Agenda

Health and Social Services Haldimand and Norfolk

Haldimand-Norfolk
Health and Social Services Advisory Committee

May 30, 2022
9:30 a.m.
Council Chambers

Pages

7.4. Quality, Planning, Accountability, and Performance

8. Sub-Committee Reports
9. Communications
10. Other Business
11. Closed Session
12. Next Meeting

12.1. Monday June 27th, 2022

13. Adjournment

Minutes

Haldimand-Norfolk

Health and Social Services Advisory Committee

April 25, 2022
9:30 a.m.
Council Chambers

Present:	Chris Van Paassen, Ryan Taylor, Tony Dalimonte, Bernie Corbett
Absent with Regrets:	Kim Huffman, Stewart Patterson
Also Present:	Christina Lounsbury, Heidy VanDyk, Syed Shah, Stephanie Rice, Lori Friesen, Kike Ogunsulire

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1. Disclosure of Pecuniary Interest

2. Additions to Agenda

3. Presentations/Deputations

4. Adoption/Correction of Advisory Committee Meeting Minutes

4.1 Health and Social Services Advisory Committee - March 28, 2022

The minutes of the Health and Social Services Advisory Committee meeting dated March 28, 2022, having been distributed to all Committee Members and there being no errors reported, they were there upon declared adopted and signed by Chair Dalimonte.

Moved By: Chris Van Paassen
Seconded By: Bernie Corbett

Carried.

5. Update on Reports

Heidy VanDyk-Ellis, Acting General Manager, advised that all reports from the March 28, 2022 Advisory Committee Meeting were approved at council as presented.

6. Consent Items

7. Staff Reports

7.1 General Manager

7.2 Public Health

7.2.1 Acting Medical Officer of Health - Verbal Update

Dr. Strauss gave a verbal update on the sixth wave of COVID 19 in Ontario and how it appears to have crested. He presented four different graphs showing the cases in Ontario over time, Hospitalizations and ICU Admissions in Ontario over time, Covid-10 Deaths per 100,000 by Health Unit (neighbours) and Covid 19 Deaths per 100,00 by Health Unit (rural, western Ontario). Dr Strauss mentions to the Committee Members that the Palxovid medication to help treat COVID 19 is now available to residents in Haldimand and Norfolk. Dr Strauss will provide this verbal report written format to the next Board of Health Meeting.

7.2.2 HSS 22-010 - Ontario Seniors Dental Program

Moved By: Ryan Taylor
Seconded By: Bernie Corbett

THAT Staff Report HSS 22-010, OSDCP – Request for Proposals be received as information;

AND THAT Approval be granted for a modified procurement process to be completed seeking proposals from qualified community dental professionals for a period of six (6) months from July 1, 2022 to December 31, 2022 with an option to extend the agreement on the same terms and conditions for one (1) additional six (6) month term.

Carried.

7.3 Social Services and Housing

7.3.1 HSS 22-014 - Homeless Prevention Services - Emergency Housing Program

Moved By: Bernie Corbett
Seconded By: Ryan Taylor

THAT Staff report HSS-22-014, Homeless Prevention Services – Emergency Housing Program, be received as information;

AND THAT Council direct staff to issue a Request for Proposal (RFP) for enhanced emergency housing and homeless prevention programs which may include additional locations for emergency housing and warming and cooling centres in both Counties;

AND FURTHER THAT Council direct staff to bring back a report outlining the results of the RFP.

7.4 Quality, Planning, Accountability, and Performance

8. Sub-Committee Reports

9. Communications

9.1 Registration is Now Open for 2022 Annual General Meeting, Conference, Section Meetings, and Optional Pre-Conference Workshop!

Anyone choosing to register for the upcoming Annual General Meeting Conference, Section Meetings and or Pre Conference Workshop can do so by contacting Heidy VanDyk Acting General Manager for Haldimand Norfolk Health and Social Services or Christina Lounsbury, Administrative Coordinator for Haldimand Norfolk Health and Social Services

Moved By: Ryan Taylor
Seconded By: Chris Van Paassen

Carried.

10. Other Business

11. Closed Session

Moved By: Bernie Corbett
Seconded By: Ryan Taylor

That Health and Social Services Advisory Committee enter closed session at 10:12 AM to discuss Municipal Act, 2001, Section 239(2)(h) as amended as the subject matters pertains to information explicitly supplied in confidence to the municipality or local board of Canada, a province or territory or Crown agency of any of them.

Carried.

11.1 HSS 22- 012 - Homeless Prevention Program Report

Pursuant to the Municipal Act, 2001 Section 239(2)(h) (h) information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them;

Moved By: Chris Van Paassen
Seconded By: Bernie Corbett

That council receive confidential staff report HSS 22-012 as information;

AND THAT staff proceed as directed in closed session and outlines in the confidential report;

AND THAT Council authorize the Mayor and Clerk to sign the required Transfer Payment Agreement with the Ministry of Municipal Affairs and Housing;

AND THAT the necessary budget amendments be made tot he 2022 Social Housing levy supported operating budget as outlined in the confidential staff report.

Carried.

11.2 HSS 22-015 - Social Services Relief Fund (SSRF), Phase 5

Pursuant to the Municipal Act, 2001 Section 239(2)(h) (h) information explicitly supplied in confidence to the municipality or local board by Canada, a province or territory or a Crown agency of any of them;

Moved By: Bernie Corbett
Seconded By: Chris Van Paassen

that committee reconvened at 10:32 a.m.

Carried.

Moved By: Bernie Corbett
Seconded By: Chris Van Paassen

That council received confidential staff report HSS-22-015 as information;

AND THAT Staff proceed as directed within the confidential staff report;

AND FURTHER THAT staff bring back a full report in open session as soon as it's feasible.

Carried.

12. Next Meeting

May 23, 2002 - Victoria Day Holiday. Postponing meeting till Monday May 30, 2022 @ 9:30am

13. Adjournment

To: Members of the Health and Social Services Advisory Committee

From: Dr. Matt Strauss, Acting Medical Officer of Health

Date: May 30, 2022

Re: Acting Medical Officer of Health Update

The sixth wave of Covid-19 in Ontario has concluded. Hospitizations in Haldimand-Norfolk are markedly down, with just one Covid positive individual currently in hospital and zero in ICU. The majority of deaths in Covid-positive individuals over the last few months have not been due to Covid. Those deaths that have been due to Covid have generally occurred in individuals who were otherwise moribund and receiving palliative care.

It is unlikely that we will see further waves of Covid-19 until Fall/Winter. Covid-19 is receding as a matter of public health concern.

Of increasing public health concern, have been reports of avian flu, severe acute hepatitis and monkeypox. We are actively monitoring these matters. I am pleased to say that there have been no cases of any of these reported in our jurisdiction. Even so, we are actively planning for the likelihood that there will be.

Board of Health Meeting – June 07, 2022

Advisory Committee Meeting – May 30, 2022

Subject:	Vector-borne Disease Program Update 2021-2022
Report Number:	HSS-22-017
Division:	Health and Social Services
Department:	Haldimand Norfolk Health Unit
Purpose:	For Information

Recommendation(s):

THAT Staff Report HSS 22-017, Vector-borne Disease Program Update 2021-2022, be received as information;

AND THAT the Board of Health support the HNHU's Vector-borne program activities which include active surveillance, and education regarding prevention strategies for vector-borne diseases.

Executive Summary:

This report provides information about the Haldimand-Norfolk Health Unit's (HNHU) comprehensive vector-borne disease (VBD) program that is in place to monitor local tick and mosquito populations for diseases such as Lyme Disease (LD), West Nile Virus (WNV) and Eastern Equine Encephalitis (EEEv). This report highlights the public health initiatives that encourage the public to take preventative measures against tick and mosquito bites. Furthermore, there is a discussion of Vector-borne Disease program activities in the previous year, and an overview of plans for 2022.

Discussion:

VBDs are human illnesses that are caused by bacteria, viruses and parasites. These illnesses or infections are transmitted to humans by vectors such as mosquitoes, ticks, flies, sandflies, and fleas. Mosquitos are known to be responsible for transmitting the majority of vector-borne diseases.

The VBDs specifically addressed in this report include Lyme Disease (LD), West Nile Virus (WNV) and Eastern Equine Encephalitis (EEEv).

The purpose of the VBD program is to monitor mosquito and tick populations to determine the risk of LD, WNV and EEEv to the public. The information gathered

through surveillance will help the HNHU make decisions regarding the development and implementation of vector control plans.

The HNHU has formulated a plan to mitigate the risk of VBDs to the community. However, this plan will not completely eliminate the risk.

Surveillance of VBDs includes mosquito trapping and tick dragging. This is supplemented by a review of official reports and statistics from other public agencies. The objective is to determine the trends and risks of VBDs locally. The HNHU communicates the results of surveillance initiatives to health care providers. With this information, health care providers (HCP) are able to better diagnose and treat patients.

Lyme Disease

1. Transmission and Presentation

LD is an infectious disease caused by the Borrelia bacterium that is transmitted to humans by the bites of infected deer ticks (blacklegged tick). The deer tick must be attached to a person for at least 24 hours before the bacteria can spread.

The most common signs of infection is an expanding area of redness on the skin, known as erythema migrans or bull's-eye rash. This rash, typically, appears at the site of the tick bite about a week after it occurred. Other early symptoms may include fever, fatigue, headache, muscle pain, joint pain, as well as paralysis of facial muscles.

2. Clinical and Surveillance Data

a) Active Tick Surveillance:

In 2021, the HNHU did not identify any new risk areas for LD.

Due to the ongoing COVID-19 pandemic, tick dragging for LD surveillance purposes was not performed during this year.

Estimated risk areas are locations where deer ticks have been identified or are known to occur and where humans have the potential to come into contact with infected ticks. Estimated risk areas are calculated as a 20 km radius from the centre of a location where deer ticks were found through drag sampling.

b) Human Case Surveillance:

In 2021, there were 26 human cases of LD identified within the HNHU compared to 7 in 2020 and 11 in 2019. Out of the 26 cases identified in 2021, 24 resided in Norfolk County.

In 2021, there were 1,597 reported human cases of LD in Ontario. This number is up from 809 cases in the previous year and similar to the 1,159 cases reported in 2019. Little information is available about the fluctuation in the number of cases over the last few years. Possible reasons for the increase in the number of cases this year may include increases in provincial travel to LD risk areas as restrictions due to the COVID-19 pandemic were changed and the effect of weather on tick populations. Warmer temperatures are expected to increase the incidence of Lyme Disease through increased tick maturation rates and a longer available season of transmission.

