Haldimand-Norfolk Health Unit – Board of Health

June 1, 2021
2:00pm
Council Chambers
2nd Floor County Administration Building
50 Colborne Street South, Simcoe*

Live Stream: www.norfolkcounty.ca/watch-norfolk-county-meetings/

*Due to Covid-19 restrictions, there is no public access to Council Chambers. Proceedings are web-streamed live and archived on the County's website. Deputations are presented electronically.

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1. **Approval of Agenda/Changes to the Agenda**

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4. **Adoption/Correction of Board of Health Meeting Minutes**

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A) Staff Report HSS 21-11 36
Re: Public Health Management Overtime Policy

8. **Confirming By-Law**

A) By-law 2021-13-BH 64
Being a By-Law to Confirm the Proceedings of The Board of Health for the Haldimand-Norfolk Health Unit at this Board of Health Meeting held on the 1st of June, 2021

9. **Adjournment**

Contact Information

Kevin Klingenberg, Deputy County Clerk

Kevin.Klingenberg@norfolkcounty.ca

access NORFOLK
Accessible formats available

Meeting schedules available online at http://www.norfolkcounty.ca/council_meetings/

Haldimand-Norfolk Health Unit
Board of Health Minutes

May 4, 2021
2:00pm
Council Chambers*
*Conducted as a virtual meeting

Present: Chair Kristal Chopp, Tom Masschaele, Michael Columbus, Chris Van Paassen, Ryan Taylor, Amy Martin, Ian Rabbitts.

Absent with Regrets: Kim Huffman

Also Present: Dr. Shanker Nesathurai, Jason Burgess, Kevin Klingenberg, Heidy Van Dyk, Teresa Olsen,

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Ceremonial Activities (Item 1)

Approval of Agenda/Changes to the Agenda (Item 2)

1. **(Taylor/Martin)**
   THAT the agenda of the Board of Health be approved as presented.

   Carried.

Disclosure of Pecuniary Interest (Item 3)

Presentations (Item 4)

A) Medical Officer of Health Update

Dr. Shanker Nesathurai provided an update on the COVID-19 pandemic in the Haldimand-Norfolk Health Unit, the Health Unit's response efforts and local vaccination update. Dr. Shanker responded to questions of the Board.

2. **(Masschaele/Van Paassen)**
   THAT the presentation from Dr. Shanker Nesathurai be received as information.

   Carried.

Adoption/Correction of Board of Health Meeting Minutes (Item 5)

A) Board of Health – April 7, 2021 minutes

The minutes of the Board of Health Meeting dated April 7, 2021 having been circulated for review and there being an omission noted were declared adopted as presented, signed by the Chair and Board Clerk and affixed with the Corporate Seal.

Communications (Item 6)

A) Information memo - Stephanie Pongracz, Director, Public Health
Re: Ontario Seniors Dental Care Program Capital Funding – Simcoe Office

3. (Martin/Columbus)
THAT the communications from Stephanie Pongracz regarding Ontario Senior Dental Care Program Capital Funding be received as information.

Carried.

Board member Taylor discussed the communication item. Heidy Van Dyk, Acting General Manager of Health and Social Services responded to questions of the Board.

General Announcements (Item 7)

Closed Session (Item 8)

4. (Columbus/Masschaele)
THAT the Board convene in closed session at 2:39 PM to discuss the following matters:

A) Information memo – Jason Burgess, CAO
Re: Legal and Labour Relations update

B) Information Memo – Heidy Van Dyk, Acting General Manager of Health and Social Services
Re: Operational Update

Pursuant to Section 239 (2) (b)(d)(k) of the Municipal Act, 2001 as the subject matter relates to personal matters about an identifiable individual, including municipal or local board employees; labour relations or employee negotiations; and a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board.

Carried.

5. (Taylor/Martin)
THAT the Board reconvene in open session at 2:59 p.m.

Carried.

6. (Rabbitts/Masschaele)
THAT thee information memo from Jason Burgess regarding Legal and Labour relations be received as information;

AND THAT staff be directed to release a public memo regarding the information provided.

Carried.

7. (Van Paassen/Taylor)
THAT the information memo from Heidy Van Dyk regarding an Operational Update be received as information.

Carried.

Confirming By-Law (Item 9)

8. (Taylor/Columbus)
THAT By-law 2021-11-BH Being a By-Law to Confirm the Proceedings of The Board of Health for the Haldimand-Norfolk Health Unit at this Board of Health Meeting held on the 4th of May, 2021 be approved, signed by the Chair and Board Clerk and affixed with the Corporate Seal.

Carried.

Adjournment (Item 10)

9. (Masschaele/Taylor)
THAT the Board be adjourned at 3:02 p.m.

Carried.

_____ _____

Board of Health Chair Deputy Clerk

Haldimand-Norfolk Health Unit
Special Board of Health Minutes

May 18, 2021
1:30pm
Council Chambers*
*Conducted as a virtual meeting

Present: Chair Kristal Chopp, Tom Masschaele, Michael Columbus, Chris Van Paassen, Ryan Taylor, Amy Martin, Kim Huffman.

Absent with Regrets: Ian Rabbitts (until 2:52 PM)

Also Present: Jason Burgess, Kevin Klingenberg, Heidy Van Dyk, Erin Anderson, Dr. Alex Hukowich, Ken Hewitt, Cathy Case

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Disclosure of Pecuniary Interest (Item 1)

Approval of Agenda/Changes to the Agenda (Item 2)

1. **(Martin/Masschaele)**
   THAT the agenda of the Board of Health be approved as presented.

   Carried.

Closed Session (Item 3)

2. **(Huffman/Van Paassen)**
   THAT the Board of Health convene in Closed Session at 1.35 P.M. to speak about Staff Report HSS 21-09 regarding the topic of interim medical officer of health, pursuant to Section 239 (2) (d) of the Municipal Act 2001 as amended as the subject matter pertains to labour relations or employee negotiations.

   Carried.

3. **(Martin/Huffman)**
   THAT the Board reconvene in open session at 2:37 P.M.

   Carried.

Discussion Items (Item 4)

A) Discussion item: Appointment of Interim Medical Officer of Health

4. (Huffman/Masschaele)
THAT Staff Report HSS 21-09, Appointment of Interim Acting Medical Officer of Health, be received as information;

AND THAT the Board of Health appoint Dr. Alex Hukowich as the Interim Acting Medical Officer of Health from May 21, 2021 to such point as the Board appoints an Acting Medical Officer of Health;

AND FURTHER THAT the Board of Health direct staff to notify the Ministry of Health, Deputy Minister of Promotion and Public Health Division and the Chief Medical Officer of Health of the appointment of Dr. Alex Hukowich as the Interim Acting Medical Officer of Health.

Carried.

B) Staff Report HSS 21-10
Re: Acting Medical Officer of Health Recruitment

Heidy Van Dyk, Acting General Manager of Health and Social Services presented staff report 21-10 regarding Acting Medical Officer of Health Recruitment and responded to questions of the Board.

Board member Rabbitts joined the meeting.

5. (Van Paassen/Columbus)
THAT Staff Report HSS 21-10, Acting Medical Officer of Health Recruitment, be received as information;

AND THAT the Board of Health establish a recruitment sub-committee consisting of four (4) members designated by Norfolk County Council and three (3) members designated by Haldimand County Council;

AND FURTHER THAT the Acting General Manager of Health & Social Services be directed to work with Haldimand County General Manager of Corporate Services to provide administrative support to the recruitment sub-committee;

AND FURTHER THAT a copy of this resolution be provided to the Haldimand County Clerk so that the appointment of Haldimand County Councillors to the recruitment subcommittee can be completed.

Defeated.

6. (Martin/Huffman)
THAT Staff Report HSS 21-10, Acting Medical Officer of Health Recruitment, be received as information;

AND THAT the Board of Health establish a recruitment sub-committee consisting of four (4) Norfolk County Councillors and three (3) Haldimand County Councillors or their designates;

AND FURTHER THAT the Acting General Manager of Health & Social Services be directed to work with Haldimand County General Manager of Corporate Services to provide administrative support to the recruitment sub-committee;

AND FURTHER THAT a copy of this resolution be provided to the Haldimand County Clerk so that the appointment of Haldimand County Councillors to the recruitment subcommittee can be completed.

Carried.

Confirming By-Law (Item 5)

7. (Martin/Huffman)
THAT By-law 2021-12-BH Being a By-Law to Confirm the Proceedings of The Board of Health for the Haldimand-Norfolk Health Unit at this Special Board of Health Meeting held on the 18th of May, 2021 be approved, signed by the Chair and Board Clerk and affixed with the Corporate Seal.

Carried.

Adjournment (Item 6)

8. (Van Paassen/Masschaele)
THAT the Board be adjourned at 3:12 p.m.

Carried.

_____ _____

Board of Health Chair Deputy Clerk

Health and Social Services
Haldimand and Norfolk

Memo

To: Health & Social Services Advisory Committee Members

From: Heidy Van Dyk

Date: May 14, 2021

Re: Community Safety and Well Being Plan Update

The purpose of this information memo to provide an update on the development of the Community Safety and Well Being (CSWB) Plan. The planning process has been delayed due to the pandemic however steps are being taken currently to complete this project.

Advisory Committee will recall that the Province has mandated that all communities have a CSWB Plan completed by July 1, 2021. Haldimand and Norfolk Counties previously decided to complete one plan for the two County area and that Health & Social Services would take the lead on this project. The development of the plan involves identifying the risk factors that negatively impact community safety and well being and developing a strategic plan to address these risks. Community engagement is an important part of the planning process.

The Acting General Manager of Health & Social Services and a representative from Haldimand County will act as Project Sponsors. Kim Shippey, President of KMJ Consulting has been secured as the Project Lead. Ms. Shippey was previously the Executive Director of the United Way of Haldimand Norfolk and partnered with Health & Social Services during the first waves of COVID-19 to support vulnerable people during the pandemic. Through this partnership and her work with the United Way, Ms. Shippey is very familiar with the community partners who will need to be engaged in the planning process.

The project is able to be completed within the prescribed timeline and budget. Staff will provide updates to the Health & Social Services Advisory Committee as the plan is developed.

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From: Loretta Ryan <loretta@alphaweb.org>
Sent: Friday, May 7, 2021 1:14 PM
To: All Health Units <AllHealthUnits@lists.alphaweb.org>
Subject: Calling All Board of Health Members - Register now for the alPHa 2021 AGM & Conference

PLEASE ROUTE TO:

All Board of Health Members
All Members of Regional Health & Social Services Committees
All Senior Public Health Managers

Good Day Board of Health (BOH) Section Members,

Have you registered yet for the **Association of Local Public Health Agencies (alPHa) 2021 Annual General Meeting & Conference, Ontario's Public Health System: Challenges – Changes – Champions**?

alPHa is pleased to be holding its first online event with co-hosts, the Northwestern Health Unit Board of Health and the University of Toronto's Dalla Lana School of Public Health. The conference includes remarks from the federal and provincial Ministers of Health, Chief Public Officer of Health of Canada, and President of the Association of Municipalities of Ontario. Dr. Jane Philpott will give a keynote address on the Ontario Integrated Data Platform and Public Health Analytics. In addition, there will be a concurrent session with the leadership from Public Health Ontario. I would be remiss if I didn't note that pre-pre-conference (8:00 am EST) we will also be showcasing the great Northwest!

The Annual General Meeting includes a business meeting and a resolutions session. This will be followed by the alPHa 2020 and 2021 Distinguished Service Awards for individuals in recognition of their outstanding contribution to public health. The luncheon event will feature a keynote by emcee Dr. Adelstein Brown, Dean of University of Toronto's Dalla Lana School of Public Health.

