partners. On December 15, 2015 the Truth and Reconciliation Commission (TRC) of Canada released a report detailing 94 Calls to Action for Canadians, many of which apply to public health.[2] The OPHS explicitly refer to relationship building with Indigenous/First Nations partners under the Foundational Standard of Health Equity. Further, the *Relationship with Indigenous Communities Guideline, 2018* is meant to assist public health in the implementation of the Health Equity Standard.

Algoma Public Health's geographic boundaries intersect with 8 Indigenous/First Nation communities. Approximately 13.8% of the population in the Algoma District report Indigenous Identity, compared to 2.8% in Ontario.[3] The proportion of Indigenous children in Algoma aged 14 and under is higher than non-Indigenous children (22.9% and 12.9%, respectively).

Table 1 Brief demographic profile of Indigenous and Non-Indigenous residents in Algoma, 2016[3]

	Indigenous	**Non-Indigenous**
Average Age	35.9 years	46.4 years
% of children aged 14 and under	22.9%	12.9%

Data notes: Population region used is the Algoma Census Division and not the District of Algoma Health Unit region due to data availability. This may have minor implications on the numbers presented above.

APH Program

APH has engaged with Indigenous/First Nations partners from a program and agency level for the past several years. Program-specific activities have focused on: tobacco misuse prevention with youth in Garden River and Thessalon First Nations, participation on a district-wide Fetal Alcohol Spectrum Disorders (FASD) committee, Diabetes Prevention Strategy Project and breastfeeding support and awareness with the North Shore's Maamwesying First Nation.

Agency-wide work has focused on: exploring relationship frameworks with Maamwesying First Nation (2015), cultural awareness training for APH staff (2015), Service Level Agreement with Garden River Wellness Centre (ongoing for the past 15 years), and current participation in the 'relationship building with First Nations and public health' Locally-Driven Collaborative project (LDCP)(2017). APH has also recently crafted a land acknowledgement, which is shared at staff and community gatherings.

APH is 1 of 5 northeastern health units participating in the LDCP project that seeks to explore principles and practices regarding First Nations engagement to improve community health.[1] The LDCP project expects to further emphasize how public health units can operationalize the *Relationship with Indigenous Communities Guideline, 2018*, based on the evidence-based principles of: respect, trust, self-determination, and commitment.[1]

It's important to note that APH does not have jurisdictional authority over the 8 Indigenous/First Nations communities that align with the APH catchment area, as the federal government is responsible for these areas.[4] Because public health unit funding for programs and services is partially provided by the Ontario Ministry of Health and Long-Term Care (MOHLTC), the nature of APH activities thus reflects these federal/provincial boundaries. Within this context the Ontario Public Health Association (OPHA) has resolved to work towards reconciliation with its Indigenous/First Nation partners.[5] APH's involvement with the current LDCP further commits the agency in approaching First Nations engagement in a meaningful, evidence-based way.

Next Steps

As guided by the *Relationship with Indigenous Communities Guideline, 2018* and the upcoming results from the LDCP project, APH will continue to focus on relationship-building with Indigenous/First Nations communities in the Algoma District. Cultural awareness training will continue for staff, and the land acknowledgement will continue to set the stage at internal and external events and gatherings. These activities, coupled with broader, relationship-focused efforts, will support APH and its partners in reducing health inequities and improve and protect the health and well-being of the entire population of Algoma.

APH PARTNERSHIPS

We have recently been approached by the Ontario Aboriginal HIV/AIDS Strategy (OAHAS) as they desire to expand their service delivery to the SSM and Algoma area. We are exploring options for sharing of office space.

Respectfully submitted,

Dr. Marlene Spruyt

References

1. Relationship Building with First Nations and Public Health Research Team. (2017). Relationship building with First Nations and public health: Exploring principles and practices for engagement to improve community health – Literature Review. Sudbury, ON: Locally Driven Collaborative Projects. Available from: http://www.publichealthontario.ca/en/ServicesAndTools/Documents/LDCP/FirstNationsTeam_LiteratureReview_FINAL.pdf

2. Truth and Reconciliation Commission of Canada. (2015). Honoring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada. Available from: www.trc.ca

3. Statistics Canada. (2017). Focus on Geography Series, 2016 Census. Statistics Canada Catalogue no.98-404-X2016001. Ottawa, Ontario. Data products, 2016 Census. Available from: http://www12.statcan.gc.ca/census-recensement/2016/as-sa/fogs-spg/Facts-CD-Eng.cfm?TOPIC=9&LANG=Eng&GK=CD&GC=3557

4. Simeone, T., for the Parliament of Canada. (2001). Federal-Provincial Jurisdiction and Aboriginal Peoples. Available from: https://lop.parl.ca/content/lop/ResearchPublications/tips/tip88-e.htm

5. Ontario Public Health Association. (2017). OPHA's Resolution on the Public Health Response to the Truth and Reconciliation's Call to Action. Available from: http://opha.on.ca/Advocacy-and-Policy/Position-Paper,-Resolutions-and-Motions.aspx

Algoma Public Health Finance and Audit Committee Report

June 13, 2018

Attendance: Serge Saccucci, Ian Frazier, Dr. Patti Avery, Adrienne Kappes, Dr. Marlene Spruyt, Dr. Jennifer Loo, Justin Pino, Joel Merrylees, Tania Caputo

Prior to reviewing the draft financial statements for the period ending April 30, 2018, Justin Pino, Chief Financial Officer provided an overview with respect to the format of the financial statement. This discussion provided insight into the revenue and expenses of the Public Health and Community Health Programs. The objective was to assist the finance committee members in the understanding of the financial statement for the organization.

The financial statement for the three-month period ending April 30, 2018 were discussed and reviewed. With respect to the revenue and expenses as per the statement of operations, there was sufficient revenue to cover expenses. With respect to the balance sheet, the working capital position continues to trend in a satisfactory manner due to the cash and short term investments that are available.

The organization outsources their information technology (IT) services. The agreement with our provider expires on April 1st, 2019 and given the dollar amount a formal tender is required. At this time there have been discussions exploring shared services opportunities with other health units within the Northeast area. To provide ample time to review any collaboration opportunities, the Finance Committee recommended the extension with the current IT service provider for an additional year.

Sergio Saccucci,
Finance and Audit Committee Chair

Algoma Public Health
(Unaudited) Financial Statements April 30, 2018

Algoma Public Health
Statement of Operations
April 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	$ 1,751,090	$ 1,751,090	$ 1	$ 3,502,179	0%	100%
Provincial Grants - Cost Shared Funding	2,436,400	2,436,400	-	7,309,200	0%	100%
Provincial Grants - Public Health 100% Prov. Funded	998,548	998,985	(437)	2,996,950	0%	100%
Fees, other grants and recovery of expenditures	169,218	234,371	(65,153)	699,214	-28%	72%
Provincial Grants - Funding for Prior Yr Expenses	0	0	-	-		
Total Public Health Revenue	$ 5,355,256	$ 5,420,846	$ (65,589)	$ 14,507,543	-1%	99%
Expenditures						
Public Health Cost Shared	$ 3,646,424	$ 3,875,674	$ 229,250	$ 11,510,592	-6%	94%
Public Health 100% Prov. Funded Programs	849,654	996,956	147,302	2,996,951	-15%	85%
Total Public Health Programs Expenditures	$ 4,496,078	$ 4,872,630	$ 376,552	$ 14,507,543	-8%	92%
Excess of Rev. over Exp. Cost Shared Funding	$ 710,284	$ 546,187	$ 164,097	$ 2		
Excess of Rev. over Exp. 100% Prov. Funded	148,894	2,029	146,865	(2)		
Provincial Grants for Prior Yr Expenses	-	-	-	-		
Total Rev. over Exp. Public Health	$ 859,178	$ 548,216	$ 310,962	$ (0)		
Healthy Babies Healthy Children						
Provincial Grants and Recoveries	$ 356,011	356,004	(7)	1,068,011	0%	100%
Expenditures	331,121	354,736	(23,615)	1,068,011	-7%	93%
Excess of Rev. over Fiscal Funded	24,890	1,267	23,622	(0)		
Public Health Programs - Fiscal 18/19						
Provincial Grants and Recoveries	$ -	-	-	134,651		
Expenditures	-	-	-	134,651		
Excess of Rev. over Fiscal Funded	-	-	-	-		
Community Health Programs						
Calendar Programs						
Revenue						
Provincial Grants - Community Health	$ -	$ -	$ -	$ -		
Municipal, Federal, and Other Funding	92,375	110,833	(18,458)	332,500	-17%	83%
Total Community Health Revenue	$ 92,375	$ 110,833	$ (18,458)	$ 332,500	-17%	83%
Expenditures						
Child Benefits Ontario Works	854	8,167	7,313	24,500	-90%	10%
Algoma CADAP programs	90,173	102,667	12,494	308,000	-12%	88%
One-Time Funding programs	0	0	-	-	#DIV/0!	#DIV/0!
Total Calendar Community Health Programs	$ 91,026	$ 110,833	$ 19,807	$ 332,500	-18%	82%
Total Rev. over Exp. Calendar Community Health	$ 1,349	$ (0)	$ 1,349	$ 0		
Fiscal Programs						
Revenue						
Provincial Grants - Community Health	$ 461,761	$ 461,723	$ 38	$ 5,646,442	0%	100%
Municipal, Federal, and Other Funding	72,451	88,151	(15,700)	719,753	-18%	82%
Other Bill for Service Programs	1,121		1,121			
Total Community Health Revenue	$ 535,332	$ 549,873	$ (14,541)	$ 6,366,195	-3%	97%
Expenditures						
Brighter Futures for Children	5,445	9,537	4,092	114,447	-43%	57%
Infant Development	46,046	53,482	7,436	643,783	-14%	86%
Preschool Speech and Languages	50,763	51,105	341	614,256	-1%	99%
Nurse Practitioner	11,291	11,954	664	145,452	-6%	94%
Genetics Counseling	33,245	30,650	(2,595)	367,806	8%	108%
Community Mental Health	287,474	293,875	6,400	3,526,498	-2%	98%
Community Alcohol and Drug Assessment	58,793	60,346	1,553	724,152	-3%	97%
Healthy Kids Community Challenge	10,234	18,750	8,516	112,500	-45%	55%
Stay on Your Feet	8,510	8,333	(177)	100,000	2%	102%
Bill for Service Programs	1,476	-	(1,476)	-		
Misc Fiscal	-	-	-	-		
Total Fiscal Community Health Programs	$ 513,278	$ 538,033	$ 24,755	$ 6,348,894	-5%	95%
Total Rev. over Exp. Fiscal Community Health	$ 22,054	$ 11,840	$ 10,214	$ 17,301		