Doctors currently use clinical evidence and laboratory testing to diagnose patients with Lyme Disease. Clinical diagnosis involves determining the circumstances of the patient's exposure to the tick such as:

- the length of time that the tick was attached to the patient
- the tick being engorged with blood
- signs and symptoms of the patient
- the geographical area in which the patient was bitten

Laboratory diagnosis involves the testing of the patient's blood for the presence of antibodies to the LD causing agent *Borrelia burgdorferi*. Both methods of diagnosis allow Health Care Providers to determine if their patient is infected and if treatment is required. Blood tests may be insensitive during the early stage of illness, as it can take 4-6 weeks for the body's antibodies to respond. Therefore, blood tests should only be considered to supplement clinical diagnosis during the early stage. However, blood samples become more useful during late stages where clinical symptoms are non-specific and the sensitivity of the test increases significantly.

West Nile Virus

1. Transmission and Presentation

West Nile fever is an infection by the WNV, which is typically spread by mosquitoes. In about 80% of infections, people have few or no symptoms. About 20% of people develop a fever, headache, vomiting, or a rash. In less than 1% of people, there is inflammation of the brain or spinal cord. This can be associated with a stiff neck, high fever, confusion and seizures; in these cases, recovery may take weeks to months, and may be incomplete. On occasion, infection may be fatal.

WNV is a virus mainly transmitted to people through the bite of an infected mosquito. Mosquitoes transmit the virus after becoming infected by feeding on the blood of birds that carry the virus.

2. Clinical and Surveillance Data

a) Mosquito trapping and testing

In 2021, the Haldimand-Norfolk Health Unit trapped mosquitoes each week from June 16th 2021 to August 25th 2021. Mosquito traps were set at eight different locations - four in Norfolk County and four in Haldimand County. Trapped mosquitoes were sent for bi-weekly testing from these locations.

In total, there were 121 pools of mosquitoes tested for WNV in 2021. None of those mosquitoes tested positive for WNV. Similarly, there were no WNW positive mosquito pools identified in HNHU for the year 2020.

Provincially, in 2021 there were 105 positive mosquito pools identified in Ontario compared to 171 in 2020, and 71 in 2019.

WNV is endemic in HNHU, however, the number of human cases of WNV and the number of traps testing positive for WNV can fluctuate widely from year to year and are highly dependent on weather conditions. Higher temperatures and increased rainfall are associated with more positive traps and cases of WNV, year over year.

b) Human case surveillance

In Haldimand-Norfolk, there were no human cases of WNV identified in 2021. There was also no cases identified in 2020 and 1 human case in 2019.

In 2021, there were 23 reported human cases of WNV in Ontario compared to 77 in 2020 and 19 in the year 2019.

Eastern Equine Encephalitis

1. Transmission and Presentation

EEEv, also known as sleeping sickness, is a disease that is spread to humans and horses by mosquitoes. The onset of the illness is usually 4 to 10 days after being bitten by an infected mosquito. The progression and severity of the illness depends on the age of a person and immune system. The disease can result in system or neurological illness. Some people become infected but may not have signs or symptoms.

2. Clinical and Surveillance Data

a) Mosquito trapping and testing

Mosquito trapping efforts in Haldimand and Norfolk Counties did not find any mosquito pools positive for EEEv in 2021.

b) Human and equine case surveillance

No human or equine cases of EEEv were identified in 2021 within HNHU, which was also the case in 2020 and 2019. Provincially, in 2021 there was 1 case of equine EEEv identified. This is comparable to the 2 cases in the previous year and down from a total of 7 cases in 2019. Like WNV, EEEV is influenced by temperature and precipitation; therefore, activity will vary yearly. Additionally, there is a vaccine available for the equine population, influencing the number of equine cases reported each year.

2021 Public Awareness Activities

The ongoing COVID-19 pandemic has had a significant impact on all areas of Public Health programs, including the health unit's ability to execute public awareness campaigns for the VBD program. Educational programs aimed at school-aged children have not been possible due to school closures and COVID-19 response efforts.

Public awareness through radio, social media, newspapers, and smart TV ads continued through 2021 and information about Vector-borne Disease remains available on the health unit website.

Permanent signage remained in place in parks and other public spaces in tick-prone areas. Public Health Inspectors on the Environmental Health Team also responded to inquiries from the public and provided guidance and education about how to protect themselves and their families.

Vector-borne Disease Program Plans for 2022

a) Tick Surveillance:

Tick dragging within HNHU will resume this year in the spring and fall seasons. As all of Norfolk County has been identified as a risk area for Lyme disease previously, the 2022 tick dragging activities will focus on sites found within Haldimand County. Three proposed sites for tick dragging this year have been identified.

The identification of LD risk areas within both Haldimand and Norfolk Counties has assisted residents and visitors to become aware of the risks within the community and take necessary precautions against LD. It has also assisted health care providers to manage patients that have been exposed to ticks in these risk areas. Most of Norfolk County and Haldimand County are already identified as risk areas for LD.

Estimated risk areas are calculated as a 20 km radius from the centre of a location where deer ticks were found.

b) Mosquito Trapping

Trapping of mosquitoes and laboratory analysis will continue in Haldimand and Norfolk in 2022 to maintain the mosquito surveillance program. Trapped mosquitoes will continue to be tested for WNV and EEEv.

This year, the HNHU's WNV program will focus on surveillance, case management, promotion and responding to standing water issues. The Environmental Health Team will continue to remind the public that WNV is endemic to Ontario and precautions are needed throughout the mosquito season.

c) Public Education

The HNHU will continue their efforts to increase public awareness about Vector-borne Disease in 2022. The Environmental Health Team will be working with the Communications Department to ensure delivery of educational messaging through radio, social media, newspapers, HNHU website, and smart TV ads.

The health unit is also working with the County's Parks Departments to ensure availability of Tick Warning Signs in tick-prone areas as well as local hospitals and physicians to increase awareness of the potential for Lyme Disease infection in the area.

The HNHU will also continue to develop promotional campaigns to raise awareness and build supportive environments to prevent and mitigate mosquito bite exposures via social network messaging and the HNHU webpage.

Emerging Diseases:

Mosquito-borne Diseases

There are a number of emerging VBDs that the HNHU continues to monitor. Some of the most important emerging VBDs include Zika Virus, Dengue Fever and Chikungunya.

Zika Virus1. Transmission and Presentation

Zika virus is a viral infection transmitted by *Aedes aegypti* and *Aedes albopictus* mosquitoes, and can be transmitted sexually by an infected partner.

The majority of cases of Zika virus infection are asymptomatic or present with fever, rash and conjunctivitis. However, Zika infection in pregnancy can result in an array of congenital complications, including microcephaly, referred to as Congenital Zika Syndrome.

Dengue Fever

1. Transmission and Presentation

Dengue (or dengue fever) is a disease caused by one of four types of dengue viruses and is spread to humans by the bite of mosquitos, particularly the *Aedes aegypti* and *Aedes albopictus* species. This disease can cause severe flu-like symptoms and in severe cases can be fatal. The symptoms most commonly appear three to fourteen days after being bitten by an infected mosquito, and include symptoms such as high fever, severe headache, pain behind the eyes, joint and muscle pain, nausea, vomiting and a rash. It is common for some people to show no symptoms and most people recover from dengue fever after a few days.

Chikungunya

1. Transmission and Presentation

Chikungunya virus infection is a febrile illness caused by the chikungunya virus. It is transmitted by *Aedes egypti* or *Aedes albopictus* mosquitoes. Symptoms of Chikungunya develop 2-12 days after being bitten by infected mosquitoes. Common symptoms include high fever, polyarticular joint pain (severe, symmetrical and localized to the limbs), rash, headache, myalgia, and nausea may also occur. Most people recover from acute illness within 7 days, but some people will experience persistent fatigue, malaise and joint pain for weeks to months. Rare complications include meningoencephalitis, uveitis, myocarditis, hepatitis, and bleeding dyscrasias.

Tick-borne Diseases

Across Canada, there has been an emergence in tick-related infections beyond Lyme disease. Other tick borne diseases that can impact human health include Anaplasmosis, Babesiosis, Powassan virus. Warmer temperatures may increase the incidence of these infections through increased tick maturation rates and a longer season of transmission.

Anaplasmosis

1. Transmission and Presentation

Anaplasmosis is transmitted to humans by the black-legged tick, *Ixodes scapularis*, the same tick that transmits Lyme disease. The first symptoms usually appear within 1–2 weeks following the bite of an infected tick and include fever, headache, chills, and muscle aches. Severe symptoms may include difficulty breathing, hemorrhage, renal failure, or neurological problems.

Babesiosis

1. Transmission and Presentation

Babesiosis is a rare and life-threatening infection of the red blood cells that's usually spread by ticks. It's caused by tiny parasites called Babesia, which enter your bloodstream when you're bitten by an infected deer tick. Signs of Babesiosis start 1 to 8 weeks after you come in contact with the parasite that causes the disease. Sometimes you won't notice any symptoms. Symptoms include body aches, chills, fever and malaise, although some individuals with this virus may also be asymptomatic. In rare cases a Babesiosis infection may lead to hemolytic anemia, a life-threatening condition where red blood cells are destroyed faster than they can be created.

Powassan Virus

1. Transmission and Presentation

Powassan encephalitis is a serious but rare tick-borne illness caused by the Powassan virus and can be transmitted to humans through the bite of an infected tick. It may also be transmitted by consumption of raw milk from certain infected animals. It cannot be transmitted from person-to-person. The Powassan encephalitis virus causes inflammation and swelling in the lining of the brain and spinal cord (encephalitis and meningoencephalitis). Symptoms occur within 4-18 days and include headache, fever, stiff neck, drowsiness, nausea and vomiting.

The HNHU's Vector-borne Disease program will continue to monitor for new cases of these diseases. As these diseases are transmitted through bites from infected ticks and mosquitoes, public health messaging around the use of personal protective equipment, landscaping precautions, and awareness remain the main methods to help protect the public.

Financial Services Comments:

Norfolk County
The report as presented does not contain any direct financial implications.