The afternoon BOH Section meeting includes updates on key public health topics with:

- Dr. Kieran Moore, Member of the Minister's COVID-19 Vaccine Distribution Task Force;
- Antonio Gómez-Palacio, Post-Pandemic Communities and the Community Wellbeing Framework, Partner, DIALOG;
- Monika Turner, Director of Policy, Association of Municipalities of Ontario; and
- James LeNoury, alPHa's Legal Counsel.

We will also have elections for the BOH Regional Representatives/alPHa Board Directors 2021-2023. Nominations for North East, North West and Central East Region representatives must be submitted by May 28, 2021. Please note that nominations that were received in anticipation of the 2020 AGM, need to be reconfirmed by this same date.

Be sure and check for program updates on the website, emails, alPHa's newsletter: *Information Break* and twitter: @PHAgencies.

This is an event you won't want to miss! Looking forward to seeing you 'virtually' at alPHa's online 2021 AGM & Conference on June 8, 2021.

Best regards,

Trudy Sachowski
Chair, Boards of Health Section, Association of Local Public Health Agencies

I respectfully acknowledge the traditional territory of the Anishinaabe Nation of Treaty 3 and the Métis homeland. Today, this land is home to many diverse Indigenous people from across Turtle Island and I recognize their enduring presence. I am grateful to have the opportunity to work and live in this territory.

Loretta Ryan, CAE, RPP
Executive Director
Association of Local Public Health Agencies (alPHa)
480 University Avenue, Suite 300
Toronto, ON M5G 1V2
Tel: 416-595-0006 ext. 222
Cell: 647-325-9594
loretta@alphaweb.org
www.alphaweb.org

Office of the County Warden
789 Broadway Street, Box 3000
Wyoming, ON N0N 1T0

Telephone: 519-845-0801
Toll-free: 1-866-324-6912
Fax: 519-845-3160

April 26, 2021

The Right Honourable Justin Trudeau, P.C., MP
Prime Minister of Canada
Office of the Prime Minister
80 Wellington Street Ottawa, ON K1A 0A2
Sent via email: justin.trudeau@parl.gc.ca

The Honourable Chrystia Freeland, P.C., M.P.
Deputy Prime Minister and Minister of Finance
Privy Council Office, Room 1000
80 Sparks Street Ottawa, ON K1A 0A3
Sent via email: chrystia.freeland@parl.gc.ca

Dear Prime Minister Trudeau and Deputy Prime Minister Freeland:

Re: Basic Income for Income Security during COVID-19 Pandemic and Beyond

At its meeting held on February 3rd, 2021, Lambton County Council received correspondence to the federal government from the Thunder Bay District Health Unit dated November 20, 2020 with respect to using a basic income to address food security. This letter is intended to express our support for these efforts to provide income solutions to reduce food insecurity.

Income is one of the strongest predictors of health, and it makes sense that focusing on population health interventions to address socioeconomic factors will impact health outcomes far greater than individual focused interventions.

Prior to COVID-19, 8% of Lambton County residents reported moderate or severe food insecurity: experiencing actual issues with procuring an adequate quality or quantity of food, or worrying about the source of their food. Since COVID-19, this pre-existing issue has become more apparent and worrisome with Statistics Canada reporting an increase to 14.6% or 1 in 5 households. This increase was anticipated due to many individuals facing precarious employment, reduced hours of work, or loss of job altogether, coupled with increasing food prices.

Food insecurity is associated with significantly higher annual provincial health care costs; one study showed total health care costs were 49% and 121% higher among households experiencing moderate or severe food insecurity, respectively. People without consistent access to enough healthy food struggle to eat a nutritious diet,

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putting them at increased risk of health problems such as chronic and infectious diseases, low birth weight pregnancies, and poor child growth and development. Undernourished children also do not perform as well at school academically, have difficulty concentrating in class, and have poorer psychosocial outcomes than those who are fortunate enough to eat a balanced diet.

Annual analysis of the local cost of a nutritious food basket has continued to illustrate how little money a family of four on a social assistance budget would have left to cover the costs of childcare, transportation, and other basic needs, after paying for shelter and healthy food.

As a result of the COVID-19 pandemic, we can anticipate the exacerbation of existing disparities, creating an even wider gap between those with opportunity and those without. Local concerns around homelessness, poverty, food insecurity, transportation, mental health and addictions, child and partner violence, and the needs of Indigenous people have been amplified.

Lambton County Council agrees that income solutions are an effective long-term response to the issues of income security, poverty, food insecurity, to improve overall community health and well-being.

Sincerely,

Kevin Marriott
Chair, County of Lambton Board of Health
Warden, County of Lambton

cc: The Hon. Doug Ford, Premier of Ontario
The Hon. Monte McNaughton, Minister of Labour, MPP, Lambton-Kent-Middlesex
The Hon. Bob Bailey, MPP, Sarnia-Lambton
Dr. David Williams, Chief Medical Officer of Health
The Hon. Lianne Rood, MP, Lambton-Kent-Middlesex
The Hon. Marilyn Gladu, MP, Sarnia-Lambton
Pegeen Walsh, Executive Director, Ontario Public Health Association
Association of Local Public Health Agencies
Ontario Boards of Health

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

From: Loretta Ryan, Executive Director

Subject: ***alPHa Resolutions for Consideration at the June 8, 2021 Annual General Meeting***

Date: May 10, 2021

Please find enclosed a package of the resolutions to be considered at the Resolutions Session taking place during the 2021 Annual General Meeting (AGM).

This resolution was received prior to the deadline for advance circulation. It has been reviewed and recommended by the alPHa Executive Committee to go forward for discussion at the Resolutions Session. (As of this writing, late resolutions were not received and are not included in this package. Late resolutions are indicated as such and not typically reviewed by the Executive Committee.)

Sponsors of resolutions should be prepared to have a delegate introduce and move the resolution(s).

IMPORTANT NOTE FOR LATE RESOLUTIONS:

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

To have a late resolution considered it must be first submitted in writing to loretta@alphaweb.org by 4:30 pm on Thursday, May 27, 2021. The Chair will quickly review the resolution to determine whether it meets the criteria of a proposed resolution as per the "Procedural Guidelines for alPHa Resolutions".

If the resolution meets these guidelines, it proceeds to the membership to vote on whether there is time to consider it. A successful vote will garner a 2/3 majority support. If this is attained, it will be displayed on the screen and read aloud by its sponsor followed by a discussion and vote. Any late

resolution(s) will go through this process.

We value timely and important resolutions and want to ensure that there is a process to consider all resolutions.

IMPORTANT NOTE FOR VOTING DELEGATES:

Members must register to vote at the Resolutions Session. A registration form is attached. Health Units must indicate who they are sending as voting delegates and which delegates will require a proxy vote on or before 4:30 pm on June 1, 2021. Only one proxy vote is allowed per person.

Eligible voting delegates include Medical Officers of Health, Associate Medical Officers of Health, Acting Medical Officers of Health, members of a Board of Health and senior members in any of alPHa's Affiliate Member Organizations. Each delegate will be voting on behalf of their health unit/board of health.

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

Attached is a list describing the number of votes for which each Health Unit qualifies.

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

Enclosures:
Resolutions Voting Registration Form
Proxy Voting for Resolutions
Number of Resolutions Votes Eligible Per Health Unit
June 2021 Resolutions for Consideration

Association of Local PUBLIC HEALTH Agencies

480 University Avenue
Suite 300
Toronto ON M5B 1J3Tel:
(416) 595-0006
Fax: (416) 595-0030
E-mail: info@alphaweb.org

Providing leadership in public health management

2021 alPHa Resolutions Session
10:30 AM to 11:30 AM
alPHa Annual General Meeting

REGISTRATION FORM FOR VOTING

Health Unit _____

Contact Person & Title _____

Phone Number & E-mail _____

Name(s) of Voting Delegate(s):

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

Please email this form to lKoch@nwhu.on.ca by 4:30 pm on June 1, 2021 .

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

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Association of Local PUBLIC HEALTH Agencies

Number of Resolutions Votes Eligible Per Health Unit

HEATLH UNITS	*VOTING DELEGATES*
Toronto*	**20**
POPULATION OVER 400,000	**7**
Durham	
Halton	
Hamilton	
Middlesex-London	
Niagara	
Ottawa	
Peel	
Simcoe-Muskoka	
Waterloo	
York	
POPULATION OVER 300,000	**6**
Windsor-Essex	
POPULATION OVER 200,000	**5**
Eastern Ontario	
Kingston, Frontenac, Lennox and Addington	
Southwestern	
Wellington-Dufferin-Guelph	
POPULATION UNDER 200,000	**4**
Algoma	
Brant	
Chatham-Kent	
Grey Bruce	
Haldimand-Norfolk	
Haliburton, Kawartha, Pine-Ridge	
Hastings-Prince Edward	
Huron	
Lambton	
Leeds, Grenville and Lanark	
North Bay Parry Sound	
Northwestern	
Perth	
Peterborough	
Porcupine	
Renfrew	
Sudbury	
Thunder Bay	
Timiskaming	

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

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

2021 alPHa Resolutions Session
10:30 AM to 11:30 AM
alPHa Annual General Meeting

PROXY VOTING FOR RESOLUTIONS - EXAMPLES

If a health unit is entitled to a maximum of 5 votes and they have 5 registered attendees, each of whom are eligible to vote, the health unit will not be entitled to any further votes, proxy or otherwise, beyond their allotted five votes.

Scenario 1:
A health unit is entitled to 5 votes and there will be 5 eligible voters attending the Resolutions Session:

Person A gets 1 vote
Person B gets 1 vote
Person C gets 1 vote
Person D gets 1 vote
Person E gets 1 vote
TOTAL: 5 votes allocated (since 5 is the maximum the HU is entitled to)

Here in this case, nobody is assigned the proxy because there are enough eligible voters attending the Session.

The proxy vote is used only when the maximum number of votes is not met by the number of eligible voters. For example:

Scenario 2:
A health unit is entitled to 5 votes and only 3 eligible voters are attending the Resolutions Session:

Person A gets 1 vote + 1 proxy = 2 votes allocated
Person B gets 1 vote + 1 proxy = 2 votes allocated
Person C gets 1 vote (no proxy) = 1 vote allocated
TOTAL = 5 votes allocated (since 5 is the maximum the HU is entitled to use)

You will note that in the above scenario, an eligible voter may carry 1 vote + 1 proxy, provided the maximum number of votes for his/her health unit is not exceeded. Each delegate can only carry a maximum of one proxy.

The health unit must decide (before the conference) which of its conference attendees should be assigned voting privileges (usually some combination of the MOH, Chair of BOH, BOH members, and if none of these are attending, then a senior manager who is allowed to vote on behalf of the board of health). By completing the attached Voting Registration Form in advance, this allows the health unit to determine beforehand who will be voting.