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 Four Months Ending April 30, 2018
(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	1,212,882	1,212,882	0	2,425,762	0%	50%	1,211,486	1,211,486	0
Levies Vector Bourne Disease and Safe Water	29,716	29,716	0	59,433	0%	50%	29,717	29,717	0
Levies District	508,492	508,492	0	1,016,984	0%	50%	505,076	501,190	3,886
Total Levies	**1,751,090**	**1,751,090**	**0**	**3,502,179**	**0%**	**50%**	**1,746,279**	**1,742,393**	**3,886**
MOH Public Health Funding	2,376,967	2,376,967	0	7,130,900	0%	33%	2,376,966	2,376,967	(1)
MOH Funding Vector Borne Disease	36,233	36,233	0	108,700	0%	33%	36,233	36,233	(0)
MOH Funding Safe Water	23,200	23,200	0	69,600	0%	33%	23,200	23,200	0
Total Public Health Cost Shared Funding	**2,436,400**	**2,436,400**	**0**	**7,309,200**	**0%**	**33%**	**2,436,399**	**2,436,400**	**(1)**
MOH Funding Needle Exchange	21,567	21,567	0	64,700	0%	33%	16,901	16,900	1
MOH Funding Haines Food Safety	8,200	8,200	0	24,600	0%	33%	8,200	8,200	0
MOH Funding Healthy Smiles	256,633	256,633	0	769,900	0%	33%	256,634	256,633	1
MOH Funding - Social Determinants of Health	60,167	60,167	0	180,500	0%	33%	60,167	60,167	0
MOH Funding - MOH / AMOH Top Up	41,718	42,150	(432)	126,451	-1%	33%	0	0	0
MOH Funding Chief Nursing Officer	40,501	40,500	1	121,500	0%	33%	40,501	40,500	1
MOH Enhanced Funding Safe Water	5,167	5,167	0	15,500	0%	33%	5,167	5,167	0
MOH Funding Unorganized	176,800	176,800	0	530,400	0%	33%	171,701	171,700	1
MOH Funding Infection Control	104,134	104,133	1	312,400	0%	33%	104,134	104,133	1
MOH Funding Diabetes	50,000	50,000	0	150,000	0%	33%	50,000	50,000	0
MOH Funding Northern Ontario Fruits & Veg.	39,126	39,133	(7)	117,400	0%	33%	0	0	0
Funding Ontario Tobacco Strategy	144,534	144,534	0	433,600	0%	33%	144,533	144,533	0
MOH Funding Harm Reduction	50,000	50,000	0	150,000	0%	33%	0	0	0
One Time Funding	0	0	0	0		0%	0	0	0
Total Public Health 100% Prov. Funded	**998,547**	**998,984**	**(437)**	**2,996,951**	**0%**	**33%**	**857,938**	**857,933**	**5**
Funding for Prior Yr Expenses	**0**	**0**	**0**	**0**		**0%**	**0**	**0**	**0**
Recoveries from Programs	33,924	20,783	13,141	27,450	63%	124%	3,354	3,354	(0)
Program Fees	73,584	79,255	(5,671)	237,764	-7%	31%	80,460	83,248	(2,788)
Land Control Fees	14,350	53,333	(38,983)	160,000	-73%	9%	18,900	53,333	(34,433)
Program Fees Immunization	35,903	61,667	(25,764)	185,000	-42%	19%	60,885	59,833	1,052
HPV Vaccine Program	298	7,000	(6,703)	20,000	0%	1%	289	1,300	(1,011)
Influenza Program	0	0	0	25,000	0%	0%	1,490	1,100	390
Meningococcal C Program	77	1,000	(924)	10,000	0%	1%	842	600	242
Interest Revenue	11,084	4,667	6,417	14,000	137%	79%	4,138	3,557	580
Other Revenues	0	6,667	(6,667)	20,000	0%	0%	0	0	0
Total Fees, Other Grants and Recoveries	**169,219**	**234,372**	**(65,153)**	**699,214**	**-28%**	**24%**	**170,357**	**206,325**	**(35,969)**
Total Public Health Revenue Annual	**$ 5,355,256**	**$ 5,420,846**	**$ (65,590)**	**$ 14,507,544**	**-1%**	**37%**	**$ 5,210,972**	**$ 5,243,052**	**$ (32,079)**

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 Four Months Ending April 30, 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	*Comparison Prior Year:* *YTD Actual 2017*	*YTD BGT 2017*	*Variance 2017*
Salaries & Wages	$ 2,716,444	$ 2,953,346	$ 236,902	$ 8,868,131	-8%	31%	$ 2,500,049	$ 2,809,794	$ 309,745
Benefits	704,753	701,726	(3,027)	2,105,552	0%	33%	643,855	661,753	17,899
Travel - Mileage	18,946	40,166	21,219	120,775	-53%	16%	18,299	42,620	24,321
Travel - Other	33,750	25,000	(8,750)	75,000	35%	45%	16,525	25,981	9,456
Program	132,406	217,047	84,641	669,715	-39%	20%	163,275	221,828	58,553
Office	34,566	38,970	4,404	116,909	-11%	30%	36,060	44,750	8,690
Computer Services	229,951	225,294	(4,657)	700,881	2%	33%	188,443	233,173	44,730
Telecommunications	81,435	101,101	19,667	303,304	-19%	27%	82,813	82,265	(548)
Program Promotion	43,095	54,963	11,868	167,223	-22%	26%	17,744	56,932	39,188
Facilities Expenses	256,588	265,000	8,412	795,000	-3%	32%	275,127	266,783	(8,344)
Fees & Insurance	124,259	131,150	6,891	228,450	-5%	54%	164,059	144,032	(20,027)
Debt Management	153,633	153,633	0	460,900	0%	33%	153,633	153,633	0
Recoveries	(33,747)	(34,766)	(1,018)	(104,297)	-3%	32%	(32,161)	(22,803)	9,359
	$ 4,496,079	$ 4,872,631	$ 376,552	$ 14,507,543	-8%	31%	$ 4,227,720	$ 4,720,742	$ 493,023

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 – April 2018

Reporting Period

The April 2018 financial reports include four 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 one month results from operations year ended March 31st, 2019.

Statement of Operations (see page 1)

Summary – Public Health and Non Public Health Programs

As of April 30th 2018, Public Health programs are reporting a $311k positive variance.

Total Public Health Revenues are indicating a negative $66k variance. This is a result timing of receipts of Fees, Other Grants & Recoveries. 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 $377k 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. The successful candidate started in May resulting in budgeted salary dollars not being spent for four months. 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 3.6 Public Health FTE positions that have been budgeted but have yet to be filled.

In May, APH was notified that it will be receiving up to an additional $214,000 in base funding and up to $227,000 in one-time funding. APH's Public Health budget will be revised as of May 2018.

Resource planning deliberations are occurring to help meet the needs of the agency. The rate at which the Salary and Wages expense positive variance is increasing will begin to slow down as positions are filled.

Community Health Calendar programs are operating within budget.

APH's Community Health Fiscal Programs are one month into the fiscal year and as such actual expenses are relatively aligned with budget.

Public Health Revenue (see page 2)

Public Health funding revenues are showing a negative $66k variance.

The municipal levies are within budget.

Cost Shared and 100% Provincially Funded revenues are within budget.

Notes Continued...

Fees, Other Grants & Recoveries are showing a negative variance of $65k. Land Control Fees are showing a negative $39k variance. In addition, Program Fees Immunization is showing a $26k negative variance. APH typically captures the bulk of its fees between the spring and fall months. As the year progresses it is anticipated these positive variances will decrease.

Public Health Expenses (see page 3)

Salary & Wages

The $237k 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. The successful candidate started in 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 3.6 Public Health FTE positions that have been budgeted to but have yet to be filled.

Travel

Travel – mileage expense is indicating a positive $21k variance. Staff travel within the district typically increases from spring to fall. As the year progresses this positive variance is expected to reduce.

Program

Program expense is indicating a positive $85k variance. This is primarily a result of timing of expenses not yet incurred. In addition, payment to the schools with regards to the Northern Ontario Fruits and Vegetables program was planned for April however the payment occurred in May.

Telecommunications

Telecommunications is showing a positive $20k variance. April's cell phone bill was processed in May contributing to the positive variance. Spending for the year is also below what was budgeted.

Financial Position - Balance Sheet (see page 7)

APH's liquidity position continues to be stable and the bank has been reconciled as of April 30th, 2018. Cash includes $525k in short-term investments.

Long-term debt of $5.38 million is held by TD Bank @ 1.95% for a 60 month term (amortization period of 180 months) and matures on September 1, 2021. $314k 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 April 2018	**April 2018**	December 2017
Assets		
Current		
Cash & Investments	**$ 3,379,521**	$ 2,931,699
Accounts Receivable	**275,874**	489,631
Receivable from Municipalities	**321,542**	30,769
Receivable from Province of Ontario		
Subtotal Current Assets	**3,976,937**	3,452,099
Financial Liabilities:		
Accounts Payable & Accrued Liabilities	**1,434,217**	1,436,721
Payable to Gov't of Ont/Municipalities	**193,960**	543,083
Deferred Revenue	**426,874**	512,747
Employee Future Benefit Obligations	**2,704,275**	2,704,275
Term Loan	**5,554,992**	5,554,992
Subtotal Current Liabilities	**10,314,318**	10,751,817
Net Debt	**-6,337,382**	-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	**14,576,488**	13,614,152

Algoma PUBLIC HEALTH
Santé publique Algoma

Briefing Note

www.algomapublichealth.com

To: Algoma Public Health Board of Health

From: Dr. Marlene Spruyt, MOH/CEO
Justin Pino, CFO

Date: June 13th, 2018

Re: Information Technology Services Outsourcing Contract

☐ For Information ☐ For Discussion ☒ For a Decision

ISSUE:

Algoma Public Health (APH) outsources its information technology (IT) services. The current Service Level Agreement (SLA) with the service provider is set to expire April 1st, 2019. As per APH's Procurement Policy 02-04-030, given the dollar amount of the contract, a formal Request for Proposal (Tender) is required.

APH has committed resources to exploring shared services opportunities with other health units within the Northeast, known as the Northeastern Collaboration Project. IT services is within the scope of this project. IT shared service options may be presented by the consultant once the project is completed currently scheduled for October 2018. As a result more information may be available late this year that could be beneficial for the Board of Health to have prior to committing to a long-term service contract for IT services.

APH currently outsources its entire IT operations and has no internal resource with the technical expertise to articulate what specifications would be required to service APH's IT requirements. APH would have to be procure the services of a consultant to help assess the specifications needed in the Request for Proposal when APH is ready to go out to tender. This evaluation would take some time in advance of any Request for Proposal being issued. Also, if a transition plan is needed among service providers, this will take time as well.

The issue is whether APH should begin the tendering process immediately in preparation for the current contract expiration on April 1, 2019 or wait until the Northeastern Collaboration Project is completed to assess the best course of action at that time as it relates to IT services for APH and other Northeastern Health Units.

RECOMMENDED ACTION:

1) It is advised that the Finance and Audit Committee of the Board recommend to the Board of Health to approve a one-year extension to the existing Service Level agreement with the current IT service provider under the same terms and conditions as the existing contract.

2) It is recommended that the Finance and Audit Committee of the Board recommend to the Board of Health that the Board wait until the Northeastern Collaboration project is completed prior to going out to tender for IT Services.