The Approved 2022 Board of Health Budget includes $1,790,600 for the Environmental Health Team to support a range of programs including Vector-borne Diseases. The Environmental Health Team is funded at 70% (to a cap) by the Ministry of Health via Mandatory Programs, and 30% by the shared municipal levy. Levy funded costs are shared between Haldimand and Norfolk Counties per the cost sharing agreement.

Haldimand County

Haldimand Finance staff have reviewed this report and agree with the information provided by Norfolk Financial Services

Interdepartmental Implications:

Norfolk County

Haldimand County

The Health Unit has historically practiced various marketing strategies to address the Vector-borne Disease Program as outlined in this report. Staff are requesting that the marketing and educational messaging / materials continue to be provided to Haldimand staff in order to share this information with residents and visitors alike.

Consultation(s):

Communications: The Vector-borne Disease Program has an education and awareness component that provides an opportunity for the Health Unit to:

1. Share information about preventative measures the public can take to protect themselves from mosquito and tick bites.

2. Be transparent and keep the public informed on:

    a. how active mosquitos and ticks are during the season, results of trapped mosquito pools testing positive for WNV year over year and LD estimated risk areas identified by the HNHU

    b. the number of confirmed human cases of WNV, LD or EEEv.

Collaborations: The VBD program provides an opportunity for the Health Unit to collaborate with partners such as health care providers to ensure effective public health and health care services are provided to the community. Information collected from active surveillance programs helps in the management of persons suspected of having Vector-borne diseases.

Strategic Plan Linkage:

This report aligns with the 2019-2022 Council Strategic Priorities “Focus on Service”

Explanation: The Vector-borne program will focus public health services required to protect the health of the community. The key is education of the community with the goal of minimizing the likelihood of exposure to mosquito and tick bites.

Conclusion:

The Vector-borne program will focus public health services required to protect the health of the community. The key is education of the community, with the goal of minimizing the likelihood of exposure to mosquito and tick bites.

Attachment(s):

Approval:

Approved By:

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Board of Health Meeting – June 07, 2022

Advisory Committee Meeting – May 30, 2022

Subject:	Safe Voluntary Isolation Sites Program
Report Number:	HSS-22-018
Division:	Health and Social Services
Department:	Haldimand Norfolk Health Unit
Purpose:	For Decision

Recommendation(s):

THAT Staff Report HSS-22-018, Safe Voluntary Isolations Sites Program, be received as information;

AND THAT the Board of Health supports and approves the HNHU's application to the Public Health Agency of Canada for the Safe Voluntary Isolation Sites Program.

Executive Summary:

This report provides information about the Safe Voluntary Isolation Sites Program (SVISP) that is offered by the Public Health Agency of Canada (PHAC). The SVISP aims to decrease community transmission of COVID-19 by providing funding for projects that address gaps identified for individuals who are unable to safely self-isolate due to housing conditions, such as International Agricultural Workers.

Discussion:

COVID-19 continues to be a disease of public health significance in 2022. The government of Canada is focused on efforts to delay and slow the spread of this disease and address underlying issues faced by vulnerable populations at higher risk of transmission. The Safe Voluntary Isolation Sites Program (SVISP) is an initiative that the Public Health Agency of Canada (PHAC) has established and will complement other investments and health measures, by addressing gaps within the existing isolation support infrastructure.

The SVISP aims to decrease community transmission of COVID-19 by providing funding for projects that address gaps identified for individuals who are unable to safely self-isolate due to housing conditions, such as International Agricultural Workers.

Norfolk County, dubbed Ontario's Garden due to fertile soil and a robust agri-food industry, welcomes over 4500 International Agricultural Workers (IAWs) every growing season. These IAWs are at higher risk of transmitting Covid-19 both within the community and the farm, due to living conditions within congregate settings.

The Government of Canada has identified $100 million for the SVISP as part of the efforts to address the COVID-19 pandemic. The Haldimand Norfolk Health Unit has this opportunity to apply for funding from PHAC for the SVISP that would be of benefit to IAWs, farmers, and both counties of Haldimand and Norfolk.

Eligible expenditures are costs directly related to approved projects such as personnel, travel and accommodation, material and supplies, equipment, rent, utilities, performance measurement/evaluation. Reimbursement by PHAC will be based on actual expenditures incurred:
a) salaries, benefits and consultant fees directly related to the project;
b) office supplies, printing and postage;
c) rental of office space, utilities (if not included in rental agreement), and equipment such as office/project requirements (computers; equipment for children, adults with special needs, etc.);
d) travel expenses and accommodation project activities such as private vehicle mileage, air, train or bus fares, project-related meals, and accommodation costs, which must not exceed the rates permitted for travel on government business (National Joint Council: Travel Directive);
e) insurance (recipients must ensure that any public events funded by the Program are covered by appropriate insurance);
f) third-party project evaluation and audit services; and
g) other costs related to the approved project (e.g. lodging costs, on-site security costs, cleaning personnel, etc.).

The Haldimand-Norfolk Health Unit would like to apply for this funding opportunity. This initiative would support farmers and IAWs by providing a funded safe isolation space that would not be a financial burden to our community farmers, and would help to mitigate the spread of COVID-19 at farms and in our community. In the past, farmers were able to apply for funding directly from PHAC to receive reimbursement, but going forward, this option is not available. Through the SVISP program, operators with farms in outbreak situation will be invited to collaborate with the HNHU to provide International Agricultural Workers a designated safe isolation space at no cost to the farmer through a reimbursement model. PHAC agrees to have quarterly review of funding to meet the needs of communities of Haldimand and Norfolk.

Financial Services Comments:

Norfolk County
The Approved 2022 Board of Health budget does not include an allocation for the Safe Voluntary Isolation Sites program. If the Board of Health supports the program, an application will be submitted to the Public Health Agency of Canada. The request will

include budgeted costs as outlined in Table 1, with an expected project lifetime of July 2022 to March 2023.

If approved by the PHAC, a follow-up memo will be provided to the Board requesting an amendment as provided in Table 1, unless otherwise noted (should the approval amount be different from the request).

Table 1 – PHAC Funding Request for the SVISP

Cost Category	Average Daily Budget[1] ($)	Nine Month Budget[1] ($)
Land/Building Rental	1,040	285,000
Meals	520	142,500
IPAC and Laundry Supplies	164	45,000
Administration (10%)	191	52,500
Total	**$1,915**	**$525,000**

[1]Daily and nine month budgets are based on 8 applicants/day

It is anticipated that the program budget will be sufficient to remain 100% funded without requiring a levy ask. In addition, since the program can be offered within the existing staffing complement, existing levy funded staff time will be allocated to the 100% funded program, resulting in a surplus.

Haldimand County

Haldimand Finance staff have reviewed this report and agree with the information provided by Norfolk Financial Services. Future costs or savings over and above the 100% funding envelope would be shared based on the applicable cost sharing agreement.

Interdepartmental Implications:

Norfolk County

Haldimand County

As mentioned, Haldimand farmers (as applicable) have the same opportunity to apply for funding from PHAC for the SVISP as Norfolk farmers.

Consultation(s):

Finance: The SVISP has financial considerations that must be accounted for in a budget amendment for the HNHU.

Collaborations: The SVISP provides an opportunity for the Health Unit to collaborate with partners such as the farming community to ensure effective public health and

health care services are provided to farms and International Agricultural Workers. This collaboration will assist in the management of IAWs needing to isolate due to Covid-19 and mitigating the risk of transmission on the farm and in our community.

Strategic Plan Linkage:

This report aligns with the 2019-2022 Council Strategic Priorities “Focus on Service”

Explanation: The Safe Voluntary Isolation Sites Program will focus public health services required to protect the health of International Agricultural Workers and the community, while establishing positive relationships with farmers. The key is reduction of transmission of Covid-19 on the farm and in our community.

Conclusion:

The Safe Voluntary Isolation Sites Program will focus public health services required to protect the health of International Agricultural Workers (IAWs) and our community. The key is to provide safe isolation space for IAWs who are at high risk of transmitting Covid-19 due to housing conditions as well as supporting our farming community.

Attachment(s):

- Program Guide – Safe Voluntary Isolation Sites Program (FINAL). pdf

Approval:

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Safe Voluntary Isolation Site Program – Program Guide

Safe Voluntary Isolation Site Program (SVISP) – Program Guide

Section 1: Overview

Canada remains focused on efforts to delay and slow the spread of COVID-19. Federal efforts have sought to address underlying issues faced by vulnerable people at higher risk of transmission during the pandemic. However, evidence indicates that individuals from lower-income and densely-populated neighbourhoods are disproportionately affected by COVID-19. Individuals from these neighbourhoods may have more difficulty safely isolating at home due to factors such as overcrowding and/or resource constraints.

To this end, the Safe Voluntary Isolation Sites Program (SVISP) will be help to support infection prevention and control by providing isolation spaces for individuals who are unable to safely isolate at home, thereby helping to limit contact and spread in the communities that have been amongst the most impacted by COVID-19.

Moreover, this initiative will complement other investments by addressing gaps within the existing isolation support infrastructure. Since the beginning of the pandemic, the Government of Canada has announced measures to support vulnerable individuals requiring assistance in safely and effectively isolating or quarantining due to COVID-19, including women and children, Indigenous peoples, temporary foreign workers and individuals experiencing homelessness.

The SVISP is being established by the Public Health Agency of Canada (PHAC) as a time-limited, targeted program in response to the continued evolution of the COVID-19 pandemic. This Program Guide outlines how funding to eligible recipients will create a voluntary isolation site where identified Canadian residents can safely self-isolate for the required period.

1.1 Context

Wide-ranging steps are necessary to mitigate and contain the spread of COVID-19, including public health measures by provinces/territories and local public health authorities to support infection prevention through effective self-isolation in order to prevent the transmission of COVID-19 in the community.

COVID-19 is a new virus and evidence on effective public health measures continues to be studied and evaluated. As such, there are few high-quality studies examining the impacts of isolation sites. However, there is a general consensus that where individuals with COVID-19 are unable to effectively isolate in their current living situation, the use of voluntary isolation sites should be considered. Over the course of the COVID-19 pandemic in 2020, international jurisdictions such as Wuhan, Chicago and New York have established isolation sites. In addition, Canada and other countries around the world have employed quarantine sites for travellers who are returning from abroad.