Resolutions for Consideration
2021

Resolutions Session
2021 Annual General Meeting
Monday, June 8, 2021
Online

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Resolution #	Title	Sponsor	Page
A21-1	REDUCING THE HARMS, THE AVAILABILITY AND YOUTH APPEAL OF ELECTRONIC CIGARETTES AND VAPING PRODUCTS THROUGH REGULATION	Middlesex-London Board Of Health	1

alPHa
Association of Local PUBLIC HEALTH Agencies

DRAFT alPHa RESOLUTION A21-1

TITLE: **Reducing the Harms, the Availability and Youth Appeal of Electronic Cigarettes and Vaping Products through Regulation**

SPONSOR: **Middlesex-London Board of Health**

WHEREAS electronic cigarettes (e-cigarettes), also referred to as electronic nicotine delivery systems, vapour products, vapes or vapourizers, were first introduced into the Canadian market in 2004; and

WHEREAS an alPHa resolution in 2014 requested that Health Canada and the Ontario Ministry of Health and Long-Term Care provide for the public health, safety and welfare of all Ontario residents by: ensuring manufacturing consistency of e-cigarettes; conducting research on the long-term health effects of e-cigarettes and exposure to secondhand vapour; and, regulating the promotion, sale and use of e-cigarettes in Ontario; and

WHEREAS there are no long-term studies on the health effects of using e-cigarettes that can conclusively show they do not pose a health risk to the user; and

WHEREAS there is substantial evidence that some chemicals present in e-cigarette aerosols are capable of causing DNA damage and mutagenesis, and that long-term exposure to e-cigarette aerosols could increase the risk of cancer and adverse reproductive outcomes; and

WHEREAS there is inconclusive evidence that e-cigarettes are effective as a cessation tool to help people break their addiction to nicotine; and

WHEREAS in Canada, most people who use e-cigarettes also smoke tobacco cigarettes (dual users), maintaining tobacco use and nicotine addiction over time; and

WHEREAS data shows that the concurrent use of cigarettes and e-cigarettes is even more dangerous than smoking cigarettes alone due to increased exposure to toxicants and nicotine; and

WHEREAS the use of e-cigarettes has grown at an exponential rate, with a 74% increase in youth vaping in Canada from 8.4% in 2017 to 14.6% in 2018; and

WHEREAS e-cigarette prevalence rates among Canadian grade 7 to 12 students have doubled from 10% in 2016-17 to 20% in 2018-19, with prevalence rates of past-30-day use being higher among students in grades 10 to 12 (29%) than those in grades 7 to 9 (11%); and

WHEREAS 56% of Ontario students in grades 7 to 12 who have used an e-cigarette in the past year are vaping nicotine; and

WHEREAS there is substantial evidence that e-cigarette use increases the risk of cigarette smoking initiation among non-smoking youth and young adults; and

WHEREAS simulation models in the United States show e-cigarette use represents more population-level health harms than benefits, with an estimated 80 youth and young adults starting to use an e-cigarette product for every cigarette smoker who quits; and

WHEREAS a January 2020 statement from the Council of Chief Medical Officers of Health (CCMOH) outlines regulatory and policy recommendations for the federal, provincial/territorial and municipal governments to address the rapidly emerging public health threat of increased vaping prevalence; and

WHEREAS As of July 1st, 2020, the sale of most flavoured vaping products and all vaping products with nicotine concentrations higher than 20 mg/mL are restricted to specialty vape stores and provincially licensed cannabis retail outlets because they are age-restricted (19 years plus) retail environments; and

WHEREAS In Ontario, the sale of menthol, mint and tobacco-flavoured e-cigarettes are permitted at convenience stores, gas stations, and any other retail environment where children and youth have access; and

WHEREAS additional regulatory measures will serve to further strengthen the goal of tobacco use prevention, cessation and a reduction in use of all nicotine-containing products by regulating vapour products as equivalent to commercial tobacco products;

NOW THEREFORE BE IT RESOLVED that the Association of Local Public Health Agencies (alPHa) write to the federal and provincial Ministers of Health acknowledging the steps already taken by the Governments of Canada and of Ontario to address the epidemic of youth vaping, and urge that they enact the following policy measures based on those recommended by the Council of Chief Medical Officers of Health:

- A ban on all vapour product and e-substance flavours except tobacco;
- A cap on the nicotine concentration levels in any vapour product to 20 mg/mL, in alignment with the European Union Tobacco Products Directive;
- The application of the same plain and standardized packaging regime that is applied to commercial tobacco products and accessories to vapour products;
- The enforcement of strict age-verification measures for online sales, including age-verification at time of purchase and proof of legal age at delivery;
- Limit tobacco and vapour product and accessory sales to licensed, age-restricted tobacconists, specialty vape shops and cannabis retail shops respectively;
- The enactment of a tax regime on vapour products and the establishment of product set price minimums to discourage use of all tobacco and vaping products; and,
- An increase to the legal age for the sale and supply of tobacco and vaping products and accessories to 21 years of age.

AND FURTHER that alPHa advise all Ontario Boards of Health to advocate for and support local municipalities to develop bylaws to regulate the retail sale and the use of tobacco and vapour products;

AND FURTHER, that the Prime Minister of Canada, the Chief Public Health Officer of Canada, the Premier of Ontario and the Chief Medical Officer of Health of Ontario be so advised.

Supplementary information attached (14 pages)

Statement of Sponsor Commitment

The Middlesex-London Board of Health share the concerns of Health Canada and the Ontario Ministry of Health regarding the increase in vapour product use by young people in Canada. The Board is encouraged by the commitment to develop regulatory measures to reduce youth access and appeal of vaping products. The popularity of e-cigarettes has been explosive among our youth. It threatens to addict a whole new generation to nicotine products, reversing what has been a downward trend in smoking rates and nicotine addiction among Canadian youth. We are not alone in our concern. Our public health staff are working closely with our school communities, municipalities and public health partners to counter the use and popularity of e-cigarettes to prevent youth, young adults and non-tobacco users from becoming addicted to vaping products. Using a comprehensive approach that includes education and awareness targeted to youth, parents and adult influencers, and the enforcement of the *Smoke-Free Ontario Act, 2017*, we are committed to helping our youth develop the personal skills that will support their efforts to adopt healthy lifestyle behaviours free of all tobacco industry products. However, despite our concerted efforts to prevent initiation of vapour product use and addiction to nicotine among youth, we are being met with limited success because of the allure and attraction of these products. The ease of accessing vaping products at corner stores and through online sales, the smoother vaping experience provided by the development of nicotine salts, and despite some regulation the continued availability of high nicotine concentrations and flavours, has posed significant challenges in our efforts to halt vapour product uptake.

Under the *Smoke-Free Ontario Act, 2017,* smoking and the use of vaping products is prohibited on school grounds and within 20 metres of school property. The use of vaping products inside and outdoors on school property has become a substantial problem for elementary and secondary school staff. In the 2018-2019 school year, Tobacco Enforcement Officers (TEOs) with the Middlesex-London Health Unit issued 207 warnings and charges in 2018-2019 by Health Unit Inspectors responsible for enforcing the *Smoke-free Ontario Act, 2017*. As of February 2020, just prior to the pandemic shut down, 151 warnings and charges for the 2019-2020 school year have been issued. Health Unit Inspectors report that students caught vaping on school property often state that because of their addiction to nicotine, they are unable to wait for class breaks to leave school property to vape, and instead they are choosing to vape inside school washrooms, change rooms, classrooms and on school buses. Public Health Nurses working in our secondary schools have reported that students are sharing with them alarming experiences of adverse reactions to high doses of nicotine, including headaches, nausea, elevated heart rate, general malaise, and, in extreme situations, seizures. Data from the 2019 Ontario Student Drug Use and Health Survey shows that in Middlesex-London, 19%* (11.8-29.1%) of students in grades 7 to 12 reported weekly or daily e-cigarette use (vaping) in the past 12 months *(*interpret with caution).

Too much remains unknown about the short- and long-term health effects of vaping to ignore this growing public health issue. Across Canada, as of February 18, 2020, there were 18 cases of 14Tvaping-associated lung illness1 reported to the Public Health Agency of Canada, resulting in the hospitalization of 14 people including a 17-year-old high school student from the London area who spent 47 days in the hospital, part of it on life support (Government of Canada, 2020). In the United States, as of February 18, 2020, there have been a total of 2807 hospitalized 14Te-cigarette or vaping product use-associated lung injury (14TEVALI) cases including 68 deaths (CDC, 2020). At this time, there has yet to be a consistent product, substance, or additive that has been isolated as the cause in these cases. Continued efforts are needed from all levels of government to address the harms, the availability and youth appeal of e-cigarettes and vaping products through regulations like those contained in this resolution.

Dr. Christopher Mackie, Medical Officer of Health for the Middlesex-London Health Unit will be able to provide clarification on this resolution at the alPHa Annual General Meeting in June.

Background Summary

Electronic cigarettes (e-cigarettes), also referred to as electronic nicotine delivery systems, vapour products, vapes or vapourizers were first introduced into the Canadian market in 2004 (Heart and Stroke Foundation, 2018). In 2014, alPHa Resolution A14-2, "*Regulating the Manufacture, Sale, Promotion, Display, and Use of E-Cigarettes*" was carried at the Annual General Meeting. The resolution requested that Health Canada and the Ontario Ministry of Health and Long-Term Care provide for the public health, safety and welfare of all Ontario residents by ensuring manufacturing consistency of e-cigarettes; conducting research on the long-term health effects of e-cigarettes and exposure to secondhand vapour; and regulating the promotion, sale and use of e-cigarettes in Ontario (Association of Local Public Health Agencies, 2014). Since 2014, the e-cigarettes available in the market have rapidly evolved and the growing public health concerns associated with product safety and an exponential increase in youth vaping have prompted the need for stricter regulations and immediate public health intervention. A January 2020 statement was released by the Council of Chief Medical Officers of Health (CCMOH), outlining regulatory and policy recommendations for the federal, provincial/territorial and municipal governments to address the rapidly emerging public health threat of increased prevalence of vaping (Public Health Agency of Canada, 2020).

When vaping products initially entered the market, they closely resembled a traditional cigarette, however, now they have become complex units that come in different shapes and sizes, with features that allow for customization in device configuration. There are newer products on the market, such as JUUL, SMOK, and VYPE, that use nicotine salts in novel, youth-friendly USB designs. These products have a higher nicotine content, and have become immensely popular with youth, due to their small, discrete design and recharging capabilities using computers and phone chargers (American Cancer Society, 2020).

In May 2018, Bill S-5, *An Act to Amend the Tobacco Act and Non-Smokers' Health Act,* received Royal Assent and e-cigarettes, with or without nicotine, became legal in Canada. According to Health Canada (2018), this new legislative framework applied a harm reduction approach to vaping product regulations, striking a "balance between protecting youth from nicotine addiction and tobacco use, and allowing adults to legally access vaping products as a less harmful alternative to cigarettes" (Health Canada, 2018). The opening of the legal e-cigarette market in Canada led to increased vapour product availability and promotion, contributing to an exponential increase in vaping prevalence rates (Hammond, et al., 2019). The legalization of vaping products containing nicotine occurred despite firm evidence that they were effective as cessation devices and without conclusive evidence regarding their safety.

Health Effects of Vaping

Emerging data suggests that vapour products may be safer than combustible tobacco products; however, this data is not yet conclusive, and there is consensus among the public health community that vapour products and the aerosol that vaping devices produce are not harmless (U.S. Department of Health and Human Services, 2016).

Vaping devices are still relatively new, and more research is needed to fully understand both the short- and long-term health risks associated with vaping. According to Bhatta and Glantz (2019), the use of e-cigarettes appears to be an independent risk factor for the development of respiratory disease, but more longitudinal studies are needed. In the absence of conclusive longitudinal evidence, there is consensus that vapour products expose users to harmful toxins, including cancer-causing chemicals, diacetyl, volatile organic compounds, heavy metals, and ultrafine particles that can be inhaled deeply into the lungs (Centers for Disease Control and Prevention, 2020; U.S. Department of Health and Human Services, 2016; National Academies and Science, Engineering and Medicine (NASEM), 2018). These substances have been linked to increased cardiovascular and non-cancer lung disease (U.S. Department of Health and Human Services, 2016). Additionally, there is substantial evidence that some chemicals present in e-cigarette aerosols are capable of causing DNA damage and mutagenesis, and that long-term exposure to e-cigarette aerosols could increase risk of cancer and adverse reproductive outcomes (NASEM, 2018).