BACKGROUND:

APH currently uses MicroAge Technical Services for its IT service needs. MicroAge provides onsite professional consulting and technical support services. The SLA includes:

- Electronic Health Record Support
- Network monitoring/infrastructure support
- System Administration and Security
- Asset Management
- Hardware maintenance
- Internet Service provision
- Server maintenance
- CISCO Switches, Routers, VoIP, Firewalls
- Workstation/Monitor
- Xerox Printers
- Helpdesk
- 24 x 7 Coverage
- Antivirus
- E-mail System Administration

Items not included in the SLA which MicoAge performs is:

- IT Strategic Support
- Cell Phone administration

The current breakdown of MicroAge resources is:

- System Engineer (Manager)
- System Engineer (Flexible depending on demands)
- Senior Software Developer (EHR Support)
- Junior Software Developer (Intranet Support)
- Help Desk (daily troubleshooting support)

FINANCIAL IMPLICATIONS:

IT services are required in one form or another. That may include the traditional outsourcing model that APH currently has or may include in-house options. The extension of the SLA for one year will result in the continuation of $460,000 of outsourced services for an additional year as per the existing terms of the SLA. Once the Northeast Collaborative project is completed, APH's Board of Health may have more information available to determine next steps with respect IT services mode of delivery for APH.

CONTACT:

J. Pino, Chief Financial Officer

Perth District Health Unit
653 West Gore Street
Stratford, Ontario N5A 1L4
(519) 271-7600 • www.pdhu.on.ca

June 14, 2018

Honourable Jody Wilson-Raybould
Minister of Justice
House of Commons
Ottawa, ON K1A 0A6

Dear Minister Wilson-Raybould;

RE: Repeal of Section 43 of the Criminal Code

The Board of Health of the Perth District Health Unit considered the attached resolution from the Haliburton, Kawartha, Pine Ridge District Health Unit at its regular meeting on March 21, 2018. The following motion was passed:

> **That the Board support the Haliburton, Kawartha, Pine Ridge District Health Unit letter re Repeal of Section 43 of the Criminal Code.**

This is not the first time the Board of Health considered the repeal of Section 43 of the Criminal Code of Canada. In September 2005, the Board of Health for the Perth District Health Unit first adopted a resolution to support the repeal of Section 43 of the Criminal Code of Canada and affirmed its position on potential harm and ineffectiveness of the physical punishment of children by endorsing the Joint Statement on Physical Punishment of Children and Youth. The Perth District Health Unit works in collaboration with other local community agencies to further our goal of ensuring optimal preconception, pregnancy, newborn, child, youth and parental and family health. Our work includes comprehensive public health interventions related to preparation for parenting and positive parenting. The repeal of Section 43 of the Criminal Code of Canada which would afford children the same protection from physical assault as adults is a long overdue policy change that supports this community work.

Sincerely,

Teresa Barresi
Chair, Board of Health

/cp

Encl.

c. The Right Honourable Justin Trudeau, Prime Minister of Canada
John Nater MP
Randy Pettapiece, MPP
Kids First Steering Committee
Association of Local Public Health Agencies
All Ontario Public Health Units

HALIBURTON, KAWARTHA, PINE RIDGE DISTRICT HEALTH UNIT

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.

alPHa
Association of Local
PUBLIC HEALTH
Agencies

June 2018

DISPOSITION OF RESOLUTIONS

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

RESOLUTIONS CONSIDERED
at June 2018 alPHa Annual General Meeting

Resolution Number	Title	Sponsor	Action from Conference	Page Number
A18-1	Sustainable Funding for Local Public Health in Ontario	Peterborough Public Health	Carried as amended	1-2
A18-2	Public Health Support for a Minimum Wage That is a Living Wage	Peterborough Public Health	Carried	3-4
A18-3	Public Health's Role in Food Affordability Surveillance	Ontario Dieticians in Public Health	Carried as amended	5
A18-4	Extending the Ontario Pregnancy and Breastfeeding Nutritional Allowance to 24 Months	Southwestern Public Health	Carried as amended	6-7
A18-5	A Comprehensive Approach to Infection Prevention and Control (IPAC) in Regulated Health Professional Settings	Simcoe Muskoka District Health Unit	Carried as amended	8-9

alPHa
Association of Local PUBLIC HEALTH Agencies

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

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 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

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

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);
- 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

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, Métis and Inuit, whether in partnership with existing boards of health or in alternate models, are able to benefit fully from what public health has to offer.

ACTION FROM CONFERENCE: **Resolution CARRIED AS AMENDED**

alPHa
Association of Local PUBLIC HEALTH Agencies

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.

ACTION FROM CONFERENCE: **Resolution CARRIED**

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; and

WHEREAS both the 2018 Provincial Budget 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"; and

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

WHEREAS the Ministry of Health and Long-term Care's Population Health Assessment and Surveillance Protocol (2018) 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 a comprehensive role for Public Health and provide resources to support Public Health's role in the collection of food affordability data and in formalizing the process to develop an Ontario Market Basket Measure.

ACTION FROM CONFERENCE: **Resolution CARRIED AS AMENDED**

alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa RESOLUTION A18-4

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

SPONSOR: **Southwestern 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.

AND FURTHER that alPHa recommend that the Ministry of Community and Social Services:

1. Increase the Pregnancy/Breastfeeding allowance (Ontario Works Directive 6.5 and Ontario Disability Support Program Directive 6.5) to $145/month ($162/month if mother or infant is lactose intolerant) for the first 12 months of life to align with the Special Diet Allowance (Ontario Works Directive 6.6 and Ontario Disability Support Program Directive 6.4), which is provided to formula feeding mothers, for the first 12 months of life; and

2. Provide a $40/month Special Diet Allowance for formula feeding mothers from 12 to 24 months of age; and

3. Remove the requirement for mothers to disclose and have a health professional sign off on their chosen feeding method in order to be eligible to receive the income allowance.

ACTION FROM CONFERENCE: **Resolution CARRIED AS AMENDED**

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 publicly disclose on the findings; and

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

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 through mandatory education and a move toward 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) That base funding be sufficiently enhanced for the role of Boards of Health to respond to the increasing demands of IPAC complaints and lapses; and
5) That the Province of Ontario provides funds to support any extraordinary costs to Boards of Health in responding to such increased demands.

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.

ACTION FROM CONFERENCE: **Resolution CARRIED AS AMENDED**

June 18, 2018

Premier-Elect Doug Ford
Legislative Building
Queen's Park
Toronto ON M7A 1A1

Dear Premier-Elect:

Re: Dedicated Funding For Local Public Health Agencies From Cannabis Sales Taxation Revenue

On April 27, 2018 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Hastings Prince Edward Public Health regarding dedicated funding for local Public Health agencies from cannabis sales taxation revenue. The following motion was passed:

GBHU BOH Motion 2018-39

Moved by: David Inglis Seconded by: Mitch Twolan

"THAT, the Board of Health support the resolution from Hastings Prince Edward Public Health urging the provincial government to dedicate a portion of the cannabis excise tax revenue from the federal government to local Public Health agencies in Ontario."

Carried

Sincerely,

Hazel Lynn, MD, FCFP, MHSc
Acting Medical Officer of Health
Grey Bruce Health Unit

Cc: All Ontario Boards of Health

Encl.

HASTINGS PRINCE EDWARD
Public Health

Main Office – Belleville
179 North Park Street, Belleville, ON K8P 4P1
T: 613-966-5500 |1-800-267-2803 | **F:** 613-966-9418
TTY: 711 or 1-800-267-6511
www.hpepublichealth.ca

March 28, 2018

Premier Kathleen Wynne
Legislative Building
Queen's Park
Toronto, ON M7A 1A1

Re: Dedicated funding for local Public Health agencies from cannabis sales taxation revenue

Dear Premier Wynne,

At its meeting on March 06, 2018, the Hastings Prince Edward (HPEPH) Board of Health passed the following motion:

THAT the HPEPH Board of Health urge the provincial government to dedicate a portion of the cannabis excise tax revenue from the federal government to local Public Health agencies in Ontario.

On December 12, 2017, the Federal Government announced that the revenue generated from the taxation of cannabis sales will be split with provinces and territories according to the following principals:

- Provinces and territories will receive 75% of this revenue while the federal government will retain 25%.
- The federal portion of cannabis excise tax revenue will be capped at $100 million annually and any revenue above this limit would be provided to provinces and territories.
- With respect to this revenue, provinces and territories will work with municipalities according to shared responsibilities towards legalization.

Subsequently, on March 09, 2018 the Ontario Government sent a press release titled, **"Ontario Supporting Municipalities to Ensure Safe Transition to Federal Cannabis Legalization"**. In the release it was noted that it would: "Provide public health units with support and resources to help address local needs related to cannabis legalization." While this release made no specific reference to how much, or how resources would be invested within the Public Health system, it is reassuring that the Ontario Government recognizes the importance of investment in the comprehensive cannabis control strategy delivered by local public health agencies. To help meet the Government of Ontario's twin goals of creating a safe and sensible framework to

North Hastings
1P Manor Ln., L1-024, PO Box 99, Bancroft, ON K0L 1C0
T: 613-332-4555 | **F:** 613-332-5418

Prince Edward County
Suite 1, 35 Bridge St., Picton, ON K0K 2T0
T: 613-476-7471 | **F:** 613-476-2919

Quinte West
499 Dundas St. W., Trenton, ON K8V 6C4
T: 613-394-4831 | **F:** 613-965-6535

manage legalized cannabis, and of having the lowest provincial/territorial smoking rate in Canada, it is essential to invest in the prevention pillar of the comprehensive cannabis control strategy and to provide adequate resources for the implementation and enforcement of the revised smoke-free legislation that now includes cannabis.

Local Public Health agencies are uniquely placed to increase public awareness of the health risks of cannabis use and driving under the influence of cannabis. Local Public Health agencies are also primed to prevent the renormalization of smoking through the legalization of cannabis. This Public Health work is foundational to helping keep our communities healthy and safe – a goal that we share with the Government of Ontario.

Although local Public Health agencies are partially funded by municipalities, we recognize that their ability to share funding from cannabis excise tax revenue with local Public Health agencies may be limited due to other conflicting priorities. With dedicated funding from this revenue, local Public Health agencies will be better resourced to provide the essential public awareness work, education and enforcement that is required with the legalization of cannabis. It is important that prevention be a pillar of cannabis legalization from the outset and dedicated funding to local Public Health agencies is an important component of supporting and strengthening this pillar.

We urge the Ontario Government to dedicate sufficient resources to local Public Health agencies to ensure that both education and enforcement are a priority.

Thank you for your consideration of this request. Please do not hesitate to contact me if you have any questions or concerns.

Sincerely,

Maureen Piercy
Chair
Hastings Prince Edward Public Health Board of Health

Copy
Honourable Charles Sousa, Provincial Minister of Finance
Honourable Dr. Helena Jaczek, Provincial Minister of Health and Long-Term Care
Mr. Todd Smith, MPP, Prince Edward-Hastings
Mr. Lou Rinaldi, MPP, Northumberland-Quinte West
Association of Local Public Health Agencies
Boards of Health in Ontario
Dr. Ian Gemmill, MOH HPEPH

June 18, 2018

Windsor-Essex County Health Unit
1005 Ouellette Avenue
Windsor ON N9A 4J8

To Whom It May Concern:

Re: Recommendation/Resolution Report – Oral Health Report Update 2018

On May 25, 2018 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached recommendation/resolution report and Oral Health Report Update from Windsor-Essex County Board Of Health. The following motion was passed:

GBHU BOH Motion 2018-50

Moved by: Arlene Wright Seconded by: David Shearman

"THAT, the Board of Health for the Grey Bruce Health Unit support the resolution from Windsor-Essex County Health Unit regarding municipal water fluoridation; and FURTHER THAT this report and resolution be shared with local media."