For example, preliminary socio-economic data from Toronto Public Health and Public Health Ontario have revealed that lower-income neighborhoods have been disproportionately affected by COVID-19, including its most severe outcomes. Individuals from these neighbourhoods may have more difficulty properly isolating themselves due to their household circumstances (e.g., crowded housing), leading to the potential for greater disease transmission.

Limiting the potential for COVID-19 to spread within households is particularly important given that a study of COVID-19 found a 30% household transmission rate, which is a much higher rate than SARS or MERS. A study using modelling found that institutional isolation led to a 57% reduction in COVID-19 cases, in comparison to a 20% reduction through home-based isolation. This evidence supports the need for this type of service and its potential to impact community transmission.

The Government of Canada has taken steps to address some of the underlying issues faced by vulnerable people that contribute to higher risk during the pandemic. This includes other measures such as investing $157.5 million in the Reaching Home program to support Canadians experiencing homelessness; investing $50 million in the Women and Children Fleeing Gender Based Violence program; putting in place public health support for First Nations and Inuit communities including up to 160 temporary assessment, screening and isolation units, and retooling of existing facilities, ready-to-move trailers, and mobile structures; and boosting protections for Temporary Foreign Workers by supporting Canadian employers with some of the incremental costs associated with the mandatory 14-day isolation period. Additionally, the Safe Restart Agreement with the Provinces and Territories includes a dedicated funding track for vulnerable populations ($740 million over the next six to eight months).

The SVISP fulfills a niche: individuals who have housing, do not necessarily need the full range of social services, but are unable to safely self-isolate due to factors like crowded, multi-generational housing. It is being offered by PHAC to complement the existing rapid-response tools, as well as the efforts of provincial and territorial public health partners in response to the COVID-19 pandemic.

Section 2: Objectives and Principles

2.1 Objectives

The SVISP aims to decrease community transmission of COVID-19 by addressing gaps identified for individuals who are unable to safely self-isolate due to housing conditions.

The goals of this Program are to:

1) Increase the availability and accessibility of voluntary isolation site(s),
2) Ensure the safety of individuals making use of voluntary isolation site(s), and
3) Support integration of voluntary isolation site(s) into relevant COVID-19 prevention and control efforts, as necessary.

All activities must support the establishment of isolation sites that offer services to individuals affected by COVID-19, who are having difficulty safely isolating at home due to factors such as overcrowding and/or resource constraints.

2.2 Principles

The SVISP has three (3) guiding principles. Applications for this funding opportunity should:

1) Be informed by local Public Health authority's knowledge of their community, including, epidemiological trends, local data and broader COVID-19 infection prevention and control plans;
2) Contribute to reducing community transmission of COVID-19; and,
3) Consider the socio-demographic, cultural, and other diversity factors of the individuals using the voluntary isolation site(s).

Section 3: Applicant Capacity

Proposals must establish eligibility and the relationship of proposed projects or activities to program objectives and priorities, and contain the following elements:

- **Organizational information:** A description of the potential eligible recipient. In cases where the recipient is not another order of government or its entity, the organizational information should include details of ownership, management, governance structure, experience, financial results, etc., as applicable.

- **Rationale:** This section should illustrate the risk of increased COVID-19 community transmission related to an inability of individuals to self-isolate in their usual place of residence, and should make specific reference to the guiding principles of the Program.

- **Budget:** The budget should include a financial plan that includes planned expenditures, a forecast of cost of the project and details on its financing (including other sources of proposed funding), and the amount of any federal, provincial, territorial or municipal assistance or tax credit, received or likely to be received for the project. The budget should also include the cost per room per night.

- **Implementation/Workplan:** This section should include relevant timelines and/or milestones for the operation of the voluntary isolation site, and where applicable, related public health functions.

- **Monitoring/evaluation and reporting plan:** The *Invitation to Submit a Funding Request* (ISFR) includes a Performance Measurement/ Evaluation Plan template to complete. The Reporting Plan sets out firm requirements (deliverables and dates), which the recipient must adhere to for the duration of the project.

Section 4: Funding Details and Requirements

4.1 Funding details and requirements

The SVISP provides funding for projects that aim to decrease community transmission of COVID-19 by addressing gaps identified for individuals who are unable to safely self-isolate due to housing conditions.

Interested applicants can request the ISFR (see Application Process below). Applicants must demonstrate sufficient existing financial and human resource capacity to support the project's implementation and evaluation.

To inform the development of future initiatives, PHAC will collaborate with Provinces/Territories (P/Ts) to identify potential applicants to ensure that ISFRs reach the target audience.

4.2 Funding amount and duration

Funding is national in scope and aims to support the needs identified by local public health authorities. The Government of Canada has identified $100 million for the SVISP as part of the efforts to address the COVID-19 pandemic. Selected projects will represent different scales for both larger and smaller sites, based on the needs identified by eligible recipients. Actual funding will be determined based on assessment of applications by eligible recipients for eligible projects and activities.

All projects will be completed by March 31, 2022.

To facilitate the completion of an ISFR, an example cost model is below for reference:

Example Cost Model		
Cost Categories	**Notional Daily Cost (per occupant)***	**12-Month Cost (per occupant)***
Lodging	$150.00	$54,750.00
On-Site Staff and Social Support	$20.00	$7,300.00
Security	$20.00	$7,300.00
Transportation	$10.00	$3,650.00
Food	$65.00	$23,725.00
Infection Prevention and Control (IPAC) Supplies	$5.00	$1,825.00
Cleaning Services	$15.00	$5,475.00
Laundry Services	$15.00	$5,475.00
Total	**$300.00**	**$109,500.00**

Please note: These costs and cost categories are intended to be illustrative and it is recognized that many factors will influence costs including economies of scale and local costs of supplies/living. For example, the Toronto pilot site is based on 140 occupants.

Section 5: Eligibility

To be eligible for funding, proposed projects must align with the Program's Objectives and Principles, described above. Applicants must also clearly demonstrate how their funding request meets the following eligibility criteria for recipients and activities.

5.1 Eligible recipients

Applicants who fall under the following categories may be considered for funding:

a) provincial, territorial, local governments and their agencies, organizations and institutions supported by provincial and territorial governments (e.g., regional health authorities, etc.); and

b) not-for-profit organizations including voluntary organizations, societies and coalitions.

5.2 Eligible activities

The project activities will:

a) Contribute substantively to PHAC's strategic outcome of "healthier Canadians, reduced health disparities, and a stronger public health capacity"; and
b) Develop and maintain Canada's ability to prepare for public health emergencies.

All activities must support the establishment of isolation sites that offer services to individuals affected by COVID-19, who are having difficulty safely isolating at home due to factors such as overcrowding and/or resource constraints.

5.3 Eligible expenditures

Eligible expenditures are costs directly related to approved projects such as personnel, travel and accommodation, material and supplies, equipment, rent, utilities, performance measurement/evaluation. Reimbursement by PHAC will be based on actual expenditures incurred:

a) salaries, benefits and consultant fees directly related to the project;
b) office supplies, printing and postage;
c) rental of office space, utilities (if not included in rental agreement), and equipment such as office/project requirements (computers; equipment for children, adults with special needs, etc.);
d) travel expenses and accommodation project activities such as private vehicle mileage, air, train or bus fares, project-related meals, and accommodation costs, which must not exceed the rates permitted for travel on government business (National Joint Council: Travel Directive);
e) insurance (recipients must ensure that any public events funded by the Program are covered by appropriate insurance);
f) third-party project evaluation and audit services; and
g) other costs related to the approved project (e.g. lodging costs, on-site security costs, cleaning personnel, etc.).

A detailed budget will be required as part of the application process.

Project activities should not be undertaken or expenses incurred prior to the signing of a funding agreement by all parties.

5.4 Ineligible activities and expenditures

The following activities and expenses are not eligible for funding:

a) Statutory and extended benefits exceeding the 20% ceiling not included in employee group benefits plans by virtue of employment/labour (dental, medical, pension benefits, RRSPs) agreement or equivalent;
b) Statutory and extended benefits exceeding the 20% ceiling;
c) Performance pay (bonus); severance/separation/termination payments; and maternity leave; and compensation during extended absence;
d) Travel and hospitality expenses that exceed the National Joint Council rates;
e) Rental charges for use of recipient owned equipment (i.e., computers);
f) Rental costs claimed for property/space owned by or donated to the recipient;
g) Capital costs such as the purchase of land, buildings, or vehicles;
h) Basic qualification training for staff (e.g. early childhood educator);
i) Membership fees;
j) Direct services which are part of the jurisdiction of other governments, (e.g., medical treatment and services, schools/education system, daycares services);
k) Provision of services that are the responsibility of other levels of government;
l) Overhead/administrative fees expressed as a percentage of ongoing operational support of an organization;
m) Costs of ongoing activities for the organization (not directly related to the funded project);
n) Stand-alone activities such as (a "stand-alone activity" would be considered as such when there is no program intervention with a project audience, etc.);
o) Audio visual production or website/smartphone application development and maintenance;
p) Conferences, symposia, and workshops as stand-alone projects;
q) Profit-making activities; and,
r) Pure research in any discipline (Pure research is original investigation undertaken to gain new scientific or technical knowledge and understanding, but without specific applications).

Section 6: Application and Assessment Process

6.1 Application process

The application process requires the completion of an ISFR. To obtain a copy of the ISFR template, or for additional information about this funding stream, please contact phac.cgc.solicitations-csc.aspc@canada.ca, and reference "Safe Voluntary Isolation Sites Program" in the subject line.

The SVISP is being established as a time-limited, targeted program in response to the continued evolution of the COVID-19 pandemic. As such, there is no deadline for submissions. All ISFRs must be submitted via email to: phac.cgc.solicitations-csc.aspc@canada.ca and the COVID-19 support inbox: PHAC.COVID.support.ASPC@canada.ca. Receipt of ISFRs will be acknowledged via email. Please ensure that your email address is included in your application and that SVISP is clearly identified in the email subject line.

Successful applications will be determined based on the results of a review process and budgetary considerations. The PHAC reserves the right to allocate funding to areas of greatest concern based on local epidemiology, demographic, and/or other relevant considerations.

6.2 Assessment criteria

Funding decisions for this solicitation will be based on the results of a competitive proposal assessment process and available funds. To ensure transparency of the review process, the assessment criteria is included in the ISFR. The reviewing of funding requests is completed by three (3) Health Portfolio officers who do not work directly on the Program. All Health Portfolio officers are required to complete a Conflict of Interest Declaration Form before completing the assessment.