Vaping Products for Cessation Requires Further Review

E-cigarettes are marketed by the vapour product industry as a tool to help people quit smoking. Available evidence indicates that e-cigarettes deliver lower levels of carcinogens than conventional cigarettes, and according to NASEM (2018), there is conclusive evidence that completely substituting e-cigarettes for combustible tobacco cigarettes reduces users' exposure to numerous toxicants and carcinogens present in combustible tobacco. However, there is no safe level of exposure to commercial tobacco smoke (Inoue-Choi, et al., 2016) and there is inconclusive evidence that e-cigarettes are effective as a cessation tool to help people break their addiction to nicotine (U.S. Department of Health and Human Services, 2020; NASEM, 2018). Vaping products have not been approved by Health Canada as a smoking cessation aid because they are not currently tested, manufactured, and regulated as such in Canada.

Dual use, a term used to describe the concurrent use of e-cigarettes and tobacco cigarettes, is a real concern that can compromise cessation efforts among cigarette smokers (Czoli, et al., 2019). According to a recent Canadian report published by the Propel Centre for Population Health Impact at the University of Waterloo, half (52.7%) of e-cigarette ever users and a majority (64.58%) of past 30-day e-cigarettes users also reported being current smokers, suggesting that the rate of dual use in Canada is high (Reid, et al., 2019). Overall, nearly half (44.6%) of e-cigarette ever users who were also cigarette smokers reported using an e-cigarette when they were unable to smoke, or to smoke fewer cigarettes (Reid, et al., 2019). Dual users often report using e-cigarettes to help them quit or to reduce their smoking (Czoli, et al., 2019; Wang, et al., 2018). However, for cigarette smokers trying to quit smoking using vaping products, the use of e-cigarettes is associated with lower odds of being successful in their quit attempt (Kalkhoran & Glantz, 2016; Glantz & Bareham, 2018). Maintaining tobacco use and nicotine addiction through dual use may also pose additional health risks to the user. Compared to individuals who only use e-cigarettes, there is emerging evidence that dual users have increased risk of breathing difficulties, asthma and chronic obstructive pulmonary disease, which is indicative of adverse health effects on the respiratory system (Wang et al., 2018; Bhatta & Glantz, 2019).

Youth Vaping and Nicotine Addiction

Youth vaping rates are increasing at an alarming rate, with a 74% increase in vaping among Canadian youth observed from 2017 to 2018 (Hammond, et al., 2019). Results from the 2018-19 Canadian Student Tobacco, Alcohol and Drugs Survey (CSTADS) show that e-cigarette prevalence rates among Canadian

grade 7 to 12 students have doubled from 10% in 2016-17 to 20% in 2018-19, with prevalence rates of past 30-day use being higher among students in grades 10 to 12 (29%) than those in grades 7 to 9 (11%) (Health Canada, 2019). Of additional concern, the results indicate that students who reported using an e-cigarette (with or without nicotine) in the past 30 days are vaping frequently, with approximately 40% reporting daily or almost daily use (Health Canada, 2019). The 2019 Ontario Student Drug Use and Health Survey (OSDUHS) reinforces the need for intensive public health intervention. Vaping rates have doubled among Ontario students in grades 7 to 12 in the two-year survey period between 2017 and 2019, with 23% reporting e-cigarette use in the past year (184, 200 students) compared to 11% in 2017 (Boak, et al., 2019). About 13%, or 1 in 8 report using an e-cigarette weekly or daily, which is up from 2% in 2015 (Boak, et al., 2019).

According to the manufacturer, a single pod that is used in the JUUL e-cigarette device contains as much nicotine as a pack of cigarettes (Willett, et al., 2018). Nicotine is a highly addictive substance that can have adverse effects on the developing brain (Health Canada, 2019; NASEM, 2018, U.S. Department of Health and Human Services, *2016*). Research has shown that exposure to nicotine before the age of 25 can negatively alter the brain and can cause long-lasting negative effects on attention, memory, concentration, and learning, decreased impulse control, increased risk of experiencing mood disorders (such as depression and anxiety), and increased risk of developing nicotine dependence and addiction. (NASEM, 2018; Health Canada, 2019; Goriounova & Mansvelder, 2012). Compared to the adult brain, an adolescent brain finds nicotine more rewarding and will progress faster to nicotine dependence and addiction (Goriounova & Mansvelder, 2012; Health Canada, 2019). Some vapour devices have the capability of delivering higher amounts of nicotine compared to conventional cigarettes, which could put young people at even greater risk of developing nicotine dependence (U.S. Department of Health and Human Services, 2016). The OSDUHS data illustrates that over- exposure to nicotine by young people is a public health concern; 56% of Ontario students in grades 7 to 12 who have used an e-cigarette in the past year (2019) are vaping nicotine, a significant increase from 2015 when only 18.8% of students reported vaping with nicotine (Boak, et al., 2019).

In addition, there is substantial evidence that e-cigarette use increases the risk of ever using combustible tobacco cigarettes among youth and young adults (NASEM, 2018). One study found that young people who use e-cigarettes are four times more likely to smoke tobacco cigarettes; an effect that is especially pronounced in low-risk youth who do not exhibit risky behaviours, sensation-seeking personality traits, or cigarette susceptibility (Berry, et al, 2019). When attempting to weigh the harms against the potential benefits that e-cigarettes may yield through cessation and harm reduction, the current state of evidence is concerning. Simulation models that have been tested in the United States show e-cigarette use represents more population-level health harms than benefits, with an estimated 80 youth and young adults starting to use an e-cigarette product for every cigarette smoker who quits (Soneji, et al., 2018).

Current State of Vapour Product Regulations

On December 21PstP, 2019, Health Canada published the *Vaping Products Promotion Regulations (VPPR)*, in the Canada Gazette, Part I. The proposed regulations intend to address the rapid increase in youth vaping, to raise awareness about the harms of vapour product use, and to mitigate the impact of vaping product promotion on young persons and non-users of tobacco products. On August 7, 2020 the final Vaping Products Promotion Regulations came into force with the exception of the point-of-sale display prohibition, which came into force on September 6, 2020. The regulations prohibit advertising that can be seen or heard by young people; prohibit the display of vaping products that can be seen by

youth at point of sale; and, require that all vaping product advertisements convey a health warning (Health Canada, 2019). Health Canada had also proposed online advertising restrictions and the use of social media influencers; however, these restrictions have not been enacted. On December 19th, 2020 Health Canada published the Concentration of Nicotine in Vaping Products Regulations to the Canadian Gazette, Part 1. The proposed regulations intend to protect youth by lowering the concentration of nicotine in a vaping product to 20 mg/mL.

In Ontario on January 1st, 2020, the promotion of vapour products at convenience stores, gas stations and other retail outlets where youth under the age of 19 have access was prohibited by regulation under the *Smoke-Free Ontario Act, 2017.* On February 28th, 2020, Ontario Minister of Health Christine Elliott announced that Ontario is proposing regulatory changes for Cabinet members' consideration that, if approved, would place restrictions on where flavoured and high nicotine vapour products are sold, while also expanding vaping prevention initiatives and services to quit vaping. (Ministry of Health, 2020 February 28). Regulations were set to come into force on May 1PstP, 2020; however, due to the COVID-19 pandemic, the government changed the implementation of Regulation 268/18 to July 1st, 2020. Details of the regulations include: restricting the retail sale of most flavoured vapour products to specialty vape stores and cannabis stores, restricting the retail sale of high nicotine vapour products (more than 20 mg/mL) to specialty vape stores, and requiring specialty vape stores to ensure that vapour product displays and promotions are not visible from outside their stores. Ontario's proposed approach also included enhanced cessation services through increasing access to services to help people quit vaping through Telehealth and enhancing mental health and addiction services and resources to include vaping and nicotine addiction. However, these initiatives were not introduced. Lastly, Ontario is proposing to work with major online retailers of vapour products to ensure compliance with age restricted sales, as well as establishing a Youth Advisory Committee to provide advice on vaping initiatives in an effort to reduce the prevalence of youth vaping (Ministry of Health, 2020). It is unclear at this time where these initiatives stand.

Health Canada and the Ontario Ministry of Health should be commended for their commitment to work collaboratively with national, provincial and territorial partners to address vaping, but continued pressure and additional regulations are required at the federal, provincial and municipal levels.

Vapour Product and E-Substance Flavours

Flavour is a perception involving many senses, including taste, aroma, and feelings of cooling and burning within the mouth and throat (Small & Green, 2012). The documented evidence within the food consumer science literature demonstrates that flavour impacts the appeal of consumable goods, and that flavour preferences direct food selection (Piqueras-Fiszman & Spence, 2016; Etiévant, et al., 2016). Youth and young adults are particularly influenced by flavours (Mennella, et al., 2005). Due to pervasive marketing tactics and the addition of attractive candy and fruit flavours to vapour products, sales of e-cigarettes are growing rapidly across Canada and around the world, with over 1,000 e-liquid flavours available in the marketplace under the banner of 460 different brands (Euromonitor International, 2015). Given the known and potential short- and long-term health effects of vaping and the lack of longitudinal health data, Health Canada and the Ministry of Health need to strengthen the current approach to regulating flavoured e-substances by enacting a ban on the manufacturing and sale of flavoured e-cigarettes and e-substances, except for tobacco flavouring. Until e-cigarettes are deemed to be effective smoking cessation aids through rigorous scientific study and they are licensed and strictly regulated as approved cessation aids by Health Canada, the manufacturing and sale of flavoured vaping products should be prohibited.

Restricting the Concentration and/or Delivery of Nicotine

Nicotine is a highly addictive substance that poses significant risk, especially to young people. To reduce youth appeal and to protect the developing youth brain, acceptable nicotine concentration levels for vapour products should be more closely aligned with the approved nicotine concentrations for nicotine replacement therapeutic products (e.g. patches, gum, mist, inhalers, lozenges) already approved and regulated as cessation aids in Canada. Regardless of the type or power of any e-cigarette device, the nicotine concentration level for e-substances purchased in Canada should not exceed 20 mg/mL. This level is in alignment with the European Union Tobacco Products Directive (20 mg/mL), which states that this concentration allows for delivery of nicotine that is comparable to a standard cigarette (Health Canada, 2019). More research is needed to determine how consistent and uniform nicotine dosing could be established in e-cigarette devices; this would create a more unified market that could be better regulated and controlled. Additionally, more research and intensive investigation into the effectiveness of e-cigarettes as smoking cessation aids are required prior to setting government policy that promotes vapour products as tools to help people quit.

Appearance and Product Packaging Design

In November 2019, Canada joined the 13 other countries that have already implemented plain and standardized tobacco product packaging regulations. With strict promotion and advertising rules in effect for tobacco products across Canada, the package became an important marketing tool for tobacco manufacturers. Acting as mini billboards, the tobacco industry used colours, images, logos, slogans and distinctive fonts, finishes, and sizing configurations of packages to make their product appealing and attractive to existing and new tobacco users (Smoke-Free Ontario Scientific Advisory Committee (SFO-SAC, 2010). The design of the package can make its contents appear safe to use, undermining the visibility, credibility and effectiveness of health warnings. According to Moodie, Mackintosh, Hastings and Ford, (2011), studies have determined that the colour, shape and size of a package can influence consumer behaviour and contributes to consumer perceptions of the product. There is substantial documented evidence that confirms that plain packaging reduces the attractiveness of tobacco products, particularly among young people and women, making plain and standardized tobacco product packaging one of the most effective tobacco control policy measures to reduce consumption (SFO-SAC, 2010).