Carried

Sincerely,

Hazel Lynn, MD, FCFP, MHSc
Acting Medical Officer of Health
Grey Bruce Health Unit

Cc: Local Media

Encl.

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

519-258-2146 | www.wechu.org 1

Windsor 1005 Ouellette Avenue, Windsor, ON N9A 4J8
Essex 360 Fairview Avenue West, Suite 215, Essex, ON N8M 3G4
Leamington 33 Princess Street, Leamington, ON N8H 5C5

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.

Oral Health Report 2018 Update

WINDSOR-ESSEX COUNTY
HEALTH UNIT

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

Authors: Mathew Roy
Epidemiologist

Ramsey D'Souza
Manager, Epidemiology & Evaluation

Contributors: Kim Casier
Oral Health Manager

Nicole Dupuis
Health Promotion Director

Dr. Wajid Ahmed
Acting Medical Officer of Health

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

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Windsor-Essex County
Health Unit

1005 Ouellette Avenue
Windsor, Ontario N9A 4J8
www.wechu.org
519-258-2146

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:

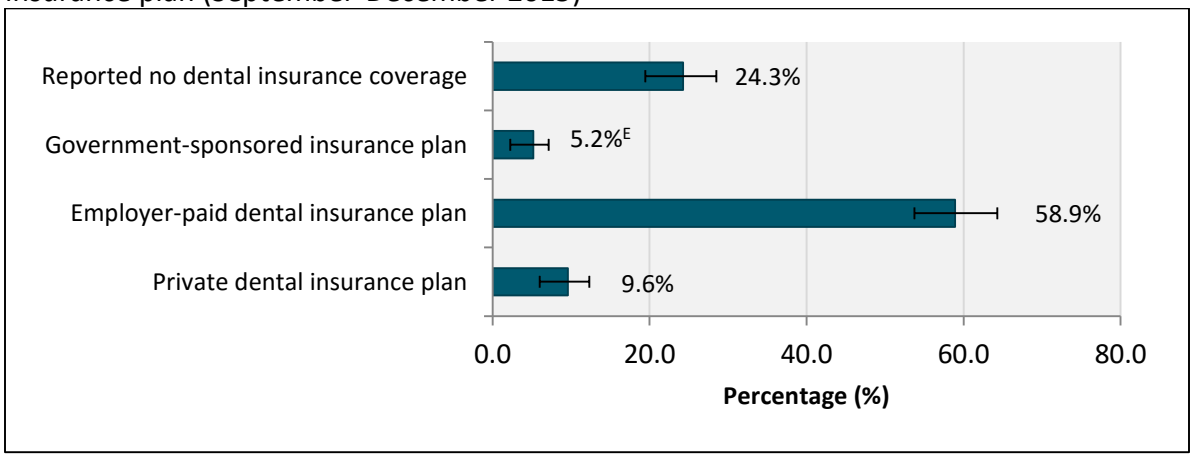
- Dental insurance coverage
- Early childhood dental habits
- Support for community water fluoridation
- Emergency department visits for oral health issues
- Day surgeries for oral health (caries-related) issues

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

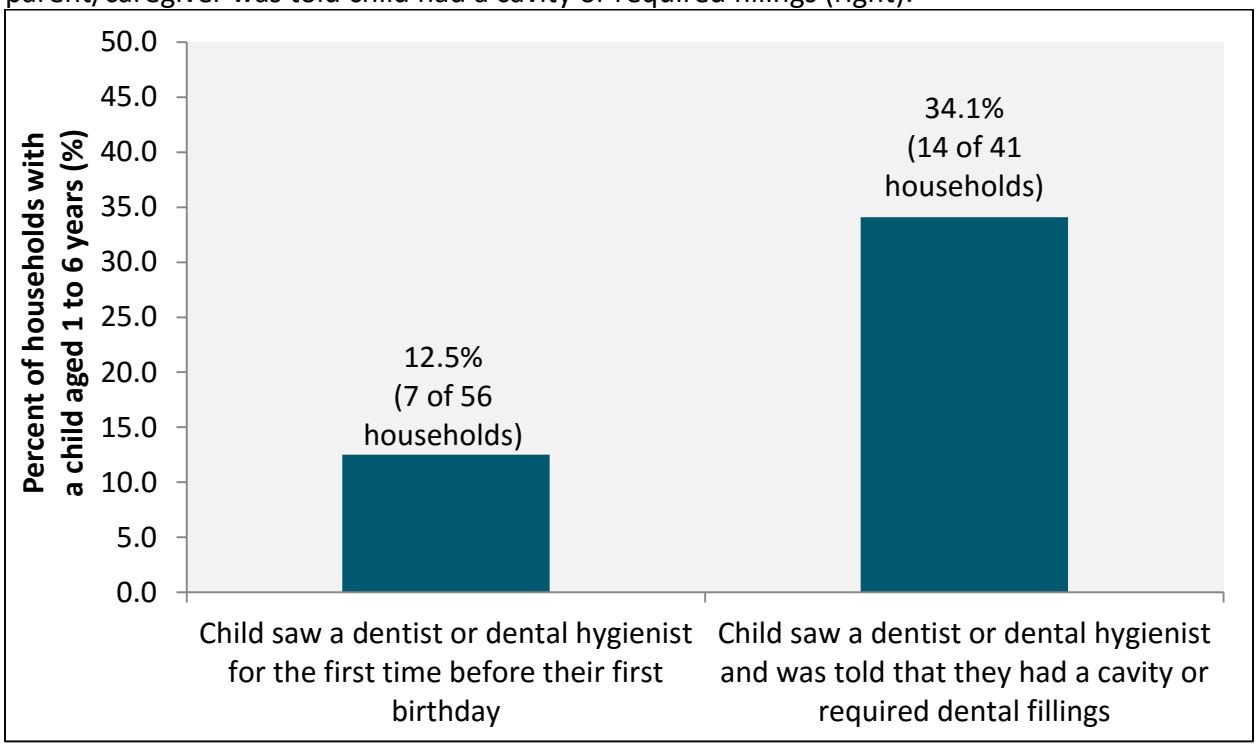
Note: Sample size of 401 respondents. Respondents who did not know the type of insurance plan they had are not depicted in this figure (< 10 respondents).

[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.

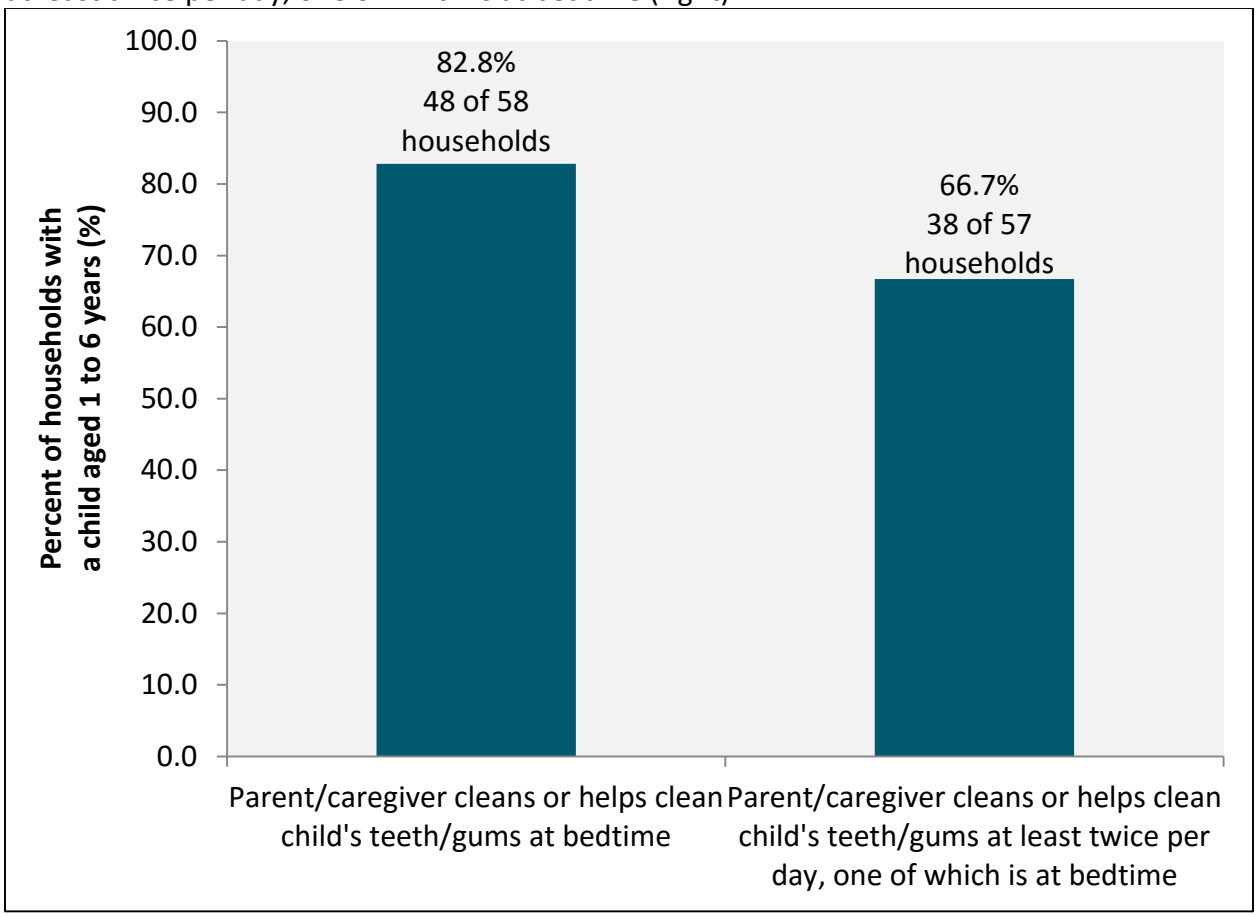
Figure 2. The percentage of households in Windsor-Essex County with a child between 1 and 6 years that saw a dental professional: for the first time before their first birthday (left); parent/caregiver was told child had a cavity or required fillings (right).



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).