Listed below are the elements found in the ISFR that define the criteria against which the funding request will be assessed:

a) Capacity of Organization / Suitability;
b) Identification of the Project Audience (reach) and Project Beneficiaries (impact);
c) Project Activities, Relevance and Need;
d) Partnership and Collaboration (financial and non-financial);
e) Workplan and Timetable;
f) Performance Measurement / Evaluation Plan; and
g) Detailed Budget and Cost Effectiveness.

If the funding request is incomplete, Program officials may contact the applicant to submit missing elements, as long as all applicants in the same situation are given the same opportunity, and that the additional information provided does not give an applicant an advantage over other applicants.

It is the Program's responsibility to determine whether a funding request is recommended for approval or is rejected, based on the recommendations of the reviewers, and taking into account administrative/financial considerations. At the end of the reviewing period, the Program will complete a record of decision that identifies the ranking of the funding requests based on a nominal score.

At the recommendation for funding stage, the Program consultant / Centre for Grants and Contributions (CGC) Operations responsible officer can contact an applicant if there is a need to have them make adjustments to their funding request (such as adjusting the project work plan, budget, etc.). To ensure fairness and transparency, all conversations, correspondence and the dissemination of information are documented.

Not all applications will be funded. PHAC is under no obligation to enter into a funding agreement as a result of an ISFR.

PHAC reserves the right to:

- reject any submission received in response to an ISFR invitation;
- accept any submission in whole or in part; and
- cancel and/or re-issue this invitation at any time.

PHAC will not reimburse an applicant for costs incurred in the preparation or submission of an ISFR.

Section 7: Other Considerations

7.1 Performance Measurement requirements

PHAC will provide the Treasury Board a status report following six (6) months of program spending to show how funds have been used to address the identified needs under the SVISP.

Projects will be required to develop an Evaluation and Performance Measurement plan, which includes monthly reporting to the Program on the number of individuals offered access to the isolation site. For each individual using the site, we will require disaggregated demographic data, as per Statistics Canada definitions.

Other reporting will be required on a quarterly basis to evaluate:

- the effectiveness of the project activities to ensure safety of individuals making use of voluntary isolation site(s); and,
- the effectiveness of the integration of SVISP into relevant COVID-19 prevention and control efforts.

7.2 Official language requirements

The Government of Canada is committed to enhancing the vitality of the English and French linguistic minority communities in Canada (Francophones living outside the province of Quebec and Anglophones living in the province of Quebec), supporting and assisting their development, and fostering the full recognition and use of both official languages in Canadian society.

Applicants must ensure that project activities are accessible in one or both official languages depending on the reach and needs to the target audience. For additional information, refer to the Official Languages Act website.

7.3 Gender-based analysis plus (GBA+) requirements

The Government of Canada is committed to Gender-based Analysis Plus (GBA+). GBA+ is an approach to help reflect on and better understand peoples' multiple identity factors (e.g., race, gender, sexual orientation), the interactions or intersections amongst these various identity factors and how that may impact their experiences with policies, programs and initiatives. Experiences occur within and interact with connected systems and structures of power, oppression, and privilege (e.g., racism, sexism, heterosexism, and cissexism). The aim of GBA+ is to develop awareness of the differential impacts on diverse and intersecting identities in order to enable the creation of equitable policies, programs and initiatives.

Applicants are expected to demonstrate that the above considerations have been incorporated into their project proposal and site operation, using a GBA+ framework or other critical tool. For additional information refer to the GBA+ website, and the Key Health Inequalities in Canada: A National Portrait.

7.4 *Lobbying Act*

Amendments to the *Lobbying Registration Act* and Regulations have broadened the definition of lobbying. We encourage applicants to review the revised Act and Regulations to ensure compliance. For additional information, visit Office of the Commissioner of Lobbying of Canada website.

7.5 Research ethics approval

All projects that include research or evaluation involving humans must be approved by a research ethics board (REB) that adheres to the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans. In addition, project leads should consult the Tri-Council Policy Statement website before the research portion of the project begins. Projects can submit to Health Canada and the Public Health Agency of Canada's REB if they are not in a context with existing REB infrastructure. Research is defined as an activity designed to test a hypothesis or answer a specific research question, permit conclusions to be drawn, and extend knowledge through the use of scientific methods and standardized protocols, systematic collection or analysis of data, or other types of inquiry. Evaluation is considered to be a form of research and it is anticipated that all evaluation projects will require ethics approval.

Section 8: Contact Us

To obtain additional information about this Program, please contact: phac.cgc.solicitations-csc.aspc@canada.ca; and the COVID-19 support inbox: PHAC.COVID.support.ASPC@canada.ca with “Safe Voluntary Isolation Sites Program” clearly outlined in the email subject line.

Annex – Toronto Pilot Project

In early spring 2020, the City of Toronto identified a need for voluntary isolation sites following their reflections on the first wave of COVID-19. Based on preliminary socio-economic data from Toronto Public Health (TPH), evidence indicated that individuals from densely-populated neighbourhoods may have more difficulty safely isolating at home due to factors such as overcrowding and/or resource constraints. As one of Canada's largest urban centres, Toronto looked for options that could help the city address this gap and reduce the high rates of COVID-19 community transmission.

Looking to build upon the rapid-response tools rolled out by the Government of Canada, the city of Toronto reached out to the federal government through regional officials for PHAC to determine the possibility of creating a voluntary isolation site for individuals who are unable to safely self-isolate at their usual place of residence.

Through June and July, the City of Toronto, in collaboration with provincial and local health officials, worked to draft a proposal to establish a voluntary isolation site with 140 beds, using an existing hotel facility. The proposal suggested that a federal investment could help establish a site where individuals affected by COVID-19 who live in housing that may be crowded or have insufficient space to allow for proper distancing from household contacts to self-isolate. It noted that this potential partnership could support the Government's broader objective to support vulnerable individuals requiring assistance in safely and effectively isolating or quarantining due to COVID-19. Reflecting on the numbers from the early days of the pandemic, when the City of Toronto reached around 200 new cases daily, TPH estimated that 10-15 individuals would have been eligible to use a Toronto-based site on a daily basis.

Supported by the Centre of Grants and Contributions, PHAC officials independent of the Program reviewed the unsolicited proposal through the lens of how a potential federal investment could contribute to the Government's broader objectives to advance COVID-19 prevention and control efforts. The proposed Toronto pilot was evaluated against the proposed rationale and feasibility of scope, timeframe for implementation, budget and costing details, monitoring and reporting plan, and its overall relevance to the directions and objectives of PHAC in light of COVID-19.

The decision to fund the pilot/experimental Toronto site was based on the evidence-based rationale for how the proposed project would contribute to reducing community transmission of COVID-19, clear costing and budget details, and how the site logistics would be operated by local health officials. The expected results of the proposed site would also help to develop and maintain Canada's ability to prepare for public health emergencies. This decision was shared by PHAC on September 3, 2020 at the pandemic-oriented Federal-Provincial-Territorial (FPT) Special Advisory Committee (on Health).

On September 11, 2020, the Minister of Health announced an investment of $13.9 million in funding over 12 months for TPH to support the operation of a voluntary self-isolation facility in Toronto, with capacity for 140 occupants. The site officially opened on September 12, 2020. The selected facility for the site was chosen based on its successful performance for another TPH-run isolation site for people experiencing homelessness, was in a non-residential area that did not pose any challenges to adjacent facilities, and was well-located in an area with a high proportion of cases compared to the rest of the city.

PHAC is now working with provincial and territorial governments and municipal health partners to determine how the Safe Voluntary Isolation Site Program to could work in other cities and municipalities across Canada facing similar challenges. PHAC will continue to monitor overall trends and rates of community transmission as the situation surrounding COVID-19 evolves.

Board of Health Meeting – June 07, 2022

Advisory Committee Meeting – May 30, 2022

Subject: 2022 Haldimand-Norfolk Health Unit Funding and Accountability Agreement – BUDGET AMENDMENT
Report Number: HSS-22-022
Division: Health and Social Services
Department: Haldimand-Norfolk Health Unit
Purpose: For Decision

Recommendation(s):

THAT Staff Report # HSS-22-022 Haldimand-Norfolk Health Unit Funding and Accountability Agreement be received as information;

AND THAT the Approved 2022 Haldimand-Norfolk Health Unit Operating Budget beamended to include $2,031,300 in base and one-time funding;

AND THAT the Approved 2022 Capital Budget be amended to include $150,000 in one-time funding;

AND THAT the Board of Health endorse the delivery of one-time programs as outlined in the report;

AND FURTHER THAT the Board of Health approves extension of the COVID-19 program staff until December 31, 2022.

Executive Summary:

This report is to advise the Board of Health on the outcome of the Annual Service Plan and Budget Submission (ASP). It also provides information on the current Public Health funding and accountability agreement, requests approval for the funding to be received, and requests that the current Board of Health operating budget be amended.

Discussion:

The Ministry of Health (MOH) requires submission of an ASP to accompany the request for funding for mandatory and related programs. The ASP was submitted to Ministry of Health (MOH) on April 1, 2022. BOH report HSS-22-05 on ASP was presented on April 5, 2022 for endorsement. The Ministry of Health (MOH) has communicated the Approved Allocations via the Amending Agreement on May 2, 2022. This report is presented to the Board for approval, with base and one-time budget adjustments requesting a budget amendment.

Base Programs
The Amending Agreement includes increases to Mandatory Programs and the Ontario Seniors Dental Care Program (OSDCP). For Mandatory Programs, the allocation is an additional $54,000 or a 1.0% increase compared to the 2021 allocation. For the OSDCP, the increase totals $95,400. The differences between the Annual Service Plan (ASP) requests and Approved Allocations are outlined in Table 1.

Table 1- Base Programs Funding

	Request	ASP Request ($)	Approved Allocation ($)	Increase/ (Decrease) ($)
1	Mandatory Programs (70%)	5,431,900	5,486,300	54,400
2	MOH/AMOH Compensation Initiative (100%)	103,600	103,600	0
3	Ontario Seniors Dental Care (100%)	537,900	633,300	95,400
	Total	**$6,073,400**	**$6,223,200**	**$149,800**

Staff recommend the Mandatory Programs funding increase be used to offset the municipally shared levy contributions of Haldimand and Norfolk counties. The OSDCP increase will be used to offset eligible costs within that program, which remain 100% funded by the MOH.