The same principles and body of evidence can be applied to the regulation of vapour products and their packaging. Devices are being manufactured to look like small, discrete everyday objects, so that youth can hide vaping behaviour from teachers and parents. In Ontario, the ability to “stealth vape” in school washrooms and classrooms is undermining efforts that school staff and Public Health Unit staff are taking to promote and enforce the *Smoke-Free Ontario Act, 2017* on school property. E-cigarette use on school property is normalizing e-cigarette use among youth; the ability to skirt the law increases the appeal of these products. The devices can be customized and personalized, which complements the lifestyle messaging that youth are receiving from the internet and on social media. The lifestyle messaging often depicts cheerful and stylish smokers taking back “their right to smoke” in public by using e-cigarettes (Heart and Stroke, 2018). The messaging promotes e-cigarettes as a safe alternative to tobacco products, without communicating the potential health concerns related to the inhalation of toxic chemicals, heavy metals, and nicotine found in the vapour (Tozzi & Bachman, 2014). To reduce youth appeal, the same plain and standardized packaging regime that has been applied to commercial tobacco and cannabis products should also be applied to vapour products.

Restricting and Enforcing Online Retail Access and the Role of Age-Restricted Retail Outlets

Besides the availability of e-cigarette devices at retail outlets such as convenience stores, gas stations, grocery stores, tobacconist shops, and specialty vape stores, e-cigarette devices and e-substances are widely available for sale through websites and social media (Hammond, et al., 2015). While many online e-cigarette vendors use age-verification measures during online purchase, people under the age of 18 years are still able to purchase e-cigarettes and e-substances online. Research conducted by Williams, Derrick, and Ribisl (2015) in North Carolina showed that the overall success rate for youth purchases of e-cigarettes online was 93.7%. False birth dates were entered into the website and no delivery company attempted to verify recipients' ages at point of delivery, with 95% of e-cigarette deliveries being left at the door (Williams, Derrick & Ribisl, 2015). Anecdotally, many youth and young adults who vape report that they obtain these products online. Online vendors may be both less able and less inclined to take effective measures to limit sales to minors; some online vendors accept a simple declaration of a client's age. Strict age-verification measures are required for online sales, including age-verification at time of purchase and proof of legal age at delivery. Active enforcement of online sales to assess compliance is also required. Additionally, at the time of delivery, confirmation of age by government-issued identification should be required. The enforcement of age restriction legislation for online retailers can be challenging; however, creative solutions may exist, including the requirement for internet service providers to ban online retailers from continuing to sell products online if they routinely ignore legislated sales to minors restrictions.

Best practice evidence from tobacco control literature provides insight regarding product accessibility and its impact on tobacco use initiation. Greater availability and density of retail outlets increases consumption, normalizes product use, decreases the ability to succeed in quit attempts and undermines health warnings (SFO-SAC, 2010). Similarly, we see alcohol availability as a contributor to alcohol normalization, alcohol use, and resulting alcohol harm (Centre for Addiction and Mental Health, 2019). The accessibility of both tobacco and vapour products is inconsistent with the extensively documented burden of illness from commercial tobacco product use and the emerging evidence regarding the short- and long-term health effects from vaping. The Ontario Ministry of Health's proposal to limit the sale of flavoured vapour products that contain highly concentrated levels of nicotine to age-restricted specialty vape shops is a positive step forward; however, the need to reform the retail environment for both tobacco and vaping products is a public health imperative. Limiting the sale of tobacco products to licensed, age-restricted tobacco retail outlets (i.e. tobacconists) and limiting the sale of vapour products to licensed, age-restricted specialty vape shops and cannabis retail outlets would reduce the availability and accessibility of these products to youth.

Enactment of a Tax and Vapour Product Pricing Regime

There is unequivocal evidence documented in the tobacco control literature that price increases result in decreased demand and use of cigarettes, and increased intentions to quit smoking (SFO-SAC, 2010). As of January 23, 2020, the provinces of British Columbia, Alberta and Prince Edward Island have proposed or passed legislation to tax vapour products (Jeffords, 2020 January 23). There exists the opportunity to enact a tax regime on vapour products to reduce the consumption of vapour products by youth and young adults, both of whom tend to be more price sensitive than adults (U.S. Department of Health and Human Services, 2000). The revenue from tobacco taxes along with the revenue from the taxation regime applied to vaping products could be used to fund comprehensive tobacco and vapour product control programming, including prevention and cessation efforts, enforcement, and research.

A complementary measure to increase the retail price of tobacco and vapour products is to mandate a minimum pre-tax set price minimum (Feighery, et al., 2005). Setting minimum price limits can inhibit the manufacturers' ability to employ discount pricing and the retail sale of low-cost brands to absorb and offset the price increases from taxation (SFO-SAC, 2010). Minimum price polices are effective and widely used to reduce the consumption and associated harms from alcohol (Anderson, Chisholm & Fuhr, 2009). The taxation level and the set price minimums for vapour products should be set independently from tobacco products, with careful consideration being given to ensure that e-cigarettes do not become more expensive than cigarettes.

Increasing the Legal Age to 21 Years of Age

In Canada, under the *Tobacco and Vaping Products Act*, the sale or supply of tobacco and vaping products is illegal to anyone under the age of 18 years. In Ontario, the sale and supply of tobacco and vaping products is governed by the *Smoke-free Ontario Act, 2017;* the legal age of sale or supply is 19 years of age.

The importance of delaying the initiation of tobacco product use by young people has been well established in the evidence, including nicotine addiction and the corresponding negative impacts on youth brain development, respiratory symptoms, negative impacts on the growth and development of lung tissue, and the development of atherosclerosis and increased risk of heart disease (U.S. Department of Health and Human Services, 2012). According to simulation modelling conducted by the Institute of Medicine of the National Academy of Sciences (IOM) (2015) in the United States, raising the legal age of sale or purchase of tobacco products to 21 or 25 years of age would have a substantial impact on preventing or delaying the initiation of tobacco use; the simulation predicted a 12% reduction in smoking rates if the legal age was changed to 21 years (IOM, 2015). Increasing the legal age of tobacco product access to 21 years of age has the potential to delay youth initiation, while also reducing the burden of illness from over exposure to nicotine, carcinogens and smoke during adolescence (Pope, Chaiton, & Schwartz, 2015). There exists the opportunity to apply findings from the tobacco control literature to curb youth access to vaping products.

In the United States, tobacco and vaping products are regulated by the U.S. Food and Drug Administration (FDA). On December 20th, 2019, it became illegal to sell any tobacco product, including cigarettes, cigars and e-cigarettes to anyone under the age of 21 years across the United States (FDA, 2019). There appears to be public support in Canada for raising the legal age to 21 years for vaping products; according to an Ipsos poll of 1002 Canadians conducted for Global News between December 3 and December 5, 2019, approximately 8 out of 10 respondents support raising the minimum age for use of these products to 21 years (Yourex-West, 2019 December 23).

The Role of Ontario Boards of Health and Municipal Regulations

Municipalities and local public health agencies have taken a leadership role in advocating for and implementing laws about smoke-free indoor and outdoor spaces to reduce physical exposure to second-hand smoke and tobacco product use. In addition to the extensively documented health harms from exposure to second-hand smoke, Social Cognitive Theory and Social Ecological Theory suggest that the more children and youth are exposed to tobacco product use, the more likely they are to become tobacco product users themselves (SFO-SAC, 2010). Role modelling a tobacco-free culture plays an important role in preventing tobacco use initiation. Smoke-free spaces legislation also plays an

important role in promoting and supporting quit attempts by those already addicted to nicotine trying to break their addiction (SFO-SAC, 2010). The same approach to controlling exposure to aerosol and exposure to vapour product use has already been taken by many municipalities across Ontario; however, there exists the opportunity to further strengthen municipal regulations to exceed protections currently provided for under the *Smoke-Free Ontario Act, 2017* and allows for specificity in prescribed prohibited spaces to meet community need.

Another opportunity for municipalities to address vaping is to explore issues that pertain to the retail sale of vaping products. Research shows that increased retail availability to substances, such as alcohol and tobacco, results in increased consumption, contributing to significant health care costs and social harms (SFO-SAC, 2016). Vapour product retail outlet density and the proximity of retail outlets to youth-serving facilities are neighbourhood planning and zoning controls that municipalities could explore. Municipalities should also explore the implementation of licensing bylaws, and a move toward a system of designated sales outlets or caps on the number of licenses issued as a way to enact and strengthen retail controls at the local level.

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Board of Health – June 01, 2021

Subject:	Public Health Management Overtime Policy
Report Number:	HSS 21-11
Division:	Health and Social Services
Department:	Health and Social Services Administration
Purpose:	For Decision

Executive Summary:

The Ministry of Health requires that a Board of Health have a Corporate Policy on non-contractual overtime payments for this to be included in the annual service plan funding application. Staff have previously issued reports including the latest report CS21-10 on February 2, 2021 for a determination of a special overtime compensation policy for Health Unit staff related to the COVID pandemic. The Board of Health at the February 2, 2021 meeting made a decision for overtime payment, but did not set a go forward policy that can be referred to by staff for our current and future funding applications.

This report does not encompass the compensation for overtime to the Medical Officer of Health or non-public health staff that are involved in COVID efforts.

Discussion:

As previously noted staff filed for overtime costs from the Ministry as part of the 2020 funding submission. Prior to payment of any received funds staff require approval from Council for this temporary policy change to deal with the COVID pandemic. Staff are able to include overtime costs in the 2021 funding submission if a local corporate policy exists to support payment of these costs.

Staff have provided previous suggestions on policy considerations for the Board of Health to consider. Staff recommend a policy in which the following characteristics are included:

1) That payments will only be made if it is funded from the Ministry, there should be no impact on the tax levy.
2) There be a reasonable allowance for usual unpaid overtime, management compensation is based upon the premise that some unpaid overtime is required from time to time.
3) There is appropriate management oversight for the recording of overtime.
4) A maximum amount of overtime is established.

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Financial Services Comments:

Financial services will only recommend a policy that requires funding from the Ministry.

Interdepartmental Implications:

There are potential implications to other departments. Any payments to management employees in other parts of the corporation (for example the Long Term Care Home, Paramedic Services, Corporate Services) would be subject to a separate report to Council.

Consultation(s): None

Strategic Plan Linkage:

This report aligns with the 2019-2022 Council Strategic Priority "Focus on Service".

Explanation:
Due to the lack of resources, overtime has been required from all staff. Unionized staff are compensated for additional hours and or other schedule requirements, management staff are not compensated for these additional requirements.

Conclusion:

That the Board of Health set a policy for non-union overtime compensation related to the COVID pandemic. The policy can range from no additional overtime compensation to a previous recommendation to Council or to some other decision of the Board.

Recommendation(s):

THAT this report be received for information by the Board of Health.

AND THAT Board of Health provide recommendations to staff for provisions related to a policy for non-union overtime compensation.

Attachment(s):

Board of Health February 2, 2021 Report.

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Board of Health – February 02, 2021

Subject:	Haldimand-Norfolk Health Unit COVID-19 Extraordinary Costs Funding
Report Number:	CS 21-10
Division:	Corporate Services
Department:	Financial Services
Purpose:	For Decision

Executive Summary:

The Ministry of Health has allowed for Boards of Health to submit for reimbursement of extraordinary costs arising from the COVID-19 pandemic. The funding is to be used to offset 2020 levy supported Public Health pandemic costs. Staff submitted for total costs of $6,133,777, of which $5,338,200 was deemed eligible and approved for reimbursement by the Ministry. The items deemed eligible for reimbursement included but are not limited to redeployed staff time and overtime (paid and accrued unpaid), both County's interim care centres, and all other eligible medical and operating supplies and equipment. The items ineligible for reimbursement included the Electronic Medical Records (EMR) system and the FTEs not approved for by the Board of Health.