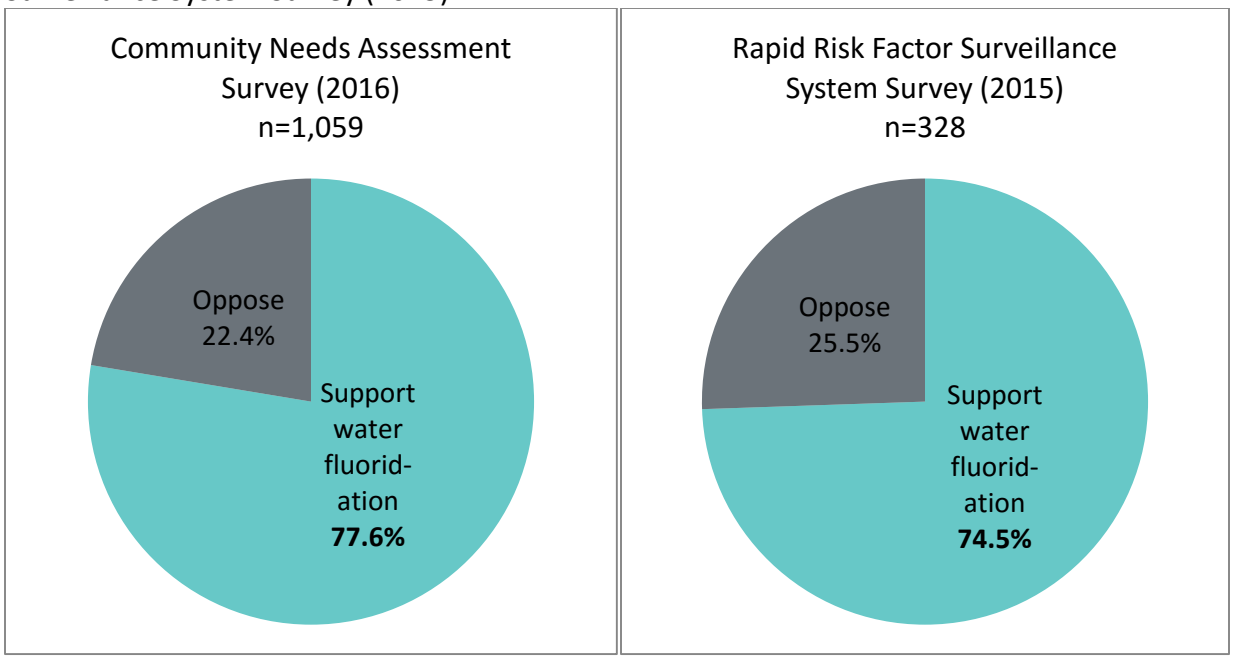
Source: Rapid Risk Factor Surveillance System (RRFSS), Jan-Apr 2016 and Jan-Apr 2017, Windsor-Essex County Health Unit

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).

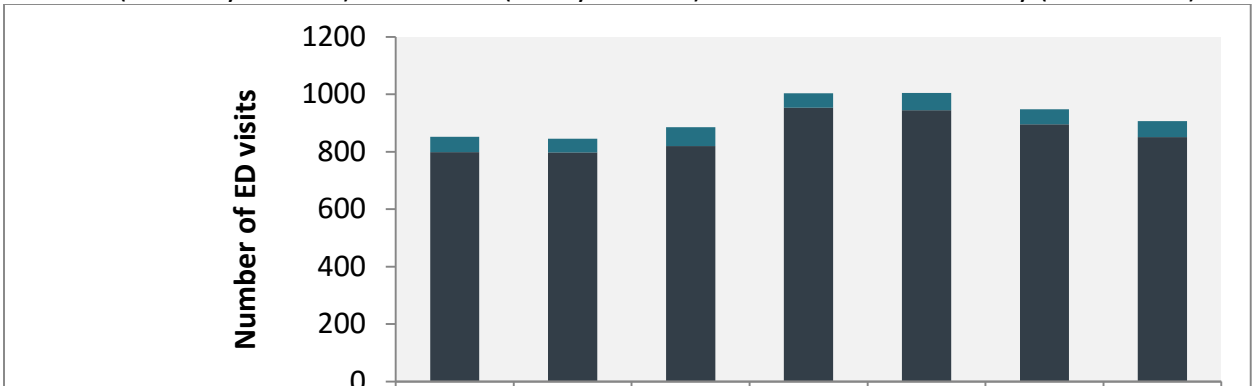
The number of EDs visits in Windsor-Essex County for oral health issues is reported by year in **Figure 5**. On average there were 921 ED visits annually for problems related to oral health (between 2010 and 2016), corresponding to an average annual rate of 240 oral health-related ED visits per 100,000 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).

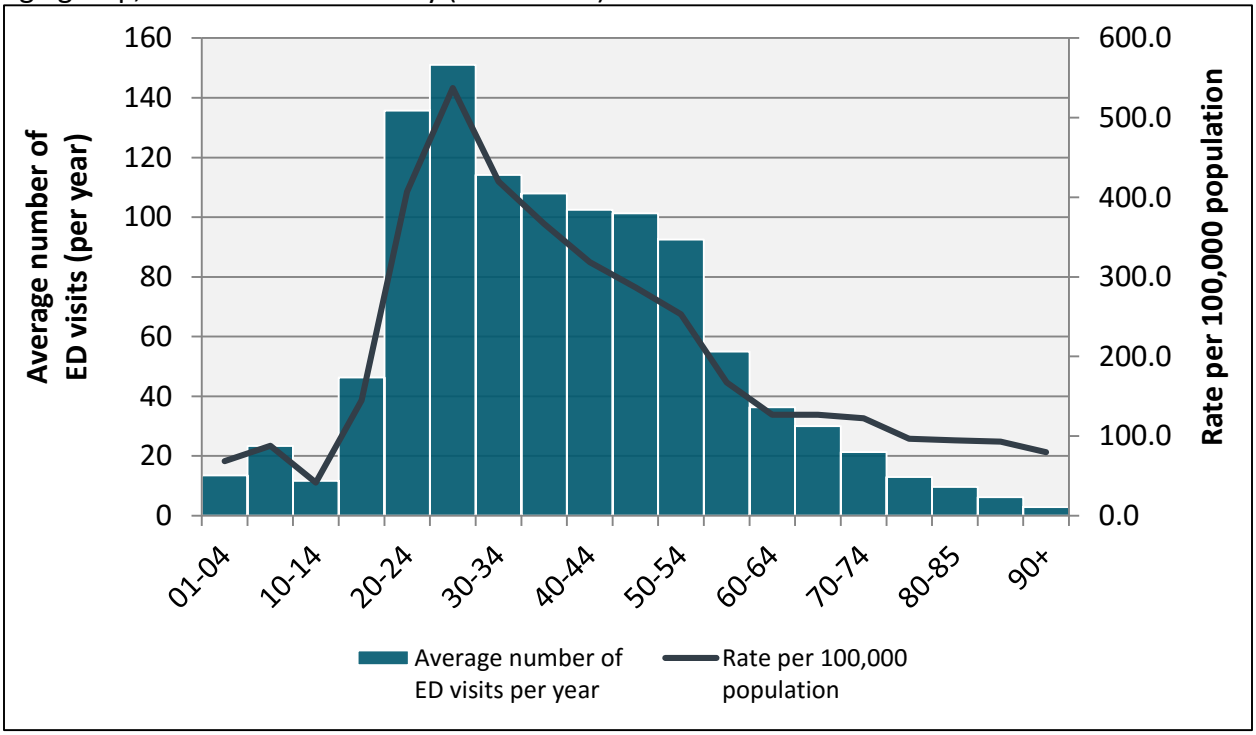
Figure 5. The annual number of oral health-related emergency department (ED) visits by children (1 to 17 years old) and adults (≥ 18 years old) in Windsor-Essex County (2010-2016)



	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

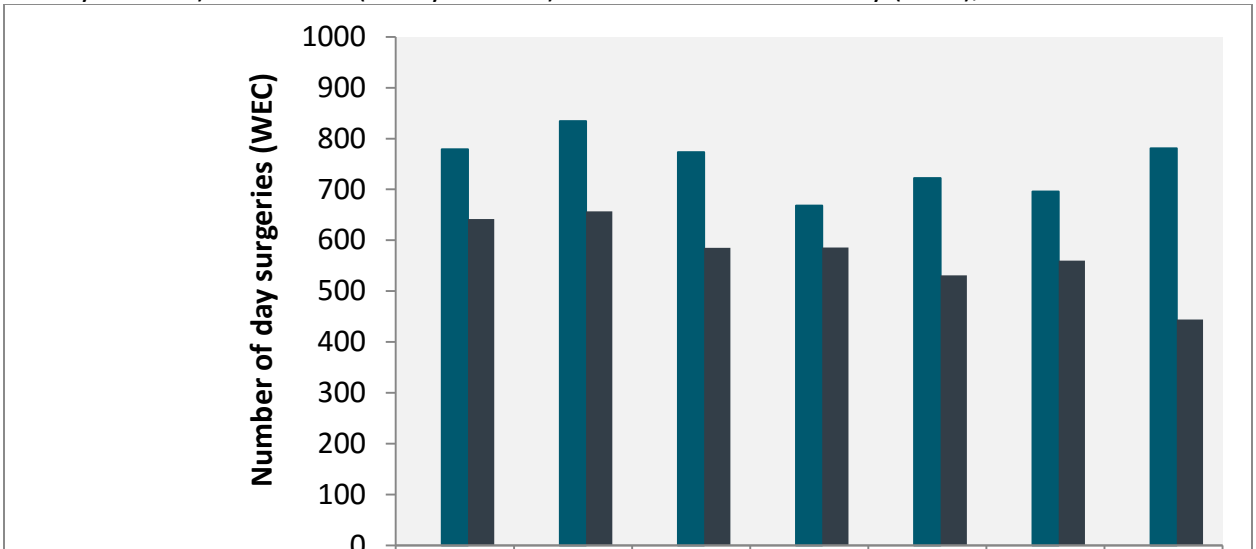
The most common type of day surgery for children in Canada is for oral health issues primarily caused by early childhood cavities. In fact, nearly 1 in 3 day surgeries among children are for oral health issues (Canadian Institute for Health Information, 2013). Despite the commonness of this problem, 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.

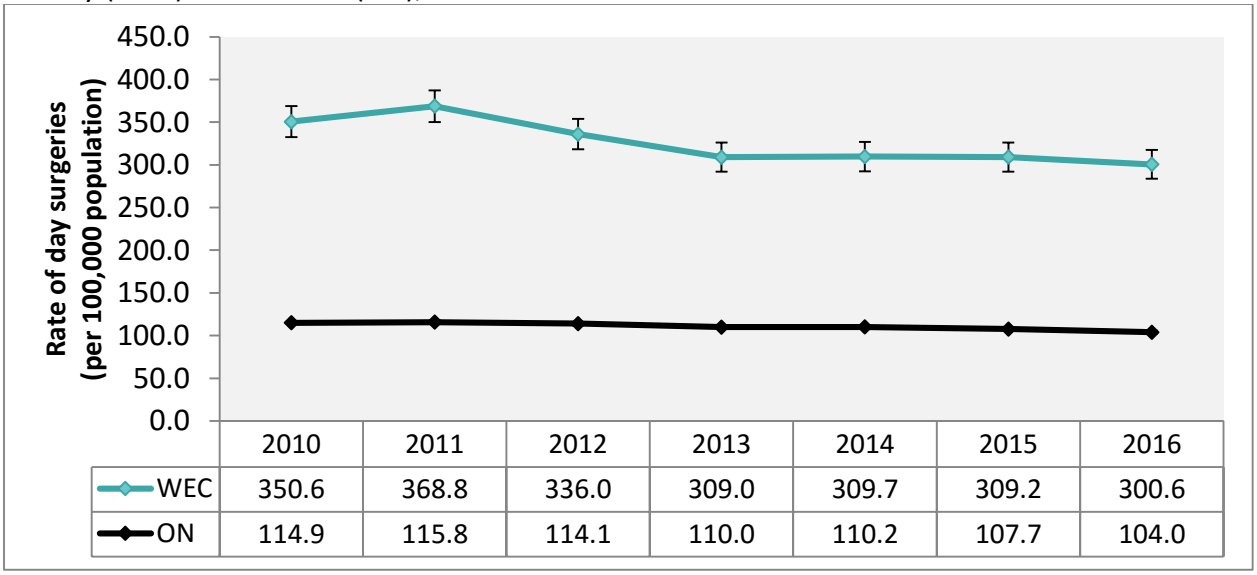
Figure 7. The number of day surgeries for oral health (caries-related) issues among children (1 to 17 years old) and adults (≥ 18 years old) in Windsor-Essex County (WEC), 2010-2016.