One-Time Programs
For the 2022 funding year, the maximum funding available for one-time programs is $4,064,800. Requests are outlined in tables below based on the fiscal period they relate to.

In total, staff submitted eight one-time funding requests, four of which were approved. Additionally, two requests from the prior year were extended for another year, and two requests represent new programs. Finally, two requests are carryover of previously approved programs where funds could not be fully utilized during the 2021-22 fiscal year.

Calendar year requests are approved for the period of January 1 to December 31, 2022. Table 2 outlines the difference between the ASP and Approved Allocations.

Table 2 - One-Time Programs Funding – Calendar

	Request	ASP Request ($)	Approved Allocation ($)	Increase/ (Decrease) ($)
1	Cost-Sharing Mitigation	0	325,000	325,000
2	COVID-19: General Program	2,688,700	1,045,100	(1,643,600)
3	COVID-19: Vaccine Program	1,812,000	1,449,600	(362,400)
	Total	**$4,500,700**	**$2,819,700**	**($1,681,000)**

As was the case in 2021, requests #2 and #3 (COVID-19 General and Vaccine programs) have been given an initial allocation from the MOH. This is to support Public Health Units by offering cash flow based on a percentage of what was submitted in the ASP. The Ministry has committed to fund all eligible COVID-19 costs within both programs.

Fiscal year requests are approved for the period of April 1, 2022 to March 31, 2023. Table 3 outlines the difference between the ASP and Approved Allocations.

Table 3 - One-Time Programs Funding – Fiscal

	Request	ASP Request ($)	Approved Allocation ($)	Increase/ (Decrease) ($)
1	Needle Exchange Program	0	19,000	19,000
2	Public Health Inspector Practicum[1]	28,300	28,300	0
3	Smoke-Free Ontario Tablets	1,500	3,000	1,500
4	School-Focused Nurses Initiative[2]	0	373,400	373,400
5	Temporary Retention Incentive for Nurses	0	100,800	100,800
6	Strategic Option Analysis[3]	0	150,000	150,000
7	OSDCP Capital: Gilbertson[3]	0	469,400	469,400
	Total	**$29,800**	**$1,143,900**	**$1,114,100**

[1]Public Health Inspector Practicum – currently levy funded; funding will be used to offset the shared levy.
[2]School-Focused Nurses – program ends December 31, 2022.
[3]Strategic Option Analysis and OSDCP Capital: Gilbertson – requested separately as carryover from 2021-22.

Needle exchange program received $ 19,000. This amount will be used to install safe and secure sharps disposal units at some designated places.
Ontario government has introduced a temporary financial incentive to support nursing retention and stabilize the current nursing workforce during this critical time. An additional allocation of $100,800 for the Temporary Retention Incentive for Nurses was approved for fiscal year 2021-22. The fiscal period is based on payment guidelines and requirements for eligibility.

One-time funding requests that were not approved by the MOH are outlined in Table 4. The Ministry may allow for specific in-year requests to be made, as was the case in previous years.

Table 4 - One-Time Program Funding – Not Approved

	Program Description		ASP Request ($)
1	Mental Health and Addiction Services		124,200
2	Women's Health Services		124,200
3	Non-Intervention Crisis Training		12,000
4	IPAC Barriers to support Protocols		20,000
	Total		**$280,400**

Financial Services Comments:

Norfolk County

The Approved 2022 Haldimand-Norfolk Health Unit Operating Budget was developedbased on the most recent information from the Ministry of Health (MOH) at that time. This included using 2021 Approved Allocations. The result was funding of $6,073,400 being included in the budget. From Table 1, an amendment of $149,800 is required for base programs.

One-time program funding, unless known during budget development, is not included in the proposed budget. Due to this, the Health Unit's requests for the COVID-19 General and Vaccine programs were based on anticipated requirements to the end of the year. Although the Ministry has committed to funding all COVID-19 eligible costs for both the Extraordinary Costs and Vaccine programs, staff are recommending the budget be amended to only include current commitments outlined in Table 2. Eligible approved requests outlined in Table 2 and Table 3 will not affect the levy as funding will be included to offset additional eligible expenditures. Programs outlined in Tables 2 and 3 result in an amendment request for $1,881,500.

The Ontario Seniors Dental Care Program capital initiative for Gilbertson and the Strategic Option Analysis project have been extended to March 31, 2023, net of year-to-date spending. An amendment is not required for the OSDCP project as it is already included in the capital budget. The Strategic Option Analysis will be added as a capital project in the budget, with an approved allocation of $150,000.

If approved, the 2022 budgets will be amended to include MOH funding of $2,181,300 as outlined in Table 5, of which $82,700 is a decrease to the shared levy contribution. The Proposed 2023 Board of Health budget will include

appropriate fiscal funding to support offsetting costs within their approved allocations, up to March 31, 2023.

Any realized surplus or deficit at the end of the calendar year will be shared by Haldimand and Norfolk Counties as per the cost sharing agreement.

Table 5 – Budget Amendment Summary

	Description	Approved Budget ($)	Approved Allocation ($)	Variance ($)
1	Base Mandatory Programs	6,073,400	6,223,200	149,800
2	One-Time Programs (HNHU)	616,000	950,700	334,700
3	One-Time Programs (COVID-19)	947,900	2,494,700	1,546,800
4	One-Time Capital Programs	640,000	790,000	150,000
	Total	**$8,277,300**	**$10,458,600**	**$2,181,300**

Program FTE impacts have been included in Table 6. Unless the MOH provides communication that programs will be extended, all one-time programs included in the table will be ending December 31, 2022.

Table 6 – FTE Impacts[1]

	Description	Approved Budget	Approved Allocation	Variance
1	COVID-19 General Program[2]	8.60	17.20	8.60
2	COVID-19 Vaccine Program	0.00	16.74	16.74
3	School-Focused Nurses Initiative	2.90	5.00	2.10
	Total	**11.50**	**38.94**	**27.44**

[1]Extension of the staff will not impact the temporary status of the current and additional FTE's to permanent
[2]COVID-19 General Program - the FTE impact represents an extension of positions from June 30th to December 31st, 2022

Haldimand County

Haldimand Finance staff have reviewed this report and agree with the information provided by Norfolk Financial Services. As noted, any realized surplus or deficits will be cost shared based on the applicable cost sharing agreement.
As provided by Norfolk staff, the Ministry hosted a call regarding the amending agreements for all Health Units. At that time, they announced allocation for new program funding (i.e. Needle Exchange) for Health Units as noted in Table 3 – even

though it was not one of the areas identified as a program area seeking funding specific to the needs of the Haldimand-Norfolk Health Unit. No explanation was provided regarding the allocation breakdown/calculations, or where the new programs came from.

Additionally, no rationale was provided by the Province as to why the programs in Table 4 were not approved, where others in Table 3 were; other than the Province had limited resources for all requests.

Interdepartmental Implications:

Norfolk County

Haldimand County

Consultation(s):

N/A

Strategic Plan Linkage:

BOH Strategic Plan Linkage:

Communication, Healthy, Supportive Environment, Organizational Strength and Quality and Performance: The ASPBS adheres to the MOH requirements to secure funds to achieve the OPHS and all the strategic goals.

Strategic Plan Linkage:

Financial Sustainability and Fiscal Responsibility: The ASPBS adheres to the MOH requirements for budget submissions to secure the funding required to fulfill the OPHS, with the focus on local needs.

Conclusion:

This report is to advise the Board of Health of the new schedules from the Ministry of Health for the 2022 funding year, to request the Board endorse the new agreement and to request the budget be amended.

Attachment(s):

- New Schedules to Public Health Funding and Accountability Agreement (2022) for the Haldimand Norfolk Health Unit

Approval:

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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 2022

SCHEDULE "A"
GRANTS AND BUDGET

Board of Health for the Haldimand-Norfolk Health Unit

DETAILED BUDGET - MAXIMUM BASE FUNDS (FOR THE PERIOD OF JANUARY 1ST TO DECEMBER 31ST, UNLESS OTHERWISE NOTED)	
Programs/Sources of Funding	**Approved Allocation ($)**
Mandatory Programs (70%)[1]	5,486,300
MOH / AMOH Compensation Initiative (100%)[2]	103,600
Ontario Seniors Dental Care Program (100%)[3]	633,300
Total Maximum Base Funds[4]	**6,223,200**

DETAILED BUDGET - MAXIMUM ONE-TIME FUNDS (FOR THE PERIOD OF APRIL 1, 2022 TO MARCH 31, 2023, UNLESS OTHERWISE NOTED)			
Projects / Initiatives			**2022-23 Approved Allocation ($)**
Cost-Sharing Mitigation (100%)[5]			325,400
Mandatory Programs: Needle Exchange Program (100%)			19,000
Mandatory Programs: Public Health Inspector Practicum Program (100%)			28,300
Mandatory Programs: Smoke-Free Ontario Enforcement Tablet Upgrades (100%)			3,000
COVID-19: General Program (100%)[5]			1,045,100
COVID-19: Vaccine Program (100%)[5]			1,449,600
School-Focused Nurses Initiative (100%)[6]	# of FTEs	**5**	373,400
Temporary Retention Incentive for Nurses (100%)			100,800
Total Maximum One-Time Funds[4]			**3,344,600**

MAXIMUM TOTAL FUNDS	**2022-23 Approved Allocation ($)**
Base and One-Time Funding	**9,567,800**

DETAILED BUDGET - MAXIMUM ONE-TIME FUNDS (FOR THE PERIOD OF APRIL 1, 2021 to MARCH 31, 2022, UNLESS OTHERWISE NOTED)	
Projects / Initiatives	**2021-22 Approved Allocation ($)**
Temporary Retention Incentive for Nurses (100%)	100,800
Total Maximum One-Time Funds[4]	**100,800**

2021-22 CARRY OVER ONE-TIME FUNDS[7] (CARRY OVER FOR THE PERIOD OF APRIL 1, 2022 to MARCH 31, 2023)		
Projects / Initiatives	**2021-22 Approved Allocation ($)**	**2022-23 Carry Over Amount ($)**
Mandatory Programs: Strategic Option Analysis (100%)	150,000	150,000
Ontario Seniors Dental Care Program Capital: New Dental Operatory and Upgrades – Health and Social Services (100%)	640,000	469,400
Total Maximum One-Time Funds	**790,000**	**619,400**

NOTES:

(1) Base funding increase for Mandatory Programs is pro-rated at $40,800 for the period of April 1, 2022 to December 31, 2022; therefore, maximum base funding flowed for the period of January 1, 2022 to December 31, 2022 will be $5,472,700.