Discussion:

On April 23, 2020, the Ministry of Health (MOH) announced to Boards of Health in Ontario that $100 million would be made available to support Health Units' extraordinary costs in their efforts to monitor, detect and contain the COVID-19 pandemic within the Province. Health Units were required to track costs separately from base programs in order to submit a request for reimbursement.

The Haldimand-Norfolk Health Unit is unique in that it requires costs to be tracked separate from those of Norfolk County's municipal expenses. At the onset of the pandemic, Financial Services staff set up a work order tracking system to identify COVID-19 costs separately from base Health Unit programs.

Through the efforts of the entire Corporation, including Health Unit staff and Haldimand County, Financial Services staff were able to determine which costs were attributable to Public Health and complete an application to the MOH that was submitted on September 18th, 2020.

The total amount requested for reimbursement was $6,133,777. Included in this claim were costs for redeployed staff, overtime (paid and accrued unpaid), both County's

interim care centres, eligible medical and operating supplies and equipment to name the larger costs.

Once submitted, staff worked with the MOH to provide additional support for the amounts and details included in the application and to answer any questions that followed. As a result, the Ministry approved the application while making note that final approvals should be communicated to Boards of Health near the end of the calendar year. On December 30th, 2020 the MOH communicated the Health Units' approved allocation.

The Haldimand-Norfolk Health Unit was approved for $5,338,200 in one-time COVID-19 Extraordinary Costs funding. The funding is 100% Provincial and does not require a Municipal cost share. In early 2021, the MOH communicated the items deemed ineligible for funding; the Electronic Medical Records (EMR) system and FTEs not approved by the Board of Health (HSS 20-21) as the application included the original full 30.0 FTE COVID-19 team compliment as well as the equipment and supplies to support those FTEs. All other costs were deemed eligible, including but not limited to redeployed staff time, paid and accrued unpaid overtime and both interim care centres. Additional details on eligible extraordinary costs can be found in Schedule B, on page 9 of the Attachment 1 - Public Health Funding and Accountability Agreement.

Without the funding of the EMR, management has placed this project on hold. Recent changes and increased features to the existing Provincial software has allowed the Health Unit with support from the Corporate Services team to develop a partial work from home strategy. This will reduce the department's operational risks and provide some greater flexibility for staff. Management will re-apply for funding for the EMR system at a later date. The long term modernization of Health Unit records would still be a priority after the COVID response has concluded. The MOH has communicated that a similar application process will be made available for the 2021 calendar year and the MOH may also allow health units to apply for costs that arose in 2020 subsequent to the previous submission period.

<u>Previously deferred matter – Management Overtime Compensation</u>

Previously an in-camera report was presented to Council regarding management overtime compensation. This issue was deferred by the Board of Health in order to await more information including confirmation regarding the Ministry's funding. We have now received the funding that was applied for by the Health Unit for this matter, which was applied for in a similar manner as many other health units. Management will pay out the funds pursuant to the terms of the submission.

The MOH has informed us that additional funding intakes for extraordinary costs will be made available to the health unit. The CAO has recognized that the submission for these specific costs were outside our existing policies and Board of Health approval should have been obtained prior to that submission. As such prior to any further submission the Board of Health should provide specific direction to management on this

issue. The CAO had previous solicited input from Board members on this topic as well as input from Haldimand County on this matter. The payment of overtime compensation to management in the health unit is not taken lightly as it has serious implications not only in the Health Unit but across other Norfolk County departments and within Haldimand County. The implications are due to the fact that you will have inconsistency between employee compensation approaches based on the departments that they work in.

Prior to submitting for costs to the MOH again, staff are recommending that the Board of Health provide management with firm direction on this issue, by choosing one of the following options or another option as they deem appropriate:

Option 1

Endorse a policy based approach for any future applications for funding from the MOH for management overtime compensation.

Staff's suggested policy based approach would contain the following key attributes, the full policy will be developed subsequently by staff. Key attributes are:

- No Health Unit management overtime compensation will be paid unless it is funded by the Ministry. In other words there can be no negative impact on the tax levy.
- Applications for funding for overtime compensation will reflect a reasonable amount of assumed unpaid overtime for management staff. This amount will be set at an average of 44 hours per week, in other words until an employee exceeds 44 hours a week on average for the funding period no overtime compensation will be applicable.
- Total overtime compensation cannot exceed 20% of an individual's normal compensation or salary levels for that period.
- Overtime over the 44 hours in weekly period will require specific approval from leadership and any overtime exceeding 55 hours will require approval from the GM of Health and Social Services or the CAO.

This option provides a number of increased controls for overtime use and compensation.

The proposed attributes of this approach is less generous to the employees that what was previously approved for funding by the MOH on our last submission. The MOH essentially approved all overtime at straight time. This option would reduce future requests to the MOH for funding on this matter as there would be less overtime eligible for funding.

Option 2

Direct management maintain existing policies and as such to no longer apply for overtime based compensation for management staff.

This option will likely have negative human resource impacts for the Health Unit specifically.

Financial Services Comments:

The Approved 2020 Board of Health Operating Budget includes $636,700 for the COVID-19 team, as amended with report HSS 20-21. At this point, staff anticipate the allocated funding will be fully utilized to help offset the financial impact COVID-19 has had on the levy budget. The funding will be reconciled during the MOH's annual settlement process, typically occurring during calendar Q2. Should costs exceed the funding, the 2020 cost share for the Health Unit is approximately 40.88% Haldimand and 59.12% Norfolk.

Regarding the options presented, both are designed so that there is no impact to the local taxpayer.

Interdepartmental Implications:

N/A

Consultation(s):

General Manager, Health & Social Services
Director, Haldimand-Norfolk Health Unit
Director, Quality, Planning, Accountability and Performance
Haldimand County Corporate Services

Strategic Plan Linkage:

This report aligns with the 2019-2022 Council Strategic Priority "Build Solid Foundations".

Explanation:
Utilizing Provincial grant funding to offset any potential deficits resulting from unbudgeted COVID-19 extraordinary pandemic costs is linked to Norfolk County's initiative for financial sustainability.

Conclusion:

The Haldimand-Norfolk Health Unit received $5.3 million from the Ministry of Health to be used to offset extraordinary costs and financial pressures arising from the COVID-19 pandemic during the 2020 calendar year. The amount was determined through consultation with Haldimand County and processes set up to track Public Health costs separate from Municipal costs and base programs.

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Staff would like to acknowledge the Ministry of Health and the Province of Ontario for their commitment to supporting the Board of Health and the municipal taxpayers during these difficult times.

For future submission, the Board of Health can direct staff on the preferred policy.

Recommendation(s):

THAT Report CS 21-10 Haldimand-Norfolk Health Unit COVID-19 Extraordinary Costs Funding be received as information;

AND THAT the $5,338,200 in COVID-19 Extraordinary Costs Funding from the Ministry of Health be accepted;

AND THAT Council directs staff to be guided by Option __(Council to insert Option # 1 or #2)__ for future Health Unit management overtime issues related to the COVID19 response;

AND FURTHER THAT the Board of Health endorse funding be applied against eligible COVID-19 levy funded expenditures within the Approved 2020 Board of Health Operating Budget.

Attachment(s):

Attachment 1 - Public Health Funding and Accountability Agreement

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New Schedules to the Public Health Funding and Accountability Agreement

BETWEEN THE PROVINCE AND THE BOARD OF HEALTH

(BOARD OF HEALTH FOR THE HALDIMAND-NORFOLK HEALTH UNIT)

EFFECTIVE AS OF THE 1ST DAY OF JANUARY 2020

SCHEDULE "A"
GRANTS AND BUDGET

Board of Health for the Haldimand-Norfolk Health Unit

DETAILED BUDGET - MAXIMUM BASE FUNDS (FOR THE PERIOD OF JANUARY 1, 2020 TO DECEMBER 31, 2020, UNLESS OTHERWISE NOTED)			
Programs/Sources of Funding	**2019 Approved Allocation ($)**	**Increase / (Decrease) ($)**	**2020 Approved Allocation ($)**
Mandatory Programs (70%)	5,757,300	(325,400)	5,431,900
MOH / AMOH Compensation Initiative (100%)[1]	121,000	(17,400)	103,600
Ontario Seniors Dental Care Program (100%)	537,900	-	537,900
Total Maximum Base Funds[2]	**6,416,200**	**(342,800)**	**6,073,400**

DETAILED BUDGET - MAXIMUM ONE-TIME FUNDS (FOR THE PERIOD OF APRIL 1, 2020 TO MARCH 31, 2021, UNLESS OTHERWISE NOTED)			
Projects / Initiatives			**2020-21 Approved Allocation ($)**
Mitigation (100%)[3]			325,400
Mandatory Programs: Public Health Inspector Practicum Program (100%)			10,000
COVID-19: Extraordinary Costs (100%)[3]			5,338,200
COVID-19: Public Health Case and Contact Management Solution (100%)[4]			25,200
COVID-19: School-Focused Nurses Initiative (100%)[5]	# of FTEs	5.0	335,000
Capital: Expansion of Dunnville Satellite Office (100%)[6]			125,000
MOH / AMOH Compensation Initiative (100%)			6,900
Ontario Seniors Dental Care Program Capital: New Dental Operatory and Upgrades – Health and Social Services(100%)[6]			300,000
Ontario Seniors Dental Care Program Capital: New Operatory and Dental Suite – Dunnville Satellite Office (100%)[6]			323,000
Temporary Pandemic Pay Initiative (100%)[7]			64,900
Total Maximum One-Time Funds[2]			**6,853,600**

MAXIMUM TOTAL FUNDS	2019-20 Approved Allocation ($)	2020-21 Approved Allocation ($)
Base and One-Time Funding	**6,416,200**	**12,927,000**

DETAILED BUDGET - MAXIMUM ONE-TIME FUNDS (FOR THE PERIOD OF APRIL 1, 2021 to MARCH 31, 2022, UNLESS OTHERWISE NOTED)			
Projects / Initiatives			**2021-22 Approved Allocation ($)**
Mitigation (100%)[8]			325,400
COVID-19: School-Focused Nurses Initiative (100%)[9]	# of FTEs	5.0	165,000
Total Maximum One-Time Funds[2]			**490,400**

NOTES:
(1) Cash flow will be adjusted to reflect the actual status of current MOH and AMOH positions.
(2) Maximum base and one-time funding is flowed on a mid and end of month basis. Cash flow will be adjusted when the Province provides a new Schedule "A".
(3) One-time funding is for the period of January 1, 2020 to December 31, 2020.
(4) One-time funding is approved for the period of June 15, 2020 to March 31, 2021.
(5) One-time funding is approved for the period of August 1, 2020 to March 31, 2021.
(6) One-time funding is approved for the period of April 1, 2020 to March 31, 2021, or such later EXPIRY DATE as agreed to by the parties.
(7) One-time funding is approved for the period of April 24, 2020 to August 13, 2020.
(8) One-time funding is approved for the period of January 1, 2021 to December 31, 2021.
(9) One-time funding is approved for the period of April 1, 2021 to July 31, 2021.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***BASE FUNDING***

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

Mandatory Programs: Harm Reduction Program Enhancement

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

Local Opioid Response

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

Local response plans, which can include harm reduction and education/prevention, initiatives, should contribute to increased access to programs and services, and improved health outcomes (i.e., decrease overdose and overdose deaths, emergency room visits, hospitalizations). With these goals in mind, the Board of Health is expected to:

- Conduct a population health/situational assessment, including the identification of opioid-related community challenges and issues, which are informed by local data, community engagement, early warning systems, etc.
- Lead/support the development, implementation, and evaluation of a local overdose response plan (or drug strategy). Any plan or initiative should be based on the needs identified (and/or gaps) in your local assessment. This may include building community outreach and response capacity, enhanced harm reduction services and/or education/prevention programs and services.
- Engage stakeholders – identify and leverage community partners to support the population health/situational assessment and implementation of local overdose response plans or initiatives. This should include First Nations, Métis and Inuit communities where appropriate.
- Adopt and ensure timely data entry into the Ontario Harm Reduction Database, including the Transition to the Ontario Harm Reduction Database and ensure timely collection and entry of minimum data set as per direction from the Province (to be provided).