	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].

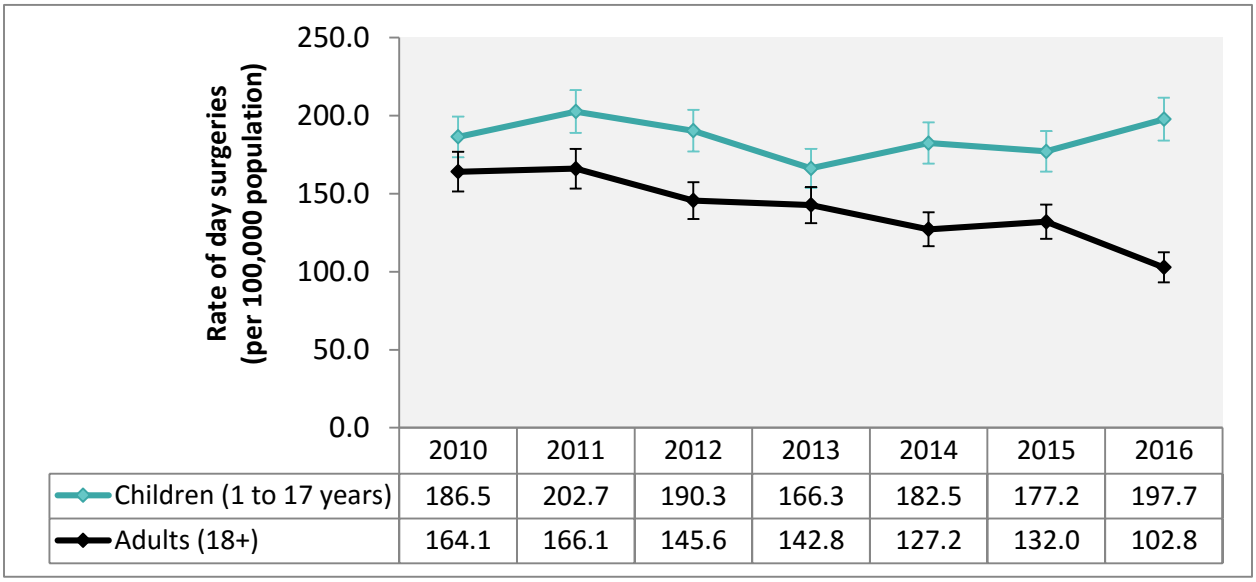
Figure 8. The rate of day surgeries for oral health (caries-related) issues in Windsor-Essex County (WEC) and Ontario (ON), 2010-2016.



	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].

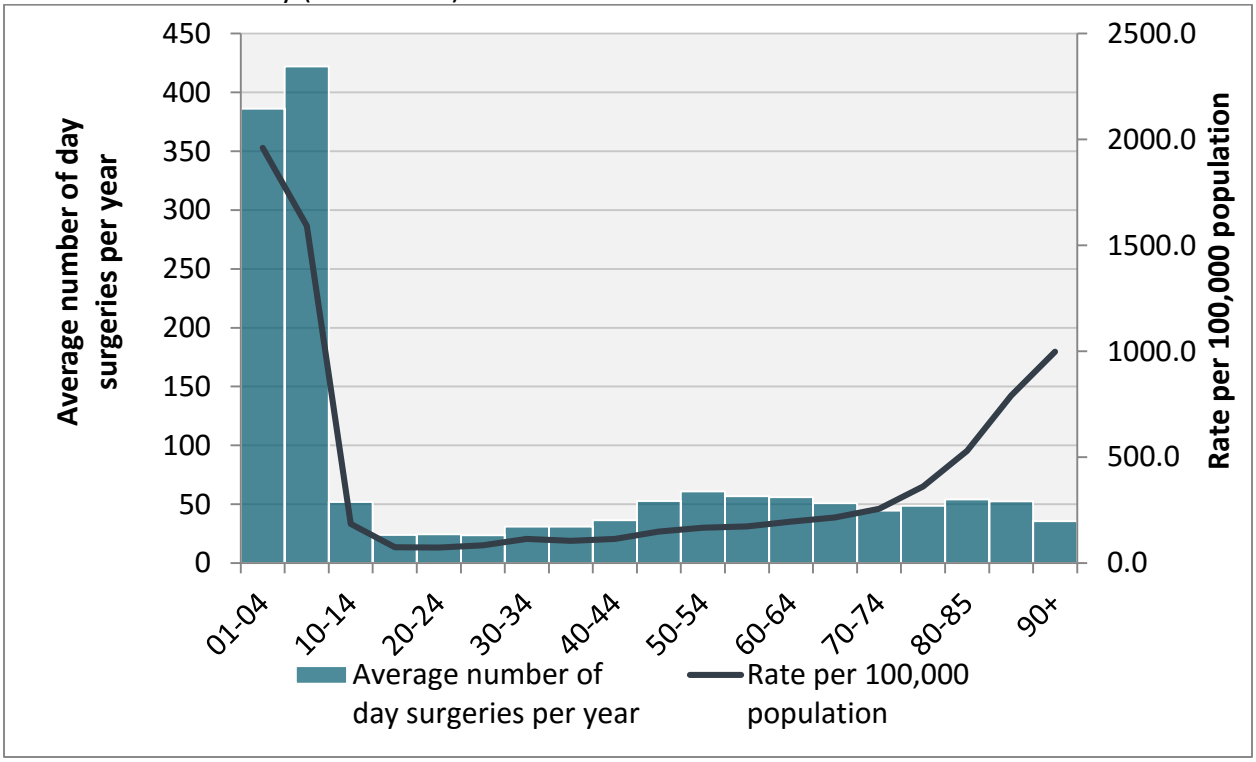
Figure 9. The rate of day surgeries for oral health (caries-related) issues among children (1 to 17 years) and adults (≥ 18 years old) in Windsor-Essex County (WEC), 2010-2016.



	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

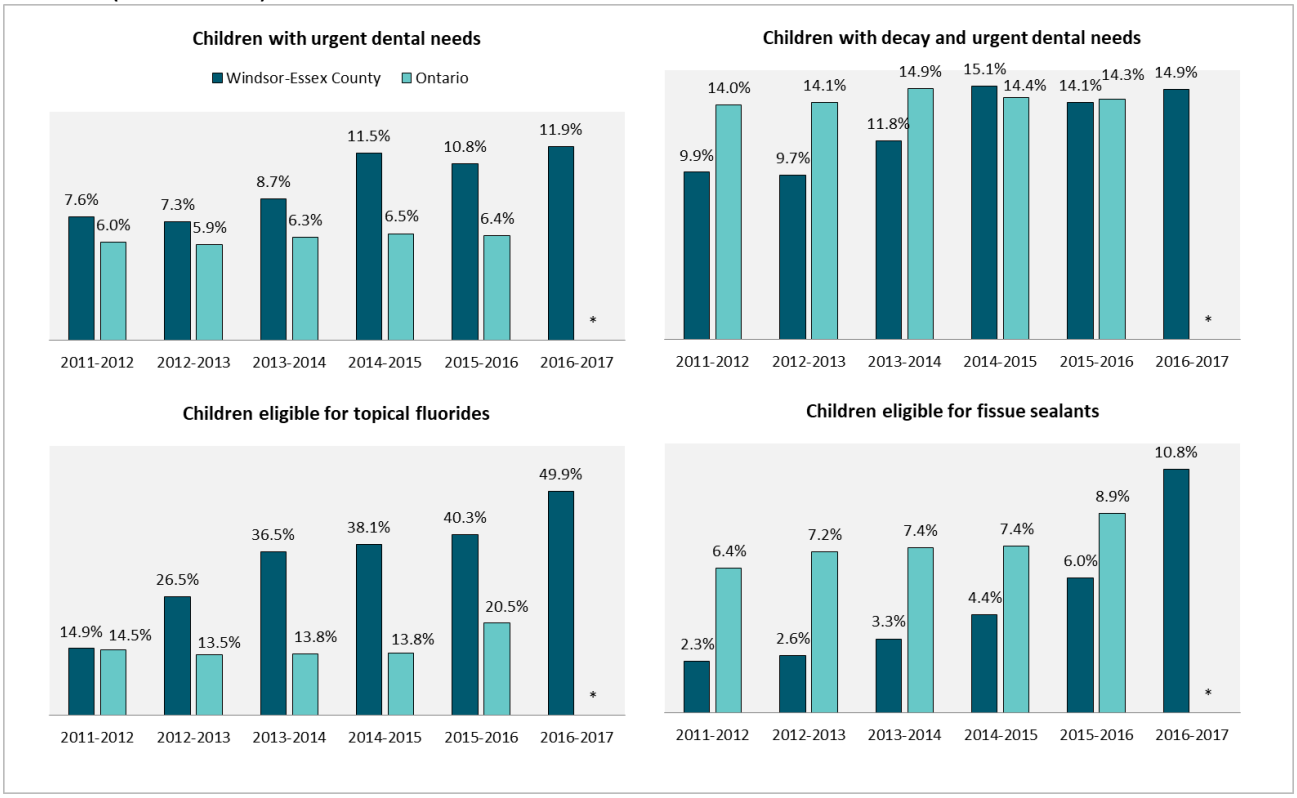
increase in children eligible for topical fluoride. There were also an increasing proportion of children eligible for fissure sealant and scaling, but incidences of fluorosis remain relatively rare.

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).