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

(3) Base funding increase for the Ontario Seniors Dental Care Program is pro-rated at $71,550 for the period of April 1, 2022 to December 31, 2022; therefore, maximum base funding flowed for the period of January 1, 2022 to December 31, 2022 will be $609,450.

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

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

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

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

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***BASE FUNDING***

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

Mandatory Programs: Harm Reduction Program Enhancement

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

Local Opioid Response

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

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

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

Naloxone Kit Distribution and Training

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

Type of Funding	***BASE FUNDING***

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

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

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

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

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

Type of Funding	***BASE FUNDING***

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

Opioid Overdose Early Warning and Surveillance

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

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

Mandatory Programs: Healthy Smiles Ontario Program

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

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

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

Type of Funding	***BASE FUNDING***

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

Mandatory Programs: Nursing Positions

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

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

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

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

Type of Funding	***BASE FUNDING***

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

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

Mandatory Programs: Smoke-Free Ontario

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

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

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

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

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

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

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

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***BASE FUNDING***

Ontario Seniors Dental Care Program (100%)

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

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

Program Enrolment

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

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

Program Delivery

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

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

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***BASE FUNDING***

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

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

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

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

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

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

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

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

Other Requirements

Marketing

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

Revenue

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

Community Partners

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

Type of Funding	***BASE FUNDING***

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

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

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

Cost-Sharing Mitigation (100%)

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

Mandatory Programs: Needle Exchange Program (100%)

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

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

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

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

Mandatory Programs: Smoke-Free Ontario Enforcement Tablet Upgrades (100%)

One-time funding must be used for the purchase of Smoke-Free Ontario Enforcement Tablets to support the Tobacco Inspection System software for mobile units. Eligible costs may include costs for peripheral devices (e.g., car chargers, batteries, mouse, keyboard, mobile printers, etc.) and applicable taxes.

COVID-19: General Program (100%)

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

Eligible costs include, but are not limited to:

- Staffing – Salaries and benefits, inclusive of overtime for existing or redeployed Board of Health staff (including management staff directly engaged in COVID-19 activities); staff redeployed from associated regional governments; new temporary or casual staff; salaries and benefits associated with overtime worked by indirect staff (e.g., finance, human resources, legal, communications, etc.) and management staff (where local Board of Health policies permit such arrangements) that have not been redeployed directly to COVID-19, but have incurred overtime due to working on COVID-19 related activities.

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

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

- Travel and Accommodation – for staff delivering COVID-19 service away from their home office location, or for staff to conduct infectious disease surveillance activities (swab pick-ups and laboratory deliveries).
- Supplies and Equipment – small equipment and consumable supplies (including laboratory testing supplies and personal protective equipment) not already provided by the Province, and information and information technology upgrades related to tracking COVID-19 not already approved by the Province.
- Purchased Services – service level agreements for services/staffing with community providers and/or municipal organizations, professional services, security services, cleaning services, hazardous waste disposal, transportation services including courier services and rental cars, data entry or information technology services for reporting COVID-19 data to the Province (from centres in the community that are not operated by the Board of Health) or increased services required to meet pandemic reporting demands, outside legal services, and additional premises rented by the Board of Health.
- Communications – language interpretation/translation services, media announcements, public and provider awareness, signage, and education materials regarding COVID-19.
- Other Operating – recruitment activities, staff training.

Other requirements of this one-time funding include:

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

The following are examples of non-admissible expenditures:

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

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

- Costs associated with municipal by-law enforcement.
- Electronic Medical Record systems.

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

COVID-19: Vaccine Program (100%)

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

Eligible costs include, but are not limited to:

- Staffing – salaries and benefits, inclusive of overtime, for existing staff or redeployed Board of Health staff (including management staff directly engaged in COVID-19 activities); staff redeployed from associated regional governments; new temporary or casual staff; and, salaries and benefits associated with overtime worked by indirect staff (e.g., finance, human resources, legal, communications, etc.) and management staff (where local Board of Health policies permit such arrangements) that have not been redeployed directly to COVID-19, but have incurred overtime due to working on COVID-19 related activities. Activities include providing assistance with meeting provincial and local requirements for COVID-19 surveillance and monitoring (including vaccine safety surveillance, adverse events and number of people vaccinated), administering the COVID-19 vaccine, managing COVID-19 Vaccine Program reporting requirements, and planning and deployment of immunization/ vaccine clinics.
- Travel and Accommodation – for staff delivering COVID-19 Vaccine Program services away from their home office location, including transporting vaccines, and transportation/accommodation for staff of mobile vaccine units.
- Supplies and Equipment – supplies and equipment associated with the storage and handling of the COVID-19 vaccines (including vaccine refrigerators, freezers, coolers, etc.), small equipment and consumable supplies (including personal protective equipment) not already provided by the Province, supplies necessary to administer the COVID-19 vaccine (including needles/syringes and disposal, sterile gauze, alcohol, bandages, etc.) not already provided by the Province, information and information technology upgrades related to tracking COVID-19 immunization not already approved by the Province.
- Purchased Services – service level agreements for services/staffing with community providers and/or municipal organizations, professional services, security services, cleaning services, hazardous waste disposal, transportation services (e.g., courier services, transporting clients to vaccination clinics), data entry or information technology services for reporting COVID-19 data related to the Vaccine Program to the Province from centres in the community that are not operated by the Board of Health or increased services required to meet pandemic reporting demands, outside legal services, and additional premises leased or rented by the Board of Health.
- Communications – language interpretation/translation services, media announcements, public and provider awareness, signage, and education materials regarding COVID-19 immunization outreach.

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

- Other Operating – recruitment activities, staff training.

Other requirements of this one-time funding include:

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

The following are examples of non-admissible expenditures:

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

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

School-Focused Nurses Initiative (100%)

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

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

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

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

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

The initiative is being implemented with the following considerations:

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

Qualifications required for these positions are:

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

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

Temporary Retention Incentive for Nurses (100%)

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

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

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

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

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

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

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

In addition:

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

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

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

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

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***OTHER***

Infectious Diseases Programs Reimbursement

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

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

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

Leprosy

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

Tuberculosis

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

Vaccine Programs Reimbursement

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

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

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

Influenza

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

SCHEDULE "B"

RELATED PROGRAM POLICIES AND GUIDELINES

Type of Funding	***OTHER***

Meningococcal

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

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

Human Papillomavirus (HPV)

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

SCHEDULE "C"

REPORTING REQUIREMENTS

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

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

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

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

Definitions

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

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

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

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

Report Details

Annual Service Plan and Budget Submission

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

Quarterly Standards Activity Reports

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

Annual Report and Attestation

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

Annual Reconciliation Report

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

COVID-19 Expense Form

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

MOH / AMOH Compensation Initiative Application

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

Temporary Retention Incentive for Nurses

- The Board of Health will be required to monitor and report on the number of full-time employees receiving the incentive, as well as the number of eligible part-time / casual hours. Key reporting timelines, which are subject to change, are as follows:
  - **June 1, 2022:** status update on progress of first payments to be provided to the Province.
  - **October 3, 2022:** status update on progress of second payments to be provided to the Province.

SCHEDULE "D"

BOARD OF HEALTH FINANCIAL CONTROLS

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

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

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

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

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

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

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

Examples of potential controls to support this objective include, but are not limited to:

- Independent review of an aging accounts receivable report to ensure timely clearance of accounts receivable balances.
- Separate accounts receivable function from the cash receipts function.
- Accounts receivable sub-ledger is reconciled to the general ledger control account on a regular and timely basis.
- Original source documents are maintained and secured to support all receipts and expenditures.

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

Examples of potential controls to support this objective include, but are not limited to:

- Policies are implemented to govern procurement of goods and services and expense reimbursement for employees and board members.
- Use appropriate procurement method to acquire goods and services in accordance with applicable policies and directives.
- Segregation of duties is used to apply the three (3) way matching process (i.e., matching 1) purchase orders, with 2) packing slips, and with 3) invoices).
- Separate roles for setting up a vendor, approving payment, and receiving goods.
- Separate roles for approving purchases and approving payment for purchases.
- Processes in place to take advantage of offered discounts.
- Monitoring of breaking down large dollar purchases into smaller invoices in an attempt to bypass approval limits.
- Accounts payable sub-ledger is reconciled to the general ledger control account on a regular and timely basis.
- Employee and Board member expenses are approved by appropriate individuals for reimbursement and are supported by itemized receipts.
- Original source documents are maintained and secured to support all receipts and expenditures.
- Regular monitoring to ensure compliance with applicable directives.
- Establish controls to prevent and detect duplicate payments.
- Policies are in place to govern the issue and use of credit cards, such as corporate, purchasing or travel cards, to employees and board members.
- All credit card expenses are supported by original receipts, reviewed and approved by appropriate individuals in a timely manner.
- Separate payroll preparation, disbursement and distribution functions.

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

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

Information Memo

To: Health and Social Services Advisory Committee
Date: May 30, 2022
Division: Health and Social Services
Department: Public Health
Subject: Ontario Senior Dental Program – Program Overview & Update

Recommendation(s):

THAT the Information Memo regarding the Ontario Seniors Dental Care Program be received as information.

Background

This memo is to provide the Board of Health (BOH) an overview of the Ontario Seniors Dental Care Program (OSDCP), and an update on activities to date.

Discussion:

In the 2019 provincial budget, the Ontario Seniors Dental Care Program (OSDCP) was introduced for low income seniors. The objective of the OSDCP was to prevent chronic disease and increase the quality of life, while reducing the burden on the health care system. The program would provide preventive, restorative and diagnostic services to seniors. Eligibility criteria was determined by the Ministry of Health (MOH), as well as enrollment and renewal. The program is to be funded at 100% provincial funding with no levy contributions from the municipalities.

As per the Ministry's directives, the program services are to be delivered through salaried dental providers in Public Health Units (PHUs), Community Health Centers (CHCs) and Aboriginal Health Access Centers (AHACs).