Naloxone Kit Distribution and Training

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

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

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***BASE FUNDING***

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

Use of NARCAN® Nasalspray

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

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

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RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***BASE FUNDING***

- That the Province does not guarantee supply of Narcan, nor that Narcan will be provided to the Board of Health in a timely manner.

Opioid Overdose Early Warning and Surveillance

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

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

Mandatory Programs: Healthy Smiles Ontario Program

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

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

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

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***BASE FUNDING***

- Aggregate screening, enrolment, and utilization data for any given month must be submitted by the 15th of the following month to the ministry in the ministry-issued template titled Dental Clinic Services Monthly Reporting Template.
- Client-specific clinical data must be recorded in either dental management software (e.g., ClearDent, AbelDent, etc.) or in the template titled HSO Clinic Treatment Workbook that has been issued by the ministry for the purposes of recording such data.

- The Board of Health must enter into Service Level Agreements with any partner organization (e.g., Community Health Centre, Aboriginal Health Access Centre, etc.) delivering services as part of the HSO Program. The Service Level Agreement must set out clear performance expectations, clearly state funding and reporting requirements between the Board of Health and local partner, and ensure accountability for public funds.
- Any significant change to previously approved HSO business models, including changes to plans, partnerships, or processes, must be approved by the Province before being implemented.
  Any contract or subcontract entered into by the Board of Health for the purposes of implementing the HSO Program must be conducted according to relevant municipal procurement guidelines.

Mandatory Programs: Nursing Positions

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

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

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

The Board of Health shall only employ a Social Determinants of Health Nurse with the following qualifications:
- The position is required to be to be a Registered Nurse; and,

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RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***BASE FUNDING***

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

Mandatory Programs: Smoke-Free Ontario Strategy

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

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

MOH / AMOH Compensation Initiative (100%)

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

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

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

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

Ontario Seniors Dental Care Program (100%)

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

STAGE 1: Beginning Fall 2019 – The government announced the launch and staged implementation of the OSDCP on November 20, 2019. During the first stage of implementation, dental services are

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RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***BASE FUNDING***

available for eligible seniors through Boards of Health and participating Community Health Centres and Aboriginal Health Access Centres. Through Stage 1, dental care was initiated and is provided to eligible low-income seniors through Boards of Health, and participating Community Health Centres, and Aboriginal Health Access Centres based on increasing Board of Health operational funding and leveraging existing infrastructure.

STAGE 2: Beginning Winter 2020 – The second stage of the program, which began in winter 2020, and will continue throughout the year, will expand the program by investing in new dental clinics to provide care to more seniors in need. This will include new dental services in underserviced areas, including through mobile dental buses and an increased number of dental suites in Boards of Health, and participating Community Health Centres, and Aboriginal Health Access Centres. The second stage of the program began in Winter 2020 and will continue throughout the year.

Program Enrolment

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

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

Program Delivery

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

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

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

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RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***BASE FUNDING***

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

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

- *Clinical service delivery costs*, which are comprised of:
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff of the Board of Health or local service delivery partner which provide clinical dental services for the Program.
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff of the Board of Health or local service delivery partner which undertake ancillary/support activities for the Program, including: management of the clinic(s); financial and programmatic data collection and reporting for the clinic(s); and, general administration (e.g., reception services) at the clinic(s).
  - Overhead costs associated with the Program's clinical service delivery such as: clinical materials and supplies; building occupancy costs; maintenance of clinic infrastructure; staff travel associated with clinical service delivery (e.g., portable clinics, mobile clinics, long-term care homes, if applicable); staff training and professional development associated with clinical staff and ancillary/support staff, if applicable; office equipment, communication, and information and information technology.

- *Oral health navigation costs*, which are comprised of:
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff engaged in: client enrolment assistance for the Program's clients (i.e., assisting clients with enrolment forms); program outreach (i.e., local-level efforts for identifying potential clients); and, oral health education and promotion to the Program's clients.
  - Salaries, wages, and benefits of full-time, part-time, or contracted staff that undertake the following ancillary/support activities related to oral health navigation: management, financial and programmatic reporting, and general administration (if applicable).
  - Overhead costs associated with oral health navigation such as: materials and supplies; building occupancy costs incurred for components of oral health navigation; staff travel associated with oral health navigation, where applicable; staff training and professional development associated with oral health navigation and ancillary/support staff, if applicable; office equipment, communication, and information and information technology costs associated with oral health navigation.
  - Client transportation costs in order to address accessibility issues and support effective program delivery based on local need, such as where the enrolled OSDCP client would otherwise not be able to access dental services. Boards of Health will be asked to provide information on client transportation expenditures through in-year reporting and should track these expenditures and the number of clients accessing these services accordingly.

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

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

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RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***BASE FUNDING***

Other Requirements

Marketing

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

Revenue

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

Community Partners

- The Board of Health must enter into discussions with all Community Health Centres and Aboriginal Health Access Centres in their catchment area to ascertain the feasibility of a partnership for the purpose of delivering this Program.
- The Board of Health must enter into Service Level Agreements with any partner organization (e.g., Community Health Centres, Aboriginal Health Access Centres) delivering services under this Program. The Service Level Agreement must set out clear performance expectations, clearly state funding and reporting requirements between the Board of Health and the local partner, and ensure accountability for public funds.
- The Board of Health must ensure that base funding is used to meet the objectives of the Program, with a priority to deliver clinical dental services to clients, while staying within the base funding allocation.

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RELATED PROGRAM POLICIES AND GUIDELINES

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

Mitigation (100%)

One-time mitigation funding must be used to offset the increased public health program costs of municipalities as a result of the cost-sharing change.

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

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

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

COVID-19: Extraordinary Costs (100%)

One-time funding must be used by the Board of Health to offset extraordinary costs associated with monitoring, detecting, and containing COVID-19 in the province.

Eligible costs include, but are not limited to:

- Salaries and benefits associated with surveillance, case and contact management (investigation/follow-up), inclusive of overtime for existing staff, or hiring other employees (new temporary or casual staff) to assist with COVID-19 response, staff used or engaged to manage COVID-19 reporting requirements, management staff related to COVID-19 activities, and back-filling of staff who have been re-assigned to support COVID-19 response.
- Travel and accommodation for staff delivering COVID-19 service away from their home base, or for staff to conduct the infectious disease surveillance demands (swab pick ups and laboratory deliveries).
- Supplies and equipment, including laboratory testing supplies, information and information technology upgrades related to tracking COVID-19, and replenishment of inventories for the delivery of mandatory public health programs and services.
- Purchased services, including security services, transportation services including courier services and rental cars, data entry or information technology services for reporting COVID-19 data to the ministry from centres in the community that are not operated by the public health unit or increased services required to meet pandemic reporting demands, staff wellness initiatives (i.e., increased Employee Assistance Program services), and additional premises rented.
- Communications, including media announcements, public and provider awareness, signage, and education materials.

The Board of Health is required to retain records of COVID-19 spending for future follow-up.

COVID-19: Public Health Case and Contact Management Solution (100%)

The Provincial Case and Contact Management Action Plan aims to ensure case and contact management is effective in containing the spread of COVID-19 by:

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RELATED PROGRAM POLICIES AND GUIDELINES

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

- Supporting public health units with additional centralized resources;
- Expediting data entry to speed process and provide timely analytics;
- Integrating with supporting provincial systems and services; and,
- Improving technology tools and providing one provincial system.

To that end, the Public Health Case and Contact Management (CCM) I&IT Solution will be used for Ontario to manage cases and contacts of COVID-19. Built on the Salesforce platform, this provincially-funded solution replaces the use by public health units of the integrated Public Health Information System (iPHIS) for COVID-19 case and contact management and reporting.

The goal is to streamline public health unit processes through improved system workflows for COVID-19 case and contact management. This will include eventual elimination of faxed lab results through direct integration of lab records from the provincial laboratory repository (OLIS) with the CCM Solution, working in close collaboration with Ontario Health to ensure the quality, timeliness, and completeness of OLIS data. Provincial reporting will continue to occur from iPHIS CRN without the need for re-entering data. The CCM Solution will also support remote workforces and have efficient onboarding with a secure two-factor authentication process replacing the need for VPN tokens.

One-time funding must be used by the Board of Health for costs associated with onboarding and ongoing operations of the components of the CCM Solution already implemented, as well as to adopt components of the CCM Solution scheduled for implementation and the associated readiness activities and business process transformation.

Conduct Ongoing Operations and Implementation of Upgrades (releases and enhancements) for the implemented components of the CCM Solution:

- Engage in continuous review of business processes to seek improvements, efficiencies and best practices;
- Implement and support identified improvements and best practices;
- Participate in the development of use-case scenarios for enhancements and releases, as required;
- Provide Subject Matter Expert Functional Testing resources for selected enhancements or releases, as required;
- Participate in the development of operational and enhanced surveillance reports, as required;
- Implement any defined workarounds;
- Conduct data cleaning and duplicate record resolution;
- Prepare and implement plans to address the data collection, transformation, entry and validation from all reporting sources and methods to the CCM Solution;
- Maintain local training materials and programs;
- Maintain internal Board of Health support model including the Problem Resolution Coordinator role and ensuring integration with the Province's service model;
- Implement internal Board of Health incident model including the Incident Coordinator role for privacy incident and auditing practices and ensuring integration with the Province's incident model;
- Review and adjust existing system accounts, roles and responsibilities to ensure correct authorization and access levels are being provided to account holders;

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

- Assign required roles, responsibilities, and accounts to staff members and complete all necessary registration processes;
- Implement and adhere to data standards, security, audit and privacy policies and guidelines;
- Maintain the security and technical infrastructure required for the operation of the CCM Solution including the approved level(s) of the supported browser(s);
- Ensure required security and privacy measures are followed for transferring data, applying password protection and encrypting devices where personal and personal health information is involved;
- Confirm appropriate privacy, security, and information management related analyses, activities and training have been executed in accordance with your Board of Health's obligations as a Health Information Custodian under the *Personal Health Information Protection Act* (PHIPA) and other applicable laws and local business practices and processes;
- Sign required agreements with the Ministry prior to production use of CCM Solution;
- Participate in surveys, questionnaires and ad-hoc reviews, as required;
- Participate in structured reviews and feedback sessions including; working groups, committees, forums, and benefit analysis sessions as required;
- Maintain communications with both internal staff and external stakeholders;
- Provision of human resources to provide support within at least one (1) of the following categories, as required:
  - Business Practices and Change Management,
  - Release Planning and Deployment,
  - Information Governance,
  - Audit Policies and Guidelines,
  - Data Standards and Reporting,
  - Data Analytics,
  - Integration,
  - User Experience, and
  - Technical (IT) Experience.