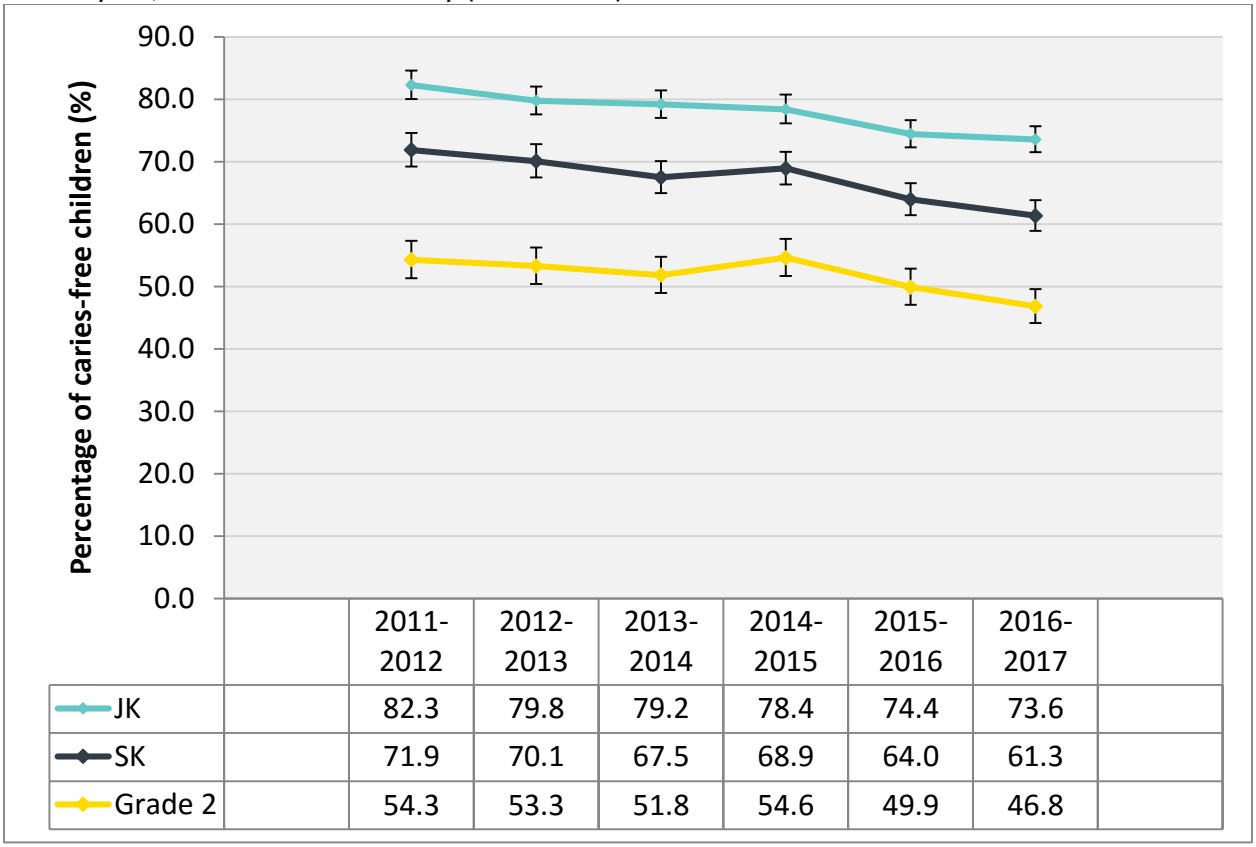


Source: Oral Health Information Support System [2011-2017], Ministry of Health and Long-Term Care (Accessed April 12, 2018).
*Comparison data for Ontario (2016/2017) was not available at the time of data extraction. Denoted by an asterisk in the figure.

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).

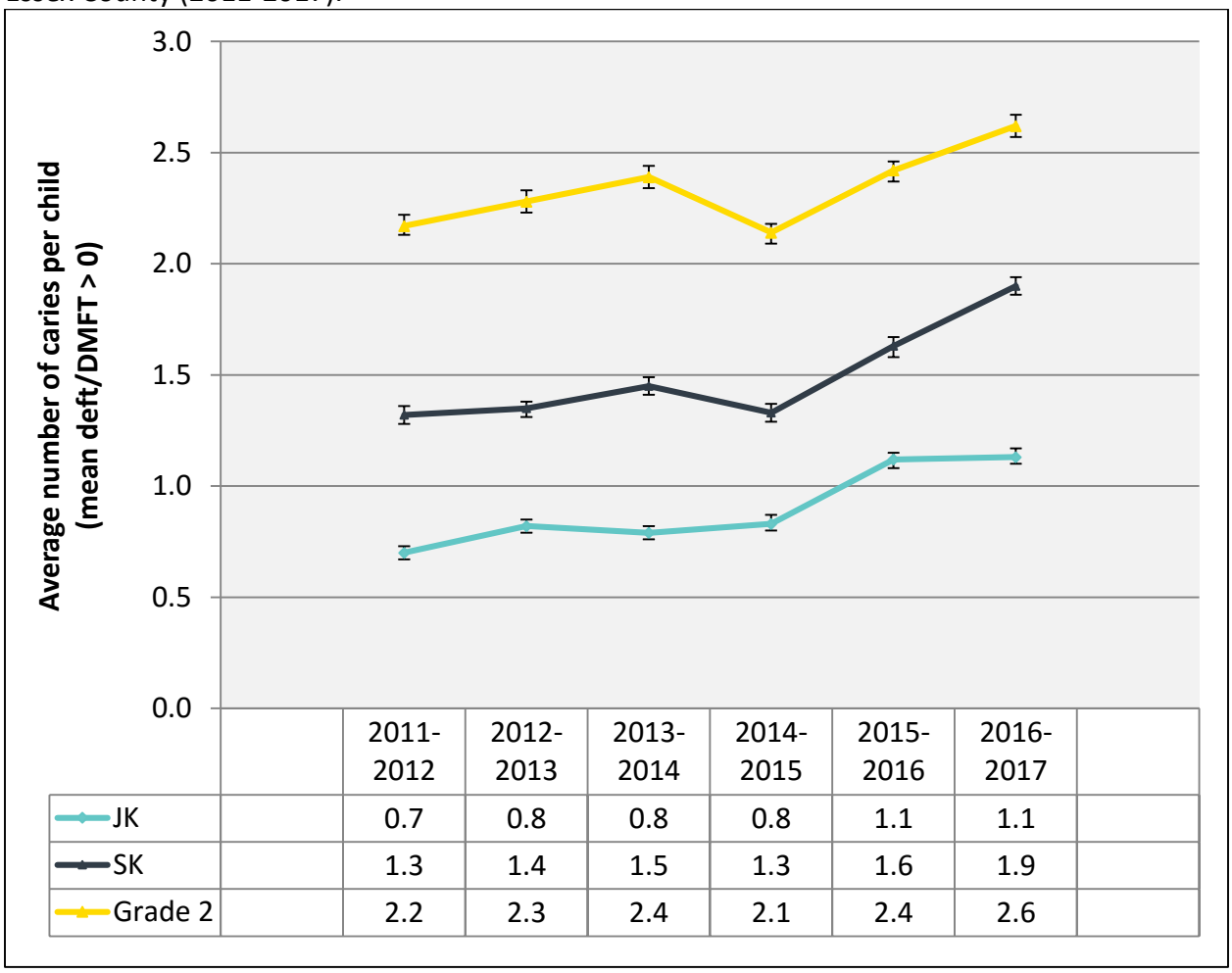


	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017
JK	82.3	79.8	79.2	78.4	74.4	73.6
SK	71.9	70.1	67.5	68.9	64.0	61.3
Grade 2	54.3	53.3	51.8	54.6	49.9	46.8

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).



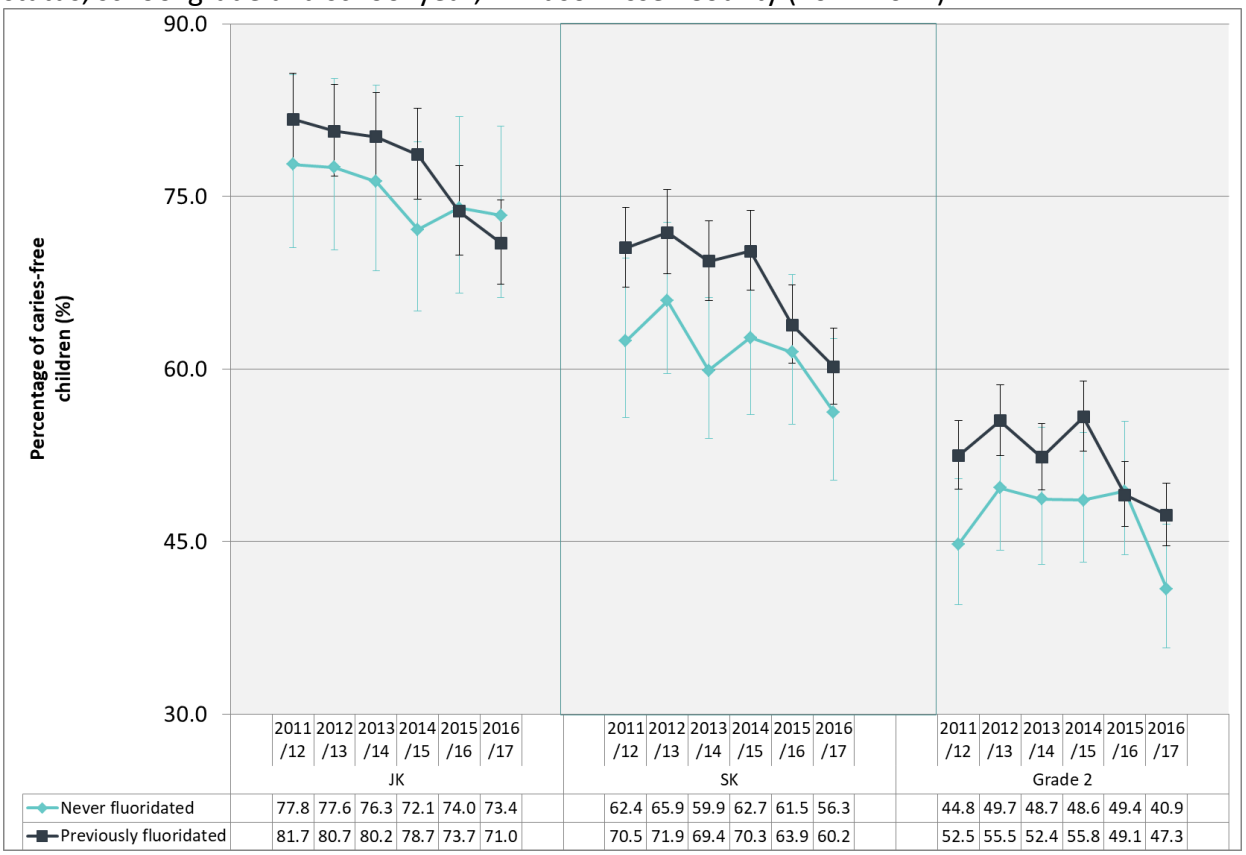
	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017
JK	0.7	0.8	0.8	0.8	1.1	1.1
SK	1.3	1.4	1.5	1.3	1.6	1.9
Grade 2	2.2	2.3	2.4	2.1	2.4	2.6

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).