HNHU received $537,900 in 2019 as operational funding for the implementation of the program. Implementation as directed by the Ministry was to be as follows:

- Pre-Implementation Activities: needs assessment by PHU, and development of capital funding proposals, PHU staffing and recruitment and onboarding, program promotion and outreach

- Stage 1: Program launch, service delivery through leveraging existing dental infrastructure, capital funding release and commencement of capital builds
- Stage 2: Program expansion implemented with new dental infrastructure

Staff report HSS 19-39 was presented to the Board on September 3, 2019, providing an overview of the OSDCP, and made recommendations to the Board to accept the funding from the Ministry for the program and to hire 3.0 FTE's including a 0.5 FTE dentist to deliver the program.

The Board advised that staff be directed to explore a fee for service program with local dentists and report back to the Board.

Staff report HSS 19-42 was presented to the Board on September 17, 2019, providing the Board with feedback following consultation with the MOH. The MOH confirmed that the "fee for service" reimbursement model was not permitted, and the BOH may enter into temporary partnership contracts with other entities/organizations or service providers to facilitate the launch of the program. Following the approval of the staff report, a modified Request for Proposals (RFP) was developed and issued to the marketplace. Contracts were executed with three (3) community providers for a period of six months. The OSDCP was officially launched by the MOH in November, 2019, and the HNHU facilitated eligible clients in accessing the services through the community partners.

Staff report HSS 20-02 was presented in January 2020, advising the Board of notification received from the MOH to HNHU for one-time capital funding of $623,000. The funds were to be used for enhancing already existing dental infrastructure, to increase clinical spaces and capacity to deliver dental care services to the eligible seniors in the Simcoe (Gilbertson) and Dunnville Health Unit offices. No additional/ matching funding would be required from the tax levy. The report advised that in addition to the seniors program, the infrastructure enhancement would be beneficial to the Healthy Smiles Ontario Program in meeting Infection Prevention and Control (IPAC) requirements. The HSO program is offered by the HNHU in accordance with Ontario Public Health Oral Health Protocol, and provides oral health services to approximately 3,500 youth and children 17 years and below annually. The funding was accepted and staff proceeded with preparing the capital project.

Construction planning began in 2020, but was halted in March, as a result of the COVID-19 pandemic. Construction recommenced in 2021. However, the on-going COVID-19 pandemic resulted in significant increase in construction and equipment costs, as well as delays in construction work from the frequent lockdowns.

These developments led to staff reports HSS 20-13, HSS 20-19 with staff recommendations to the Board to:

- Extend current contracts of community dentists in providing services to seniors
- Amend the 2020 operational budget and 2020-2029 capital plan to allow the use of surplus OSDCP operational funding to support increase capital costs.

The Ministry of Health has been provided with regular updates of the capital projects, and has given HNHU an extension to the deadline for the completion of the capital funding expenditure till March 31, 2023. Construction of the dental operatory at the Dunnville office has now been completed, and construction at the Simcoe office is expected to be completed in August 2022.

In February 2021, a modified procurement process seeking proposals from dental professionals to provide services for the OSDCP was issued to the marketplace. Contracts were executed with four (4) community providers until June 30, 2022. Another modified procurement process requesting for proposals is underway for a period of six months to ensure continuity of the OSDCP pending completion of the Simcoe dental operatory in August.

In 2022 (January – April), 181 seniors have accessed the program with 263 visits and a reimbursement amount of $197,353.25. The community providers are remunerated on an hourly basis, with a range of payment as follows

a. Dental Hygienists : $175- $270 per hour
b. Dentists : $375 - $925 per hour

Services provided to the seniors include

- Examinations/Assessments
- Preventive services
- Restorative services
- Radiographs
- Oral surgery services
- Anesthesia
- Endodontic services
- Periodontal services

An evaluation of the service delivery model will be conducted by the HNHU Planning & Evaluation team at the end of the year, and presented to the Board.

This update was circulated to Norfolk County Financial Services and Haldimand County for comments, and as there are no municipal financial impacts, there were no additional comments made on the memo.

Attachment(s):

None

Conclusion:

None

Approval:

Approved By:
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Council-In-Committee Meeting – June 14, 2022

Advisory Committee Meeting – May 30, 2022

Subject:	Canada-Wide Early Learning and Child Care Agreement Funding – BUDGET AMENDMENT
Report Number:	HSS-22-019
Division:	Health and Social Services
Department:	Haldimand Norfolk Social Services and Housing
Purpose:	For Decision

Recommendation(s):

THAT Council receive staff report HSS-22-019 as information;

AND THAT Council accept the Canada-Wide Early Learning and Child Care (CWELCC) Agreement funding from the Ministry of Education, in the amount of $2,515,907;

AND FURTHER THAT the Approved 2022 Levy Supported Operating Budget be amended to include 1.0 permanent FTE and $2,516,000 for the CWELCC system, as outlined in the report.

Executive Summary:

The purpose of this staff report is to advise Council of the Province's implementation of the Canada-Wide Early Learning and Child Care (CWELCC) Agreement and to request the CWELCC funding allocation be accepted.

Under the agreement with the federal government, Ontario will receive $13.2 billion, which Ontario will use over five years, to reduce fees for families and deliver an average of $10 a day child care for eligible children by September 2025.

In 2022, Haldimand and Norfolk will receive $2,515,907 under Ontario's CWELCC System, as part of a transitional allocation approach. In the initial rollout, this funding has been allocated to address fee reductions, workforce compensation, administration and accounts for inflation.

Discussion:

Funding under the Canada-Wide Early Learning and Child Care Agreement (CWELCC) will be used to build and leverage the success of Ontario's existing early learning and

child care system by increasing quality, accessibility, affordability and inclusivity in early learning and child care, towards achieving the following objectives.

Fee Reduction

A graduated approach to fee reductions will begin in Spring 2022 as follows:

- A fee reduction of up to 25% (to a minimum of $12 per day) for eligible children retroactive to April 1, 2022
- A 50% daily fee reduction on average for eligible children by the end of calendar year 2022
- $10 average daily child care fees for eligible children September 2025.

Fee Subsidy Parental Contribution Reduction

To ensure an equivalent fee reduction for families receiving child care fee subsidy who pay a parental contribution, amendments have been made under O. Reg 138/15. The amendments require Consolidated Service Managers (CMSMs) and District Social Services Administration Boards (DSSABs) to reduce by 25% the parental contribution for eligible children who hold a spot with a licensed program that has enrolled in the CWELCC System. CMSMs and DSSABs will calculate the parental contribution reduction for fee subsidy families and provide the Licensee with the parental contribution refund amount.

Workforce Compensation

Workforce compensation funding is available to eligible staff employed by Licensees regardless of the age of the children they are supporting.

Eligible staff categories will have their hourly wage increased to align with the wage floor and will be eligible for an annual increase, including staff in licensed before and after school programs for 6-12 years.

Upon acceptance of this funding, staff will work with the Ministry of Education and our Finance Department to develop an application process, policies and audit procedures in alignment with financial practices, to enroll and fund interested licensees in Haldimand and Norfolk with the above noted objectives.

Financial Services Comments:

Norfolk County

The Approved 2022 Levy Supported Operating Budget does not include an allocation for the CWELCC, with the Provincial and Federal governments in negotiations during the municipal budget process. The Ministry has provided a summary of the program allocation, outlined in Table 1. If approved, the budget will be amended as presented, rounded to a total of $2,516,000.

Table 1 – CWELCC System Budget Amendment

Description	Allocation ($)
Fee Reduction	2,209,000
Licensee Workforce Compensation	180,958
Administration (5%; 1.0 FTE and related operating expenditures)	125,949
Total	2,515,907

The CWELCC Administration allocation provided by the Ministry is sufficient to support a 1.0 permanent FTE to administer the program, as well as related operating expenditures such as support from IT and Finance. Staff are currently considering the scope and requirements of the position.

As with any new program, it should be noted that there will be anticipated increased administrative requirements such as additional reporting and accounting as examples. Additional FTEs for corporate administrative support staff are not being requested at this time, however, there will be additional operating pressures because of this program. A net levy increase will not be realized at this time for these costs, as no additional support staffing request has been made at this time; however, this assumes that the work will be provided by current staffing levels, and to accommodate this support, there will be an offsetting reduction of support to current operations. It should be noted that in the future, there could be additional overtime or future staffing requests brought forward due to the work pressures associated with increasing demands of new programs.

Financial Management & Planning staff anticipate the funds made available to the CMSM will be sufficient to operate the program at this time, and a municipal levy contribution will not be required. Future budget years will include program expenditures and funding per the annual amending agreement. Should a levy requirement be identified in future budgets, a report will be presented to Council for consideration.

Haldimand County

Haldimand Finance staff have reviewed this report and agree with the information provided by Norfolk Financial Services. There is no levy impact as a result of this budget amendment as the funding envelope is 100%. Future costs over and above the 100% funding would be cost shared based on the applicable cost sharing agreement and should be ranked and evaluated during the appropriate budget process.

Interdepartmental Implications:

Norfolk County

Haldimand County

Although the program is 100% funded for 2022, future financial impacts are unknown at this time. Normally, decisions to request FTE's would be evaluated during the appropriate budget process, in order to be ranked and reviewed with other priorities impacting the levy, but due to the timing of receipt of this funding announcement, this was not possible. It is anticipated if future requests for staff do come forward as a result of this program, it will be presented as part of the budget process.

Consultation(s):

Strategic Plan Linkage:

This report aligns with the 2019-2022 Council Strategic Priority.

Explanation:
Focus on Service: Accepting the CWELCC System funding allows staff to determine licensee allocations and distribute funding to reimburse families the retroactive fee reduction and support families with greater affordability across the child care system.

Foster Vibrant Creative Communities: The provision of accessible, affordable and high quality licensed child care and early years programming allows families with children to connect with and fully participate in the community. The funding allocated to Haldimand and Norfolk by the Ministry of Education will be used to help address affordability, inclusion, and increase wages within the child care sector.

Conclusion:

Staff have been notified by the Ministry of Education of initial funding made available to Service System Managers to support the implementation and initial roll out of the CWELCC System. This includes funding to reduce fees through a graduated approach, increase wages of eligible child care staff in alignment with a newly established provincial wage floor, and support administration expenses for planning and implementation of the CWELCC System locally. This allocation was not included in the 2022 Levy Supported Operating Budget, therefore, a budget amendment is required to reflect this allocation. The CWELCC System is 100% funded by the Ministry of Education and there are no municipal cost sharing requirements associated with this

investment. All spending will be within the funding envelope with no risk of overspending.

Attachment(s):

- None

Approval:

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