Conduct Deployment and Adoption Activities for components of the CCM Solution scheduled for implementation:

- Review of business processes and workflows and implement changes required to support adoption of new components as per specific Board of Health requirements and best practices best practices;
- Participate in the development of use-case scenarios for new components, as required;
- Provide Subject Matter Expert Functional Testing resources for new components, as required;
- Develop local training plans, materials and programs and complete and execute training plans for new components, as required;
- Complete data mapping and dry runs of data migration/ data integration, validate data migration/data integration results and address duplicate record resolution and data transformation and cleansing, as required;
- Assign required roles, responsibilities, and accounts to staff members and complete all necessary registration processes, as required;
- Support onboarding activities for the CCM Solution and components;
- Complete deployment checklists as per required activities;

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RELATED PROGRAM POLICIES AND GUIDELINES

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

- Establish and implement internal Board of Health support model including providing the Problem Resolution Coordinator and ensuring integration with the Province's service model;
- Establish and implement internal Board of Health incident model including providing the Incident Coordinator and ensuring integration with the Province's incident model;
- Implement the security and technical infrastructure required for the operation of the CCM Solution including the approved level(s) of the supported browser(s) as communicated by the Ministry and the use of encrypted drives, devices and files;
- Confirm appropriate privacy, security, and information management related analyses, activities and training have been executed in accordance with your Board of Health's obligations as a Health Information Custodian under PHIPA and other applicable laws and local business practices and processes;
- Implement required security and privacy measures for transferring data, applying password protection and encrypting devices where personal health information is involved;
- Maintain and execute a communication/information plan for both internal staff and external stakeholders;
- Sign required agreements with the Province prior to production use of the CCM Solution;
- Provision of human resources to provide support within at least one (1) of the following categories, as required:
  - Business Practices and Change Management,
  - Release Planning and Deployment,
  - Integration,
  - User Experience, and
  - Technical (IT) Experience.

If the Board of Health has agreed to be a Builder and Early Adopter it must also use the one-time funding toward the following activities for the CCM Solution as noted below:

- Provide special public health unit support services to the Province for the CCM Solution to assist with defining requirements; designing features; prioritizing requirements; supporting resolution of public health specific issues; assessing and testing releases and enhancements; identifying business process improvements and change management strategies; and conducting pilots, prototyping and proof of concept activities;
- Chair/Co-Chair Working Group(s), as required;
- For Builder and Early Adopter activities above, provision of human resources to provide support within at least three (3) of the following categories, as required:
  - Release Planning and Deployment,
  - Information Governance,
  - Business Practices and Change Management,
  - Audit Policies and Guidelines,
  - Data Standards and Reporting,
  - Data Analytics,
  - Integration,
  - User Experience, and
  - Technical (IT) Experience.

COVID-19: School-Focused Nurses Initiative (100%)

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RELATED PROGRAM POLICIES AND GUIDELINES

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

The School-Focused Nurses Initiative was created to support additional nursing FTE capacity in every board of health to provide rapid-response support to school boards and schools in facilitating public health and preventative measures related to the COVID-19 pandemic.

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

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

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

The initiative is being implemented through a phased-approach for the 2020-21 school year, with the following considerations:

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

Qualifications required for these positions are:

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

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

Capital: Expansion of Dunnville Satellite Office (100%)

One-time funding must be used for the retrofit of the Dunnville site. Eligible costs include construction, mechanical and electrical expenses to retrofit the site, including the construction of an AODA compliant reception area, lighting and security upgrades, and furnishings.

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RELATED PROGRAM POLICIES AND GUIDELINES

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

Other requirements of this one-time funding include:

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

MOH / AMOH Compensation (100%)

One-time funding must be used for costs associated with top-up for salaries and benefits, and for applicable stipends to eligible MOH and AMOH positions at the Board of Health and cannot be used to support other physicians or staffing costs.

The maximum one-time funding allocation in Schedule A of the Agreement does not necessarily reflect the cash flow that the Board of Health will receive. Cash flow will be adjusted by the Province based on up-to-date application data and information provided by the Board of Health during the funding year.

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

Ontario Seniors Dental Care Program Capital: New Dental Operatory and Upgrades – Health and Social Services (100%)

As part of the Ontario Seniors Dental Care Program, one-time funding is being provided to support capital investments in public health units, Community Health Centres and/or Aboriginal Health Access Centres across the province for enhancing infrastructure to increase clinical spaces and capacity to deliver dental care services for eligible seniors.

One-time funding must be used to convert the preventive clinic to also provide restorative dental services. Eligible costs include the addition of a new dental operatory and x-ray machine, upgrades to the existing dental chair, expansion of the sterilization area, and furniture and equipment.

Other requirements of this one-time funding include:

- Any changes to the scope of the project, including anticipated timelines, require prior review and approval by the Province.
- One-time funding is provided with the understanding that no additional operating funding is required, nor will it be made available by the Province, as a result of the completion of this project.

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RELATED PROGRAM POLICIES AND GUIDELINES

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

- The Board of Health must ensure that any goods and services acquired with this one-time funding should be procured through an open and competitive process that aligns with municipal and provincial procurement directives to the greatest extent possible.
- The Board of Health must ensure that this project is compliant with associated legislated standards (i.e., Building code/associated Canadian Standards Association requirements) and infection/prevention and control practices as appropriate to the programs and services being delivered within the facility.

Ontario Seniors Dental Care Program Capital: New Operatory and Dental Suite – Dunnville Satellite Office (100%)

As part of the Ontario Seniors Dental Care Program, one-time funding is being provided to support capital investments in public health units, Community Health Centres and/or Aboriginal Health Access Centres across the province for enhancing infrastructure to increase clinical spaces and capacity to deliver dental care services for eligible seniors.

One-time funding must be used for a new preventive and treatment operatory and dental suite. Eligible costs include the addition of a new dental operatory, equipment for a sterilization and pump room, and furniture.

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

Temporary Pandemic Pay Initiative (100%)

1. Purpose
- To provide additional support for eligible Board of Health employees who are experiencing severe challenges and are at heightened risk during the COVID-19 outbreak, the Province is providing a pandemic pay increase between April 24, 2020 and August 13, 2020 for the public health sector.
- The Temporary Pandemic Pay Initiative is a targeted program designed to support Board of Health employees who face a real and perceived risk of COVID-19 exposure, where maintaining physical distancing is difficult or not possible.

2. Pandemic Pay Funds
- The Province will: determine the Board of Health's eligibility; the amount of Pandemic Pay one-time funding the Board of Health may be eligible to receive; and, provide the Board of Health with

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

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

Pandemic Pay one-time funding for the purposes of administering the Temporary Pandemic Pay Initiative.

3. Board of Health's Obligations

- The Board of Health will:
  - Be required to determine and identify eligible employees;
  - Pay Pandemic Pay funds to each eligible employee that the Board of Health employs in accordance with the Temporary Pandemic Pay calculations as set out in section 5;
  - Make reasonable efforts to set out Temporary Pandemic Pay as a separate line item from other amounts paid to eligible employees in a pay stub or other document provided to eligible employees;
  - Only use Pandemic Pay one-time funding for the purposes of paying eligible employees and the costs incurred under statute or contract because of the payment of Temporary Pandemic Pay. For greater clarity, the Temporary Pandemic Pay one-time funding may not be used for administrative costs or any other purpose for which funding is provided to the Board of Health under the Agreement;
  - Create and maintain records that document: number of employee hours eligible for hourly pandemic pay, tracked per mid-term and final reporting periods, gross amount of hourly pandemic pay paid out to eligible employees, gross amount of pandemic pay lump sum paid out to eligible workers, amount of statutory contributions paid by employers as a result of providing pandemic pay to eligible workers, amount paid by the Board of Health to address statutory or collective agreement entitlements as a result of providing pandemic pay, and completed attestations for lump sum payments;
  - Provide the Province with such information and records, including the records listed above as may be requested in order to calculate the Board of Health's entitlement to Pandemic Pay one-time funding or to evaluate the outcomes and effectiveness of the Board of Health's use of Pandemic Pay one-time funding; and,
  - At the request of the Province, provide communications materials to eligible employees concerning the Temporary Pandemic Pay Initiative.

4. Eligibility

- The eligibility period for the Temporary Pandemic Pay Initiative is from April 24, 2020 up to and including August 13, 2020.
- The following Board of Health employees (in a full-time or part-time capacity) are eligible for Temporary Pandemic Pay:
  - Nurses that have consistent and ongoing risk of exposure (i.e., direct/in-person client interaction) to COVID-19 (Infection Prevention and Control Nurses, Nurse Practitioners, Registered Nurses, Registered Practical Nurses, Public Health Nurses).
- For additional clarity, all other Board of Health employees (including individuals employed in a management capacity) are not eligible for Temporary Pandemic Pay one-time funding approved as part of this Agreement.

5. Calculation of Temporary Pandemic Pay

- Temporary Pandemic Pay for each eligible employee shall be calculated based on the following criteria during the eligibility period set out in section 4.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

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

- Temporary Pandemic Pay is to be calculated in addition to an employee's regular wages and is not part of base salary;
- For each hour worked during the eligibility period, the eligible employee shall be paid four dollars ($4);
- Where an eligible employee works more than one hundred (100) hours in one of the designated four-week periods set out below, they shall be paid an additional lump sum payment of two hundred and fifty dollars ($250) for that period and up to one thousand dollars ($1,000) over these sixteen (16) week:
    - April 24, 2020 to May 21, 2020
    - May 22, 2020 to June 18, 2020
    - June 19, 2020 to July 16, 2020
    - July 17, 2020 to August 13, 2020

- Subject to the Province's sole discretion to determine the amount, the following shall be included in the calculation of Temporary Pandemic Pay Funds:
    - The total amount that eligible Board of Health employees are eligible to receive as Temporary Pandemic Pay; and,
    - An amount equal to the increased costs that the Board of Health incurs pursuant to its obligations as an employer under a statutory or contractual requirement but does not include increased costs associated with any required contributions to a pension plan or benefits plan. Examples of increased costs include: Employers' statutory contributions to the Canada Pension Plan, Employers' statutory contributions to Employment Insurance, Employer Health Tax on payroll, Employers' statutory obligation to pay Workplace Safety and Insurance Board premiums, Employers' statutory payment of Vacation Pay, Employers' statutory payment of Public Holiday Pay, and Employers' statutory payment of Overtime Pay.
- The Board of Health will be required to return any funding not used for the intended purpose. Unspent funds are subject to recovery in accordance with the Province's year-end reconciliation policy.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***OTHER***

Infectious Diseases Programs Reimbursement

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

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

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

Leprosy

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

Tuberculosis

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

Vaccine Programs Reimbursement

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

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

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

Influenza

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

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***OTHER***

Meningococcal

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

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

Human Papillomavirus (HPV)

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

The Board of Health

By-Law 2020-13-BH

Being a By-Law to Confirm the Proceedings of The Board of Health for the Haldimand-Norfolk Health Unit at this Board of Health Meeting held on the 1st of June, 2021.

WHEREAS Section 56 of the Health Protection and Promotion Act, R.S.O. 1990, c.H.7, as amended, provides that every Board of Health shall pass a by-law respecting the calling and proceedings at meetings;

AND WHEREAS it is deemed expedient that the proceedings of the Board at this Board of Health Meeting be confirmed and adopted by By-Law.

NOW THEREFORE the Board of Health for the Haldimand-Norfolk Health Unit hereby enacts as follows:

1. That the actions of The Board of Health for the Haldimand-Norfolk Health Unit at this Board of Health Meeting held 1st Day of June, 2021, and each motion and resolution passed and other action taken by The Board of Health for The Haldimand-Norfolk Health Unit at this meeting are hereby adopted and confirmed as if all such proceedings were expressly embodied in this By-Law.

2. That the Chair of the Board of Health and proper officials of the Haldimand-Norfolk Health Unit are hereby authorized and directed to do all things necessary to give effect to the actions of The Board of Health referred to in the preceding section hereof.

3. That the Mayor and Clerk are authorized and directed to execute all documents necessary in that behalf and to affix thereto the Seal of Norfolk County.

ENACTED AND PASSED this 1st Day of June, 2021.

_____
Chair

_____
County Clerk