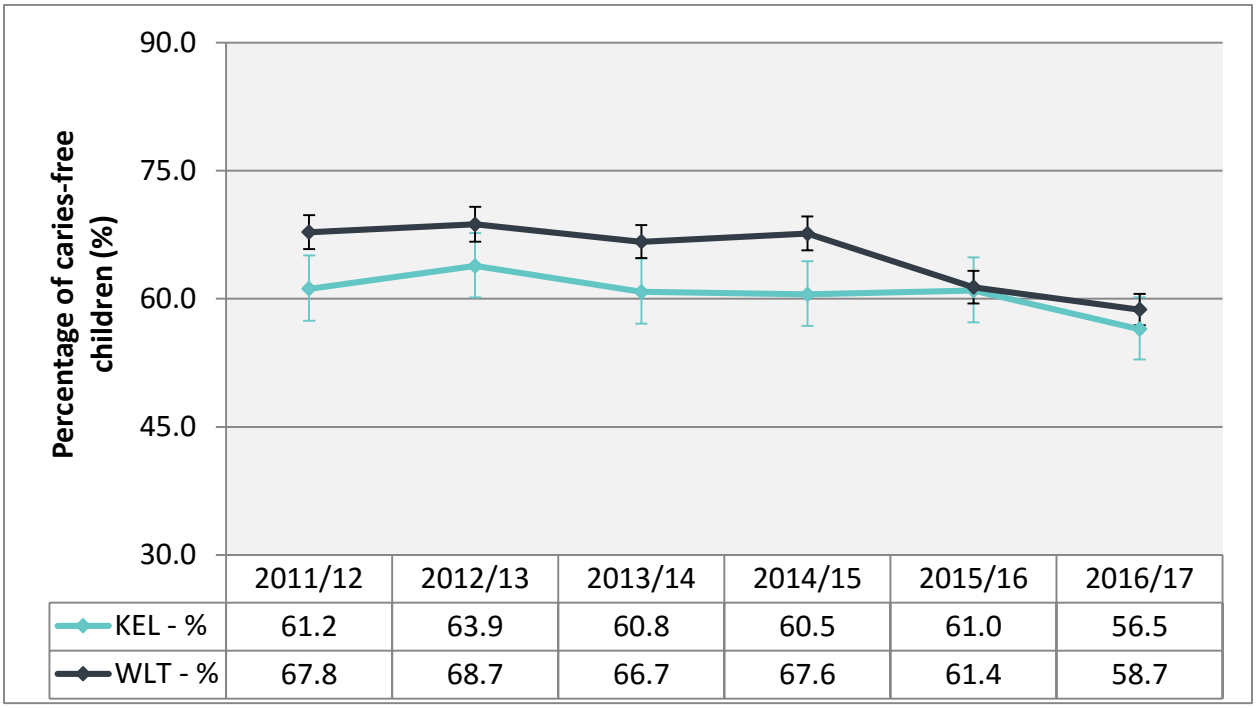


	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
JK						
Never fluoridated	77.8	77.6	76.3	72.1	74.0	73.4
Previously fluoridated	81.7	80.7	80.2	78.7	73.7	71.0
SK						
Never fluoridated	62.4	65.9	59.9	62.7	61.5	56.3
Previously fluoridated	70.5	71.9	69.4	70.3	63.9	60.2
Grade 2						
Never fluoridated	44.8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

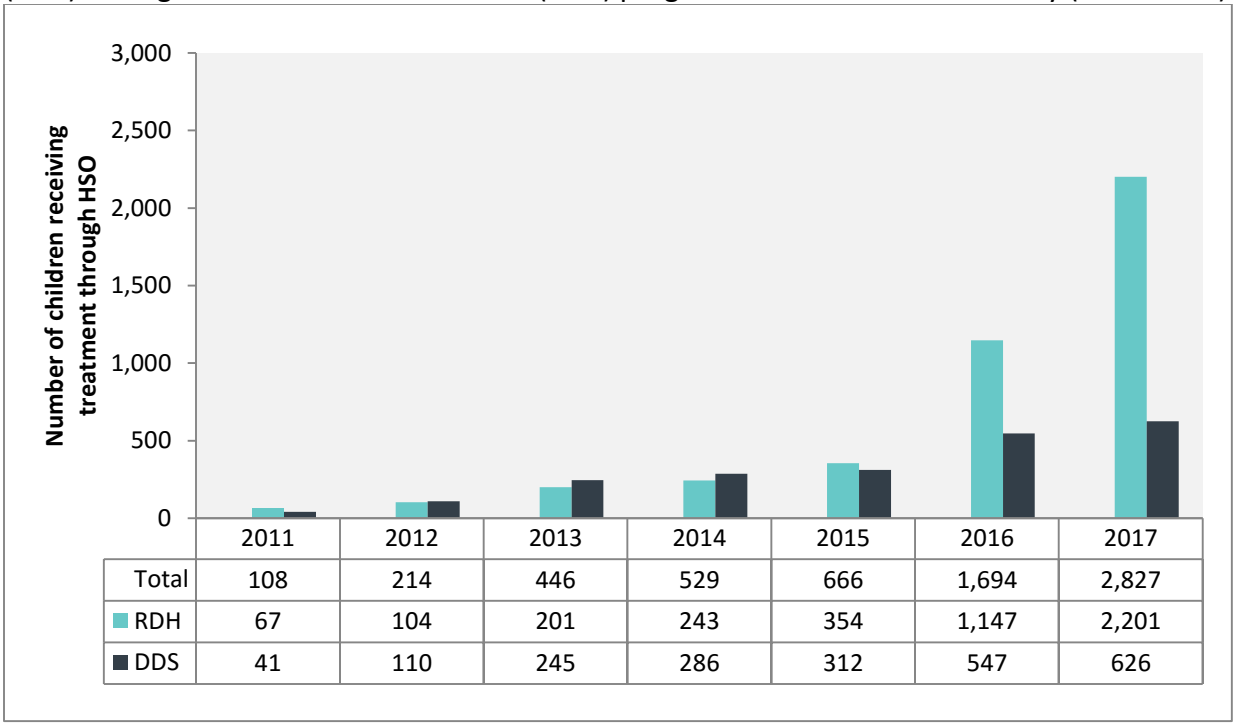
From 2011 to 2015, there was six-fold increase in the number of children receiving HSO treatments (see **Figure 17**). The large increases in treatment in 2016 and 2017 are due to the changes to HSO program in January 2016. Since the changes in 2016, there was a 67% increase in the number of children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

1005 Ouellette Avenue
Windsor, Ontario N9A 4J8
www.wechu.org
519-258-2146

June 18, 2018

Honourable Indira Naidoo-Harris
Provincial Minister of Education/
Minister Responsible for Early Years and Child Care
900 Bay Street
Toronto ON M7A 1L7

Dear Minister Naidoo-Harris:

Re: Mandatory Food Literacy Curricula in Ontario Schools

On May 25, 2018 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Kingston, Frontenac and Lennox and Addington Board of Health regarding food literacy curricula in Ontario schools. The following motion was passed:

GBHU BOH Motion 2018-51

Moved by: Mitch Twolan Seconded by: Stewart Halliday

"THAT, the Board of Health for the Grey Bruce Health Unit support the motion from Kingston, Frontenac and Lennox & Addington requesting an examination of current school curricula with regards to food literacy, and introduction of food literacy and food skills as a mandatory component of curricula in Ontario Schools."

Carried

Sincerely,

Hazel Lynn, MD, FCFP, MHSc
Acting Medical Officer of Health
Grey Bruce Health Unit

Cc: Ontario Boards of Health

Encl.

KFL&A Public Health

April 26, 2018

Hon. Indira Naidoo-Harris
Provincial Minister of Education/
Minister Responsible for Early Years and Child Care
22nd Floor, Mowat Block
900 Bay Street
Toronto, ON M7A 1L7

Dear Minister Naidoo-Harris:

Re: Mandatory Food Literacy Curricula in Ontario Schools

The Kingston, Frontenac, and Lennox & Addington (KFL&A) Board of Health passed the following motion at its April 25, 2018 meeting:

> **THAT the KFL&A Board of Health endorse provincial policy action found in the 2017 Food EPI Canada Report calling for an examination of current school curricula with regards to food literacy, and introduction of food literacy and food skills as a mandatory component of school curricula, and send correspondence to:**
>
> 1) **The Honourable Indira Naidoo-Harris, Provincial Minister of Education**
> 2) **The Honourable Dr. Helena Jaczek, Provincial Minister of Health and Long-Term Care**
>
> **And FURTHER that a copy of this endorsement be forwarded to:**
>
> 1) **Ms. Sophie Kiwala, MPP Kingston and the Islands**
> 2) **Mr. Randy Hillier, MPP Lanark-Frontenac-Lennox & Addington**
> 3) **Ontario Dietitians in Public Health Dietitians**
> 4) **The Association of Local Public Health Agencies**

Food literacy has been in decline over the past few decades and the resultant food deskilling has affected all segments of society, including children and youth. It has led to an increase of pre-prepared, packaged and convenience foods, eating away from home, and a higher consumption of processed foods that are higher in fat, salt and sugar. These foods are linked to a greater risk of diet-related chronic conditions and diseases such as obesity, heart disease and type II diabetes.

At a time when essential food literacy skills are lacking, there is a lack of opportunity to acquire these skills in the school setting. In Ontario, home economics, including food literacy education and training, was removed several decades ago from the Grade 7 and 8 curricula. Over the same time period, there has been a proliferation in processed and ready to consume foods, and marketing of unhealthy food and beverages. While food literacy curriculum is available to students, it is estimated that only one-third of Ontario students who entered Grade 9 from the 2005/06 to 2009/10 school years earned one or more credits in a course that included a food literacy component during their secondary school education.

Recently, a panel of more that 70 non-governmental experts from 44 universities, non-governmental, and professional organizations from across Canada gathered to comprehensively assess Canadian food environment polices compared to international benchmarks of current best practice. In their report *Creating healthier food environments in Canada, Current policies and priority actions*, this group recommended, among other provincial/territorial recommendations, the following policy action:

> Examine current school curricula with regards to food literacy, and introduce food literacy and food skills training as a mandatory component of school curricula. p. 7

Schools provide an opportunity to support students in making healthy choices and in gaining knowledge and food skills that will lead to developing food literacy, which will guide lifelong healthy eating habits. The KFL&A Board of Health urges the Provincial Government to examine the current school curricula with respect to food literacy, and to introduce mandatory food literacy and food skills training curricula.

Yours truly,

D. J. Doyle

Dennis Doyle, Chair
KFL&A Board of Health

Copy to: The Honourable Dr. Helena Jaczek, Provincial Minister of Health and Long-Term Care
Ms. Sophie Kiwala, MPP Kingston and the Islands
Mr. Randy Hillier, MPP Lanark-Frontenac-Lennox & Addington
Ontario Dietitians in Public Health Dietitians
The Association of Local Public Health Agencies
Board of Health members

June 18, 2018

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

Dear Ontario Film Review Board:

Re: Youth Exposure to Smoking in Movies

On May 25, 2018 at a regular meeting of the Board for the Grey Bruce Health Unit, the Board considered the attached correspondence from Peterborough Public Health regarding increased regulations to protect kids and teens from smoking in movies. The following motion was passed:

GBHU BOH Motion 2018-52

Moved by: Paul Eagleson Seconded by: Laurie Laporte

"THAT, the Board of Health for the Grey Bruce Health Unit support the recommendations from Peterborough Public Health regarding youth exposure to smoking in movies."

Carried

Sincerely,

Hazel Lynn, MD, FCFP, MHSc
Acting Medical Officer of Health
Grey Bruce Health Unit

Cc: Ontario Boards of Health

Encl.

Peterborough Public Health

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

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

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

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;
- 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 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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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

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[2] Ibid.